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PBGC wins in dispute over shutdown benefits / 3

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'Occurrence' at issue in second phase of WTC cover trial

By DOUGLAS McLEOD

NEW YORK—Five months after losing the first round in its fight to collect a double payout for the destruction of the World Trade Center on Sept. 11, 2001, WTC leaseholder Silverstein Properties Inc. is about to launch round two.

Jury selection begins tomorrow in the second phase of a trial to determine whether the Twin Towers' loss was a single event or whether, as Silverstein contends, it represented two separate occurrences requiring insurers to pay two policy limits.

In the first phase, 10 insurers won a federal jury verdict last spring that they'd bound coverage on a Willis Group Holdings Ltd. policy form that defines the loss as one event.

Combined with insurers that were previously determined to have bound coverage on the same form, the verdict meant that $2.42 billion, or more than two-thirds, of Silverstein's $3.55 billion in WTC coverage would pay only one limit on the loss (*BI*, May 3; May 10).

The second phase, to be tried by a different jury starting next Monday, will determine whether a separate group of nine insurers—representing another $1.13 billion of the program's limit—is liable for more than one occurrence under various other policy forms governing their participation.

Phase II is expected to be relatively fast-moving. While the trial's first

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Group health care cost hikes slowing

By JERRY GEISEL

Cost increases for group health care coverage are continuing to ease.

Next year, costs are projected to rise by 11.3% on average, to $7,542 per employee, according to an analysis by Hewitt Associates Inc.

This year, costs—which reflect employer and employee contributions to health care coverage—climbed by an overall average of 12.3%, according to Lincolnshire, Ill.-based Hewitt. Point-of-service plan costs increased the most, rising by an average of 16.3%, to $7,192 per employee; health maintenance organization costs rose by an average of 12.5%, to $6,519 per employee; and preferred provider organization costs climbed 9.5%, averaging $6,823.

For the purposes of Hewitt's analysis, projected costs do not reflect copayments or coinsurance for medical, hospital and prescription drug coverage. On average, employees will pay a projected $1,481 of the health insurance premium in 2005, up from $1,288 this year.

Hewitt's 2005 projection is based on a survey of budgets that employers have set and the health insurance premium increases they have received through the end of September. The actual increases, though, could be somewhat lower, if, for example, employers drop their most expensive health care plans, or, in the case of self-funded

See COSTS/page 26

2004 Election Outlook

PHOTO: NY TIMES

Sen. John Kerry and President Bush support different approaches to addressing tort law issues, such as reform of medical malpractice liability.

Bush, Kerry reform proposals diverge

Views on tort law divide candidates

By MARK A. HOFMANN

A clear line divides President Bush from his Democratic challenger when it comes to positions on issues affecting insurers and risk managers.

That line separates the president's tort reform philosophy from that of Sen. John Kerry, D-Mass., and even more so from that of Sen. Kerry's running mate, Sen. John Edwards, D-N.C. While the president has pushed repeatedly for changes in tort law that have been sought by employers, Sen. Edwards—who won fame as a plaintiffs attorney specializing in medical malpractice cases—has just as steadfastly opposed major change.

The two tickets do not diverge, though, on the issue of whether the federal government should provide a financial backstop for private insurers coping with the potential fi-

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Additional election coverage starts on page 14

International

JAMES HARDIE EXECS RESIGN

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Late News

PHOTO: GETTY

Sen. Daschle

Daschle asks Frist for asbestos compromise

Senate Minority Leader Tom Daschle, D-S.D., has called on Majority Leader Bill Frist, R-Tenn., to "outline" how he would resolve differences between the two in order to craft a legislative solution to the problem of asbestos liability. "Given the lateness of the legislative year, the only way to secure a solution is for both sides to demonstrate a willingness to give and take," Sen. Daschle wrote in an Oct. 6 letter to Sen. Frist.

ING buys P/C operations from Allianz A.G.

ING Groep N.V.'s Canadian unit has acquired Allianz A.G.'s property/casualty insurance operations in Canada. Under the terms of the agreement, ING Canada will acquire Allianz of Canada Inc. and two of its Canadian subsidiaries, though Allianz will retain its Canadian industrial lines business. The acquisition will boost ING's gross written premiums in Canada by about $600 million Canadian ($475.2 million), or 17.6%, to more than $4 billion Canadian ($3.17 billion).

Medicare Advantage program growing

Around 1.6 million additional Medicare beneficiaries will likely

See LATE NEWS/page 27

NEWSPAPER

Court upholds PBGC authority to set plan termination dates

By JERRY GEISEL

CINCINNATI—A federal appeals court has upheld the Pension Benefit Guaranty Corp.'s authority to set plan termination dates to protect its insurance program.

In overturning a 2003 U.S. District Court decision, the 6th U.S. Circuit Court of Appeals in Cincinnati found that the PBGC could set a plan termination date that would prevent the agency from being liable for so-called shutdown benefits for pension plan participants of a now-defunct steel bar manufacturer. The United Steelworkers of America argues that the PBGC owes the union members nearly $100 million in such benefits.

Pension experts had warned that affirmation of the district court's ruling could have exacerbated the PBGC's already precarious financial condition by exposing it to billions of dollars in unfunded pension benefits.

The appeals court ruling is "a great decision for the PBGC," said Carol Connor Flowe, a partner with law firm Arent Fox P.L.L.C. in Washington and a former general counsel for the PBGC.

The USWA said it will appeal the Oct. 1 ruling. "It is outrageous for this government agency to abdicate its fiduciary responsibility to the workers who had long looked to it for protection," said David McCall, USWA District 1 Director in Columbus, Ohio.

The litigation involves 2,500 steelworkers once employed at Republic Technologies International of Akron, Ohio, and centers on the shutdown benefits they negotiated as part of a collective bargaining agreement with Republic Technologies. Shutdown benefits, which are a type of early retirement benefit that is paid when a company closes a facility, are found almost exclusively in agreements with organized labor.

At issue in the case are the PBGC's authority to set termination dates for plans it takes over and how much proof it must provide to justify a termination date that could deprive plan participants of benefits they had expected to be guaranteed by the PBGC. The case is important not just to the Republic Technologies steelworkers, but also to the PBGC and employers with defined benefit plans who support the PBGC's pension insurance program through mandatory premiums.

In June 2002, the PBGC moved to terminate the Republic plans after the company announced it would be selling off assets and that the buyer would not assume the plans' liabilities. The PBGC concluded that the plans would be unlikely to pay benefits and, ultimately, would be abandoned.

On June 11, 2002, a PBGC working group recommended to then-PBGC Executive Director Steve Kandarian that the agency initiate legal action to involuntarily terminate

See PBGC/page 27

SEC mulls action against AIG

By JUDY GREENWALD

NEW YORK—U.S. Securities and Exchange Commission staff members are considering recommending that the agency bring a civil action against American International Group Inc. for alleged violations of federal securities laws with respect to three AIG press releases the agency says are misleading.

Last month, AIG announced that SEC staff are considering recommending bringing a civil suit against the New York-based insurer and its subsidiary AIG Financial Products Corp. in connection with certain transactions between Pittsburgh-based PNC Financial Services Group Inc., a diversified financial services company, and AIG Financial Products. Last week, the U.S. Department of Justice said it is also investigating AIG Financial Products Corp. in connection with the same transactions.

The three press releases cited by SEC staff are one from Jan. 30, 2002, that related to the AIG Financial Products and PNC transactions; and releases issued Sept. 21 and Sept. 29 in connection with the two announcements concerning the SEC and Department of Justice investigations.

According to AIG, the SEC said, for instance, that the 2002 release said AIG had not entered into any other transactions using the structure it did with the PNC transactions, when it had entered into five other transactions with two other counterparties. AIG said the issue raised is whether and how the five other transactions the SEC referred to differed from the PNC transactions. The SEC referred to other transactions in labeling the other two AIG press releases "misleading" as well.

"AIG believes that any contention that the three press releases are or may be false or misleading is without merit and that any action by the SEC would be unwarranted," said the insurer in a statement.

Joyce Sharaf, managing senior financial analyst at Oldwick, N.J.-based A.M. Best Co., said it does not appear so far that the issue will have any impact on AIG's day-to-day operations. "There is no information yet that would cause me to think there would be an interruption in their earnings machine or any other kind of business interruption," Ms. Sharaf said.

John Ward, chairman of the Cincinnati-based Ward Group, said that the issue should not have a material impact on AIG. "The plot thickens; it's getting a little more complicated, but it still seems to me that AIG has a strong position" that it will defend "to the hilt," he said.

PHOTO: EFE PHOTOS

Illinois Gov. Rod R. Blagojevich discusses a program the state has set up to enable residents to obtain prescription drugs from Canada and elsewhere.

Illinois, Wisconsin launch program

Two states begin Rx reimportation

By RUPAL PAREKH

Illinois and Wisconsin have launched a program to enable the states' residents to buy prescription drugs from Canada and Europe, even though federal law currently bars reimportation.

The program, called I-SaveRx, operates through a Canadian drug clearinghouse in Tecumseh, Ontario, that obtains medications from a network of 45 pharmacies in Canada, Ireland and the United Kingdom. The participating pharmacies, which were not identified, have been inspected by Illinois state regulatory agencies and certified by both states.

Illinois and Wisconsin residents can order medications using a Web site, *www.i-saverx.net*, or a toll-free telephone number. All residents of both states are eligible to participate in the program.

"Now, the nearly 13 million people who live in Illinois and the more than 5 million people who live in Wisconsin will have the opportunity to save hundreds—and in some cases even thousands—of dollars each year on the high cost of their medicine," Illinois Gov. Rod R. Blagojevich said in a statement announcing the program.

The program asserts it can save participants 25% to 50%, on average, off the retail cost of drugs, because of price controls in other countries. A three-month supply of the cholesterol-controlling drug Lipitor, for example, is available through I-SaveRx for $180 from Ireland, compared with an average $282 in the United States, according to the program. Consumers also pay shipping costs of $15 per order.

Illinois spent a year developing the program, and Wisconsin became the first state to sign on.

"There's no reason why our citizens should have to pay twice as much for safe prescription medicines as the rest of the world, but that's exactly the situation we're in because the federal government refuses to take on

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Inside Business Insurance

Online

- The **Datebook** calendar lists upcoming industry seminars and meetings and allows you to add info about your own event.
- Searchable **directories** provide access to all the listings of industry vendors found in *BI*'s Market Sourcebook.
- New **Opinion Poll** for readers: Will the upcoming phase of the World Trade Center coverage trial decide that the towers' destruction was one occurrence?

Departments

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Latest Supreme Court docket light on liability cases

By MARK A. HOFMANN

WASHINGTON—The Supreme Court appears likely to deal with an unusually sparse docket of liability-related cases in its current term.

In fact, the justices will not revisit last year's blockbuster punitive damages decision in *State Farm Mutual Automobile Insurance Co. vs. Inez Campbell et al*. In that case, the justices said that, under most circumstances, punitive damage awards that are double-digit multiples of the underlying compensatory awards are unconstitutional and that, in some cases, even punitive damage awards that are more than the underlying awards can be unconstitutional. Employer groups had petitioned the high court to review how closely state courts were following those guidelines, but the justices declined to do so last week.

Probably the most potentially significant liability case the Supreme Court faces thus far this term is *Azel P. Smith et al. vs. City of Jackson, Miss*. The case, which asks whether the Age Discrimination in Employment Act allows disparate-impact claims, began when Jackson adopted a new pay policy for public safety officers that, when compared with its previous policy, gave proportionately larger raises to employees with five or fewer years of service than it did to officers with more seniority. A group of officers, all of whom were at least 40 years old, sued, claiming that the pay rules violated the ADEA because employees with less service were likely to be younger than those with more time on the job. A three-judge panel of the 5th U.S. Circuit Court of Appeals held that the ADEA does not allow a disparate-impact suit.

"This is a case of great significance to business," said Donald B. Verrilli Jr., a partner in the Washington office of Jenner & Block, during a Supreme Court preview at the Washington Legal Foundation last month. If the high court agrees that the ADEA allows disparate-impact claims such as those allowed under the Civil Rights Act of 1964, the result could be a considerable burden to business, Mr. Verrilli said.

Discrimination of another sort is

See DOCKET/page 6

Converium faces securities probe

SEC looking for insider trading

By DAVE LENCKUS

WASHINGTON—Securities regulators in the United States and Switzerland are investigating whether there was any insider trading of Converium Holding Ltd. stock prior to the reinsurer's July 19 announcement that its second-quarter earnings would be dragged down by a $385 million reserve boost.

The Zug, Switzerland-based reinsurer's stock price fell 44.4% in one day following the announcement. Converium reported a $660 million second-quarter loss.

Converium, which was spun off from Zurich Financial Services Group Inc. in 2001, said that the reserve boost addressed worsening claims trends for U.S. liability business written between 1997 and 2001. For the first half of 2004, Converium reported a $594.3 million loss, compared with an $84.6 million profit for the year-earlier period (*BI*, July 27).

The reinsurer has since placed its U.S. units in runoff.

Converium revealed the U.S. Securities and Exchange Commission's investigation last week in a filing with the SEC.

On Oct. 8, the Swiss Exchange completed its investigation into the matter and filed its report with the Federal Banking Commission in Switzerland, an exchange spokesman said.

The spokesman would not discuss the report's conclusions, saying that the investigation will not be finalized until the Banking Commission completes its inquiry.

Rating agencies A.M. Best Co. and Standard & Poor's Corp. last month downgraded Converium's financial strength ratings below the often crucial A-grade level.

Meanwhile, at least four shareholder lawsuits seeking class-action status have been filed against Converium Holding, alleging violation of securities laws.

The suits, which were filed in federal court in New York, generally allege that the Swiss reinsurer misrepresented information on the adequacy of its loss reserves, among other things.

The class period runs from December 2001 to July 2004.

Errors & omissions

- An article in the Oct. 4 issue, "Surplus Lines Underwriters Vow to Hold the Line on Rates," mistakenly identified Liberty International Underwriters as Liberty National Underwriters. In addition, a Sept. 20 Products & Services item mistakenly identified the company as Liberty Mutual Underwriters. Liberty International Underwriters is a unit of Boston-based Liberty Mutual Group Inc.
- Two entries in the Oct. 4 "40 Under 40: People to Watch" feature contained incorrect information. Matt Yeldham is underwriting director at Wellington Underwriting Agencies Ltd., not its London-based holding company. David Ibeson, chief executive of Wellington Underwriting Agencies, is 38.
- A story in the Sept. 20 issue, "Wholesalers Find Homes for Exotic, Odd Risks," incorrectly reported that Swiss Reinsurance Co. participated in the insurance coverage backing cyclist Lance Armstrong's bonus for winning a sixth Tour de France in 2004. The company reinsured bonuses paid to Mr. Armstrong for Tour victories in 2002 and 2003.

State tort reform proponents urged to build political clout

By MARK A. HOFMANN

WASHINGTON—Achieving tort reform on the state level isn't possible unless pro-reform forces exercise considerable political clout, according to successful state tort reform advocates.

But "sometimes you see a great deal of passivity in the corporate community," said Hugh Rice Kelly, general counsel of Texans for Lawsuit Reform in Austin. Too often, "the corporate community is a little too focused on quarter-to-quarter thinking" for its own good, said Mr. Kelly during a discussion of state tort reform efforts at the American Enterprise Institute in Washington last week.

Pro-reform forces in Texas turned to small businesses and other sources that were willing to put money into the successful effort to reform the state's tort laws, he said. As a result, Texans for Lawsuit Reform was able to create one of the biggest political action committees in the state. That allows it to help its political allies, Mr. Kelly said.

And being a single-issue group, the tort reform proponents were able to remain focused, he said. By contrast, large companies have numerous legislative issues that they want to influence, he said. Tort reform is a "good government" issue that's "about No. 17 on the list" of a corporation's agenda, he said.

Reform forces finally prevailed in Texas in 2003, noted Mr. Kelly. The Texas Legislature approved comprehensive tort reform despite opposition from one of the most politically powerful trial bars in the country. The reforms included:

- Instituting a specialized type of "loser pays" system in which the losing party in a lawsuit may be required to foot at least part of the legal fees of the winner.
- Capping noneconomic damage awards in medical malpractice cases.
- Giving the state Supreme Court greater power in hearing appeals from a trial court order certifying or refusing to certify a class in a class action.
- Creating an "innocent dealer" defense in product liability cases.
- Limiting appeals bonds to the lesser of 50% of a defendant's net worth or $25 million.

"Without political power, you're

See TORT/page 24

SIIA National Educational Conference and Expo

Use of incentives seen as key to improving employee health

By MICHAEL BRADFORD

MIAMI—Employers can encourage workers to stay healthy by using financial incentives and penalties to promote lifestyle changes, a disease management executive says.

Such actions help employers change workers' perception of health care, and such a mindset change can aid companies' efforts to reduce their health care costs, he said.

Most workers consider health care an entitlement and give little thought to what impact having a healthy lifestyle could have on the cost of health care, said Richard Hodsdon, director of marketing and business development for HHS Health Options, a provider of health management services in Grand Rapids, Mich.

"When you get into an entitlement mentality...people believe that they deserve it, regardless of whatever contributing factors that they may have to the condition that they are experiencing," Mr. Hodsdon said during an educational session at the Self-Insurance Institute of America Inc.'s recent annual conference in Miami.

Such a mentality is encouraged by a system where health care premiums are the same, for example, for someone who stays fit and runs marathons and another individual who "eats two or three pizzas a week and drinks a six-pack a night," Mr. Hodsdon said.

"Both are paying the exact same amount for access to health care," Mr. Hodsdon said.

Employers can help reduce their costs by implementing changes in their health plans that encourage employees to instead view health care as a commodity, Mr. Hodsdon said.

Plans can be developed that identify workers who are likely to incur significant health care costs because of existing health conditions, unhealthy lifestyles or both, Mr. Hodsdon said. The aim of such plan designs is to make changes in managing a health condition and lifestyle before a condition develops that will "trigger traditional case management," he said.

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More coverage appears on page 24

Docket: Few liability cases slated for high court review

Continued from page 4

at the core of *Roderick Jackson vs. Birmingham Board of Education*. Mr. Jackson coached a girls' high school basketball team in Birmingham, Ala., but was relieved of his coaching duties after repeatedly complaining that the team was being subject to unlawful sex discrimination forbidden by Title IX of the Education Amendments of 1972. He was not, though, dismissed from his job as a physical education teacher. The question the court faces is whether Mr. Jackson, who was not the direct victim of the alleged sex discrimination, enjoys a private right of action under Title IX for the retaliation he suffered for complaining about unlawful discrimination. A three-judge panel of the 11th U.S. Circuit Court of Appeals held for Birmingham.

The high court will tackle environmental liability as it considers *Cooper Industries Inc. vs. Aviall Services Inc.* The case, which the justices heard last week, began when Aviall felt pressure from the state of Texas to clean up some polluted land it had bought from Cooper Industries. Aviall sued Cooper, which had admitted that it was a potentially responsible party, to recover part of the cost of cleanup. Aviall held that it had the right to recover from another PRP under the Comprehensive Environmental Response, Compensation and Liability Act, which created Superfund.

Cooper responded that it wasn't responsible for any of the cleanup costs under CERCLA because Aviall had not been ordered to clean up the site but rather had done so of its own volition. A U.S. district court and a three-judge panel of the 5th U.S. Circuit Court of Appeals agreed with Cooper, but the whole appellate court reversed the three-judge panel by holding that CERCLA doesn't require that a PRP be sued before seeking money from other PRPs.

A final liability case involves the reach of the Americans with Disabilities Act. In *Douglas Spector et al. vs. Norwegian Cruise Lines Ltd.*, the court will decide whether the ADA applies to foreign-flagged vessels as well as U.S.-flagged ships. A three-judge panel of the 5th U.S. Circuit Court of Appeals ruled earlier this year that it does not.

Drugs: Two states begin reimportation

Continued from page 3

the drug companies," Wisconsin Gov. Jim Doyle said in a statement.

Gov. Blagojevich last week urged more states to sign onto I-SaveRx, and he sent information about the program to governors around the country.

Under current federal law, reimportation of drugs is illegal by anyone other than the original manufacturer. However, the 2003 Medicare prescription drug law allows the Secretary of Health and Human Services to issue waivers to individuals for reimportation if safety standards can be met.

In addition, the FDA has staunchly opposed the importation of drugs from other countries, citing patient-safety concerns. FDA officials did not return calls seeking comment on the launch of Illinois' program.

As Illinois' program gets under way, Maine Gov. John Baldacci is seeking federal approval of a different approach to bringing in drugs from other countries.

Under the governor's bulk reimportation program, an American Indian tribe would be made the wholesale distributor of the drugs, which would be sold to area pharmacies at reduced prices and made available to consumers at lower cost.

"In tackling some of the most pressing health care issues of the day, it's clear to me and to many Maine citizens that we continue to face a growing crisis—the high cost of prescription drugs," Gov. Baldacci said in a statement. "While I hope that the federal government will soon enact prescription drug reforms, Maine cannot wait any longer."

Gov. Baldacci, a Democrat, has already given a $400,000 grant to the Penobscot Indian Nation to begin building a wholesale drug distribution center, a spokeswoman from his office said. He is now seeking an HHS waiver that would allow Maine to legally reimport drugs from Canada, she said.

Minnesota and New Hampshire also have set up Web sites that enable residents to purchase drugs from Canadian suppliers, and other states and municipalities have examined reimportation programs as a way to cut drug costs.

BI makes addition to NY bureau staff

NEW YORK—Rupal Parekh has joined *Business Insurance* as a staff reporter in the New York bureau.

Ms. Parekh

Ms. Parekh has served as an editorial intern in New York since June. She joined *Business Insurance* after obtaining a master of science degree from the Columbia University Graduate School of Journalism in New York.

Prior to attending Columbia, Ms. Parekh worked in the programs department of the Middlesex County, N.J., Cultural Heritage Commission.

Ms. Parekh also holds a bachelor of arts degree in anthropology and communication from Rutgers University in New Brunswick, N.J.

She can be reached at 212-210-0770 and by e-mail at *rparekh@businessinsurance.com*.

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Editorial

IBM pension question merits resolution

WE APPLAUD IBM CORP.'S decision to appeal a federal court ruling that its cash balance plan discriminates against older employees.

As we recently reported, IBM has agreed to partially settle a 5-year-old lawsuit by current and former employees stemming from the conversion of its traditional final-average-pay pension plan to hybrid arrangements.

Under the settlement, IBM will pay $320 million in enhanced pension benefits to participants. That part of the settlement mainly relates to the 1995 conversion of the plan to a hybrid design known as a pension equity plan.

The more important part of the proposed settlement involves IBM's cash balance plan, which succeeded the pension equity plan in 1999. As part of the settlement, IBM will appeal last year's ruling by U.S. District Court Judge G. Patrick Murphy that its plan was age discriminatory.

If IBM wins on appeal, it will have no additional liability. If it loses, its liability will be capped at $1.4 billion, also payable as enhanced pension benefits.

Obviously, IBM could have quite easily settled the case long ago and put the time and expense of continued litigation behind it.

But as Randy McDonald, IBM's senior vp of human resources, says, more than money is involved in the case.

"If the ruling in this case is upheld, many companies will be forced to end their pensions, reduce the number of employees who receive pensions or become noncompetitive, which could result in job losses," Mr. McDonald said.

We agree with IBM that Judge Murphy's ruling is not supported by judicial, regulatory or legislative authority. Indeed, in the two other cases we are aware of in which rulings have been handed down, both federal judges affirmed that the basic design of cash balance plans—in which participants receive benefit credits as well as interest credits on their accounts—does not discriminate against older employees.

Common sense certainly supports that notion. If all enrollees in a cash balance plan receive each year the same credit rate, how could that be age discriminatory?

But what we think doesn't really matter. What matters is how a federal appeals court rules on the issue, and we are glad that IBM's action paves the way for that to happen.

Let's stay united on tort reform

REGARDLESS OF WHICH party ends up controlling the White House and Congress after next month's elections, one thing is certain: Enacting any significant federal tort reform will entail an uphill battle.

That was true this year, with pro-reform majorities—albeit slim ones—in both houses of Congress and one of the most pro-reform presidents ever at the other end of Pennsylvania Avenue. Effort after effort to restore some balance to a civil justice system that sometimes seems off kilter failed to garner enough support to become law.

Fortunately, Washington is not the only battlefield upon which tort reform battles can be fought. The states provide meaningful opportunities for pro-reform forces to achieve their goals as well.

In fact, pro-reform forces have won impressive victories in states such as Texas and Mississippi, states that not all that long ago would have been considered among the least likely candidates for any sort of reform. How could that happen?

While each state is different, successful tort reform campaigns share some common characteristics. One of the key things is, of course, to reward your friends.

Lawmakers, particularly those who are willing to go to the edge to push reform, deserve more than just lip service—financial support, whether through a political action committee or individual contribution, is essential.

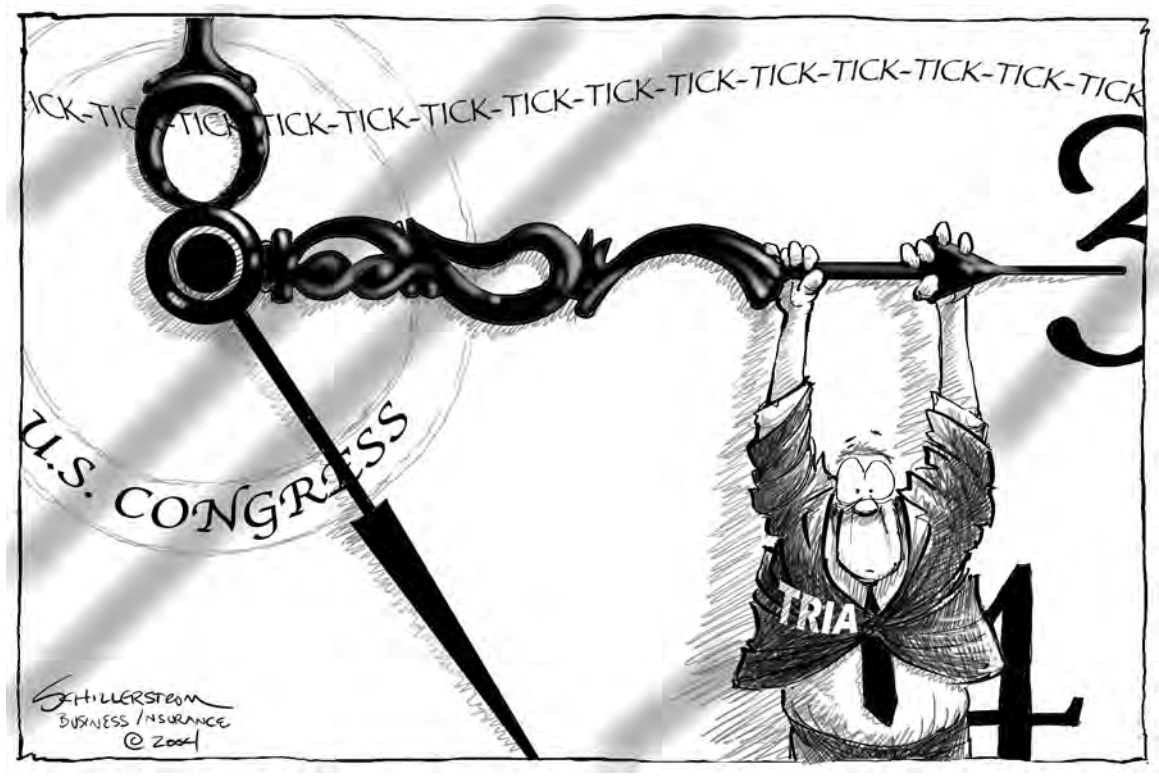
Another critical factor common in achieving reform is keeping the business community and the larger pro-reform movement united and focused on their ultimate goal.

This isn't easy—in some states, opponents have been able to cut separate deals with individual elements of the pro-reform coalitions. When that happens, reform coalitions disintegrate and their goals remain unmet.

That didn't happen in Texas and Mississippi, and pro-reform forces elsewhere would do well to study how victories could be won on what seemed to be such unfriendly turf.

While reform efforts at the federal level must continue, the states will probably present the best chances of success for the immediate future, no matter who holds the keys to the White House after the November elections.

Schillerstrom



And the beats go on...

In an effort to ensure continuing timely coverage of risk management, insurance and employee benefit-related news, *Business Insurance* has formalized a list of its reporters' assigned beats. This list is not intended to be exclusive but rather to represent core subject areas of importance to *BI* readers. *BI* welcomes ideas and tips from readers on these and other areas. Following is a list of the beats and the principal reporters for each:

Agents/brokers: Sally Roberts.
Asian markets: Michael Bradford.
Aviation/space risks: Peta Miller.
Benefits–health care and ancillary benefits: Joanne Wojcik.
Benefits–retirement savings/pensions: Jerry Geisel.
Canada–risk management and benefits: Gloria Gonzalez.
Captives/alternative risk transfer: Michael Bradford.
Claims management: Meg Fletcher.
E.U. regulatory/legislative: Sarah Veysey.
Employment practices: Judy Greenwald.
Environmental risk management: Sally Roberts.
European benefits management: Sarah Veysey.
European industry operations: London bureau.
European public entity risks: Carolyn Aldred.
European reinsurance: Sarah Veysey.
European risk management: Peta Miller.
Federal regulation/legislation–benefits: Jerry Geisel.
Federal regulation/legislation–risk management: Mark A. Hofmann.
Health care industry operations: Gloria Gonzalez.
Inland marine/transportation: Michael Bradford.
Insurance coverage litigation: Douglas McLeod.
Insurance fraud: Douglas McLeod.
Latin American markets: Roberto Ceniceros.
Marine risks: Peta Miller.
Property/casualty industry operations: Judy Greenwald.
Professional liability: Dave Lenckus.
Property loss control/catastrophe risks: Mark A. Hofmann.
Regulation of insurance: Meg Fletcher.
Reinsurance: Judy Greenwald.
Risk management profession: Dave Lenckus.
Risk securitization/capital markets risk financing: Carolyn Aldred.
Runoffs/receiverships: Douglas McLeod.
Safety/ergonomics: Meg Fletcher.
Surplus lines/wholesalers: Roberto Ceniceros.
Tort reform: Mark A. Hofmann.
Work/life benefits and EAPs: Sally Roberts.
Workers compensation: Roberto Ceniceros.

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Look at more than ratings for insurer security

By Sheila Small

Of over 100 rated insurers rendered insolvent in the past decade, more than one-third appeared healthy, bearing an 'A' or an 'A-' financial strength rating just two years before their fall. Given this track record, it is imperative that one look further than the old 'A' rating standard.

I consider myself a prudent manager, one who would rather not take unnecessary risks. As I review insurers for placement on my programs, I find that the due diligence of checking for a financial strength rating of "A-" or better is no longer sufficient, as we've all seen insurers that were once household names meet a shockingly swift demise.

Sure, the financial strength ratings bestowed by A.M. Best Co., Standard & Poor's Corp. and other rating agencies remain bellwethers of solvency. These watchdogs of insurer financial strength do risk managers a great service. But we can't expect them to do our jobs.

Risk managers must rigorously investigate any insurer under consideration to ensure, to the highest degree possible, that it will be able to pay claims years from now. After all, of over 100 rated insurers rendered insolvent in the past decade, more than one-third appeared healthy, bearing an "A" or an "A-" financial strength rating from a leading rating agency just two years before their fall. Given this track record, it is imperative that one look further than the old "A" rating standard.

Predicting the future fortunes of any insurer is difficult, but there are indicators. A company's credit rating, which reflects its ability to service long-term debt, is probably the closest thing to a crystal ball. Take a look at the credit rating of the insurer's parent company and you might be shocked by what you see. There are insurers out there with strong financial strength ratings that have long-term debt ratings nearly below investment grade.

The inability to service debt has been at the root of many recent corporate failures—in insurance as well as many other industries—so risk managers are wise to set the bar high when evaluating these long-term debt assessments. This becomes even more critical when an insurer is underwriting long-tail liabilities.

Understanding how an insurer manages its own business is also very important. Does the company get in "over its head" in certain areas of the business? Does it play the markets opportunistically? As pricing stabilizes in certain areas, is the insurer sustaining the underwriting discipline that will support long-term profitability? Or is it underwriting to win market share—and driving the market down, as we saw some now-defunct insurers do years ago? How much capacity does the insurer write "net"; how much is reinsured out? What is its process for evaluating reinsurers? Do senior managers have a substantial history with the company and a long-term commitment to it?

Analysts' reports and annual reports, past and present, are particularly useful here. If the insurer has demonstrated stability and consistency in its business strategies and in long-tail lines, such as directors and officers liability, excess casualty and environmental, I am extremely reassured. This tells me that the insurer knows its business. It knows how to underwrite difficult lines, service complex claims, manage high-stakes litigation and keep its own operations prospering.

Conversely, if an insurer follows the market opportunistically, jumping in and out of lines, I have to wonder why. I become suspicious of its underwriting strategies and question whether it understands the risks involved. Moreover, once an insurer exits a line—and, hence, no longer collects premiums on that line—it is often a challenge to get claims paid on that line expeditiously, even if the insurer is not insolvent. With no new premiums to draw from, the insurer may be reluctant to tap into more profitable lines of business to fund improperly underwritten exposures.

Conducting this additional due diligence to ensure insurer solvency places an extra burden on already-overworked risk managers, but it is essential. The property/casualty industry remains fragile and will continue to face uncertainties such as questionable reinsurance recoverables, the volatility of reserving requirements and widely unpredictable exposures on the liability side of the house. There is also the constant specter of another loss of the magnitude of the 9/11 tragedy.

By providing in-depth research on the solvency of an insurer and insights into its financial outlook and management practices, brokers can provide a vital service to their clients. Together, we must stay ahead of the trends. By the time an insurer's financial strength or debt rating is downgraded, it's typically too late, particularly when occurrence lines are involved. Those of us who manage long-tail liabilities cannot escape the consequences of past insurance purchasing decisions. And, as I discussed in a previous Perspectives article, risk managers who hope to recoup losses due from insolvent insurers via state guaranty funds are likely to find these hopes dashed fast (*BI*, Sept. 29, 2003).

The best way to ensure that you and your company have no regrets about past insurance decisions is to go for "gold medal" financial strength throughout your program, every time. Choose an insurer that knows the risks it writes—and writes to the risk—not one that capitalizes on market conditions to win market share. This way, you, as the risk manager, can feel confident that your company's risk management program will be insulated from the inherent volatility of the insurance market.

Quality is worth more; it will cost more. In any industry, the best, most reliable products rarely come at bargain-basement prices. We do not expect them to. The same applies to insurance. Quality and reliability may cost more, but when you've found it, and the claims roll in years from now, you'll be glad you shopped smart and wise.

Sheila Small is assistant treasurer-risk management and insurance for Verizon Communications Inc. in New York.

Commitment key to preventing harassment

By Art Lambert

Employers must make sincere efforts to communicate and enforce their policies regarding sexual harassment

In the words of the U.S. Equal Employment Opportunity Commission, "Prevention is the best tool for the elimination of sexual harassment." While the efforts of U.S. businesses to educate employers and employees alike on sexual harassment issues have certainly increased awareness, paradoxically, the number of claims is still on the rise.

According to a 2001 report, the number of sexual harassment cases in the workplace more than doubled from 1991 to 1998, to 15,618 from 6,883. Since 2000, the EEOC has handled over 25,000 sex discrimination charges a year. During the 1990s, U.S. employers collectively paid nearly $1 billion to resolve such claims, much of it coming from their insurance providers.

Financial settlements are also growing due to Civil Rights Act amendments that allow victims to recover for pain and suffering and punitive damages.

Considering the added insurance costs to cover the mammoth liability, the enormous financial damages and the adverse effects on the company's reputation, organizations should make every effort to prevent and minimize sexual harassment occurrences.

All organizations need to involve their human resources departments in developing and adhering to the policies and processes of managing risk in sexual harassment complaints. A common thread that runs through many large payouts is the company's failure to either communicate or enforce a policy regarding sexual harassment. In some cases, the company had a valid sexual harassment policy but did not follow the policy when confronted with complaints. In several such cases, midlevel managers tried to stifle or hide the complaints.

In order to avoid large awards, it is paramount that the company communicate the policy to the employees, so they can know to take advantage of it. Further, the company must communicate the policy—and how to respond to a complaint—to all managers.

In a recent case in New Hampshire—*Madeja vs. MPB Corp.*—the state Supreme Court upheld a $600,000 jury award in a co-worker sexual harassment and retaliation case. The case offers important guidance from a risk management perspective about how to better defend against sexual harassment going forward.

In this situation, the employer undermined its own defenses by failing to fully investigate the initial complaint, and it did not take appropriate action against the harasser, who even admitted responsibility for some of his conduct.

Nor did the company's supervisors notify human resources, as required under the company's own sexual harassment policy. In fact, management left human resources in the dark about the timing of the complaint of sexual harassment and the decision to terminate the victim.

For reasons of "low productivity," the victim was fired eight days after filing a sexual harassment complaint against her co-worker, despite receiving a favorable performance review less than three weeks earlier.

The employer argued that it had made good-faith efforts to comply with Title VII, that it had a sexual harassment policy in place and that it conducted regular training. The court found, though, that "the mere existence of a sexual harassment policy or presentation of seminars does not automatically satisfy the good faith requirement. Defendant must also show its sincere commitment to enforcing its policy."

Again, employers need to educate managers and supervisors on the proper treatment of victims and employee complaints of sexual harassment not only to stabilize the workplace and ensure ongoing productivity but also to favorably influence risk assessments for future insurance coverage. They should make managers aware of the potential for subsequent co-worker retaliation, claims of retaliatory firings and other undesirable actions. By involving human resources and appropriately responding to such complaints, the benefits to risk management are manifold.

Is your company doing all it can to defend against a potential sexual harassment lawsuit? Merely having policies in place is not enough. You must "walk the talk" and ensure not only that management and employees across the board are trained in proper procedures but that your company is strictly in compliance with its own best practices.

Art Lambert is a partner in the labor and employment practice of Epstein Becker Green Wickliff & Hall P.C. in Dallas.

ISO endorsements may spur coverage disputes

Cover may be reduced for additional insureds

By Tyrone R. Childress

Outside of the context of construction coverage and subject to wording requirements, most states allow parties to broadly shift liability prior to a loss through indemnity provisions.

Further, most courts have broadly construed additional insured coverage to encompass not just vicarious or joint negligence but the additional insured's sole negligence as well. Resisting this majority trend, the Insurance Services Office Inc. recently announced that it is introducing substantially revised additional insured endorsements (as well as a revised "insured contract" definition), which have the potential to reduce coverage for additional insureds and indemnitors dramatically.

The current additional insured commercial general liability endorsements provide coverage for liability of the additional insured "arising out of" the named insured's operations. The phrase "arising out of" has spawned numerous judicial decisions, with the vast majority of courts finding the additional insured's coverage as including the additional insured's sole negligence, so long as there is at least some nexus between the injury and the named insured's work on behalf of the additional insured. Insurers have been frustrated with the financial implications of decisions extending additional insured coverage to the additional insured's sole negligence, particularly where there is only a tenuous link between the injury or damage and its named insured's activities.

In response to this ongoing frustration, ISO has introduced a fault-based element with its new endorsements, which provide liability coverage for an additional insured only where the injury or damage is caused at least in part by the acts or omissions of the named insured. As explained by ISO in the accompanying filing memorandum: "Because the phrase 'arising out of' has been interpreted broadly by some courts, we are revising several of the additional insured endorsements to add specific language to provide an additional insured with coverage for their vicarious or contributory negligence only."

In seeking to eliminate perceived problems with its "arising out of" language, though, ISO and the insurance industry may simply have replaced that problem with a whole new set of coverage disputes. For example, a frequent additional insured claim scenario involves a named insured's employee seeking to circumvent the workers compensation limitations by suing the additional insured for further damages, by alleging an "unsafe workplace," etc. The underlying plaintiff is unlikely to include allegations in a complaint regarding the named insured/employer's negligent acts, given it is seeking to maximize the liability of the additional insured. How, then, is it to be determined whether the insurer must defend the additional insured if there are no underlying allegations against the named insured? The additional insured may be forced to develop liability facts and theories against the named insured, to the ultimate detriment of the insureds and the insurer. These new endorsements may well pit insureds against each other because the additional insured, under the new endorsements, now has an incentive to find liability exposure for the named insured in order to trigger coverage for itself.

Of additional concern to policyholders should be ISO's attempt to minimize coverage for contractual indemnity obligations between parties. Historically, CGL coverage has provided very broad coverage for indemnity obligations as long as the injury or damage is of a kind covered by a CGL policy. Indemnitors have for decades counted on their contractual liability coverage to respond to those indemnity obligations.

However, ISO's new "insured contract" definition could dramatically alter that coverage, particularly where the named insured/indemnitor has assumed indemnity obligations for the sole negligence of the indemnitee. Under this amended definition, an indemnitor and an indemnitee could enter into a legally valid indemnity agreement, which includes indemnification for the indemnitee's sole negligence, and yet the indemnitor finds its contractual liability coverage unavailable.

The practical problems associated with the new "insured contract" definition are daunting for both large and small policyholders. It will be a logistical nightmare for large policyholders to monitor the indemnity provisions in hundreds of contracts and to compare them to their indemnitors' "insured contract" policy language. Similarly, policyholders who routinely provide indemnities in their contracts must be careful that they do not create financial exposure by undertaking an indemnity obligation that is broader than their contractual liability coverage.

Additional insureds, indemnitors and indemnitees should be wary of the use of these new endorsements, particularly where the risk transfer is designed to include the sole negligence of one of the parties. Further, additional insureds can expect insurers to become increasingly aggressive in trying to characterize losses as arising from the additional insured's sole negligence, potentially pitting insureds against each other while an underlying claim is pending. While ISO's intent to further limit the insurance industry's exposures through these endorsements is clear, it is less clear whether these new endorsements will clarify these complex issues or, rather, simply result in more coverage disputes.

Tyrone R. Childress is a partner in the Los Angeles office of Howrey Simon Arnold & White L.L.P. and represents policyholders on a variety of coverage matters.

ERISA allows recovery of interest if payment delayed

Legal Briefs

The 3rd U.S. Circuit Court of Appeals ruled that an ERISA participant whose benefits were delayed but ultimately paid voluntarily could seek recovery of interest on that delayed payment as a form of "appropriate equitable relief" under ERISA.

E.I. DuPont de Nemours & Co. employed Orrin T. Skretvedt from June 28, 1974, until Feb. 7, 1995. Mr. Skretvedt received benefits for one plan governed by the Employee Retirement Income Security Act pursuant to a court judgment, while his employer voluntarily paid him benefits under the second plan after that judgment was entered. However, a magistrate judge denied Mr. Skretvedt's request for interest with regard to the delayed payment of benefits under both plans. Mr. Skretvedt appealed. The trial court denied him any relief, so he appealed.

The appellate court concluded that a constructive trust could be placed over interest actually earned by the plans if they had wrongfully delayed paying benefits. The court said that the constructive trust remedy would allow a participant, in equity, to force disgorgement of such gain received on his withheld benefits under a theory of restitution. The decision of the magistrate judge was reversed and the case was remanded.

Skretvedt vs. E.I. DuPont De Nemours, 3rd U.S. Circuit Court of Appeals, June 16, 2004 (BI/05/O.—copies not available due to length of decision)

Health premium contributions don't count in average weekly wage

A workers compensation claimant was not entitled to have the amount he paid toward the cost of his health and dental insurance added to his average weekly wage in determining his benefits, according to a Colorado appellate court.

William Midboe sustained an industrial injury in 2000 while employed by the state of Colorado. Although he suffered both a temporary and permanent disability, he continues to work for the state.

Before and after the injury, Mr. Midboe received health and dental insurance as a benefit of employment. His total contributory premiums were $301.26 per month, and the state paid the remaining portion of the premiums. Some premium changes occurred in 2002.

Including the 2002 changes would have increased his average weekly wage from $678 to $747.52. Mr. Midboe sought review of the calculation of his average weekly wage, requesting that his premium contribution be included. An administrative law judge agreed with Mr. Midboe; the Appeals Office ruled against him, though, and Mr. Midboe appealed.

The appellate court said that a claimant's average weekly wage includes the cost of health insurance only when a claimant has continued the employer's coverage at his or her own cost and, thereafter, when that coverage ends and the claimant has converted to other coverage.

According to the court, this interpretation recognizes that an employee's contribution to his or her health care premium during the period of employment does not represent an advantage or fringe benefit comprising wages that is lost when the injury occurs. The decision of the panel was affirmed.

Midboe vs. Industrial Claim Appeals Office, Colorado Court of Appeals, Sept. 25, 2003, as modified May 6, 2004 (BI/01/O.-$10)

Employee injury exclusion in CGL policy valid

An exclusion of coverage for employee injuries in a commercial general liability insurance policy issued to an employer was valid, according to a Pennsylvania appellate court.

In 1999, Janice Hogan, a waitress employed by Nickels Tavern in Philadelphia, was in the course of her employment when she fell through an open trapdoor that had been left open by a co-employee. Ms. Hogan sustained injuries to her right knee and leg. At that time, the tavern did not provide Ms. Hogan with workers compensation coverage as required by the Pennsylvania Workers' Compensation Act. In 2001, Ms. Hogan sued the tavern and its owner, seeking damages for her injuries. The tavern was covered under a CGL policy issued by underwriters at Lloyd's of London. The insurer, although informed of Ms. Hogan's suit, did not defend the legal action on behalf of the tavern and its owner, citing an "employee exclusion" contained in the insurance policy. Subsequently, a trial court awarded Ms. Hogan $279,000 in damages against the tavern and its owner. The insurer was notified of the award.

The insurer then brought this action, seeking a declaration from the court that the policy provided no coverage for liability to an employee injured in the course of employment. The trial court ruled for the insurer, and Ms. Hogan appealed.

On appeal, she argued that to allow the employee exclusion to be valid in an employer's general liability insurance policy where the employer failed to provide workers comp benefits would be contrary to public policy.

The court said that neither the exclusion clause nor the comp law prevents an injured employee from seeking damages from employers. Thus, the court said that the employee exclusion in the CGL policy was not void because of public policy. The court also said that Ms. Hogan sought damages directly from the employer and that this placed the risk and payment for damages where it belonged. The trial court decision was affirmed.

Certain Underwriters at Lloyd's vs. Hogan, Superior Court of Pennsylvania, June 8, 2004 (BI/04/N.-$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. Provide the listed number for each opinion ordered.

Risks: Clear differences between presidential hopefuls

Continued from page 1

nancial losses stemming from future catastrophic terrorist attacks. And neither has shown much interest in questions of what role—if any—the federal government should play in insurance regulation.

The New York-based Risk & Insurance Management Society Inc., which does not endorse candidates, has spotlighted medical malpractice reform, class action reform and reform of the way victims of asbestos-related diseases are compensated among its Capitol Hill priorities in recent years. Insurance industry lobbyists and tort reform advocates who share those concerns are hard pressed to come up with examples of how John Kerry would resolve those issues in the manner they desire.

'Tort reform is a priority of the insurance industry. Whether it's class action reform, asbestos reform or medical malpractice, these are important national issues.'

Leigh Ann Pusey
American Insurance Assn.

"When you look at the presidential election, there's a clear contrast on tort reform," said Carl Parks, senior vp-government affairs in the Washington office of the Property Casualty Insurers Assn. of America. "Certainly, President Bush has forcefully pursued and supported tort reform throughout his career, and it's one of the key pillars of his re-election campaign," he said. Mr. Parks noted that the president has given particular emphasis to the role that medical malpractice liability reform could play in restraining rising health care costs.

"The Kerry-Edwards campaign, I suppose, speaks for itself. Sen. Edwards is a very prominent plaintiffs attorney—and a very significant amount of support, financial and otherwise, has come from the trial bar," said Mr. Parks.

"With respect to the tickets, we look to people's voting records. Tort reform is a priority of the insurance industry. Whether it's class action reform, asbestos reform or medical malpractice, these are important national issues. There are some clear differences between these two tickets," said Leigh Ann Pusey, senior vp-federal affairs with the American Insurance Assn. in Washington.

"The point we made when Edwards was named running mate is that he was running with the support of his former colleagues of the personal injury bar," said Sherman Joyce, president of the American Tort Reform Assn. in Washington. "He didn't seem to distance himself from his former colleagues."

"In recent years, we've probably spent upwards of 50% of our time working in civil-justice-related issues. I guess only Nixon could go to China, but it's pretty hard for me to envision a Kerry-Edwards administration that embraces middle-ground reforms in medical mal, class action and asbestos," said Joel Wood, senior vp-government affairs for the Council of Insurance Agents & Brokers in Washington.

While the president has called for broad medical malpractice reforms such as capping noneconomic damages, Sens. Kerry and Edwards have suggested limited changes, most notably imposing severe sanctions on attorneys who bring "frivolous" medical malpractice lawsuits. They have both opposed broader tort reforms.

The Kerry campaign's medical

Continued on next page

PHOTO: NEW YORK TIMES

Democratic candidate John Kerry has proposed imposing penalties on attorneys who file frivolous medical malpractice suits.

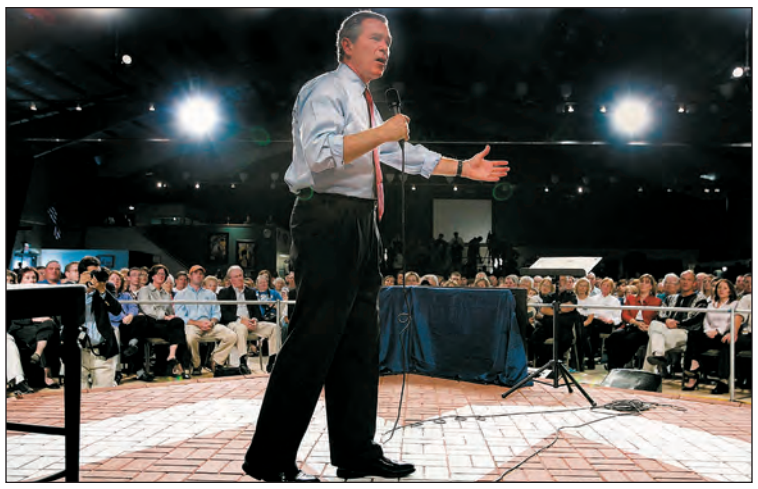

PHOTO: NEW YORK TIMES

President Bush has made tort reform a key issue in his re-election campaign.

Continued from previous page

malpractice liability proposals also call for insurance reform, including an end to "special privileges" for the insurance industry, which could mean stripping the industry of its limited antitrust immunity provided under the McCarran-Ferguson Act, said PCI's Mr. Parks.

Still, Sens. Kerry and Edwards appear to have differing views on the insurance industry itself, noted Mr. Wood. "Kerry has never been one, unlike his running mate, to make bashing insurance companies a ritual part of his stump speech as a senator," he said.

Sen. Kerry, "to his credit," has followed the lead of Sen. Chris Dodd, D-Conn., on issues such as TRIA, Mr. Wood said. "And as a longtime member of the Senate Banking Committee, he was not a major force on our issues, but he certainly wasn't a demagogue either," he said.

Sen. Kerry did take a few swipes at captive insurance companies during the primary campaign, though. He accused one of his rivals for the Democratic nomination—former Vermont Gov. Howard Dean—of presiding over "a snowy Bermuda, as a tax haven for insurance companies." Sen. Kerry has not revisited the subject since Gov. Dean withdrew from the race.

Although there are clear differences between President Bush and Sen. Kerry on some risk management issues, there is little difference between the two on the need for a federal terrorism insurance backstop, industry observers note. AIA's Ms. Pusey pointed out that though President Bush has a track record of supporting TRIA, it has not been strictly a partisan issue, with Sen. Kerry having voted for it as well.

"We hope to get a two-year extension of TRIA before this election. In any event, TRIA will continue to be a critical issue in Congress and for the administration, whoever's elected. But we don't see TRIA as a partisan issue," said PCI's Mr. Parks.

But on most issues, insurers would find themselves more in agreement with a GOP-dominated government than a Democratic one, said David Winston, senior vp-federal affairs for the National Assn. of Mutual Insurance Cos. in Washington.

'TRIA will continue to be a critical issue in Congress and for the administration, whoever's elected.'

Carl Parks
Property Casualty Insurers Assn. of America

"Whether it's asbestos, class action reform or tort reform in general, one could say, as a general statement, that the industry would fare better under a Republican administration," he said.

But Mr. Winston stressed that "we're a bipartisan organization." The current composition of Congress—which is not expected to change dramatically as a result of next month's elections—means that industry has to have friends on both sides of the aisle, he said. To get any major initiative passed in the U.S. Senate "requires that you have significant Democratic support to get 60 votes," he said, referring to the number required to choke off filibusters and bring a bill to a vote.

The question of insurance regulation also defies partisan politics, noted Mr. Winston. NAMIC, like PCI, supports a continuation of state-based insurance regulation, although both groups want to see it reformed significantly. AIA, CIAB and RIMS also support the creation of optional federal charters for insurers that seek them.

"With respect to insurance regulation, you have to look at it on a member-by-member, committee-by-committee basis," said Mr. Winston.

Elections to decide top regulator in several states

By MEG FLETCHER

Incumbent insurance commissioners are seeking re-election this November in four of five state contests—Montana, North Carolina, North Dakota and Washington.

Newcomers will face off only in Delaware, where Republican incumbent Donna Lee Williams decided not to run.

More turnover among governor-appointed insurance commissioners may occur, though, depending on the outcome of gubernatorial races in six states.

Incumbent governors are not candidates in Missouri, Utah and West Virginia, according to the National Governors Assn. Incumbents are seeking re-election, though, in Indiana, New Hampshire and Vermont.

Business Insurance has highlighted the 10 main candidates seeking four-year terms as the top insurance regulator in their respective states.

Delaware

Voters will chose between two newcomers—Democrat Matthew Denn and Republican David H. Ennis.

According to statements on Mr. Denn's campaign Web site, he is an attorney with Wilmington, Del.-based Young, Conaway, Stargatt & Taylor L.L.P. He did not respond to repeated efforts by *Business Insurance* to contact him.

As Gov. Ruth Ann Minner's legal counsel from 2001 to 2003, Mr. Denn wrote and helped achieve passage of several of her legislative initiatives, including those protecting patients' rights.

Mr. Denn's key issues include the need to scrutinize workers compensation rate increases. He suggested allowing businesses to comment on proposed increases, "so the proper balance is struck." In addition to supporting auto rates that "are not excessive," he favors controlling the cost of health insurance and expanding coverage by creating a statewide buying pool for small businesses and individuals.

Republican candidate David H. Ennis, 64, has been a state representative for 24 years. For most of that time, he has served as chairman or vice chairman of the House's Banking and Insurance Committee. He also has served as a member of the National Conference of State Legislatures' task force on insurance.

Mr. Ennis also is a management consultant and community college administrator.

He said his qualifications include state and national experience in insurance matters, including testifying several times before Congress and "a reputation as a good facilitator."

Specifically, "I was asked to serve as a facilitator between hospital administration, physicians and trial lawyers," Mr. Ennis said. That resulted in the passage of legislation requiring that a judge approve an affidavit of merit provided by an expert witness before a health care negligence lawsuit can be filed. The measure also establishes a grace period for investigating the merits of potential claims and increases patient access to medical records.

In addition, Mr. Ennis said, "I am able to be more neutral on insurance issues" than his opponent, whom Mr. Ennis described as a trial lawyer.

Montana

Democratic incumbent John Morrison, 43, cites several accomplishments in his quest for a second term.

The former plaintiffs attorney emphasized the passage of a consensus privacy law, improved access to health insurance and the prosecution of insurance scams. During his tenure, the insurance department also rehabilitated a health insurance company and made Montana a captive domicile, he said.

He also oversaw the implementation of uniform technology-based regulatory procedures, such as agent licensing, which are encouraged by the National Assn. of Insurance Commissioners.

Nationally, Mr. Morrison said he has worked on the campaign against insurance fraud and on issues stemming from the Sept. 11, 2001, terrorist attacks.

He also has participated in the NAIC's Consumer Information Source, a service that provides consumers with a variety of information about insurers and helps them file complaints with insurance departments.

The Republican challenger is Duane Grimes, 47, who operates a business that warehouses and transports computer parts as well as other related operations, including the renting of vehicles.

Mr. Grimes, who earned a master's degree in public administration, previously worked in personnel administration for various state agencies from 1993 to 1999, mostly recently for the state's Department of Revenue.

Mr. Grimes said his background

Continued on next page

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Incumbent insurance commissioners are seeking re-election this November in four of five state contests—Montana, North Carolina, North Dakota and Washington.

Newcomers will face off only in Delaware, where Republican incumbent Donna Lee Williams decided not to run.

More turnover among governor-appointed insurance commissioners may occur, though, depending on the outcome of gubernatorial races in six states.

Incumbent governors are not candidates in Missouri, Utah and West Virginia, according to the National Governors Assn. Incumbents are seeking re-election, though, in Indiana, New Hampshire and Vermont.

Business Insurance has highlighted the 10 main candidates seeking four-year terms as the top insurance regulator in their respective states.

Delaware

Voters will chose between two newcomers—Democrat Matthew Denn and Republican David H. Ennis.

According to statements on Mr. Denn's campaign Web site, he is an attorney with Wilmington, Del.-based Young, Conaway, Stargatt & Taylor L.L.P. He did not respond to repeated efforts by *Business Insurance* to contact him.

As Gov. Ruth Ann Minner's legal counsel from 2001 to 2003, Mr. Denn wrote and helped achieve passage of several of her legislative initiatives, including those protecting patients' rights.

Mr. Denn's key issues include the need to scrutinize workers compensation rate increases. He suggested allowing businesses to comment on proposed increases, "so the proper balance is struck." In addition to supporting auto rates that "are not excessive," he favors controlling the cost of health insurance and expanding coverage by creating a statewide buying pool for small businesses and individuals.

Republican candidate David H. Ennis, 64, has been a state representative for 24 years. For most of that time, he has served as chairman or vice chairman of the House's Banking and Insurance Committee. He also has served as a member of the National Conference of State Legislatures' task force on insurance.

Mr. Ennis also is a management consultant and community college administrator.

He said his qualifications include state and national experience in insurance matters, including testifying several times before Congress and "a reputation as a good facilitator."

Specifically, "I was asked to serve as a facilitator between hospital administration, physicians and trial lawyers," Mr. Ennis said. That resulted in the passage of legislation requiring that a judge approve an affidavit of merit provided by an expert witness before a health care negligence lawsuit can be filed. The measure also establishes a grace period for investigating the merits of potential claims and increases patient access to medical records.

In addition, Mr. Ennis said, "I am able to be more neutral on insurance issues" than his opponent, whom Mr. Ennis described as a trial lawyer.

Montana

Democratic incumbent John Morrison, 43, cites several accomplishments in his quest for a second term.

The former plaintiffs attorney emphasized the passage of a consensus privacy law, improved access to health insurance and the prosecution of insurance scams. During his tenure, the insurance department also rehabilitated a health insurance company and made Montana a captive domicile, he said.

He also oversaw the implementation of uniform technology-based regulatory procedures, such as agent licensing, which are encouraged by the National Assn. of Insurance Commissioners.

Nationally, Mr. Morrison said he has worked on the campaign against insurance fraud and on issues stemming from the Sept. 11, 2001, terrorist attacks.

He also has participated in the NAIC's Consumer Information Source, a service that provides consumers with a variety of information about insurers and helps them file complaints with insurance departments.

The Republican challenger is Duane Grimes, 47, who operates a business that warehouses and transports computer parts as well as other related operations, including the renting of vehicles.

Mr. Grimes, who earned a master's degree in public administration, previously worked in personnel administration for various state agencies from 1993 to 1999, mostly recently for the state's Department of Revenue.

Mr. Grimes said his background

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in public policy would help him to improve the quality of life for residents, who, he said, deserve a healthy, competitive insurance climate, with affordable and accessible insurance. "A handful of public policies, particularly those that reduce litigation, can make all the difference," he said.

North Carolina

Democrat Jim Long, 64, is seeking his sixth term as insurance commissioner in North Carolina, which also includes the post of state fire marshal.

Mr. Long, an attorney, was first elected commissioner in 1984. He previously served as a state representative.

"After 20 years as insurance commissioner, I have the experience to keep our insurance industry on the right track. I negotiate fairly with insurance companies to keep rates low while maintaining a thriving, competitive market," he said. "I have the skills to deal with companies while keeping the citizens' interests in mind."

Mr. Long said his most important issues include protecting consumers through outreach programs, including hotlines. In addition, he is concerned about contributing to the safety of citizens through prevention programs and building code administration.

His Republican challenger is C. Robert Brawley, 60, who has been an insurance agent for 32 years; currently, he operates Brawley & Associates in Mooresville, N.C., which sells primarily life/health products. In addition, he had an 18-year career as a state representative through 1998, including serving on the House Insurance Committee for most of that period.

Mr. Brawley also holds a Chartered Life Underwriter designation and is a certified instructor in continuing education.

"My experience, knowledge and ability to work with others will change the Department of Insurance to a more responsive, efficient and consumer-friendly entity," Mr. Brawley said. "There will be better enforcement of rules and regulations in all areas regulated by the department, and there will be more competition in the North Carolina insurance market."

Earlier this year, Mr. Brawley said his priorities included a performance audit of the department and a meeting of health care industry participants to respond to the crisis in health care.

North Dakota

As he seeks his second term, Republican incumbent Jim Poolman, 34, pledges to "continue to work to maintain a competitive marketplace for insurance consumers but make sure there are strong safeguards in place to protect the buying public."

Mr. Poolman previously served eight years as a state representative. He also previously worked as a bank trust officer.

He was elected vp of the NAIC in December 2003 but resigned, citing family responsibilities when he declined to seek the organization's presidency in an interim election last month (*BI*, Sept. 6).

Mr. Poolman describes himself as "an aggressive yet fair regulator." During his tenure, consumers have benefited from new laws, including "some of the toughest privacy standards in the nation" as well as a crackdown on insurance fraud to save consumers "millions of dollars in prescription drug costs," he said.

Terry L. Barnes, 52, the owner of an auto glass repair operation, is the candidate for the Democratic-NPL (Non-Partisan League) Party.

Mr. Barnes emphasizes the importance of having a businessman who has paid insurance premiums in the post.

He said the state's residents need a commissioner who is "consumer-friendly." Mr. Barnes also said he is concerned about affordable health care, auto and long-term care insurance.

Washington

Democratic incumbent Mike Kreidler, 61, is seeking a second term because he believes that he can play a key role in finding workable solutions to the problems of rising insurance rates and the lack of medical insurance coverage, which "has hurt families and communities."

Mr. Kreidler said his legislative background at both the state and federal level helps him understand the process. He served as a U.S. representative from 1993 to 1995, and previously as a state senator , state representative and school board member.

In addition, Mr. Kreidler holds a master's degree in public health and a doctorate in optometry; he previously worked as an optometrist, print shop owner and founding director of the First Community Bank in South Puget Sound, Wash.

The Republican challenger is John Adams, 64, president and owner of brokerage firm Seattle General Agency Inc. He has 34 years of underwriting, brokering and claims experience, especially in marine insurance.

Mr. Adams, who also served as a director of a local school district, seeks to "enhance market opportunities and consumer confidence." The broker said that his goals of "industry regulation reform and cost-saving uniformity will make Washington a better place for both small business and citizens."

Also running is Stephen D. Steele, a candidate on the Libertarian Party ticket who received relatively few votes in the primary.

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Contentious campaigns mark medical malpractice reform efforts

State ballot initiatives feature tort reform choices

By SALLY ROBERTS

Voters will be doing a lot more than choosing a president when they go to the polls next month.

They also, among other things, will be voting on more than 150 state ballot measures, many of which affect employers in the areas of risk management and employee benefits.

Such matters as whether to repeal a controversial "pay or play" health care mandate, whether to increase tobacco taxes to pay for a variety of health care initiatives and whether to abolish one state's workers compensation insurance fund are just a few of the issues voters will be deciding Nov. 2.

Overall, though, tort reform measures are taking center stage this election year, with voters in at least six states deciding on nine ballot measures, most of which revolve around medical malpractice.

"There's been a lot of initiative activity on tort reform issues in the past, but (medical malpractice reform) is a new, emerging area of activity and one that is going to receive a lot of contentious campaigns in the states," said Kristina Wilfore, executive director of the Washington-based Ballot Initiative Strategy Center.

Measures in Florida, Nevada, Oregon and Wyoming are receiving the most attention, not only for their medical malpractice reform efforts but also for the contentious nature of the campaigns being waged.

In Florida and Nevada, for example, bitter battles are brewing between medical groups and the trial bar, which have put up competing measures.

While Florida's Amendment 3, for example, seeks to limit attorneys' fees in medical malpractice cases to no more than 30% of the first $250,000 in damages and no more than 10% of the damages in excess of $250,000, Amendment 8 would prohibit doctors who have committed three or more incidents of medical malpractice from being licensed to practice medicine in the state. And Amendment 7 would give patients the right to review, upon request, records of health care facilities' or providers' adverse medical incidents.

In Florida, "you've got the doctors and the medical associations that qualified the malpractice cap, and then you have two measures that the state's trial lawyers are behind that don't necessarily deal with the provisions of the medical malpractice cap but put a couple of measures on that put the heat back on the doctors," Ms. Wilfore said. "It's sort of like, 'I'll see your medical malpractice cap and raise you two of these issues.' "

In Florida and Nevada, bitter battles are brewing between medical groups and the trial bar, which have put up competing measures.

Similarly in Nevada, voters will decide on three medical malpractice initiatives—one that would cap noneconomic damages and two that would repeal any limit on damage awards.

Specifically, Question 3, known as the Keep our Doctors in Nevada initiative, would cap noneconomic damages in medical malpractice cases at $350,000, limit attorneys fees, allow installment payments for damages of more than $50,000 and hold doctors financially responsible only for their percentage of fault in injuries.

Question 4, known as the Insurance Rate Reduction and Reform Act, would mandate a 20% reduction in property/casualty insurance rates for homeowners, auto and medical malpractice insurance and freezes rates at the reduced level for one year. It also would eliminate any limits on malpractice awards and prohibit caps from being placed on attorneys' fees.

Question 5, known as the Stop Frivolous Lawsuits and Protect Your Legal Rights Act, seeks to guarantee an individual's right to a fair trial, to hire an attorney and to determine the amount of compensation. It also seeks to limit the state Legislature from amending or repealing any limit on damages.

Another hotly contested initiative is on the ballot in Oregon, where Measure 35 seeks to limit noneconomic damages in medical malpractice cases to $500,000.

"An expensive campaign is being

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waged (in Oregon), as trial lawyers battle the medical community and insurers on the issue," a spokesman for the Property Casualty Insurers Assn. of America in Des Plaines, Ill., said. "Supporters of the measure—primarily hospitals, medical groups and doctors—have raised over $5 million for the campaign, while opponents—mostly trial attorneys—have raised over $2 million," the PCI spokesman said.

Voters in Wyoming also face two constitutional amendments dealing with medical malpractice reform.

Constitutional Amendment C would authorize the state Legislature to mandate alternative dispute resolution or medical panel review before an individual could file a lawsuit against a health care provider for injury or death. And Constitutional Amendment D would authorize the Wyoming Legislature to enact laws limiting the amount of noneconomic damages that could be awarded in medical malpractice cases.

In California, voters will decide whether to repeal S.B. 2, the state's controversial 'pay or play' health insurance mandate.

But it's not just medical malpractice measures that have made it onto the ballot this year. Voters in at least two other states will decide on other tort reform measures as well.

In California, for instance, Proposition 64 would restrict the state's unfair business competition law, which currently permits unfair competition suits to be brought even when there are no actual victims. Law firms often file such suits, which are known as "shakedown lawsuits," when they perceive an alleged grievance but have no plaintiffs named on the suit.

The measure, among other things, would prohibit any person other than the attorney general or local public prosecutors from bringing lawsuits for unfair competition unless he or she has suffered injury and lost money or property.

And in Colorado, voters will decide on a constitutional amendment seeking to repeal a current law that limits pain and suffering damages to $250,000 in construction default lawsuits.

In addition to removing limits on the amount of damages a property owner could collect, Amendment 34 also would eliminate the current requirement that a property owner and construction professional try to resolve the problem before bringing a lawsuit.

On the health insurance front, California voters will decide whether to repeal S.B. 2, the state's controversial "pay or play" health insurance mandate.

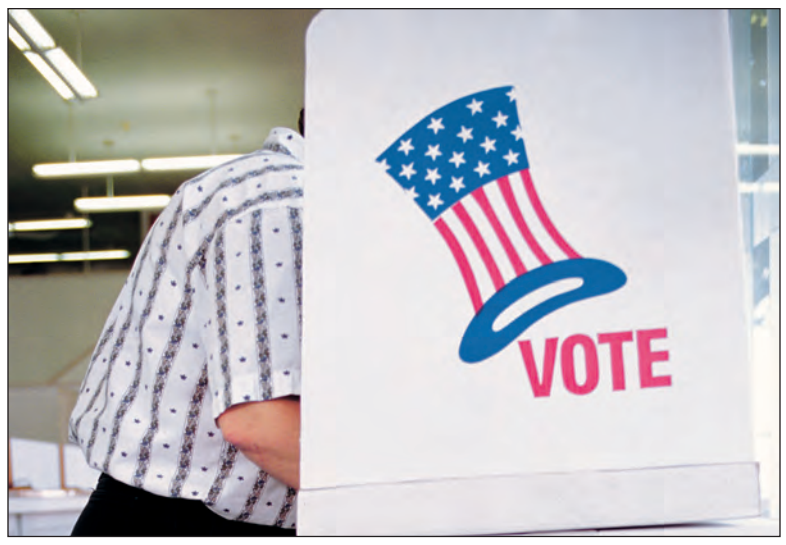
Under the mandate, which was passed by the Legislature and signed by then-Gov. Gray Davis in 2003, employers with 200 or more employees in the state would be required by Jan. 1, 2006, to pay a fee to the state or directly provide health insurance to employees and their dependents. Employers with 50 to 199 employees in the state would be required by Jan. 1, 2007, to provide health insurance to employees only.

Employers with between 20 and 49 employees in the state would be subject to the "play or play" provisions only if state law were to change to establish a tax credit equal to 20% of their state fee for health coverage. Employers with 19 or fewer employees are exempt.

In addition, three states—Colorado, Oklahoma and Montana—have initiatives on the ballot seeking increases on cigarette and tobacco taxes to help fund a variety of health care initiatives such as state health care programs, the building of a cancer center and Medicaid initiatives.

Similarly, California's Proposition 67 seeks to impose an additional 3% emergency telephone surcharge to help reimburse physicians and hospitals for uncompensated emergency medical care.

And in Oregon, voters will decide whether to enact Measure 38, which seeks to abolish the State Accident Insurance Fund, the state's quasi-public workers comp insurance fund, which has been the focus of a number of allegations of scandal.



Bush, Kerry offer contrasting plans for health care, pensions

Employee benefit issues mark candidates' differences

By JERRY GEISEL

WASHINGTON—Voters in the November presidential elections will cast ballots for two candidates with very different employee benefit agendas.

If President George Bush is re-elected, he says he will push for expanding health savings accounts and allowing employers to band together to purchase coverage through association health plans. On the pension side, President Bush would make a renewed push for new savings plans that individuals could establish.

His opponent, Sen. John Kerry, D-Mass., pledges to take a different approach to health care. He supports opening up a federal health insurance program to employers and individuals, while providing new health insurance premium tax breaks and creating federal subsidies for big health insurance claims.

Sen. Kerry also backs revamping federal law to allow the reimportation of lower-cost prescription drugs from countries such as Canada, while making a new push to enact patient protection and mental health care benefits parity legislation.

In sum, "the differences in approach on benefit issues are very apparent," said Anne Waidman, a principal in the human resources unit of PricewaterhouseCoopers L.L.P. in Washington.

"Health care represents one of the clearest differences between the two candidates," said Linda Bergthold, a consultant in the Los Angeles office of Watson Wyatt Worldwide.

On the health care side, the most striking difference in position between the two candidates involves HSAs, which Congress authorized last year as part of Medicare prescription drug legislation.

Under that law, employers, employees or both can make tax-deductible contributions to the accounts, which must be linked to high-deductible health insurance plans. Individuals can withdraw funds tax-free from their HSAs to pay for uncovered health care expenses, such as those that fall under a deductible. Unused HSA balances can be rolled over to pay for succeeding years' expenses.

On the campaign trail, President Bush has frequently championed HSAs and their portability. "You can take your account with you whenever you change jobs," he said during his acceptance speech at the Republican National Convention in New York.

While the HSA law is not even a year old, President Bush says it is time to expand the accounts through government tax breaks. He has proposed giving employers with 100 or fewer employees a refundable tax credit—up to $500 per employee—for contributions they make to employees' health savings accounts.

Additionally, for low-income individuals not covered by employer plans, President Bush's plan calls for direct government contributions of up to $1,000 a year to individual HSAs and refundable tax credits up to $2,000 to offset partially the cost of the premiums for the high-deductible health insurance plans linked to the individual HSAs.

Dallas Salisbury, president of the Employee Benefit Research Institute, a Washington-based benefits think tank, said President Bush's support of HSAs stems from his philosophy of an "ownership society," one in which the government gives individuals, through tax breaks, the means to fund a portion of their benefit expenses.

If Sen. Kerry is elected, he likely won't be backing an HSA expansion. In fact, the Massachusetts Democrat says he believes HSAs will lead to higher health insurance premium costs.

HSAs, he says, tend to attract healthier individuals, and "the people remaining in comprehensive coverage will be sicker and more expensive to insure, driving their premiums higher," according to a Kerry campaign document.

On the HSA issue, the candidates' difference of opinion is "striking," said Frank McArdle, a consultant in the Washington office of Hewitt Associates Inc.

They also differ on association health plans. President Bush is a strong proponent of AHPs, which would allow businesses—especially smaller firms—to band together and either purchase coverage from commercial health insurers or self-insure. He says that AHPs would give smaller firms greater negotiating leverage and would cut their costs. Additionally, the AHPs or insurers issuing policies would not be subject to state benefit mandates, which also could reduce costs.

Sen. Kerry, though, believes that AHPs would boost health insurance premiums for small employers not in the arrangements and lead to an increase in the number of uninsured individuals, according to a Kerry campaign document.

Rather than supporting AHPs, Sen. Kerry has proposed that small employers be allowed to purchase coverage through a pool linked to the health insurance program that now covers more than 8 million federal employees and retirees.

Coverage expansion

Both candidates also support the use of tax credits to expand coverage, though their approaches would differ. Sen. Kerry backs a 50% tax credit for small employers to offset partially the health insurance premium costs of lower-income employees. He also supports a 75% health insurance tax credit for lower-income individuals between jobs.

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Aside from the HSA tax credit to small employers contributing to the accounts, President Bush backs health insurance premium tax credits for lower-income individuals not covered under group plans. These annual credits would total $3,000 for families and $1,000 for individuals.

Sen. Kerry has also proposed that the federal government essentially reimburse employers for 75% of any individual health insurance claim exceeding $30,000. As a condition for receiving this federal subsidy, an employer would have to extend health care coverage to all its employees, including part-time employees.

In addition, Sen. Kerry has proposed that the federal government pick up the full cost of children enrolled in the Medicaid program. Such costs currently are split between the federal government and the states.

In turn, states would have to boost the amount of money individuals could earn and still be covered by Medicaid.

In the prescription drug area, Sen. Kerry would expand last year's Medicare drug law to create what his campaign calls "a meaningful, affordable drug benefit that doesn't force seniors into HMOs." He also suggests that that the drug benefits be administered through Medicare, rather than through private health insurers contracting with Medicare.

In contrast, President Bush has repeatedly hailed the Medicare prescription drug law as the most significant enhancement to Medicare in the program's nearly 40 years. He has given no indication that he would change the law if re-elected.

In an another drug benefit issue, Sen. Kerry says he would change federal law to permit the reimportation of drugs approved by the Food and Drug Administration. The Bush administration has opposed such a change. In recent months, several states, including Illinois and Wisconsin, have developed or examined reimportation programs (see story, page 3).

Patient protection

Both President Bush and Sen. Kerry support patient protection legislation, but their current interest in the issue likely differs. While President Bush in 2001 supported a compromise patient protection bill that narrowly passed the House, he has since spoken little on the issue, while his campaign documents make no mention of patient protection legislation.

By contrast, Sen. Kerry says that, if elected, he would push for patient protection legislation that would, among other things, give patients the right to see specialists and "to hold health plans accountable."

While not explicitly clear on the details, Sen. Kerry suggests that he would seek the enactment of legislation to require health insurance plans to cover mental illness expenses on the same basis as they cover other physical disorders.

"John Kerry and John Edwards will fight for mental health parity to end all discrimination against those with mental illness," states a campaign document.

President Bush's support for mental health care parity coverage is more limited. Two years ago, he said he supported parity for "serious" mental illnesses—which he did not define—but said he would oppose a parity expansion if it significantly increased health care costs.

Neither candidate has devoted much attention to pension issues, though President Bush has said that pension law should recognize that workers today change jobs with much greater frequency than did prior generations.

Perhaps in recognition of that, he has proposed legislation that would allow individuals to contribute up to $7,500 a year to so-called "lifetime savings accounts." While the contributions would be made with aftertax dollars, the earnings would accumulate tax-free and distributions could be taken any time without penalty or taxes.

President Bush also backs what he calls "retirement savings accounts," that would allow employees to contribute up to $7,500 a year in aftertax dollars to the accounts. Distributions could be taken tax-free after age 58.

On the retirement side, Sen. Kerry has proposed providing tax credits to small employers to partially defray the cost of setting up new pension plans. Sen. Kerry has not detailed the amount of the credit, though, or whether the credit would be available for new defined benefit plans, new defined contribution plans or both.

Commentary

Safe packaging, unsafe consumers

This may seem like ranting, and maybe it is. But the message is nonetheless important, and someone has to stand up and say it—for consumers' welfare and for the good of the risk management community.

We Americans are too well-protected by corporate risk management, which, oddly enough, can be a dangerous thing.

I realized this when I nearly killed myself trying to open a package of chemicals to dump into my toilet tank. You know the product: a blue and a white tablet that you pitch into the tank so that your commode water has that unmistakable poor imitation ocean blue appearance that tells visitors that they do not need to don their haz mat suits in your washroom.

Dave Lenckus

The cardboard packaging tore away easily enough from the plastic envelope in which the tablets were sealed. Even the perforated plastic envelope allows the consumer to easily divide the two individual compartments in which the tablets are contained. Why these tablets have to be separated, I don't know. Since they don't begin their chemical action until they are in water, maybe this is just some cruel joke by packaging engineers.

That's the only reasonable explanation, given that these plastic envelopes are nearly impossible to open, and separate compartments mean that consumers will have to struggle twice with this packaging. These things go light-years beyond being childproof. Houdini couldn't have escaped from one of these things, even if his hands were free and he had an oversized oxygen tank and a cordless circular saw to work with.

I didn't realize this until too late, though. At first, when I couldn't tear the package open with my hands, I assumed full responsibility and made a mental note to visit the gym more often. When Junior's school scissors didn't even scratch the pristine white packaging material, I blamed the scissors, which barely can hack through construction paper.

I next turned to my handy pocketknife, which Junior gave to me as a birthday present. I had used this little tool many times to tighten screws, open soda pop bottles and, most importantly for the chore I faced, easily slice through the packaging tape used to seal boxes sent through the mail.

But even the little red pocketknife that could struggled against the consumer-resistant packaging material that stood between me and a good housekeeping seal of approval. Though increasingly frustrated about the amount of energy and time I was spending on this task, I continued to fight with the packaging.

Unfortunately, my carelessness grew commensurately with my perseverance and frustration. As I wrestled with the packaging, the pocketknife slipped across the slick plastic envelope and across my stomach.

I was stunned for a moment at the potential gravity of the situation. Then, slowly, I peered down with dreaded anticipation. I was pretty relieved to discover I hadn't died what would have been a most embarrassing death: losing a knife fight with an unarmed toilet bowl-cleaning product.

I freely admit that if I had been injured, I would have borne full responsibility. Everybody knows that you never draw a cutting instrument toward yourself. You have to jab at the material you want to cut, though preferably not while it's on your dining room table or kitchen counter top.

But, c'mon. Why does this packaging have to be impenetrable?

And the problem is not limited to bathroom cleaning products. Packaging for other consumer chemicals, such as chlorine shock for swimming pools, is just as physically challenging to open.

Given the problems with consumer product tampering during the 1980s and early 1990s, I understand and applaud Corporate America's efforts to eliminate that risk with our food, beverage and pharmaceutical products.

But risk managers, please, allow consumers to open their germ- and algae-fighting chemicals and similar products without so much hassle.

What are you trying to protect us from? Someone slipping some poison into our poison? Or are you concerned we'll get confused and ingest our bags of nasty chemicals if some loon spikes it with something healthy, like green beans?

I think the far bigger threat is the potential litigation by consumers who suffer heart attacks, broken teeth and knife wounds while trying to tear through your product packaging.

At least the company that made my pocketknife has the right idea about packaging noningestable products. My son, under my supervision, picked out that gift from a bucket of loose, unpackaged pocketknives sitting on the hardware store counter.

Dave Lenckus can be reached at dlenckus@businessinsurance.com.

Comings & Goings

Mr. Benson

Mr. Derdzinski

Ms. Littlefield

Mr. Hickey

Agents/Brokers:

Denver-based Lockton Cos. of Colorado Inc. has named **Craig Nelson** senior vp, commercial insurance department manager. Previously, Mr. Nelson was senior vp, unit manager for the risk management unit.

Richard Huntington has joined Savannah, Ga.-based Palmer & Cay Inc. as Southwest health care practice leader in Dallas. Previously, Mr. Huntington was relationship manager in Aon Corp.'s Dallas office.

David Rudman has joined London-based Heath Lambert Group Ltd. as director in the Manchester, England, office. Previously, Mr. Rudman was regional client servicing director for Aon Corporate Risks.

Itasca, Ill.-based Arthur J. Gallagher & Co. has made two senior-level appointments:

Cindy LaMantia has been named executive vp of Arthur J. Gallagher Risk Management Services Inc. Previously, Ms. LaMantia was a senior vp at Marsh & McLennan Cos. Inc.

Michael McHugh has been named senior vp of AJGRMS. Previously, he was a vp at Marsh.

Willis Group Holdings Ltd. has made two appointments in its Denver office:

David C. Benson has been named executive vp and office leader. Previously, Mr. Benson was a client executive and new business development leader for Marsh.

Hugh Devlyn, a former vp at Aon, has joined Willis as an executive vp of the broker.

Racine, Wis.-based Johnson Insurance Services L.L.C. has named **Mike Derdzinski** executive vp of employee benefits. Previously, Mr. Derdzinski was president of the Wisconsin market for Humana Inc.

Insurers:

XL Weather & Energy Inc. has appointed **Michael Corbally** senior managing director and chief operating officer. Mr. Corbally was a co-founder of the Stamford, Conn.-based XL Capital Ltd. unit in July 2000 and was responsible for establishing and managing its risk management portfolio.

Hamilton, Bermuda-based Quanta Capital Holdings Ltd. has named **Deirdre Littlefield** president of insurance. Most recently, Ms. Littlefield was president of marine, technical risk and aviation at Quanta. Ms. Littlefield succeeds **Robert Fishman**, who left the company for personal reasons.

ACE Overseas General has named **David Robinson** executive vp, financial lines. Mr. Robinson, who will be based in London, previously was European specialty insurance manager at Chubb Corp.

Other providers:

William A. Hickey has been named chief operating officer for Cochran, Caronia & Co. Before joining the Chicago-based investment banking firm specializing in the insurance industry, Mr. Hickey was chief financial officer and executive vp of Kemper Insurance Cos.

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

Business Insurance®
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James Hardie CEO, CFO quit after report

By ELIZABETH FRY

SYDNEY, Australia—Two senior executives of James Hardie N.V. resigned their positions late last month, shortly after an inquiry determined that they had withheld information from actuaries assessing the company's exposure to asbestos claims.

James Hardie Chief Executive Officer Peter Macdonald and Chief Financial Officer Peter Shafron both resigned their positions but will remain with the company, according to a James Hardie statement. The building products manufacturer, which previously was based in Sydney, Australia, now has headquarters in Amsterdam, Netherlands.

"Mr. Macdonald will maintain responsibility for business operations, and Mr. Shafron will undertake a number of projects for the company, outside the CFO's function, in both the United States and the Netherlands," according to the statement.

PHOTO:NEWSPIX

Mr. Macdonald

The resignations follow several months of problems for the company that arose following its redomestication to Amsterdam in 2001. As part of the move, James Hardie set up a trust, the Medical Research & Compensation Foundation, providing $293 million Australian ($154 million) to pay all claims related to its former asbestos producing subsidiaries. Citing actuarial assessments, the company attested to regulators that the fund was adequate to cover its liabilities, but it was later found to have a projected funding shortfall of $2 billion Australian ($1.44 billion) (*BI,* Aug. 16).

A New South Wales government commission set up to investigate the redomestication last month issued a report faulting Messrs. Macdonald and Shafron for withholding critical data from the actuaries advising James Hardie on the likely cost of future claims. In addition, the commission determined that Mr. Macdonald had knowingly made "misleading" statements to the Australian Stock Exchange about the adequacy of the trust's funding (*BI*, Sept. 27).

Following the publication of the commission's findings, the Australian Securities and Investments Commission announced that it would launch an investigation.

In a letter to the Australian Stock Exchange announcing his resigna-

See ASBESTOS/page 24

Auto parts makers offered recall cover

By CAROLYN ALDRED

A new London market facility is offering primary product recall insurance for U.S. automotive component suppliers left stranded earlier this year when the market for such coverage disappeared.

London-based Aon Ltd.'s Product Risk Management team created a facility underwritten by a Lloyd's of London syndicate, a European-based insurer and an international insurer, said Director David Palmer.

PHOTO: GETTY

Automakers are increasingly pushing the costs of vehicle recalls onto component suppliers.

The facility was created because of a huge demand for product recall coverage from U.S. suppliers to the automotive industry, he said.

Automotive manufacturers and original equipment manufacturers increasingly are pushing the costs of vehicle recalls onto component suppliers and even demanding that component suppliers have liability insurance to cover product recalls, according to insurance brokers.

Product recall has become a major concern following massive recalls in 2000 and 2001 by Dearborn, Mich.-based Ford Motor Co. and Nashville, Tenn.-based Bridgestone/Firestone Inc. of defective tires on Ford vehicles. The Transportation Recall Enhancement, Accountability and Documentation Act of 2000, which mandated increased reporting of product failures to the National Highway Traffic Safety Administration, also raised concerns.

New York-based American International Group Inc., previously the major primary insurer of such coverage, exited the market late last year (*BI,* April 5).

Although high excess coverage is available from some reinsurers, "there has been a gaping void for U.S. risks for about a year" for primary coverage, said Mr. Palmer.

"U.S. automotive suppliers suffered a huge setback when AIG pulled out of the market. There has been a mass scramble to try and find cover but no new capacity," said Justin Whitehead, a director of London-based broker RK Harrison Insurance Brokers Ltd.

Many U.S.-based automotive component manufacturers have approached RK Harrison, a leading broker in the food and beverages product recall market, seeking coverage for their industry during the last year, Mr. Whitehead said.

Up until now, a few London-based underwriters have offered limited coverage, but mainly for European-based suppliers of noncritical components, he said.

"We are still getting a lot of inquiries, and there is a crying need for additional capacity," he said.

The new facility offers $10 million to $50 million in coverage, depending on the policyholder's retention, said Mr. Palmer. Policyholders also must have a risk assessment by Darien, Ill.-based RQA Inc., a product recall consultant. RQA's risk management services are available through the policy.

Mike Stankard, managing director of Aon Corp.'s heavy industry practice in Detroit, believes most demand for the new capacity will come from small to midsize manufacturers. "The larger…suppliers are turning to captive or finite risk solutions to cover their product recall coverage risks," he said.

FERMA debates standards' efficacy

By PETA MILLER

BRUSSELS, Belgium—The practice of risk management varies too widely and is evolving too quickly to be subject to specific standards, according to a leading European risk manager.

Instead, risk mangers should use guidelines that allow for differences in companies' interpretation of risk management, said Pierre Sonigo, group and environmental risk manager at Pechiney Groupe in Paris, a unit of Montreal-based Alcan Inc.

But such an approach will likely increase calls for regulations to be imposed on risk managers, said Nicki Dennis, head of risk market development at the British Standards Institution, an independent body that represents the United Kingdom in the development of some European Union legislation. Ms. Dennis said that risk managers should become more involved with standards development.

The two spoke at a seminar on European practices and corporate governance trends held last week in Brussels, Belgium. The seminar was sponsored by the Federation of European Risk Management Assns.

In 2003, FERMA adopted the risk management standard developed in the United Kingdom by the Institute of Risk Management, the Assn. of Insurance & Risk Managers and the Assn. of Local Authority Risk Managers.

The standard—which is now available in Danish, Dutch, French, German, Italian, Japanese, Polish, Portuguese, Spanish and Swedish—seeks to define risk management terminology, the risk management process, risk management structure and the objective of risk management. It calls for risk managers to build a risk-aware culture within their organizations; develop a risk-response process, including contingency plans and business-continu-

See FERMA/next page

Risk management, insurance functions separating: Survey

By PETA MILLER

BRUSSELS, Belgium—Risk management is now a well-established discipline within many European companies and is separated from the insurance buying function at well over one-third of organizations, according to a survey conducted for the Federation of European Risk Management Assns.

But responses differed markedly depending on where the risk managers were based, and there is growing concern that such a separation could eventually relegate risk managers at some organizations to a strict insurance-buying role, said FERMA's president.

The survey, "Risk Management: An Assessment for European Practices in 2004", was conducted between May and June by Ernst & Young and AXA Corporate Solutions and drew 269 responses from European risk managers.

FERMA issued the survey's findings last week at a seminar on European practices and corporate governance trends that it sponsored in Brussels, Belgium.

It found that 78% of risk managers said their companies have a

See SURVEY/next page

World Updates

Typhoon damages mounting in Japan

Deadly typhoons are continuing to devastate Japan, as insured property damage reaches billions of dollars. Typhoon Meari, the most recent of eight to hit the country this year, left at least 17 dead and scores of injuries as it skirted Tokyo earlier this month and blew through areas southwest of the city. Meanwhile, insured property damage from Typhoon Songda, which hit Nagasaki in early September, is estimated to reach about $2.4 billion, according to the Tokyo-based General Insurance Assn. Songda arrived a week after Typhoon Chaba, which the GIA says will cost insurers around $720 million.

Chaucer changes capacity plans

Lloyd's of London insurer Chaucer Holdings P.L.C. said it has scrapped plans to reduce the 2005 capacity of its syndicate 1084 from £400 million to £375 million ($719.0 million to $674.1 million). Chaucer said it would maintain the syndicate's capacity at £400 million to take advantage of potentially higher property and energy rates following the recent string of hurricanes in the United States. The decision follows a similar move by Hiscox P.L.C. earlier this month.

Sirius to acquire Tryg reinsurance assets

Sirius International Insurance Corp. of Sweden has agreed to buy the active reinsurance assets of Tryg Vesta Group, intending to run them off at a profit. Sirius, which is a member of White Mountains Insurance Group Ltd., said it likely will renew select property accounts within the portfolio from Copenhagen, Denmark-based Tryg-Baltica Insurance, International Insurance Co. A.S. TBI wrote gross reinsurance premiums of 716 million Danish kroner ($119.4 million) in 2003. Tryg Vesta Group in Copenhagen said in a statement that it will receive 315 million Danish kroner ($5.3 million) for the sale of its TBI unit.

Briefly noted

Swiss Reinsurance Co. expects its losses from **Hurricane Jeanne**, which struck Florida last month, to total $150 million. The Zurich-based reinsurer estimates its losses from the four recent U.S. hurricanes and Typhoon Songda in Japan will be around $750 million...**Sampo P.L.C.** has paid 269.8 million euros ($334.8 million) to Varma, Finland-based Varma Mutual Pension Insurance Co. for its 10% holding in If P&C Insurance. Sampo is now the sole owner of If.

FERMA: Opinions differ on efficacy of standards

Continued from previous page

ity programs; and prepare reports on risk for their organizations' boards and stakeholders.

But Mr. Sonigo, who is also general secretary of FERMA, questioned the need for the standard. "Standards are not good for the industry," he said.

Mr. Sonigo said standards are also dangerous because they can become a reference for legislation. "There is no way you can escape them once they are in existence," he said.

Also, risk management, like other forms of management, is such a broad discipline that the imposition of standards could be restrictive, Mr. Sonigo argued.

"If you start to standardize management, you are telling industry there is only one way of doing things," he said.

"The organization of risk management in companies varies widely, reporting varies widely, the scope of risk management, the size of department, how can that be standardized?" Mr. Sonigo asked.

And the discipline of risk management is still evolving, he added. "Right now, risk management is not in its final form, and we are not ready to produce a standard," he said.

In addition, cultural differences affect the way risk managers in different countries handle risks, Mr. Sonigo said.

The cost of implementing risk management standards is also a deterrent, he said. "Implementation requires substantial resources, externally and internally," he said.

"We should only have guidelines," Mr. Sonigo said.

But Ms. Dennis of the BSI countered that, if risk management standards are not adopted, legislators will likely impose regulatory frameworks instead.

She said that risk managers, instead of opposing standards, should communicate with national standards bodies about good and bad standards and influence the process of drafting standards.

"More people should be getting involved in standards development, instead of waiting until standards come out," she said.

Survey: Functions diverge

Continued from previous page

defined risk management policy and, out of these, 62% said they have the direct support of their senior executives.

A further 42% of risk managers said that their companies now separate their risk management and insurance functions.

There were significant differences, however, between countries on this issue.

In the United Kingdom and Germany, 62% of respondents said separate departments performed risk management and insurance buying, compared with 36% of French respondents.

The separation of insurance buying and risk management can stifle the ambitions of traditional risk managers as companies often recruit externally for the broader risk management position, said Thierry Van Santen, president of Brussels-based FERMA. When external appointments are made, the incumbent risk managers often end up as insurance managers for the organizations, he said.

"That is a big trend and (the reason) why FERMA is saying (risk managers) must move toward this new direction and be recognized as the one able to do the job," said Mr. Van Santen, who is director of risk management at Groupe Danone in Paris.

Regis Demoulin, chief commercial officer at Paris-based AXA Corporate Solutions S.A. and part of the panel presenting the survey, added that some European organizations entrust insurance purchasing to the procurement department.

Groupe Danone was faced with this issue when it was reorganizing its risk management department to ensure that it reported directly to senior management, Mr. Van Santen said.

His company ultimately decided that insurance financing must be part of the risk manager's role.

In response to survey questions about the insurance market, 79% of respondents said traditional insurance providers meet most of their coverage needs.

There is sufficient capacity for terrorism cover at an appropriate cost in the traditional insurance market, 59% of respondents said, but 48% said they were prepared to keep terrorism within their retention.

Asbestos: Executives resign after report

Continued from page 21

tion as CEO, Mr. Macdonald acknowledged the government commission's findings and said: "In the interests of James Hardie and its shareholders, the board and I have agreed that I will step aside…pending further clarification of these findings."

'The fund would like to see a negotiated settlement with James Hardie, but we are looking at the RICO legislation as a fallback position.'

Nancy Milne
Clayton Utz

James Hardie has offered to establish an additional compensation program to meet asbestos claims not covered by the MRCF, though is has not said how much additional funding it would be willing to provide (*BI*, July 19).

Lawyers for the MRCF fund said late last month that if James Hardie does not reach a satisfactory settlement with asbestos victims, the fund would sue the company under a U.S. anti-racketeering law. James Hardie is listed on the New York Stock Exchange, and a significant portion of its revenue comes from the United States.

Nancy Milne, a senior partner with Sydney law firm Clayton Utz, which represents the fund, said the MRCF is prepared to take action under the federal Racketeer Influenced and Corrupt Organizations Act.

"The fund would like to see a negotiated settlement with James Hardie, but we are looking at the RICO legislation as a fallback position. Our advice from our lawyers in the U.S. is that is that RICO legislation would be our best prospect," she said.

Tort: Political clout seen as key

Continued from page 4

not going to change the tort law," he said.

Linda Woggon, vp-governmental affairs for the Ohio Chamber of Commerce in Columbus, said that pro-reform efforts there resulted in comprehensive civil justice reform legislation in 1987, but the reforms were "chipped away by the courts until there was nothing left."

As result of unfavorable judicial rulings, reformers in Ohio turned their attention to judicial races, notably those involving the state Supreme Court, and ultimately managed to elect a pro-reform majority, she said. That majority will be tested next month, when Ohioans choose justices for the next six years.

Reform forces had some trouble in the state Legislature because of Ohio's term limit law, which results in "constant turnover," she said. Further complicating the matter is that the real electoral contest is often at the primary election level for Republicans, which can mean choosing candidates who are much more concerned about social issues than legal reform, she said. She cautioned, however, that there is no guarantee that simply because a lawmaker happens to be Republican that he or she will have any great enthusiasm for tort reform.

In Mississippi, unity among the business community and the election of an unabashedly pro-reform governor proved key to achieving significant reforms in a state that has often been cited by reformers as one of the most plaintiff-friendly in the country, said Andrew R. Stephens-vp policy and research for the U.S. Chamber Institute for Legal Reform in Washington.

Republican Gov. Haley Barbour and his running mate, Amy Tuck, made tort reform "a centerpiece of their campaign," said Mr. Stephens. At the same time, business groups remained committed to tort reform rather than splintering over parochial concerns, such as those that have doomed some federal tort reform efforts, said Mr. Stephens.

Michelle J. White, a professor of economics at the University of California at San Diego who has researched patterns in asbestos litigation, noted that over the past 30 years or so, asbestos liability cases have migrated to state courts considered to be the most favorably disposed toward plaintiffs. "Forum shopping is very profitable," she said.

In a particular state, plaintiffs attorneys will look for a court with a pro-plaintiff reputation—often a small court with only a couple of judges—in which to file asbestos-related class actions, she said. Securing pro-plaintiff judges means that procedural questions will often be answered in a pro-plaintiff manner, said Ms. White, who stressed that she is an academic and not working for or against tort reform.

"Tort reform goes beyond one state, two states, three states," she said. There will always be a state that is the most favorable to the plaintiffs bar, she said.

Michael S. Greve, director of the Federalism Project and the Liability Project at the AEI, moderated the discussion.

Annual SIIA event draws 1,500

MIAMI—The Self-Insurance Institute of America Inc. has a new look.

The organization unveiled an updated logo at its 24th Annual National Educational Conference and Expo, held Sept. 28-Oct. 1 in Miami.

The development of the new symbol, which retains its depiction of an American eagle, is part of an effort by the group to establish the SIIA brand as pre-eminent within the self-insurance and alternative risk transfer markets.

The conference drew approximately 1,500 attendees to the Fontainebleau Hilton Resort in Miami Beach.

The event, held shortly after Hurricane Jeanne swept through the state, saw very few cancellations due to the storms that pounded Florida in the preceding weeks, although some panelists were unable to attend.

SIIA will hold next year's conference in New Orleans Oct. 18-21.

More information is available from the Simpsonville, S.C.-based SIIA at 800-851-7789 or at *www.siia.org*.

Healthy: Incentives aid behavioral change

Continued from page 4

"So what we're trying to do is bring intervention earlier into the process than what we do right now," Mr. Hodsdon said, by identifying workers who need health care management services before they become claimants. "Creating a care plan around whatever their needs are—that's going to give us an advantage in containing costs."

Mr. Hodsdon stressed that the aim is not to create a methodology to ensure that all workers are of the perfect height and weight and are disease-free. Rather, "if you have a condition that we know is directly attributable to lifestyle, you now have an obligation to participate in a care-planning process to ensure that you are doing everything possible to control that disease condition. That doesn't mean you're suddenly going to lose 50 pounds or mean that you are…magically not diabetic," he said.

However, such plans would impose a responsibility on workers to avoid lifestyles that would exacerbate their conditions, Mr. Hodsdon said.

"If you are diabetic, you're going to have your hemoglobin tested, you're going to go to your primary care physician at the dates and times indicated, you're going to be on a walking program, you're going to monitor your blood sugar. There's a level of compliance that you are bringing to the table, that you are expected to provide, that you didn't have to historically," he said.

'If you have a condition that we know is directly attributable to lifestyle, you now have an obligation to participate in a care-planning process.'

Richard Hodsdon
HHS Health Options

If workers do not take on accountability under such programs, "there is a premium that you're going to have to pay for that," Mr. Hodsdon said.

For example, a plan might be designed that imposes a 10% copayment on members that participate in the enhanced case management and a 40% copay on those that do not, he said.

Employers who implement such programs generally see health care spending fall by around 3% in the second year and around 9% in the third year, Mr. Hodsdon noted.

Despite any company savings, he warned, not all employees are going to be enthusiastic about such a big cultural change, and a backlash likely will be felt. "This is not going to be well received, by and large," he said.

SIIA National Educational Conference and Expo

Claims outsourcing can benefit TPA clients

By MICHAEL BRADFORD

MIAMI—Employers using third-party administrators that outsource claims to offshore service providers should be aware of both the advantages and pitfalls that come with such arrangements, an executive with a company that provides outsourcing services contends.

Employers need to ask a few questions of their TPAs to determine whether claims are being sent offshore and to ascertain the reliability of those outsourcing services, said Brij Sharma, chief executive officer of Tela Sourcing L.L.C., a Baltimore-based company that provides outsourcing services.

It is important that a vendor providing outsourcing services have the proper "ramp-up capability," said Mr. Sharma, whose company operates a facility in India that provides U.S.-based TPAs with claims administration services. "You need to make sure the offshore vendor understands what the business needs are" and can handle an increasing volume of claims from a TPA without a decline in the level of service, he said.

'You need to make sure the offshore vendor understands what the business needs are' and can handle an increasing volume of claims without a decline in the level of service.

Brij Sharma
Tela Sourcing L.L.C.

Another good question for employers to pose is, "What are the benefits the TPA has seen, and how much will be passed to the self-funded plan?" Mr. Sharma said.

Speaking in a session at the Self-Insurance Institute of America Inc.'s annual conference in Miami, Mr. Sharma said employers should get better turnaround times on claims administered by TPAs that outsource vs. those that don't.

Mr. Sharma said that low-cost labor in India and China helps drive the savings from outsourcing. "At this point in time, clearly, India has an advantage," he said, because of the country's large pool of skilled, English-speaking labor.

Apart from the savings, outsourcing has other benefits, Mr. Sharma said. TPAs become more efficient because they can file their claims electronically to offshore locations at the end of the day and have them administered and back on their office computers by the next morning, he said.

If a TPA is not outsourcing, an employer should find out why not, Mr. Sharma said. TPAs, he said, will save money as well as improve service to their clients by outsourcing.

"From a pure cost perspective, I don't think any argument can be made against outsourcing," Mr. Sharma said. TPAs typically see sav-

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Claims: Outsourcing can benefit clients

Continued from previous page
ings of 30% to 40% when they outsource functions of their claims management services, he said.

There are some caveats, though, for TPAs that are considering sending claims offshore, Mr. Sharma said.

Outsourcing is booming, he said, and anyone with the capability to take on work is jumping on the bandwagon. "Every (information technology) company in India is ready to provide outsourcing to health care plans. You need to evaluate whether a vendor has the expertise you need for the level of service you provide," Mr. Sharma said.

It is also important to make sure the service provider has proper training and recruitment processes in place, he said.

"Do they have any health care clients, or are you going to be a guinea pig for them?" Mr. Sharma asked.

He told SIIA attendees that the Health Insurance Portability and Accountability Act "is a very big issue" when it comes to privacy and security issues. The TPA must make sure that a vendor has in place the proper guidelines and safeguards to make sure that information protected under HIPAA is guarded.

Mr. Sharma referred to a case in which a Pakistani medical records transcriber threatened to post protected health information on the Internet if she wasn't paid for her work. The transcriber, who was working on records that had been outsourced four separate times, withdrew her extortion threat after receiving partial payment (*BI*, May 31). The incident illustrated some of the privacy concerns related to outsourcing.

Employers and TPAs should know what safeguards vendors have in place to protect information and whether records are passed along to other vendors. "What are the checks that they have in place?" Mr. Sharma asked.

SIIA National Educational Conference and Expo

Self-insurers see contrast in Bush, Kerry

By MICHAEL BRADFORD

MIAMI—Self-insured employers will face one of two very different approaches to health care after the November elections.

Republicans and Democrats have "starkly different, divergent approaches about what to do about health care," said George J. Pantos, Washington counsel for the Self-Insurance Institute of America Inc.

Speaking at the SIIA's recent annual conference in Miami, Mr. Pantos said that the two sides could hardly be more different in the way they address health care concerns, with the Republicans favoring a largely privately funded approach and the Democrats favoring a government-backed catastrophe program.

President Bush advocates tackling the problem of the 44 million uninsured through a program of tax credits, expanded community health centers and allowing association health plans to offer coverage across the country, according to Mr. Pantos. The president also supports tax-deductible health savings accounts, limits on medical malpractice awards and other reforms, Mr. Pantos noted.

The president's opponent, Massachusetts Sen. John Kerry, advocates eliminating tax cuts for the wealthy to fund a government program that would pay 75% of catastrophic health care claims above $30,000 in 2006 and $50,000 in 2013, according to Sen. Kerry's Web site.

Stop-loss insurance is 'an indemnification of the employer for the employer's assumption of risk in the payment of a benefit under a self-funded plan. It's not health insurance.'

George J. Pantos
Self-Insurance Institute of America

The Democratic approach would likely lead to more government involvement in all health care plans, including self-insured plans, he said.

"It's inescapable that, if the government were paying that bill, the government would probably be making decisions as to what's covered," Mr. Pantos said.

"I bring this to your attention," he told SIIA members, "because if there is any likelihood of this bill being introduced in a Kerry administration, then I think we've got a lot of work to do to point out the shortcomings."

Mr. Pantos pointed out that while Sen. Kerry has opposed such SIIA-backed positions as capping medical malpractice awards, the senator does favor prohibiting medical malpractice lawsuits unless a qualified specialist deems the claim reasonable. "He also favors nonbinding mediation" of malpractice claims, Mr. Pantos said of the Democratic candidate.

At the state level, SIIA continues its battle to prevent states from taxing stop-loss insurance to make up deficits in state-run high-risk pools.

Rather than increase taxes, some states have made moves to assess health insurers to make up shortfalls in the pools and are looking to stop-loss underwriters to participate, Mr. Pantos explained. "The argument is that it's not fair for the stop-loss carriers not to pay their fair share of the burden."

But, Mr. Pantos said, stop-loss insurance is "an indemnification of the employer for the employer's assumption of risk in the payment of a benefit under a self-funded plan. It's not health insurance."

Because such assessments would be passed along to employers that sponsor self-funded plans, the charges would have an impact on those plans, Mr. Pantos said. Such moves should, therefore, be disallowed by the federal Employee Retirement Income Security Act, which pre-empts the state regulation of self-funded plans, he argued.

The assessments would affect the design and content of self-funded plans, Mr. Pantos said, because decisions regarding plan design are made with access to stop-loss insurance in mind. "Any policy decision of this kind that would impact on the way a plan is funded, in my view, would affect the administration of the plan. This has not been tested yet, clearly, but we contend that this certainly would be a case that would be ripe for a challenge under ERISA pre-emption if it were to come to court. And we make that point in our discussion with the state insurance departments."

More DC plans using money managers

By PHYLLIS FEINBERG

Defined contribution plan sponsors offered professionally managed accounts at a sharply higher rate in 2003 than in 2002, up to 21.8% of all plans, compared with 13.6% the year before, according to the annual survey of the Profit Sharing/401(k) Council of America.

Other survey findings include:

- 54.1% of all 401(k)/profit-sharing plans offered investment advice in 2003, up from 51.9% in 2002 and 41.4% in 2001.
- 8.4% of the plans surveyed in 2003 featured automatic enrollment, up from 7.4% in 2002.
- 87.3% of 401(k) sponsors offered 10 or more investment options in 2003, compared with 80.8% in 2002.

The number of sponsors offering professionally managed accounts—plans run entirely by money managers—in 2003 sounded too high to Don Bartolai, principal-retirement, with Mellon's Human Resources & Investor Solutions in Chicago. "One in five plans offering it sounds high to me," he said. "That's definitely not the case for the large plan sponsors I work with."

He also thought that the number of plans offering advice seemed too high. "In the plan sponsor world I live in, that's not even close."

Michael Weddell, a retirement consultant with Watson Wyatt Worldwide in Southfield, Mich., also said those numbers sounded high. "Some of the stats in the PSCA survey are kind of wild and far out," he said, adding that the number of plans offering advice is higher than normal but "not out of the ballpark."

David Wray, president of the PSCA, pointed out that while plans of all sizes responded to the survey, the majority of responses came from small plans, which are more likely than large plans to provide managed account options and one-on-one investment advice.

"Small companies are taking the lead in managed accounts," he said.

While 1,161 401(k) and profit-sharing plans responded to the survey, only 19.9% of the respondents had assets over $100 million.

Mr. Bartolai said many of the large plan sponsors he works with are talking about adding managed accounts and offering investment advice to their participants. But they're not doing it yet, he added.

According to the survey, the largest decrease in the use of investment advice was by participants in plans with 1,000 to 4,999 participants, down to 17% in 2003 from 26.1% in 2002.

The use of investment advice had the largest increase among 401(k) plans with more than 5,000 participants, with 22.8% of those participants using investment advice in 2003, compared with only 13.8% in 2002.

That increase is probably because more plans of that size are now offering an investment advice product, Mr. Wray said.

Among 401(k) plans that offer automatic enrollment, the most common default option in 2003 was balanced funds, with 36.4% of plans using them; next was stable value funds, at 30.3%; and money market funds, 19.7%. The year before, stable value funds were the most common default option, with 31.5% of plans using them; next was money market funds, at 25.9%; and then balanced funds, at 22.2%.

The number of investment options offered to participants who select their investments increased last year, according to the survey—39.8% of plan sponsors offered 11 to 15 investment options in 2003, compared with 37.1% in 2002. And in a bigger jump, 23.3% of plans offered 16 to 20 investment options in 2003, compared with only 15.5% in 2002.

Phyllis Feinberg is a reporter for Pensions & Investments, a sister publication of Business Insurance.

WTC: Second phase of cover trial begins

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phase stretched over 10 weeks of painstaking witness examinations, the second phase should be wrapped up in less than half that time, sources familiar with the litigation predict.

The burden has also shifted: Insurers in the first phase bore the burden of proving that they bound coverage on the Willis form, but Silverstein will bear the burden in the second phase of proving that the WTC loss should be treated as two occurrences under the remaining policies at issue.

The litigation, launched by lead WTC insurer Swiss Reinsurance Co. in late 2001, grew from the fact that no final policy had been issued at the time of the terrorist attack, despite Willis having placed the coverage nearly two months earlier, in time for the closing of Silverstein's lease on the complex in July 2001.

Most of the program's more than two dozen insurers argued that they had bound coverage under the Willis form, known as Wilprop, which the broker included in its original underwriting submissions on the WTC risk.

The Wilprop form defined "occurrence" as "all losses or damages that are attributable directly or indirectly to one cause or to one series of similar causes." A federal judge had earlier ruled that the WTC loss should be deemed one insured event under the Wilprop wording.

Silverstein countered during the first phase of the trial that it was in the process of shifting the program from Wilprop to a Travelers Property/Casualty Corp. form when the terrorists struck, and that the insurers knew this or had waived their right to agree to policy language.

The form produced by Travelers—a WTC primary insurer—did not include an occurrence definition and would, according to Silverstein, allow a double recovery.

The jury, though, found that 10 of the 13 Phase I insurers were bound on Wilprop. The 10—including Swiss Re and Lloyd's of London underwriters, the program's largest participants—accounted for $1.94 billion of the program's $3.55 billion limit. Before trial, five other insurers—representing another $477.2 million of the limit—had either been ruled by a judge to be governed by Wilprop or had settled with Silverstein on a one-occurrence basis.

Silverstein in August filed an interlocutory appeal of the verdict with the 2nd U.S. Circuit Court of Appeals. The appeals court has stayed any action, though, pending the ruling of U.S. District Judge Michael B. Mukasey on several post-Phase I motions.

Those motions—including Silverstein requests that Judge Mukasey overturn the verdict or order a new trial—are not likely to be resolved before the end of the trial's second phase, lawyers familiar with the case say.

The second phase, meanwhile, includes six insurers that cited their own policy forms or other forms in agreeing to insure the WTC risk, along with the three insurers found in the first phase not to be bound on Wilprop.

The Phase II insurers are Allianz Global Risks U.S. Insurance Co., a unit of Allianz A.G. of Germany; the Industrial Risk Insurers unit of GE Insurance Solutions; Travelers, now a unit of the St. Paul Travelers Cos.; the Royal Specialty Underwriting Inc. unit of Royal & SunAlliance Insurance Group P.L.C.; Gulf Insurance Co., a Travelers affiliate; Zurich American Insurance Co.; TIG Insurance Co.; the Twin City Fire Insurance Co. unit of Hartford Financial Services Group Inc.; and Tokio Marine & Fire Insurance Co.

The circumstances of these insurers differ. Allianz, for example—which participated both as a direct insurer and as a fronting insurer for Paris-based SCOR S.A.—actually issued its own policies before the Sept. 11 attack, and these included an occurrence definition. IRI and Travelers, meanwhile, bound coverage on their own policy forms; IRI's includes an occurrence definition, while Travelers' does not.

Whatever the circumstances, though, Silverstein, which will present its case first, argues that the parties' intention was to bind coverage that would treat the Sept. 11 attack as two events.

The WTC program, Silverstein asserts, was intended to respond to an immediate cause of loss—in this case, two planes striking two buildings at two separate times—rather than a larger, less immediate cause, such as Al Qaeda's plot to destroy the towers.

Silverstein's trial witnesses, court records show, will include an insurance expert who is expected to testify that custom and practice in the industry is to treat each instance of direct physical loss or damage as a separate occurrence.

Silverstein will also call an engineering expert who is expected to tell jurors that the collapse of the South Tower did not contribute to the later collapse of the North Tower, and that if only one had been hit, the other would have remained standing.

While some insurers' policies define "occurrence" as possibly including a "series" of losses from one event, Silverstein also argues that each tower's collapse constituted a series of losses because each collapse separately destroyed other buildings in the WTC complex.

Insurers, though, argue that the parties clearly intended the program to have a broad occurrence definition that would aggregate a series of similar losses as one event, sparing Silverstein multiple deductibles. While the policies' actual occurrence provisions differ, they were intended to work similarly to Wilprop's, insurers contend.

IRI, which wrote $237.2 million of the program, notes that its policy defines "occurrence" as the "sum total of all loss or damage...arising out of or caused by one event." A separate clause provides that only one deductible would be applied to each occurrence "regardless of the number of locations involved."

Under a separate IRI policy with the same occurrence definition, Silverstein aggregated two of its other 9/11 claims, paying only one deductible on losses to 7 World Trade Center and 20 Wall Street even though the buildings stood several blocks apart on opposite sides of the WTC site, IRI contends.

Allianz, meanwhile, has raised a different argument, maintaining that it is liable for just one limit not only because its policy defines "occurrence" as a series of losses from one event but also because it aggregates losses within a 72-hour period caused by "vandalism and malicious mischief."

This argument has been treated skeptically in court. Dismissing an Allianz summary judgment motion in 2003, Judge Mukasey's predecessor, U.S. District Court Judge John S. Martin Jr., expressed disbelief that the catastrophic 9/11 attack could be considered "vandalism." While admitting he hadn't fully reviewed the issue, Judge Mukasey warned at a pretrial hearing last month that the argument "has the aerodynamic qualities of a brick when you put it in front of a jury."

Nevertheless, Allianz contends that that it was industry practice at the time of the attack to cover terrorism losses in North America under vandalism and malicious mischief provisions. Soon after the 9/11 attack, while Willis officials worried that insurers might invoke the war risk exclusion, a Willis executive noted in an e-mail that "terrorism usually falls under the definition of vandalism and malicious mischief," Allianz points out.

In addition, a draft of Silverstein's first formal notice of loss to insurers, prepared by Willis, was captioned "Vandalism/Aircraft Impact—9/11/01," the insurer's filings say.

Costs: Health care cost hikes moderating

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employers, if greater cost-shifting to employees reduces utilization.

The Hewitt survey is based on information it collected from about 300 large employers offering health care coverage to a total of 18.2 million employees and dependents.

For employers, the survey results contain both bad and good news, said Dave Fortosis, a consultant in Hewitt's Chicago office.

The bad news is that next year's projected rise marks the fifth consecutive year of double-digit cost increases, with the cost increase likely to be more than double the rise in the overall Consumer Price Index.

On the other hand, cost increases are moderating. Next year's projected 11.3% increase will mark the third straight year that health care cost increases will have been lower than in the prior year.

Indeed, the 2005 projected increase is substantially less than the 15.2% average hike in 2002, the recent high water mark for cost increases, prior Hewitt surveys show.

Several trends are driving the slowdown, Mr. Fortosis said. One factor, he said, is recent rate increases the federal Medicare program has provided to physicians and hospitals, which reduces the need for medical providers to boost charges for privately insured patients to offset inadequate rates from publicly funded health insurance programs.

Additionally, costs have been moderating as less expensive generic drugs increasingly make up a greater percentage of prescriptions dispensed.

The growing use of generics has been aided by several factors, including the expiration of patent protection for several popular drugs, Mr. Fortosis said. In addition, employers' plan-design changes have increased generic usage. For example, requiring employees to pay a percentage of drug costs—rather than a flat copay—can widen the out-of-pocket cost difference between brand-name and generic drugs, giving employees a financial incentive to use the latter, he said.

Renewed competition among HMOs also is keeping premium increases to levels that haven't been seen since 2001. Aided by the substantial rate increases of the last few years, HMOs have returned to profitability and now want to maintain market share, he said.

As a result, plans are more willing to compete, and some have agreed to single-digit premium increases for 2005, he said. "There is a beginning of a return to competition."

More changes

Some employers are introducing more plan-design changes in hopes of slowing rate increases further.

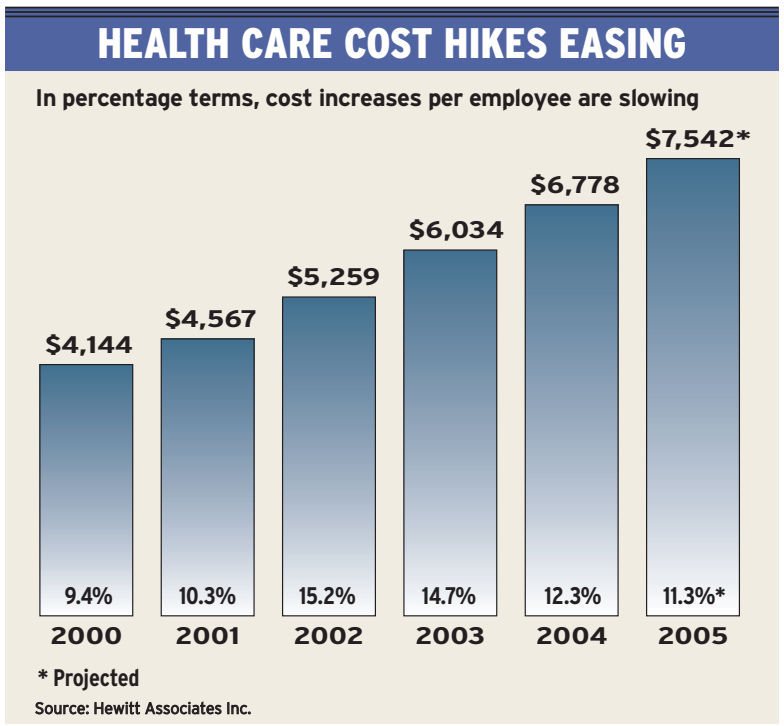
For example, more employers are amending their plans so that employee copayments for specialist visits are higher than those for primary care services, for which fees tend to be lower, Mr. Fortosis said.

On the other hand, some employers are reducing cost-sharing requirements for preventive services—such as annual physicals—to encourage greater use of those services, which can be cost-effective in the long run by promoting early intervention for some conditions.

And employers are moving into new areas as they try to drive down cost increases. Mr. Fortosis said employers are beginning to share data with employees showing how medical outcomes for a procedure vary by providers, enabling employees to evaluate and choose providers on the basis of results, not perception.

"Americans tend to think that the more expensive providers" are the best providers, Mr. Fortosis said. In fact, in assessing the quality of care among providers, the best medical outcomes are directly linked to the volume in which a medical facility performs a procedure, not the fees that are charged, he said.

A summary of the Hewitt survey is available at www.hewitt.com.



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Late News

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have access to Medicare Advantage plans as the plans, responding to higher government payment rates, expand and enter new service areas. Department of Health and Human Services Secretary Tommy Thompson said that 35 Medicare Advantage plans have made new applications to provide coverage, and 22 have applied for expansion of service areas. Medicare Advantage plans entering new markets or returning to those they exited could be good news for employers with retiree health care plans that want to encourage retirees to leave costly corporate plans.

Canadian regulators reduce pension monitoring

The number of Canadian pension plans being closely regulated by the federal government has declined in the last 18 months. The Office of the Superintendent of Financial Institutions said the number of plans on its watch list currently stands at 79, a decrease from 96 at the end of March 2003. Of those 79 plans, 60 are defined benefit plans and 19 are defined contribution plans.

Health care expenses spur look at cost cuts

Many U.S. employers plan to cut salaries and training programs, reduce their hiring and increase outsourcing and downsizing to offset the rising cost of employee health care coverage, a survey shows. The survey, conducted by the Society for Human Resource Management, asked HR practitioners to report the likelihood that their organizations may make adjustments because of the cost of providing health benefits. Among the changes respondents thought "likely" were: a decrease in hiring new staff, reported by 28%; a decrease in employee salaries/raises, 22%; and a decrease in employee training/professional development, 19%.

Food haulers urged to address terrorism risks

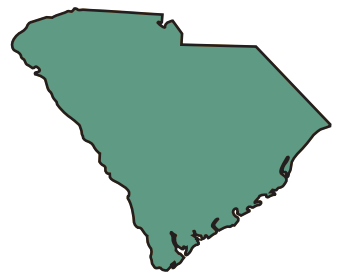
The U.S. Department of Agriculture is asking trucking companies that haul agricultural products to take steps to protect the nation's food supply from terrorism. The USDA unveiled voluntary guidelines last week that urge agricultural truckers to develop a "risk-based security management system for people, property, commodities, processes, information and information systems."

Aon sells majority stake in TPA Cambridge

Aon Corp. is selling a majority stake in Cambridge Integrated Services Group Inc. to Singapore-based technology and business-process outsourcing firm Scandent Group. Aon said that it will retain a minority interest in the claims administration company. Financial terms of the transaction were not disclosed. Cambridge had total revenues of $264 million in 2003.

Lusardi to leave XL financial products unit

Robert Lusardi has resigned as head of XL Capital Ltd.'s financial products division to "pursue personal interests" after seven years with the company, XL said. Mr. Lusardi, who will leave XL at the end of the year, will continue to offer advisory services to the company on strategic investments. He will be succeeded as chief executive officer of XL's Financial Products & Services unit by Paul S. Giordano, who is currently president of XL Financial Solutions.



South Carolina licenses 100th captive

The South Carolina Insurance Department has issued its 100th captive insurance company license, with the state on track to license a record number of captives this year. License 100 was issued to Carolina Insurance Co. of Columbia, S.C., the insurance subsidiary of Defender Services, a supplier of janitorial, housekeeping and security services. The 100th captive license comes four years after the state enacted its captive statute.

Gray predicts more storms

The hurricane forecasting team headed by William Gray at Colorado State University in Fort Collins is predicting that three tropical storms, two of which will grow into hurricanes, will form in October. The team reported that this year's hurricane season through the end of September has been more than twice as active as the full-season average for 1950-2000. Hurricane season ends on Nov. 30.

Businesses more litigious than consumers: Report

Businesses are much more likely than individual consumers to file lawsuits in U.S. courts, according to a report released by Public Citizen. The consumer organization said that based on its analysis of case filings in four jurisdictions—the states of Arkansas and Mississippi, the city of Philadelphia and Cook County, Ill.—businesses were from 3.3% to 5.8% more likely to file lawsuits than individuals. Public Citizen President Joan Claybrook said the figures show that businesses are engaged in "highly hypocritical" conduct by promoting tort reform when they are far more likely than individuals to file lawsuits. She said Public Citizen had prepared the report because businesses have "spent hundreds of millions of dollars in this (tort reform) campaign to close the courts to consumers."

Briefly noted

The **Pension Benefit Guaranty Corp.** has taken over a third pension plan of bankrupt Houston-based Kaiser Aluminum Corp. The plan, which covers more than 9,600 active and retired hourly employees, is underfunded by $328 million, and the PBGC expects to be liable for about $262 million....**J. Hyatt Brown**, chairman and chief executive officer of Daytona Beach, Fla.-based broker Brown & Brown Inc., has been named the 2005 chairman of The Council of Insurance Agents & Brokers. He succeeds Frederick J. de Grosz, president and CEO of Redwood City, Calif.-based ABD Insurance & Financial Services Inc.

Check out BusinessInsurance.com

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

Online Poll

[10/4 - 10/8]

Were you surprised that IBM Corp. decided to partially settle its cash balance pension plan suit?

IBM

Yes	17.5%
No	65.0%
No opinion	17.5%

BI Stock Index

[10/4 - 10/8]

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

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

***BI* Stock Index**	
2224.08	-0.95
Dow Jones	
10055.20	-1.35
S&P 500	
1122.14	-0.83

Largest gains

Gainsco Inc.	8.91%
Meadowbrook Insurance	4.21%
Aspen Insurance Holdings	4.17%
ING Groep N.V.	3.76%
PacifiCare Health Systems	2.87%

Largest losses

Vesta Insurance Co.	-9.59%
Clark Inc.	-8.77%
ACE Ltd.	-7.51%
United Fire & Casualty	-5.31%
MBIA Insurance Group	-5.07%

Weekly change by market segment

Brokers	-1.99%
Insurers/Reinsurers	4.95%
Managed Care Organizations	-1.05%

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

PBGC: Court upholds agency's authority

Continued from page 3

the plans. The group also recommended an immediate termination date—June 14, 2002—to prevent a triggering of the plans' shutdown benefit provisions.

Under those provisions, employees who met certain age and service requirements would be eligible for immediate pension benefits before the normal retirement age of 62 if the Republic plants where they worked were closed. The employees would be eligible for the benefits even if the facility were purchased by another employer in an asset sale and the individuals began working for the buyer.

By setting a June 14 termination date, the PBGC would avoid liability for the shutdown benefits, which would be in addition to the plan's $108 million in regular unfunded guaranteed benefits. The PBGC does guarantee shutdown benefits, but only if the plant has shut down before plan termination. On June 14, the PBGC notified Republic participants of the termination.

The risk the continuation of a pension plan poses to the PBGC—regardless of the agency's overall financial health—is the overriding factor when the PBGC sets a plan termination date.

6th U.S. Circuit Court of Appeals

On July 9, 2002, a bankruptcy court scheduled a sale of Republic assets, which were sold on Aug. 16, 2002. On that same date, Republic declared that a shutdown had occurred.

In a ruling last year, U.S. District Court Judge Peter Economus said the PBGC had the authority to terminate the plans. But he also said to justify the June 14 termination date, the PBGC would have to prove that the earlier termination date was necessary to prevent an "unreasonable" increase in the liability of the PBGC insurance program.

Because the PBGC failed to demonstrate this, the interest of plan participants in receiving the shutdown benefits would exceed that of the PBGC, Judge Economus wrote.

But the appeals court said the risk the continuation of a pension plan poses to the PBGC—regardless of the agency's overall financial health—is the overriding factor when the PBGC sets a plan termination date.

The "PBGC is expressly authorized to terminate a plan when the possible long-run loss of (the) PBGC with respect to the plan may reasonably be expected to increase unreasonably if the plan is not terminated," the appeals court said.

The Employee Retirement Income Security Act, which established the PBGC, "provides for involuntary proceedings precisely so the PBGC can protect its own financial interests," the court concluded.

A PBGC spokesman said the agency welcomed the ruling as helping to protect the financial integrity of the PBGC's insurance program.

Pension Benefit Guaranty Corp. vs. Republic Technologies International, United Steelworkers of America. No. 03-4494. 6th U.S. Circuit Court of Appeals.