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Business Insurance

www.businessinsurance.com

October 20, 2003

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\$4

Health care benefits at center of several labor disputes

Unions fight cost-shifting

By **ROBERTO CENICEROS**

Health insurance copayments increasingly are becoming a line in the sand for labor unions negotiating contracts with employers that are looking to shift some of the burden of rising health care costs.

In Southern California, employer attempts to lower their health care costs have become a sticking point in labor talks, stalling negotiations and prompting unionized grocery workers, bus mechanics and law enforcement personnel to strike last week.

But growing labor negotiation difficulty involving health benefits is not just a Southern California phenomenon, benefit experts say. Health care cost-shifting has been a contentious issue in numerous other labor negotiations, including the

recent pact between the United Auto Workers and automakers (BI, Oct. 13).

Increasingly, labor unions nationwide are taking a tough stand on rising health care expenses and employer attempts to push some of those costs onto workers, said Don Holub, director of the Labor Center at the University of Iowa in Iowa City.

Unions fear that employers are trying to move away from providing benefits that labor views as a fundamental right. So, "they are drawing a line in the sand," Mr. Holub said.

"If there is an issue to provoke a strike, health care is a prime one right now," he added. "There is a fear that, if you give in on that issue, it is going to be harder to main-

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PHOTO: EPA

Union employees of Ralphs supermarket in Los Angeles picket after being locked out over a contract dispute that centers on health care benefits.

Late News

XL warns of casualty losses

XL Capital Ltd. warned last week that its third-quarter profits will be reduced by \$184 million by losses from North American reinsurance casualty business. Standard & Poor's Corp. placed its AA rating of XL America under review—with negative implications—shortly after the announcement. The reinsurance claims are from the book of business formerly written by NAC Re Corp., which XL acquired in a \$1.2 billion deal in 1999. The claims are primarily from general liability, medical malpractice, professional liability and surety accounts written in the late 1990s.

Minnesota exploring Canadian Rx imports

Minnesota Gov. Tim Pawlenty has announced a plan to help state residents import prescription drugs from Canada. Gov. Pawlenty said that Minnesota plans to set up a Web site to help all state residents purchase drugs from Canadian pharmacies at a price negotiated



Gov. Pawlenty

by the state. In addition, the state will provide incentives for its benefit plan participants to buy drugs through the Web site. Although the plan is still developing, the state is considering waiving copayments to encourage employees to purchase the lower-cost imported drugs, Gov. Pawlenty said.

Swiss Re rating lowered to A+

A.M. Best Co. has downgraded Swiss Reinsurance Co.'s financial strength rating to A+ from A++.

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Asbestos reform plan gets OK from insurers

Larger funding burden accepted

By **MARK A. HOFMANN**

WASHINGTON—An agreement by insurers and former asbestos manufacturers on how to pay for a proposed national trust fund for victims of asbestos-related diseases removes one major hurdle—but only one—blocking passage of asbestos liability reform legislation.

After months of negotiations, insurers agreed last week to be responsible for almost \$46.03 billion in payouts from a proposed fund to compensate victims of asbestos-related disease. Businesses involved in asbestos litigation agreed to pick up more than \$57 billion of the proposed

funding contributions, as well as up to \$10 billion more in additional funding if the proposed trust fund were unable to meet all claims. The rest of the money for the roughly \$115 billion fund, which would be created under the Fairness in Asbestos Injury Resolution Act approved by the Senate Judiciary Committee in July, would come from existing asbestos compensation trust funds.

Five major insurance trade groups had initially said that they would not be responsible for more than \$45 billion in contributions to the fund. On Oct. 10, they rejected a proposal

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Patient-safety survey participation grows

But few hospitals meet Leapfrog standards

By **JOANNE WOJCIK**

WASHINGTON—A leading patient safety group is pleased that more hospitals are participating in its research but says the facilities still have work to do to improve the quality of the care they deliver.

The ongoing survey is conducted by the Leapfrog Group, which was created in November 2000 to promote patient safety and to give consumers the information they need to make informed health care decisions.

The number of hospitals that responded to the survey rose to 1,012 this year from 637 last year. As a result, nearly 80% of consumers nationwide now have access to patient-safety data on at least one hospital in their area, Suzanne Delban-

co, executive director of the Washington-based Leapfrog Group, said at a press conference last week.

In the 22 regions where Leapfrog members work with hospitals to encourage their participation in the study, the number of respondents rose to 637 from 496. Perhaps even more heartening, though, was that 37% of the hospitals submitting survey responses were located outside of those regions, Ms. Delbanco said.

The increased participation is "a product of a couple things," said Cheryl DeMars, director of quality at Leapfrog Group member The Alliance, a health care purchasing coalition based in Madison, Wis.

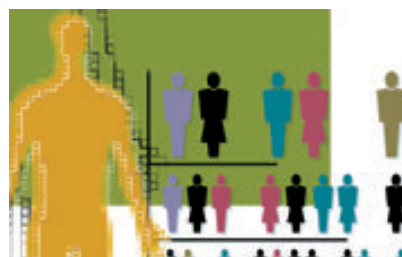
"It's the recognition of the validity of the standards that Leapfrog is

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Spotlight

WORKERS COMPENSATION

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RANKINGS OF LARGEST INDEPENDENT SAFETY CONSULTANTS

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LARGEST REHABILITATION SERVICE PROVIDERS

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U.K. regulation of Lloyd's is satisfactory, E.C. says

By NEIL HODGE

BRUSSELS, Belgium—The European Commission last week ended its inquiry into the adequacy of the U.K. government's regulation of Lloyd's of London, indicating it was satisfied with the current regulatory regime.

It is unclear what this development means for disgruntled individual investors, who, having unsuccessfully fought the market to avoid liability for massive underwriting losses, sought to hold U.K. government regulators liable for their losses. Legal experts suggest that this marks the end of E.C. involvement in the dispute, though a member of the European Parliament continues to press the commission to comment on its finding that U.K. oversight was deficient in previous decades.

The European Commission last

week stated that it is satisfied with the United Kingdom's present regulation of Lloyd's and is closing its inquiry into the matter. In addition, the commission made clear in its statement that any question about the U.K. government's past regulation of Lloyd's is not a matter for its consideration and must be addressed in a U.K. court.

Kenneth Underhill, partner in the insurance and reinsurance practice of the London-based law firm of Reynolds Porter Chamberlain, said that "from a regulatory standpoint, it is enough that the outside world can get confirmation that the U.K.'s regulation and supervision of Lloyd's has been completely approved by the commission."

David Strang, a partner with Barlow Lyde & Gilbert in London, said that "this is undoubtedly good news for Lloyd's."

"The fact that the commission is

happy with the present regulation of Lloyd's and does not want to get involved in any kind of investigation of the former supervisory regime in the U.K. pretty much spells the end of the European Parliament's petition on Lloyd's names," Mr. Strang said.

Anthony Young, chief executive of the Assn. of Lloyd's Members in London, said that "the commission's announcement that it does not feel that it is part of its remit to investigate the past regulatory regime of Lloyd's will make it a real uphill struggle for names to take recourse through the courts. The likelihood is that if the commission is satisfied, so too will the courts."

Last month, the European Parliament had asked the European Commission to review a report prepared by a parliamentary committee that questioned the adequacy of the

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PHOTO: MARK WILSON/GETTY

Homes along the Chesapeake Bay were flooded in September's storm surge of Hurricane Isabel.

Hurricanes, blackout raise quarterly losses

JERSEY CITY, N.J.—Catastrophes caused an estimated \$9.4 billion in insured property losses in the first nine months of this year, according to the Insurance Services Office Inc.'s Property Claim Services.

Third-quarter catastrophes, including Hurricane Isabel, helped push the total to more than double the \$4.1 billion in insured property damage suffered during the first nine months of last year.

This year's third quarter was the third-costliest in the past 10 years, with \$2.9 billion in insured property damage. The 2003 third-quarter losses are exceeded only by third-quarter 2001, when losses from the Sept. 11, 2001 terrorist attacks were sustained, and third-quarter 1998, when Hurricane Georges hit the Gulf Coast, according to PCS.

According to PCS, Hurricane Isabel, which lashed the North Carolina coast and ripped through several other states last month, caused an estimated \$1.17 billion in insured property damage. PCS will, however, resurvey losses later this year.

The second most severe catastrophe in the quarter was the severe thunderstorms that hit 14

Southern and Eastern states in July, causing \$815 million in damage.

The massive power outage that affected large areas of the Northeast in August, including several major cities, caused an estimated \$75 million in insured property damage. PCS said that the estimate could be revised once the exact cause of the blackout is known.

Insurers will pay nearly 886,000 commercial, personal lines and automobile claims in 30 states as a result of the third-quarter catastrophes. Virginia sustained the most insured damage during the quarter, at \$460 million. Maryland and Tennessee followed with \$410 million each.

The seven catastrophic events that hit in the third quarter—Hurricanes Claudette and Isabel, four other wind and storm events, and the blackout—are about average based on an average frequency of 6.5 for events for the third quarter in each of the past 10 years, according to PCS. PCS defines a catastrophe as an event that causes more than \$25 million in insured property damage.

—Mark A. Hofmann

FM to give policyholders \$325 million in credits

By DAVE LENCKUS

JOHNSTON, R.I.—Policyholders of Factory Mutual Insurance Co. should expect a membership credit totaling \$325 million next year because of the company's better-than-expected results over the past few years.

The credit will not have any impact on policyholders' rates at renewal, according to Shivan S. Subramaniam, chairman and chief executive officer for the Johnston, R.I.-based insurer, which does business worldwide as FM Global.

"It's two separate things," Mr. Subramaniam said. He predicted that policyholders next year still will find that FM Global's rates are competitive with other insurers'



rates.

The credit would be the second in four years for FM Global policyholders. In 2001, policyholders received a \$238 million credit that reflected the operational savings produced by the merger of entities that created FM Global. In 1999, Allendale Mutual Insurance Co., Ark-

wright Mutual Insurance Co. and Protection Mutual Insurance Co. merged with each other and their Factory Mutual loss-prevention engineering and research arm to create a single insurer.

The latest credit stems from the insurer's and policyholders' success in preventing losses, Mr. Subramaniam explained. "Financially, FM Global has performed well relative to other insurance companies, returned to profitability faster than projected, and is a stronger company today."

With a higher-than-expected growth in surplus, which Mr. Subramaniam noted has allowed the insurer to increase its capacity, management decided to reward its poli-

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Inside Business Insurance

Genetic bias legislation not needed, some say

A Senate-passed bill to prevent bias against individuals based on predictive genetic information may be targeting a problem that doesn't exist. **Page 4**

Corporate governance laws put damper on M&As

Insurer mergers and acquisitions may be a casualty of corporate governance legislation. **Page 4**

Slowing cost hikes are good news

Efforts by employers to rein in soaring health care costs demonstrate that ever-higher rates aren't inevitable, this week's editorial says. **Page 8**

Pedaling off the pounds the Dutch way

Senior Editor Dave Lenckus draws weight-reduction inspiration from a vacation in Holland. **Page 36**



European insurers oppose quarterly reporting plan

A European Parliament proposal on financial services reporting requirements would impose a burden on insurers, an industry group argues. **Page 37**

Online

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

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

• New **Opinion Poll** for readers: How well do employees understand their employers' cost of providing health care benefits?

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS.

HealthSouth woes continue as insurer seeks D&O recision

By DOUGLAS McLEOD

BIRMINGHAM, Ala.—As congressional hearings into the alleged \$2.5 billion accounting fraud at HealthSouth Corp. got under way last week, a Hartford Financial Services Group Inc. unit became the latest of several insurers seeking to rescind directors and officers liability coverage for the health care company and dozens of its current and former officials.

Twin City Fire Insurance Co. filed suit in U.S. District Court in Birm-

ingham, Ala., joining about a dozen other insurers in charging that HealthSouth and its officials concealed a massive, ongoing fraud that inflated the company's earnings by \$2.5 billion between 1998 and 2002.

The Twin City complaint came as D&O insurers and HealthSouth officials prepared for a court battle to begin next month over the impact of severability provisions in the company's policies. HealthSouth and several of its current and former officials are expected to argue

that the provisions require coverage of "innocent" officials even though 15 former HealthSouth officers—including five of its former chief financial officers—have already agreed to plead guilty to criminal charges arising from the alleged fraud.

Insurers are expected to argue that bogus HealthSouth financial statements included with the policy applications should void the coverage from inception and that the severability provisions should not
See **HEALTHSOUTH**/page 31



HealthSouth Corp. Chairman Richard Scruschy, center, confers with attorneys during a congressional subcommittee hearing last week. Several of the company's D&O insurers seek to rescind coverage.

PHOTO: SHNS/BILL CLARK



Genetic bias legislation not needed, some say

Profiling not a problem: Employers

By MARK A. HOFMANN

WASHINGTON—A Senate-passed bill designed to prevent discrimination against individuals based on predictive genetic information is targeting a problem that does not exist, employment experts say.

While not condoning discrimination on the basis of possible genetic predisposition to certain diseases, employer groups contend that, with the exception of a single high-profile case, genetic profiling has not been a significant workplace issue. In addition, many of the privacy protections proposed in the bill, the Genetic Information Nondiscrimination Act of 2003, are already contained in the Health Insurance Portability and Accountability Act of 1996, some say.

The measure—S.1053—won Senate approval by a 95-0 vote last week. The vote marked the culmination of almost seven

years of debate in the Senate over the issue, as both Democrats and Republicans offered measures to prevent discrimination based on genetic information. The issue now moves to the House, where key lawmakers promise to hold hearings on the matter. But House Education and the Workforce Committee Chairman John Boehner, R-Ohio, stopped short of saying that he would move the Senate bill along.

Among other things, the bipartisan Senate bill would prohibit employers from using genetic information when making hiring, firing, promotion or job assignment decisions. Employers would have to treat any genetic information in the same manner they treat other confidential information.

The Equal Employment Opportunity Commission would oversee the act's enforcement in the workplace. Employees would
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Errors & omissions

• Due to an editing error, the surname of Wayne McOwen was misspelled in an Oct. 6 letter to the editor. Mr. McOwen is senior vp of

government and industry relations for Guard Financial Group in Wilkes-Barre, Pa., and chairman of the Workers Compensation Committee of the National Assn. of Independent Insurers.

Risk managers mindful of terrorism coverage options

By MEG FLETCHER

CHICAGO—While risk managers of companies with significant property exposures are very concerned about their terrorism exposures, they are increasingly willing to explore a variety of insurance arrangements to cover the risk.

Recent terrorist activity in Indonesia, Iraq and Saudi Arabia, along with the increasing availability of surface-to-air missiles that can blow planes out of the sky have kept the peril fresh in risk managers' minds, according to Jason P. Herriott, war and political risk underwriter for Amlin Underwriting Ltd., a Lloyd's of London managing agency.

Mr. Herriott shared his views during a panel discussion at a Real Estate Risk Management Symposium

at Navy Pier in Chicago earlier this month.

"Terrorism is an unfortunate fact of life," said Jill Dalton, managing director and the leader of broker Marsh USA Inc.'s North American property practice.

Given the "high severity" and disruptive nature of such attacks, a company does not have to be a target itself to suffer related losses, Ms. Dalton said. A company also may be affected if it has a contractual relationship—such as that of a lender or shareholder—with a targeted company, she noted.

In addition, she said, corporate officers must consider whether to buy costly insurance for this risk, or face claims of negligence, possibly from shareholders, for not doing so.

Currently, the "options for terrorism coverage come in all shapes

and sizes," and include about eight different types of policies, Ms. Dalton said.

One policy that was developed in direct response to the U.S. government's Terrorism Risk Insurance Act of 2003 provides reinsurance coverage for insurers that are required to offer protection from "foreign" terrorism to most companies located primarily in the United States.

That policy, which Ms. Dalton describes as "all risk with TRIA only," meets those legal requirements and others, including a stipulation that terms and conditions do not "differ materially" from terms offered for core coverages, she said.

Under TRIA, an insurer's losses must exceed \$5 million and be "certified" by the Treasury Department

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17th International Reinsurance Congress

Corporate governance laws putting a damper on M&A

By MICHAEL BRADFORD

HAMILTON, Bermuda—Insurance company mergers and acquisitions may have become a casualty of corporate governance legislation, an insurance company executive contends.

The long-tail liabilities associated with insurers will likely discourage board directors from approving such deals, he said.

Instead, they will likely favor growth through the purchase of books of business rather than outright acquisitions, he said.

And concerns over existing liabilities are prompting insurers to buy more reinsurance protection, a reinsurance executive added.

"For years we've seen consolidation going on in the insurance in-



dustry," said Donald Kramer, vice chairman at ACE Ltd. in Hamilton, Bermuda. And, "you've seen, in the reinsurance industry, merger after merger after merger. But with Sarbanes-Oxley, I believe the merger-consolidation phase of the business is over," he said, referring to the federal corporate governance act enacted in 2002.

Mr. Kramer was speaking at the 17th International Reinsurance Congress sponsored by London-based Hawksmere P.L.C. in Bermuda earlier this month.

Consolidation is ceasing because of "the unique characteristics of our business," he said. "We don't know what our liabilities are, ultimately. And under Sarbanes-Oxley, with the increasing intrusiveness of
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Health plan operators hit with \$7.3 million judgment

RENO, Nev.—The U.S. Department of Labor has won a \$7.3 million default judgment against four former operators of Employers Mutual L.L.C., an allegedly fraudulent group health provider that has left an estimated \$27 million in unpaid claims since federal regulators shut it down in 2001.

A federal judge in Reno, Nev., entered the default judgment against James Lee Graf, William R. Kokott, Nicholas E. Angelos and Kari Hanson, who operated Nevada-domi-

ciled Employers Mutual and various affiliated employer groups and service providers.

The Labor Department charged in a 2001 lawsuit that the four diverted millions of dollars of plan assets from about 7,000 single-employer benefit plans to themselves and others during the first 10 months of 2001. Labor Department lawyers filed a motion for the default judgment in February, after the defendants failed to answer the complaint.

Thomas A. Dillon, a court-appointed fiduciary overseeing the Employers Mutual plans, filed a separate complaint earlier this year leveling racketeering charges against the program's former operators and negligence charges against 400 former agents and brokers who sold the plans to thousands of small employers nationwide.

Employers Mutual is unrelated to Employers Mutual Casualty Co. of Des Moines, Iowa.

—By Douglas McLeod

Insurance industry links available at BI site

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Paul Winston

Chicago Cubs gored this fan's goat

I have never been able to understand the mentality of people who file lawsuits seeking billions of dollars in punitive damages to make them whole for some alleged wrong. Until now, that is.

Now, I am looking for a hungry trial attorney to represent me in a lawsuit against the Chicago Cubs. It is likely that this would be filed as a class action on behalf of the millions of other long-suffering Cubs fans.

While it would be nice to be able to file suit in Madison County, Ill., renowned for its hospitality to class-action plaintiffs, that is a hotbed of St. Louis Cardinals support. So Cook County, Ill., will suffice.

Last week's stunning collapse of the Cubs after they seemed to have

the National League Championship Series in hand was simply the final straw on top of the already enormous burden that Cubs fans carry. We the fans are as accursed and afflicted as the team we follow year in, year out in the hopes they will reach the pinnacle of baseball. In virtually every other social and commercial endeavor, the repeated infliction of such emotional distress (1969, 1984, 1989 and now 2003) would spark a multitude of tort claims.

In fact, I think we can prove the team is at fault under almost any modern theory of liability:

● **Malpractice liability.** If ever there were poster children for professional negligence, the Cubs would be them. No team in American professional sports has gone longer without a championship. Indeed, many teams have won several championships over much shorter histories, which suggests to me the Cubs are not unlucky or cursed but guilty of incompetence. If a doctor failed to successfully perform an operation as many times as the Cubs have failed to complete a winning postseason, he or she would not only face a tide of lawsuits but probably would also be locked up.

● **D&O liability.** Other team managers and owners have figured out how to prevail over the past 95 years, why not the Cubs? One would have to assume egregious mismanagement is at work here. Cubs fans have long suspected the team's owners are more interested in fat television revenues from broadcasting Cubs games worldwide than in investing in a winning team. The team draws millions of dollars annually in ticket sales, broadcasting revenues and merchandise from hats to bobblehead dolls without providing fans a decent return on their investment. If the Cubs were a publicly traded company, team

management would be doing the perp walk by now for financial mismanagement and fraud.

● **Products liability.** If you consider the many ulcers, migraines, spongy livers and broken television sets spawned by the Cubs, a strong case can be made that this is a product inflicting bodily harm and property damage on others. Then there is the matter of the curse. Clearly, the hex that a Greek restaurateur placed on the club 58 years ago has been recklessly and willfully transferred to the fans. Let a jury decide if such karmic harm warrants damages.

● **Toxic tort.** I figure that if a homeowner can win millions of dollars for the presence of mold in a home, we can prevail in a claim that

the organisms inhabiting Wrigley Field are toxic and bad for our health. Just as mold is innocuous in most settings but potentially lethal in some, baseball players who would thrive on other teams become destructive and incompetent within the friendly confines of this park. If this analogy doesn't work, then I think we should

investigate whether that's really poison ivy lining the outfield walls.

I think \$58 billion in compensatory damages (\$1 billion for every year they have failed to get into the World Series) would suffice. Using the recent Supreme Court benchmark for calculating punitive damages brings us \$232 billion more, for a grand total of \$290 billion. That would not heal the damage to Cubs fans' hearts and souls from their unrequited loyalty to the team, but it's a start.

Of course, I would gladly settle and be made whole by having the Cubs whip the snot out of the Yankees in the 2004 World Series.

Forgive and forget

On a related note, while I am unable to forget the Cubs' many transgressions, I think forgiveness is in order for the poor fan who innocently and ignorantly knocked a foul ball from the clutches of a Cubs outfielder in game six of the NLCS.

He did not lose that game or that series; the Cubs did it themselves. And he does not deserve to be vilified and threatened, as sadly is now taking place. He is as heartbroken as the rest of us at the Cubs' fortunes and deserves our compassion. (And *that* more accurately reflects how I feel about looking for scapegoats when wrongs befall us, than the comments above.)

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Paul Winston

Business Insurance

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COMMUNICATIONS: New York: 212-210-0132
SUBSCRIPTIONS: Detroit: 888-446-1422
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Published weekly at 360 N. Michigan Ave., Chicago, Ill. 60601-3806, Fax: 312-280-3174, biweb@crain.com. Offices: 711 Third Ave., New York, N.Y. 10017-5806, Fax: 212-210-0704; 7121 Minkler St., Abita Springs, La. 70420; Fax: 985-871-4006; Suite 814, National Press Building, Washington, D.C. 20045-1801, Fax: 202-638-3155; 6500 Wilshire Blvd., Suite 2300, Los Angeles, Calif. 90048-4947, Fax: 323-655-8157; 967 Bermuda Court, Sunnyvale, Calif. 94086-6750, Fax: 408-774-1155; 34 Southwark Bridge Road, London SE1 9EU, Fax: 207-457-1440; 8157 N. Torrey Place, Tucson, Ariz. 85743, Fax: 520-579-3476; 777 E. Speer Blvd., Denver, Colo. 80203-4214; Fax: 303-733-2244; 1133 W. 108th St., Overland Park, Kan. 66210, Fax: 312-280-3174. 77 Franklin St., Suite 809, Boston, Mass. 02110-1510; Fax: 212-210-0704 \$4 a copy and \$97 a year in the U.S., \$130 in Canada and Mexico (includes GST). All other countries, \$230 a year (includes expedited air delivery). Rudolf Von Bartsch, circulation manager. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 711 Third Avenue, New York, N.Y. 10017-5806. Microfilm copies available: University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For reprints or reprint permission: Karen Brown Tucker, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806, 312-649-5319, Fax: 312-280-3174.

Editorial

Slowing cost hikes are good news

WHO WOULD HAVE thought health care cost increases averaging 12.6% would be considered good news?

Given that next year's projected cost increase, according to a recent Hewitt Associates Inc. survey, is more than two percentage points lower than this year's 14.7% rise, a drop in the rate of increase is good news for employers and insurers.

To be sure, no one envisions a return anytime soon, if ever, to a decade ago when rates were falling as managed care plans aggressively competed for market share.

But there are signs, such as the Hewitt survey, that perhaps the worst of the runup in health care costs may be over for the near term.

Employers nationwide have wised up to how plan design—a factor largely neglected during the soft

pricing of the late 1990s—contributed to the cost crisis.

Until those design changes, there often was no financial incentive for employees to be careful consumers of health care services. Deductibles or copayments often cost no more than, say, the price of a haircut.

Today, restructuring those elements is having an impact. No doubt the rise in employee cost sharing is painful to many workers, but it is a necessity if employer costs are ever to be controlled.

In another encouraging sign, employers and insurers are revamping the design of prescription drug benefits, after years in which soaring costs were the primary catalyst for higher health care expenses. Some employers, for example, are moving to coinsurance, which, unlike flat copayment designs, makes employ-

ees far more sensitive to the price differences among branded drugs.

At the same time, most insurers are encouraging use of generic drugs over branded products, which cost more but whose efficacy is the same as generics. Some insurers, for example, are giving health plan enrollees incentives—such as temporarily waiving copayments or coinsurance requirements—to switch to lower-cost generics.

And even some determined opponents of employer efforts to better control their costs are showing more flexibility, if only to a limited degree. For example, the United Auto Workers union, whose tough bargaining with U.S. automakers resulted in virtually no employee health care cost sharing, is bending in other areas. Under the most recent contract agreement, the au-

tomakers will be allowed to prune preferred provider networks to consist of providers who have demonstrated quality outcomes, best practices and cost-effectiveness.

While we think the union's refusal to share in higher premiums will be to the detriment of the automakers and employees—if jobs are cut due to automakers' difficulty in competing with rivals that have been better able to control health care costs—we are encouraged the UAW has at least acknowledged that soaring costs are a problem.

Certainly, continued action is necessary by employers to rein in soaring costs. But recent efforts demonstrate that ever-higher rates of health care cost increases are not inevitable and that the steps employers take can make a real difference.

Letters to the Editor

Industry should return to supporting forecasts

To the editor: It was with pride and sadness that I watched the accuracy of the forecasting of the course of Hurricane Isabel. The pride was from knowing that in a small way the insurance industry helped make this forecasting successful, and the sadness was from knowing that this industry support was discontinued.

In August 1997, a nonprofit organization was established with 25 members from the insurance and reinsurance industry. The Insurance Friends of the National Hurricane Center was dedicated to enhancing the timely and accurate forecasting

of tropical storms and communicating those forecasts to the public and to the insurance industry. The creation of the Insurance Friends was spearheaded by George Ramsdell, the retired senior vp and chief underwriting officer of the Continental Insurance Co., with significant help from Had Talbot, a managing director of Guy Carpenter & Co. Through their efforts, a close relationship was established with the National Hurricane Center and the International Hurricane Center at Florida International University.

Funds raised by Insurance Friends were used to support projects beneficial to the National Hurricane Center that could not be publicly funded. One of the more significant projects was to develop enhancements to the Web capabilities of the

National Hurricane Center, improving access to information. As the insurance industry well knows, enhanced communication is always critical in responding to hurricanes and in assessing potential losses.

Another significant project was the re-analysis of the National Hurricane Center's North Atlantic Data Base, or HURDAT. This extended the National Hurricane Center's tracks of tropic storms and hurricanes back to the mid-1800s, greatly improving the record many computer models used for forecasting hurricane tracks. It also laid the foundation for models that enabled the National Hurricane Center to issue five-day tract forecasts for the first time this year rather than the three-day forecasts of the past.

Unfortunately, following 9/11

the insurance industry's support for Insurance Friends waned, as its focus was drawn away from this discretionary spending. Insurance Friends was shut down at the end of last year, but not without first providing seed money for projects in the area of storm intensity, including wind and rainfall projections, which are significant factors in preparing for such storms.

As counsel to Insurance Friends and as a member of its advisory board, I found it a pleasure to have worked with Max Mayfield, the present director of the National Hurricane Center; his predecessor, Jerry Jarrell; Steve Leatherman, the chair of the Florida International University's International Hurricane Center; Bob Sheets, a former director of the National Hurricane Center and a member of the advisory board; and, in particular, Messrs. Ramsdell and Talbot, who made a lot happen with relatively few bucks.

As Max Mayfield stated in a letter to Insurance Friends in mid-2001, "I express my sincere thanks to the IFNHC for its support. I believe that this is an outstanding example of how a public/private partnership should work." Unfortunately, with a few exceptions, it was not possible to convince the industry as a whole of the significant benefit to them and to their customers from the small investment of time and money sought by Insurance Friends.

Perhaps there are some out there who could put aside their competitive instincts to revive this relationship with the National Hurricane Center in the future. Otherwise, Insurance Friends' legacy will be limited to the small but significant help it provided in the past.

Like Camelot, Insurance Friends was a shining star for a brief period of time, yet its impact on the forecasting and communications with respect to tropical storms and hurricanes should be felt for some time.

Peter H. Bickford
New York

Schillerstrom



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Workers Compensation

Spotlight Editor: Meg Fletcher

Prescription management seen lacking as costs keep rising

By MICHAEL PRINCE

Rising prescription drug spending is forcing employers and workers comp insurers to find ways to keep costs in check.

While some strategies are showing signs of success, many others that are successful for group health plans simply can't be used because of the special nature of workers compensation programs.

Drug costs in workers comp programs have been rising by around 15% year after year and now make up nearly 10% of the total workers comp health care bill, experts say. As recently as 1997, drug spending represented only 7% of medical costs, according to a study released in August by the National Council on Compensation Insurance in Boca Raton, Fla.

"The fastest-growing component of the medical expense is prescription drugs," said Joseph Paduda, principal at Health Strategy Associates, a workers comp managed care consulting firm based in Madison, Conn.

The rising cost of drugs in the past few years has forced employers and insurers to devote attention to an issue that previously received little notice, said Ash Kilada, director of risk management and benefits at Sbarro Inc. in Commack, N.Y.

"Insurance companies are just starting to address it in the past few years," he said.

What's particularly troublesome for workers comp insurers is that many of the tools available to control drug spending in group health plans are not available to them. People in workers comp programs don't pay anything for their drugs, so it's not possible to create a co-payment structure that encourages the use of lower-cost drugs, experts say.

In addition, state workers comp laws often prevent the insurer from directing a patient's care, including determining which pharmacy fills a prescription.

See DRUG COSTS/page 16



Chiropractic care of workers blamed for higher comp costs

But if closely managed, chiropractors can be effective

By JOANNE WOJCIK

While many injured workers may swear by chiropractors, most employers are more likely to swear at them when they see one listed as a treating physician on a workers compensation claim.

Unchecked chiropractic care can, and often does, drive up the cost of medical care, many employers assert.

But there are times when chiropractic care can actually save employers money in temporary disability costs by returning injured employees to work faster, some workers comp experts say.

The key, they say, is to monitor

treatment to ensure that claimants are receiving appropriate care.

In workers comp cases in which chiropractors are the exclusive provider, total costs per claim are 16% to 25% higher than in cases in which care is directed by physicians, according to a 2002 study by the Boston-based Workers Compensation Research Institute. Medical costs are 17% to 21% higher in chiropractor-treated cases when considering the costs of complete medical treatment, including physical medicine, radiology, supplies and drugs, the study also found.

"It's the kiss of death whenever I see a chiropractor on a claim," said Nancy Axtell, director of safety and

risk management at PRIDE Industries in Roseville, Calif. PRIDE specializes in placing disabled workers in jobs. "They'll treat the patient for the rest of their lives."

In fact, Ms. Axtell says she has several claims in which chiropractors have been treating claimants for a year or more after an injury.

"I believe there are some reputable chiropractors out there," she said. "But once they get in the comp system, it's like giving them an open checkbook."

Ms. Axtell said the situation is particularly acute in California, which recently enacted legislation to limit the number of chiropractic

See CHIROPRACTORS/page 28

California's comp woes illustrate risk that reforms can backfire

By ROBERTO CENICEROS

Some of the problems now plaguing California's workers compensation system can be traced, in part, to a little-understood provision embedded in reform legislation signed into law a decade ago.

Recently enacted legislation should help correct the problem, though other significant challenges remain, employers say.

But in 1993 employers and insurers didn't suspect that the provision would add to their costs and help make California's workers comp system one of the costliest in the nation.

The provision stipulated that an injured employee's doctor is presumed correct in all treatment decisions. By the time employers figured out the provision's consequences, the losses had already mounted for at least two years and would continue to do so for years after that, employers and insurers agree.

The presumption of correctness was not a key component of the 1993 reforms, which were created with input from insurers, labor, employers and other stakeholders, recalled Jill Dulich. Ms. Dulich is regional director of claims services for Marriott International Inc.'s Western region in Santa Ana, Calif.

"It just went in" as a 23rd-hour change without a lot of discussion, said Ms. Dulich, who also serves on California's Commission on Health Safety and Workers' Compensation.

It was "an almost unknown, little provision," said Peter Gorman, vp and Western regional manager in San Francisco for the Downers Grove, Ill.-based Alliance of American Insurers. But it "shifted things dramatically in favor of the worker," he said.

The presumption of correctness sought to check rising medical and legal costs by fixing a "dueling doctors" phenomenon occurring at the time. Under that situation, doctors representing employees and insur-

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Ranking of independent safety consultants
page 12

Innovative software program wins Fluor a safety award
page 22

Baystate saves millions with integrated disability plan
page 26

Ranking of largest providers of rehab services to employers
page 30

California: Presumption of correctness proves costly

Continued from page 10

ers argued over the necessary course of treatment. Their feuding increased medical and legal costs.

But employers and insurers eventually found that the presumption of correctness caused them to lose control of medical review and treatment decisions. Workers compensation judges attempting to settle disputes more often ruled in favor of employees and their doctors' opinions.

Insurers began finding it was often less expensive to pay for questionable medical procedures than to challenge treatment decisions

made by an employee's doctor. So insurers gave up the fight on more claims, Mr. Gorman said.

Then, in 1996, the Workers Comp Appeals Board in Minniear vs. Mt. San Antonio Community College extended the presumption of correctness from medical treatment decisions to permanent disability ratings and other areas of workers compensation.

So the presumption of correctness helped exacerbate one of the biggest problems in the system today, employers say. The problem is that there are no guidelines describing an appropriate amount of treat-

ment for various injuries.

Such guidelines could help limit unnecessary treatment. Additionally, workers comp judges do not have clear guidelines for assessing and rating worker injuries and disabilities. They must rely on the subjective opinions of doctors hired by employees and their attorneys.

Three different judges hearing a case involving the same permanent disability injury might reach three different conclusions on how to rate that disability for compensation purposes, employers say.

Injured employees have an incentive to see more medical

providers, while driving up medical costs, in order to find a provider that will help them obtain the highest disability rating, said Charles Bacchi, a workers comp legislative advocate for the California Chamber of Commerce.

Also, under California's system, claimant attorneys reap greater compensation when they win permanent disability awards for their clients, Mr. Bacchi added. That encourages them to involve more doctors and keep injured employees away from work.

One result is that California now has the highest frequency of perma-

nent disability claims in the nation, noted Mark Webb, state relations officer in Los Angeles for American International Group.

California differs from many other states because it seems to allow "unending medical treatment" and has "extremely loose rules" regarding the rating of permanent disability injuries for benefit awards, Mr. Bacchi agreed.

"The interaction between those two functions, over time, has morphed the system into something that is, of course, currently a monster," Mr. Bacchi said.

Employers with employees in multiple states agree that in California, medical costs and lost work time mount faster than in other jurisdictions where they operate.

Workers comp judges do not have clear guidelines for assessing and rating worker injuries and disabilities. They must rely on the subjective opinions of doctors hired by employees and their attorneys.

"A worker gets injured here in California and that injury just seems to cost a great deal more because of medical expenses," said David Sunkin, general counsel for Sherman Oaks, Calif.-based Earl Shieh Inc. "For whatever reason, that worker somehow seems to be able to stay away from work longer."

The 1993 reforms also shaped California's workers comp landscape in other ways during the past decade.

They eliminated a minimal rating floor that previously allowed the state's insurance commissioner to influence rates charged to employers. Following repeal of the minimum rate law, competitive pricing drove insurance pricing dramatically down over several years.

Yet while rates were dropping, long-term cost drivers, such as the presumption of correctness, mount-

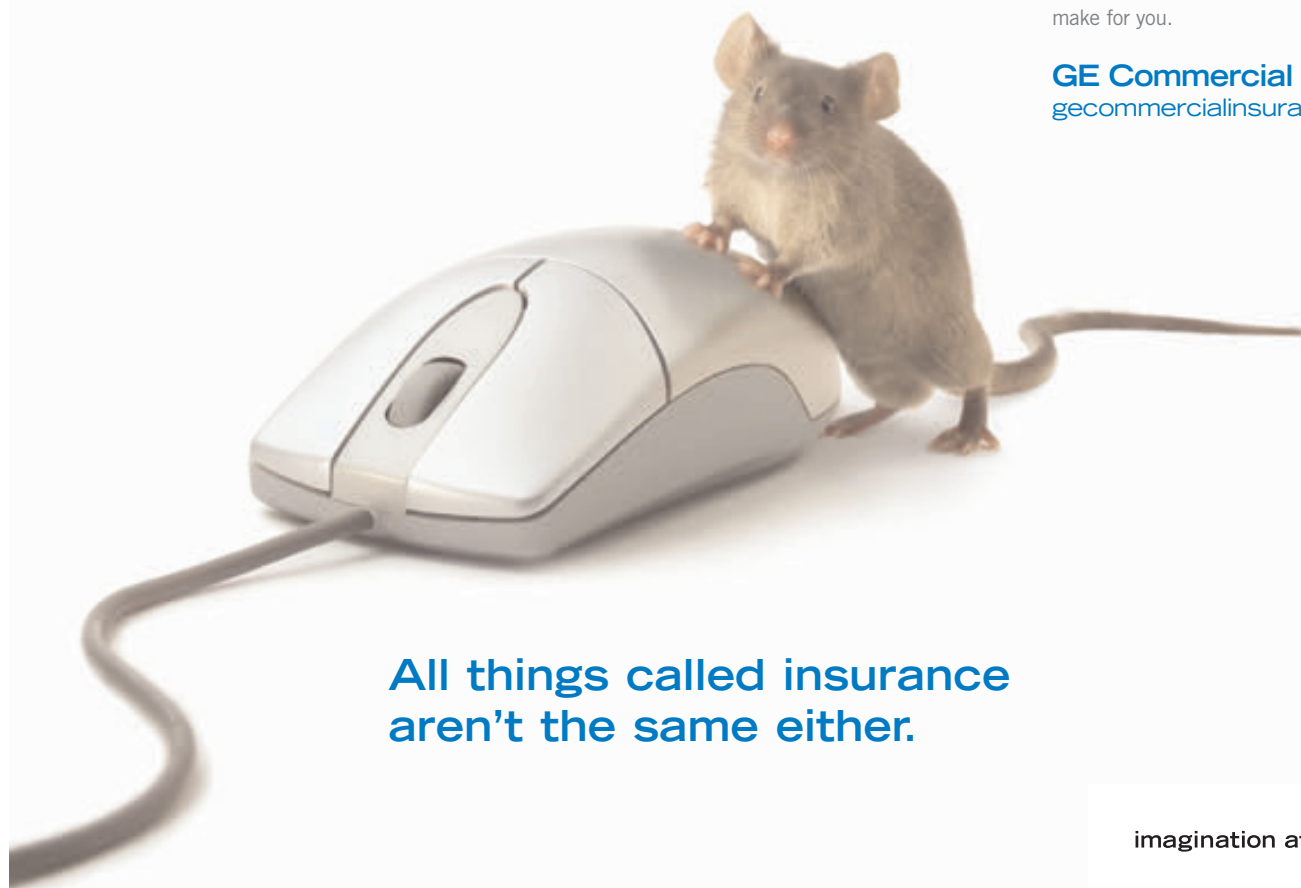
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California: Presumption of correctness proves costly

Continued from page 14

ed without anyone realizing those costs were in play, Mr. Webb said.

"You had severe price competition, but you also had a real problem trying to estimate your losses," he said. Actuarial estimates have since found that pure premium rates during the late 1990s were underestimated by as much as 50%, Mr. Webb said.

The eventual onset of a hard market, insurers realizing their real losses and continuing loss trends eventually led rates to rebound at levels that alarmed employers.

Total workers comp system costs

in California rose from \$9 billion in 1995 to \$29 billion today. During the same period, rates increased from \$2.61 to \$5.85 per \$100 of payroll, according to data from the San Francisco-based Workers' Compensation Insurance Rating Bureau.

Today, medical expenses continue to rise rapidly. "The rise in medical care expenditures is placing considerable strain on the entire workers compensation system," according to California's Commission on Health and Safety and Workers' Compensation.

The average medical cost per in-

demnity claim jumped from about \$9,000 in 1993 to \$31,000 in 2002, according to the WCIRB.

Overall, there has been a lack of medical utilization review in the system, Ms. Dulich said.

But recent legislation addressing the presumption of correctness, treatment utilization and other problems should help employers address medical costs, Ms. Dulich said.

In 2002, Gov. Gray Davis signed into law a workers compensation benefits increase bill, A.B. 749. The legislation also chipped away at the presumption of correctness. The

law restricted the presumption only to cases in which an employee pre-designated a medical provider prior to suffering an injury. But that law applied only to claims opened before Jan. 1, 2003.

More recently, legislation signed into law Sept. 30 eliminates the presumption of correctness for claims opened after Jan. 1, 2003, Ms. Dulich said.

It also requires California's Commission on Health and Safety and Workers' Compensation by July 2004 to evaluate treatment utilization guidelines and independent medical review systems used by

other states. California's Division of Workers' Compensation is then supposed to use the information to adopt medical treatment guidelines.

The guidelines will give insurers and employers a better chance when challenging medical treatment decisions. But attorneys and insurers, along with the doctors they hire, will have to battle over the application of the guidelines to each case, Mr. Bacchi said.

California could be back to a dueling doctors system with the core problem of increasing medical costs still intact, he said.

Drugs: Costs are rising

Continued from page 10

As a result, many workers comp insurers often shy away from aggressively talking to physicians about the best or most cost-effective drug therapies to employ, said Dr. David Deitz, vp, national medical director at Liberty Mutual Insurance Co. in Boston.

"We don't want to be seen as unduly influencing prescribing patterns for doctors," he said.

Rather than directing doctors, they prefer to educate them about various drugs and their relative costs, Dr. Deitz said. "We can only suggest," he said.

Another proven cost-control strategy that has limited use in workers comp programs is switching prescriptions to lower-cost generic drugs.

The majority of drug costs in workers comp are focused on a relatively small group of drugs, primarily used for pain relief, and generic use is already quite high, said Andy Mayer, senior director, workers compensation division at Express Scripts Inc. in St. Louis, Mo.

"When there is a generic equivalent, the use of generics has been high," added George Furlong, director of medical payment products at Choice Medical Management Services L.L.C., a workers comp managed care company in Tampa, Fla.

In fact, the NCCI study shows that, in workers comp, generic drugs are used 80% of the time when they are available. Also, half of drug costs are from drugs with no generic alternative, the study shows.

"It's obvious there are limited opportunities" to get much more out of generic use, said Barry Llewellyn, senior divisional executive, regulatory services for the NCCI and co-author of the study in Hoboken, N.J.

But there are strategies that can work, experts say.

One proven idea is providing an injured worker with a discount drug card run by a prescription benefit

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Drugs: Prescriptions driving up workers comp costs

Continued from page 16

manager. Using the cards, workers can access a network of pharmacies offering discounts of up to 30%.

The key to the success of any discount card is getting it into the hands of the injured worker. This is often difficult to do before the person receives a prescription, Mr. Kilda said.

"If someone can come up with a solution, it would be great," he said.

For those people who receive multiple prescriptions and, in particular, those with long-term drug needs, a discount card or a mail-order drug service produces signifi-

cant savings, Mr. Paduda said.

Another way to control costs is to reject claims for drugs that are considered inappropriate. For example, Express Scripts has a formulary for its workers comp customers, and any submitted drug that is not on the formulary needs special approval by the insurer's claims adjuster, Mr. Mayer explained. Often, though, the adjusters approve the drugs.

"We do see drugs slip through that should not be on workers comp," he said.

Many adjusters approve the claims because they don't under-

stand that the drugs are not appropriate or they fear lawsuits by injured workers over the rejection.

OxyContin abuse 'is a national concern with workers comp.'

Roger Fries
Kentucky Employers Mutual
Insurance Co.

"The risk of litigation outweighs the cost of a drug," he said.

But Dr. Deitz of Liberty Mutual disputes this assertion. While he ac-

knowledges that laws limit Liberty Mutual's claims managers' ability to control costs, they shy away from intruding into treatment out of fear of upsetting the doctors and hurting their relationships with them, he said.

"That is actually a bigger problem than fear of litigation," he said.

In addition to grappling with rising costs, employers and workers comp insurers are struggling to cope with the growing use of the painkiller OxyContin. The drug, which was originally intended for people suffering from severe, long-term pain, has become one of the

most used drugs by workers comp claimants. The concern with the drug stems from its addictive nature and how some users are abusing it.

"This is a national concern with workers comp," said Roger Fries, president and chief executive officer at Kentucky Employers Mutual Insurance Co. in Lexington, Ky.

Insurers are trying to identify those people that are abusing the drug by either receiving refills too quickly or obtaining multiple prescriptions from a variety of doctors, said Phillip Walls, vp of pharmacy services at PMSI, a workers comp PBM in Tampa, Fla.

Another concern with OxyContin is its overuse, said Dr. Deitz of Liberty Mutual. Because it's so powerful, it should be given only when other drugs fail to control an individual's pain, he said.

"It appears to be prescribed too early in the process," Dr. Deitz said.

While he would like to see overall use of OxyContin drop, workers comp insurers cannot simply reject claims for it, he said. Instead, each case has to be reviewed for signs of abuse, he said.

Abuse is not limited to OxyContin, though. People are also abusing pain medications containing the drug hydrocodone, such as Vicodin, Mr. Walls said.

"Hydrocodone is just as much, if not more, of a concern as OxyContin," he said.

To combat the abuse of OxyContin, the National Assn. of Independent Insurers has recently launched a state-level effort to pass strict guidelines for the use of the drug, said Nancy Schroeder, assistant vp of workers compensation at the NAI in Des Plaines, Ill.

The proposed guidelines would detail when the drug could be used and the type of monitoring of its use that would be needed.

"It's very new. It's an issue the industry has just become aware of," Ms. Schroeder said.



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PHOTO: COURTESY OF FLUOR HANFORD INC.

Safety software lowers worker exposure

Contractor's award-winning tool available free to other employers

By MEG FLETCHER

A software program that recently won a national innovation award was developed by Fluor Hanford Inc. and its workers at the world's largest environmental cleanup site to help them—and other companies that are adapting its free software—to better protect workers from hazards while also streamlining operations.

The "Automated Job Hazard Analysis" software was developed

by the subsidiary of Aliso Viejo, Calif.-based Fluor Corp., one of the world's largest engineering, procurement and construction contractors.

The program was designed to protect Fluor Hanford's 4,300 workers from radiological exposure to the cancer-causing residue of 60 years of plutonium production for national defense efforts at the Hanford, Wash., site, as well as to better coordinate decontamination operations there.

The 586-square-mile site, which at one time contained nine nuclear reactors and associated processing facilities, was operational from the 1940s with the Manhattan Project until 1989, when the U.S. Department of Energy ceased production there.

The decontamination and decommissioning project began in the late 1980s. It requires contractors and workers to cope with immense physical challenges, including tons of plutonium in various

forms, 2,300 tons of spent nuclear fuel, about 25 million cubic feet of buried or stored solid waste and about 270 billion gallons of contaminated drinking water.

When Fluor Hanford became the main contractor at the site in 1996, the annual worker injury rate was comparable to the industry average of 5.2, which meant that each year about five out of every 100 workers would sustain some type of injury or illness that was reportable under the requirements of the Occupational Safety and Health Administration Act, according to Dave Jackson, the contractor's director of occupational safety and health. In addition, those injured or ill workers at the site typically lost between 24 and 30 days of work annually, he said.

With Fluor Hanford in charge and with the development of the hazard analysis software, Mr. Jackson said, those numbers subsequently dropped to 1.5 injuries per 100 workers and fewer than five days lost. In addition, there has been "a significant drop" in workers compensation costs, although company-specific data are not available due to the pooling of claims from multiple contractors, he said.

"Safety is one of our core values," Mr. Jackson said. Given the nature of Fluor's business, "our only resource is our people. That's why safety is so important."

The job hazard analysis software uses a "hazard tree" analysis as a more systematic and integrated approach to reduce the number of worker injuries and better integrate information from a variety of sources, including workers, experts, reports of best practices and environmental and safety regulations and standards. It was first implemented in 1998.

The foundation of the software analysis is a list of up to 156 questions related to the hazards of performing a specific task. It results in a systematic and integrated process to answer those questions and ultimately creates a work plan that incorporates the broad-based knowledge of project participants from top to bottom, as well as the requirements of standards and regulations.

"No other system provides such a complete union of knowledge, standards and integration with work control," according to a joint statement by Miles Jaeger, the program's administrator, and Mark Hermanson, a systems analyst.

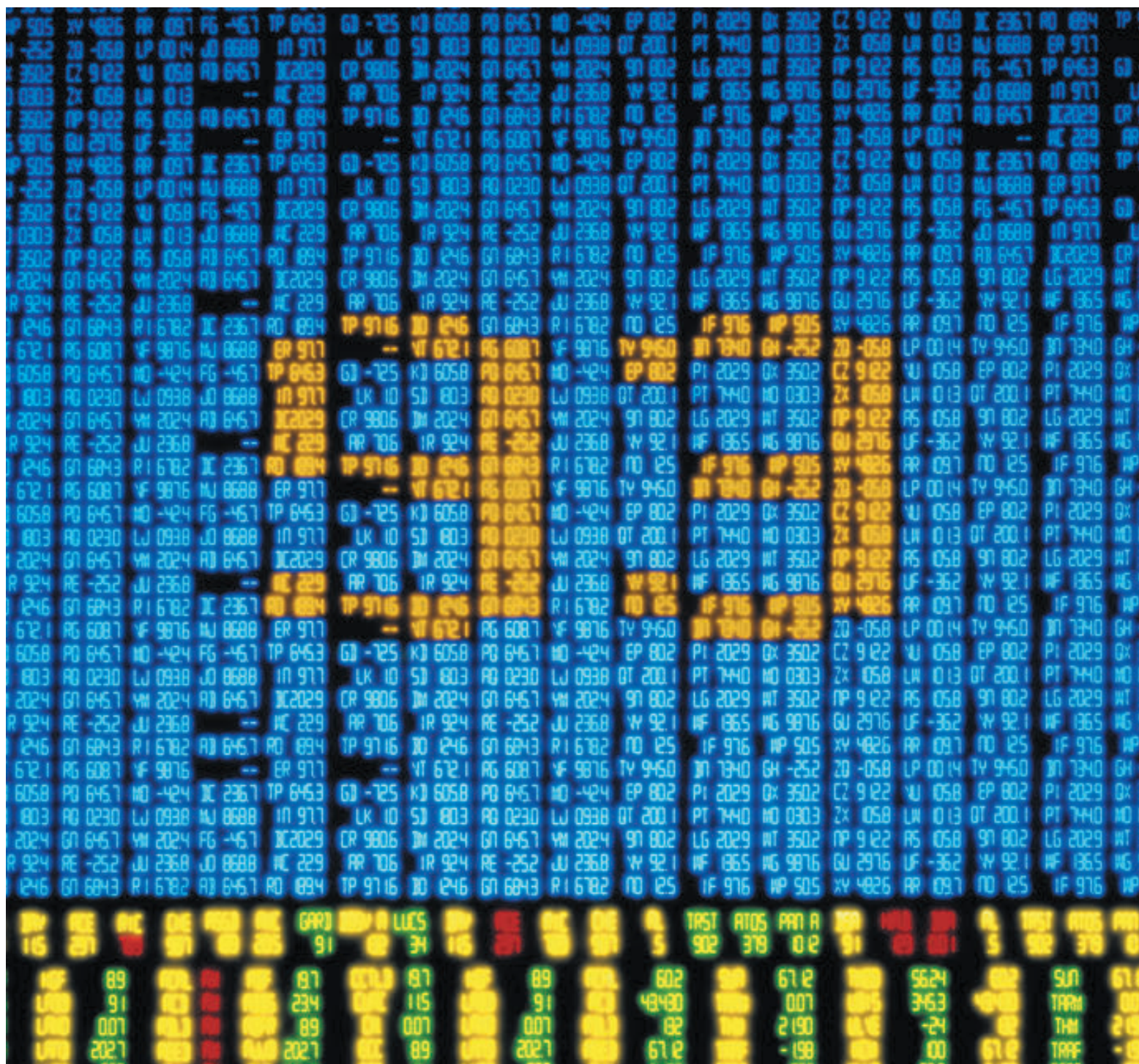
The hazard analysis process, in which workers are asked to contribute their opinions both before and after a task is completed, "has really improved morale," said Ron Oak, a spokesman for the Hanford Atomic Metal Trades Council, a group of 14 unions working at the site. About 2,000 of Fluor Hanford's 4,300 workers are affiliated with unions.

For example, "there is about a 95% chance that all the proper personal protective equipment will be

See SAFETY/page 24

Extensive equipment, such as this glovebox, shields scientist Susan Jones from radiological exposure in handling plutonium.

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INSURER TOPICS

A MONTHLY EDITORIAL SECTION SENT EXCLUSIVELY TO INSURERS AND REINSURERS

Reinsurance Strategies



Cedents pay closer attention to reinsurers' financials

Ceding companies also look for specialty services

By **RODD ZOLKOS**

Reinsurers' security and the special services they offer have become increasingly important considerations to many reinsurance buyers.

With an increased sensitivity to

changes to the ratings of reinsurers' claims-paying ability, many ceding companies are taking a long look at potential reinsurers' financial strength.

Meanwhile, many cedents also look to reinsurers to provide research and analytical support, as well as help with crafting solutions to specific problems.

"There's definitely more focus on the financials," said Mark Ricciardelli, president and chief executive officer-global casualty reinsurance at Employers Reinsurance Corp. in Avon, Conn.

Ratings "have piqued a lot of people's concern about security in the reinsurance market," Mr. Ricciardelli said. "Buyers are

much more rating-conscious."

Alan J. Levin, partner at the Edwards & Angell L.L.P. law firm in Hartford, Conn., and chairman of the firm's insurance and reinsurance practice, noted that the current reinsurance market is marked by numerous claims disputes.

See **REINSURANCE**/next page

Security rules need scrutiny / 22F

Producers should be 'trusted advisers' / 22H

IIABA elects woman president / 22H

Keeping claims operations shipshape / 22J

INSURER TOPICS

Reinsurance: Ceding companies mindful of financial ratings

Continued from previous page

"Everybody's fighting over everything," he said. "There has been a cycle lately where the life and health industry has been disputing with its reinsurers and the property/casualty industry is disputing with its reinsurers."

Mr. Levin said he thinks that trend stems from insurance companies that weren't professional reinsurers moving into that area during the soft market thinking, "I know reinsurance, too."

Now, he said, professional reinsurers are holding their clients to a higher standard than they have

historically in terms of policy language and terms and conditions. "I think that is the biggest trend we are seeing now," he said. "I think the other thing we're starting to see is many buyers of reinsurance looking at the security of risk and who the reinsurers are."

But Steven K. Bolland, president of intermediary Gill & Roeser Inc. in New York, said he thinks rating issues are so widespread among insurers and reinsurers currently that reinsurer ratings aren't a major issue for most ceding companies.

"I think it is so general and so prevalent that a vast majority of

cedents are throwing their hands up in the air and saying, 'It's a sinking tide that lowers all ships,'" Mr. Bolland said.

"I still think the vast majority of cedents' criteria is still an A-rated security," he said. "Until you see a (Munich Reinsurance Co.) or a (Swiss Reinsurance Co.) breaking through that level, I don't think we're going to see a lot of activity."

Many of the reinsurance companies taking hits to their ratings in recent months have been European companies hit hard by catastrophe losses and declines in

the value of equity investments, Mr. Bolland said. But, many appear to be surviving the downgrades.

"A lot of the companies we're talking about are the European companies who just had the worst possible combination of things hit them at the same time," he said. "But they're still there...and they're surviving quite well."

In terms of the services some reinsurers provide, which range from research and analysis to workshops and seminars, often they're particularly important to small and midsize ceding companies and can be part of a reinsurer's

strategy for reaching that market.

"It is important to certain buyers," Mr. Bolland said. "The smaller companies just don't have the expertise or the resources to do a lot of this work. So, for the smaller companies that lack the size or the scope, some of these things are critical to them."

"I think the question comes up quite often, 'What can you do to help me?' and I think the major reinsurers have been responding in a very positive way," said ERC's Mr. Ricciardelli.

Several reinsurance companies—including ERC, Swiss Re and Munich Re—do extensive research on various insurance and economic topics, often making the information available on their Web sites.

"We do a lot of research work," Mr. Ricciardelli said. In addition, the company has had customer forums on such topics as asbestosis, workers compensation and umbrella

'I think that reinsurers are kind of defining their role by saying that it's not enough for us to be a silent partner, but it's necessary for us to get involved in helping to affect the outcome.'

*Michelle Fallahi
ING Re*

liability.

There's a similar approach on the health reinsurance side, according to Michelle Fallahi, vp of medical and managed care reinsurance at ING Re in Minneapolis.

"I think that reinsurers are kind of defining their role by saying that it's not enough for us to be a silent partner, but it's necessary for us to get involved in helping to affect the outcome," Ms. Fallahi said.

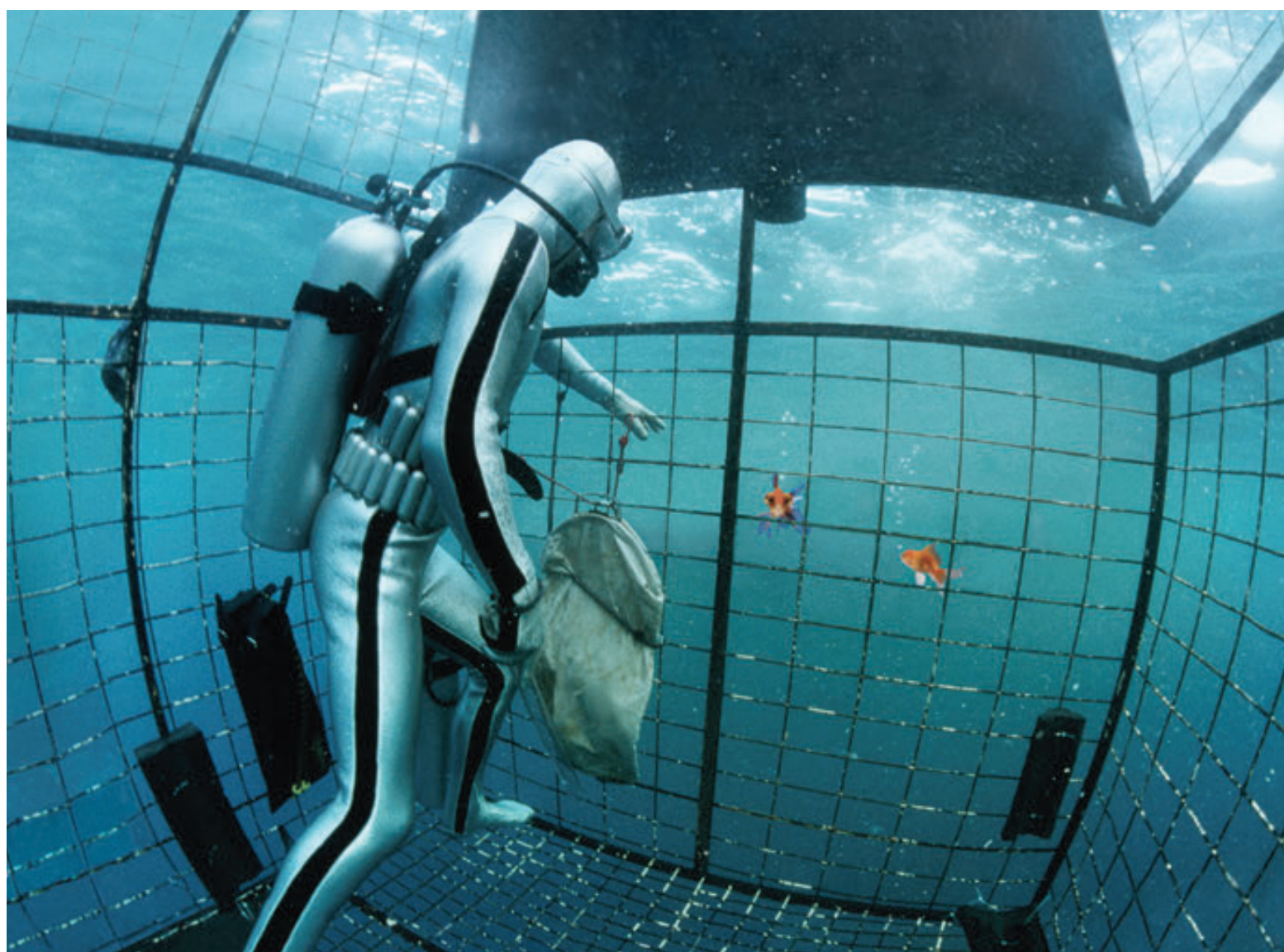
"I think it's really a situation of reinsurers having more tentacles out there in terms of resources on the more infrequent, high-dollar claims," Ms. Fallahi said. "For example, reinsurers can do research for their clients. They can bring them pharmaceutical vendor-type relationships. Some reinsurers have physicians on retainer so (health plan clients) can get second opinions."

On another front, Ms. Fallahi said ING saved clients \$11.2 million in 2002 through case management consulting, a service many health reinsurance buyers have come to rely on. "There's a variety of savings. It's pretty consistent," she said. "I think once you build that expectation, the clients miss it if they don't have it."

There's also an emphasis on adapting reinsurance coverage to meet cedents' particular needs, she said, such as issues of claims concentration.

"That situation, it's not so much one severe claim...it's the sheer number of claims that becomes the issue. That's what clients are

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INSURER TOPICS

Competition, regulation among top concerns, survey finds

Insurance industry executives expecting more M&A

By **RODD ZOLKOS**

The insurance industry will see an increase in merger and acquisition activity over the next year, according to a majority of insurance companies responding to a recent survey.

Of those surveyed at KPMG L.L.P.'s 14th Annual Insurance Industry Conference late last month in Chicago, 59% said they expect an increase in merger and acquisition activity over the next 12 months, while 11% said they expect to see M&A activity decrease and 30% said they expect the level of activity to remain the same.

In addition, executives have shifted their opinion over the past few years concerning their greatest competition.

While three years ago insurance executives surveyed said they saw international financial service firms posing the greatest competitive threat, those in this year's survey said they saw other insurance companies as their major competitors.

In KPMG's 2000 survey, 53% of those polled cited international financial service companies as the greatest competitive threat. That percentage dropped to 15% in this year's survey. Meanwhile, 62% of executives in this year's survey said they expect other insurance companies to be the greatest competition over the next three to five years, up from 32% in the 2000 survey.

The perception of the competitive threat presented by

banks also has increased over the past few years, with 12% of those surveyed this year saying they perceive banks as their major

While three years ago insurance executives saw international financial service firms posing the greatest competitive threat, this year they saw other insurers companies as their major competitors.

competitors, up from 4% in 2000. Regulatory issues and market conduct pose the greatest threat to

the insurance industry, according to 29% of the executives surveyed this year; last year, 20% called regulatory issues and market conduct the greatest threat. Concentration of risk was cited by 26% as the greatest threat, up from 17% in last year's survey, while 19% of those in this year's survey called credit risk the greatest threat, a drop from the 32% of executives that cited credit as the greatest risk last year. The percentage seeing technology risks as the greatest threat fell to 3% this year from 6% in 2002.

Risks associated with capital deployment were seen as the greatest threat facing the industry by 24% of those surveyed, nearly unchanged from the 25% that called capital deployment risks the greatest threat in last year's survey.

Categories add up to more than or less than 100% because some respondents had more than one answer for each question or did not answer each question.

The percentage of executives seeing potential for premium growth in the property/casualty market was down in the current survey from last year, to 65% from 88%, while 13% said they see the likelihood of premium decreases, up from 4% in the 2002 survey.

In the life/health market, 58% of executives said they see potential for premium increases, roughly the same as last year's 59%. Meanwhile, the percentage anticipating premium decreases declined to 11% this year, from 18% last year.

Executives surveyed were optimistic about their companies' performance over the coming year,

with 5% saying they expect their companies to perform significantly ahead of expectations and 65% saying they expect their companies to perform ahead of expectations. Only 5% of those surveyed said they expect their companies to perform significantly behind expectations.

Assessing the factors most important to their companies' growth, the largest percentage of executives, 32%, said they see underwriting as most important to future growth, with 30% citing distribution as the most significant factor. Customer focus was mentioned by 20% of executives as the most important factor in their companies' growth, with 12% citing product focus and 6% calling technology the most important factor.

The Sarbanes-Oxley Act was by far the piece of recent legislation seen as having the greatest impact on the way the executives' companies do business, mentioned by 58%, while 15% mentioned the USA PATRIOT Act, 12% mentioned the Health Insurance Portability and Accountability Act, 9% cited the Gramm-Leach-Bliley Act and 7% said the Terrorism Risk Insurance Act would have the greatest impact.

Of proposed legislation, 49% of the executives surveyed said federal regulation of the insurance industry would have the greatest impact on their business, 38% said tort reform would have the most significant effect, 10% cited universal health care and 4% said prohibition of credit-based insurance scoring would have the greatest impact.

Brokers, foreign insurers hail tax exemption guidelines

By **RODD ZOLKOS**

WASHINGTON—U.S. brokers and U.K. insurers and reinsurers are welcoming streamlined procedures from the U.S. Treasury Department aimed at foreign insurers and reinsurers looking to establish their exemption from the federal excise tax on insurance policies covering U.S. risks.

The release of the new procedures this month was driven by the fact that a new U.S.-U.K. tax treaty is set to take effect Jan. 1, and hopes that U.K. insurers could qualify for the FET exemption under the new rules prior to the treaty taking effect.

While driven by the impending effective date of the new U.S.-U.K. tax treaty, the new procedures set out Oct. 10 by the Internal Revenue Service will apply to future qualification for excise tax exemptions under all U.S. tax treaties.

The new procedures are expected to make it easier for brokers to identify insurers that are in compliance with requirements for the exemption. By making it easier to qualify for the exemption, the changes also could help insurers avoid passing on tax costs buyers.

Among other things, the new rules address the issue of insurers in treaty countries being used as a "conduit" in order to obtain tax-free treatment of premiums by passing risks through a treaty country insurer to a reinsurer in a nontreaty jurisdiction such as Bermuda. The anti-conduit restriction is a primary difference between the new U.S.-U.K. tax treaty and the one it replaces.

But, under the new Treasury

revenue procedures, the FET exemption is at risk for a transaction only if the insurance buyer or broker directs the insurer to pass a significant portion of the risk to a reinsurer in a nontreaty jurisdiction in order to avoid taxes. The FET exemption would not be jeopardized, though, if the insurer decides independently for its own business purposes to reinsure the risk into a nontreaty jurisdiction.

'Brokers don't mind being the tax collector. What they didn't want to see happening was brokers becoming the policemen.'

*Joel Wood
Council of Insurance
Agents & Brokers*

"That whole conduit thing is a real concern to the London market," said Joel Wood, senior vp of government affairs at the Council of Insurance Agents & Brokers in Washington. "And it's understandable that Treasury wants to make sure that no one is trying to get away with anything through a conduit relationship."

Because of the anti-conduit restriction, U.S. and U.K. tax authorities were unwilling to simply develop a list of treaty-eligible insurers, as was the case under the old treaty. Instead, under the new pact, U.K. insurers seeking FET-exempt status will have to enter into so-called "closing agreements" with the IRS.

Under those closing

agreements, the insurer will assume full liability for any FET obligations, will agree to maintain books and records for an appropriate amount of time and will provide a letter of credit to guarantee payment of any FET due on transactions that may not qualify for the exemption.

The Treasury Department has indicated that if insurers move promptly to submit the necessary paperwork, they should be able to have closing agreements in place before the new U.S.-U.K. tax treaty takes effect Jan. 1.

Under the new procedures, the IRS has committed to making publicly available periodically updated lists of insurers and reinsurers that have entered into closing agreements, as well as providing information on insurers and reinsurers that have terminated such agreements.

Mr. Wood said he has heard from the Council's broker members and from British insurers that they are very satisfied with the outcome of the new revenue procedures. "In fact, it's probably better than we've ever had it before," he said. And, with the publication of a list of exempt companies, "we're probably going to see better compliance," Mr. Wood said.

"Brokers don't mind being the tax collector," Mr. Wood said. "What they didn't want to see happening was brokers becoming the policemen."

While the previous arrangement has been "a somewhat troubling area for all our broker members to know who's exempt and who's not," the new procedures are "going to create ease associated with the transaction," Mr. Wood said.

Reinsurance: Security remains a concern

Continued from page 22B

concerned about," Ms. Fallahi said. "Some clients are thinking, 'If it's not terrorism, then what can it be?' Well, there are a number of things that are not terrorism-related."

For health plans, a key issue is that many reinsurance buyers are regional in nature, Ms. Fallahi said. "In the case of an HMO, maybe they're in 10 counties," she said. "So, as you might expect, they have a concentration."

Such buyers could be particularly hard hit by a natural disaster, a severe fire, a hazardous chemical leak or a train derailment, and they need to consider that kind of exposure in making their reinsurance-buying decisions, Ms. Fallahi said.

"I think they feel it's an issue that they have to address somewhere and, truly, I think they have to address what a catastrophic claim is. Is it one person with a high dollar amount or is it a group of people or an event?" Ms. Fallahi said. "I think

they really have to figure out what would they want to report to the board and then work backward from there."

For the reinsurer, the task is to work with the clients, helping them to become aware of those exposures and making the coverage available to address them, she said.

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INSURER TOPICS

Reinsurance security rules need scrutiny

Cedents concerned about recovering funds from reinsurers may find state security statutes lead to complications

By David A. Attisani
and Jennifer Aresco Brennan

In the current economy, cedents litigating with their reinsurers are showing increasing concern that their adversaries may not possess adequate assets to satisfy a future award.

To hedge against this uncertainty, many cedents seek to make their reinsurers post security, but there are limitations in traditional forms of prejudgment security in the reinsurance context and in their practical implications.

The most common method of obtaining security is by a motion directed to a court or arbitration panel based on state law. Almost every U.S. jurisdiction has enacted some form of prejudgment security statute, which often tracks the National Assn. of Insurance Commissioners' Model Unauthorized Insurers Process Act of 1949.

The purpose and operation of state statutes is not always in accord with the sophistication and needs of the parties to reinsurance transactions.

These laws, which apply to "unauthorized" foreign or alien insurers—insurers licensed in a state other than the forum state—permit an unauthorized insurer to operate without obtaining a license in all 50 states. The laws also facilitate the process by which an unsophisticated policyholder can enforce a judgment by ensuring that funds sufficient to pay a judgment are available in the forum state.

Like many rules aimed at direct insurance, these statutes have been interpreted to cover reinsurance disputes. It is obvious, though, that the purpose and operation of these statutes is not always in accord with the sophistication, wide geographic presence and needs of the parties to reinsurance transactions. Nonetheless, these statutes are the principal means of security available to cedents.

Most prejudgment security statutes provide that, before an unauthorized insurer may file a motion in its own defense, it must first deposit funds with the court clerk sufficient to pay any future judgment.

Some states, such as Illinois, specifically include arbitration disputes within the purview of the statute, but even if arbitration is not specifically mentioned, arbitrators may, by analogy, order that funds be paid into an escrow

monitored by the panel.

Not surprisingly, unauthorized insurers and reinsurers have objected to these statutes. It is not clear, for example, that cedents—which generally possess greater means and sophistication than the policyholders targeted for statutory protection—should be permitted to leverage state security statutes to

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their benefit.

Conversely, like primary policyholders, cedents argue that they are entitled to collect the

proceeds of the contract they purchased, to the extent their claims are found to be meritorious. To date, challenges to the statutes by reinsurers have been largely unsuccessful.

The appropriate enforcement of prejudgment security statutes undeniably streamlines the collection process. If funds are not

available in the forum state, the claimant need not initiate a second proceeding in a jurisdiction where the adversary maintains funds, and it is not required to "follow" an alien reinsurer to its home jurisdiction in order to attach assets.

Thus, subject to arguments that the state statutory schemes are ill-equipped to address reinsurance obligations, prejudgment security laws often provide a straightforward approach to securing an award when the

Continued on next page

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INSURER TOPICS

Continued from previous page respondent is unauthorized.

Ironically, this process is complicated when the reinsurer is authorized to do business in the forum state. Having felt victimized by the letter of laws that apparently are not directed at reinsurance proceeds, authorized reinsurers may insist that the law that requires only unauthorized reinsurers to post security be strictly enforced.

This distinction may quickly become complicated when it is clear, for example, that an authorized, risk-bearing reinsurer's foreign parent or affiliate is, in fact, funding its defense and, likely, any award. The court or arbitrator must

then determine whether to address this statutory loophole by characterizing the unauthorized company as the real party for purposes of posting security.

More fundamentally, a cedent seeking security from its authorized reinsurer may have few attractive options. Because many reinsurers maintain a national or international presence, they often do not possess real property or bank accounts in the forum state. In these common circumstances, the cedent cannot rely on a state security statute and, in most cases, it cannot efficiently employ traditional forms of attachment.

Cedents may, therefore, seek to leverage state "credit for

reinsurance" statutes, which permit cedents to take credits on their financial statements based on their purchase of reinsurance. In some states, if the reinsurer is not licensed, it must post collateral according to complex rules before the cedent can take a credit.

Accordingly, credit for reinsurance statutes may operate in the same manner as prejudgment security statutes, permitting cedents to draw on the reinsurer's line of collateral. But a cedent's ability to access these funds may be materially limited—a trust created for all cedents can, for example, precipitate a zero-sum creditors' race to the trust.

These statutes also presuppose a

nonlicensed reinsurer's compliance with collateralization requirements, based on its desire to compete with other collateralized reinsurers.

Finally, a cedent may look to state licensing requirements in order to obtain security from an authorized reinsurer.

Before granting a license to an alien reinsurer, state insurance commissions typically require proof of a carrier's ability to satisfy claims. Some common licensing requirements include proof that the insurer is legally organized under the laws of its domicile to conduct business; that the required amount of capital and surplus is available to transact business; and that funds are available to pay

losses incurred in the licensing state.

Insurers and reinsurers also must deposit funds with the state treasurer to be held in trust. Unfortunately, there is no requirement that the amounts held on deposit correlate to the company's exposure.

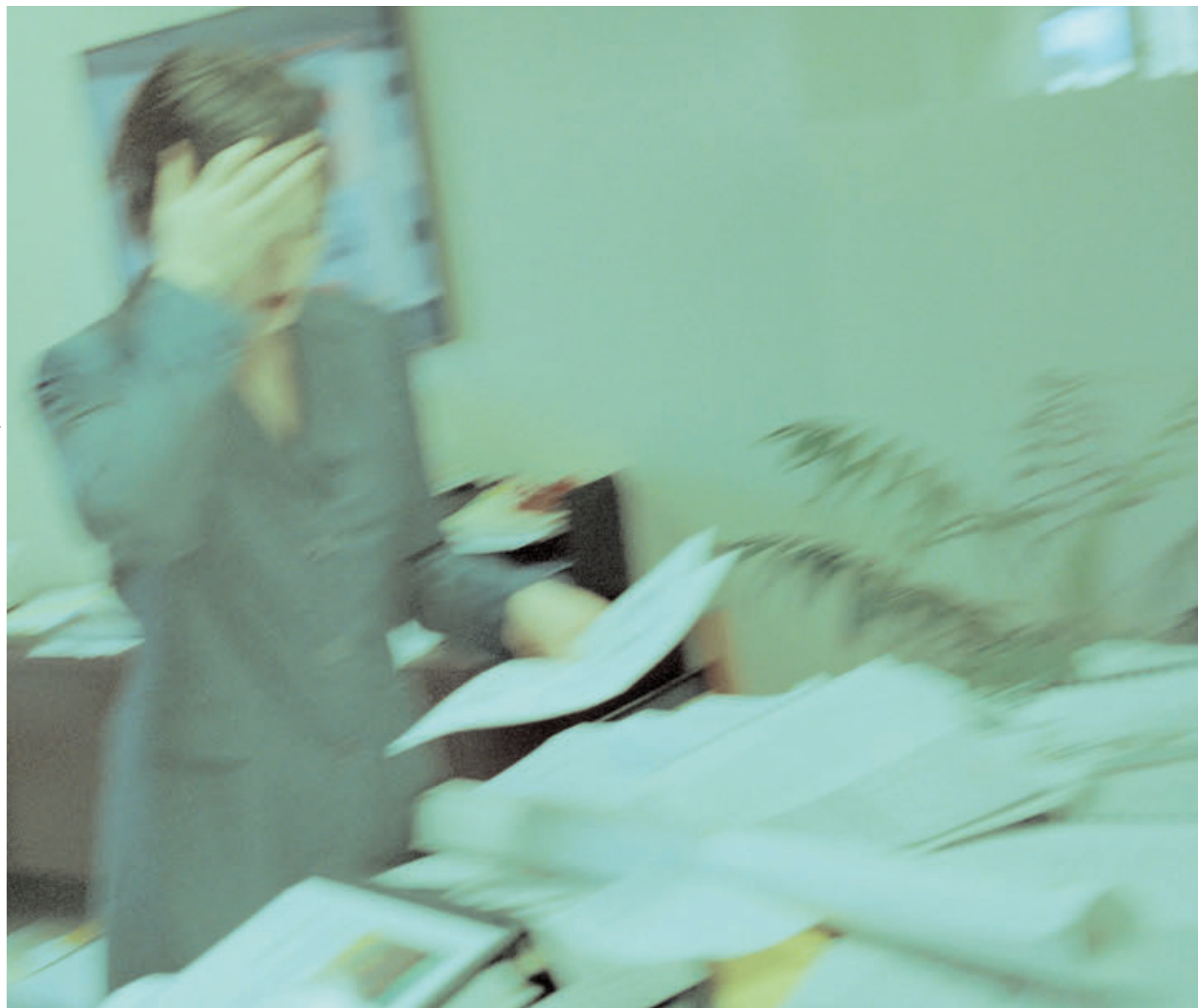
For example, the statutory deposit amounts in Massachusetts are only \$500,000 for casualty and \$700,000 for surplus lines business. Even if those funds could be attached—which is uncertain since the primary purpose of licensing requirements is to protect policyholders from insurer insolvencies—the funds on deposit likely are inadequate to satisfy a future reinsurance award. Some jurisdictions even permit reinsurers to maintain funds on deposit only in the reinsurer's domicile, which again makes attachment problematic.

In sum, if an authorized reinsurer does not maintain bank accounts or property within the forum state, one of its cedents may be left with no viable alternative but to initiate a proceeding in another jurisdiction. But these cumbersome steps may be unnecessary if the defendant is unauthorized and subject to a prejudgment security statute.

In these difficult economic times, the number of formal reinsurance disputes is seemingly on the rise, and the industry's appetite to litigate a larger number of relatively modest claims is apparently greater, particularly when one party is in runoff and there is no continuing underwriting relationship.

The collective need to obtain security in a fair, efficient and cost-effective manner has never been more acute, and the impediments to that goal have never been more obtrusive. It behooves both state legislatures and parties to future reinsurance contracts to address the needs of the industry with greater care.

David A. Attisani is a partner in the Boston law firm of Choate, Hall & Stewart, where he chairs the firm's insurance and reinsurance practice group. Jennifer Aresco Brennan practices in the same group.



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INSURER TOPICS

IIABA Convention and InfoXchange

Producers should seek status as clients' 'trusted advisers'

By ROBERTO CENICEROS

Insurance producers can excel in their client-focused business world by becoming "trusted advisers," a training consultant told the Independent Insurance Agents & Brokers of America.

Trusted adviser skills can also assist agency managers maintain optimal productivity levels by helping them retain key employees, said Brian Horan, a senior training consultant for The Richardson Co. of Lakewood, Wash.

The Richardson Co. conducts training programs for financial institutions, including Chubb & Son Inc., American International Group Inc., Zurich Financial Services Group and Marsh & McLennan Cos. Inc., Mr. Horan said. The Richardson Co. trains insurers in client relations so they can improve their interactions with the agents and brokers that place their products.

Trusted advisers are more than mere product providers or technical experts, Mr. Horan told the IIABA's Convention and InfoXchange in

Las Vegas. They establish personal relationships, combining business and social contacts, with their target audience, and they do so even when a deal is not imminent.

Mr. Horan listed other qualities of trusted advisers:



- Often they are found engaged in that style of relationship with top decision-makers such as a corporation's chief executive officer. That way they make themselves invaluable and impossible to replace.

- They put their clients first and personally invest themselves in their relationships and excel at listening and asking questions.

- They "add value" to every

interaction with their clients or intended audience.

"So when you think about the people you deal with, and you think about the relationships you have, ask yourself, 'Do I absolutely add value every time?'" Mr. Horan said. "It's not a sometime deal. It's an all-the-time deal."

The Richardson Co. has studied the best practices of trusted adviser types, he said.

"Being a trusted adviser takes a tremendous amount of time; it takes full-time effort," Mr. Horan said. Success is also more likely for those who understand the tangible behaviors of trusted advisers, he added.

Perhaps their most important practice is their "extraordinary preparation" for interacting with their target audience. They have a disciplined and strategic approach that includes planning out their relationships.

Most people prepare for such contacts by looking at the important issues from their own perspective, Mr. Horan said.

See TRUSTED/page 22J

IIABA Convention and InfoXchange

Association inaugurates first woman president

The Independent Insurance Agents & Brokers of America inaugurated Louise Canter as president during the association's Annual Convention and InfoXchange, held at Caesars Palace in Las Vegas.

Ms. Canter, the 99th president of the IIABA, is the first woman to hold the office.

"For me, it is a culmination of over 25 years of volunteer work within our association," Ms. Canter said at the convention.

"The privilege of serving not only as your president but also as your first woman president is truly an incredible honor."

Ms. Canter is senior vp of Patterson/Smith Associates in Falls Church, Va.

"Two of the greatest challenges we face in my agency—and I believe we all

face as agents—are getting new blood into our industry to perpetuate it and harnessing technology to cut costs to make us all more profitable," she said.

One of the best ways for the Big I to recruit young agents is to build on its InVEST program, Ms. Canter said. The program, a partnership between the association and member companies, creates mock insurance agencies at high schools and community colleges.

Approximately 2,000 people registered for the InfoXchange, held Sept. 21-24. The IIABA's 2004 Convention and InfoXchange is scheduled for Oct. 9-13 at the Walt Disney World Swan & Dolphin Hotel in Orlando, Fla. For more information, contact the IIABA at 800-221-7917.



Ms. Canter

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BI News flash

INSURER TOPICS

Good management keeps claims operations shipshape

Right tack needed to ensure smooth sailing for insurers

By Kevin R. Gallagher

During my years as a claims consultant, I have audited the claims operations of many insurers and third-party administrators. What I have noticed in my 15-plus years in the industry is that, in many aspects, a poorly run claims operation is similar to a sinking 18th-century ship taking on more water.

The admiral and the executive officers keep throwing money into the sinking hull—the claims operation—in hopes of patching up the leaks. These leaks are caused by spending too little time focusing on the problems, which cause damage to the hull.

Meanwhile, they push their sales department/agents and underwriters to bring in more questionable cargo to pay for maintaining the hull. Due to the large claim losses this questionable cargo creates, the sales department/agents and underwriters are forced to bring in more questionable cargo and charge higher premiums to offset the previous questionable cargo.

The claim adjusters have a difficult job. While trying to stop the leaks and patch up the holes, they are being assigned more and more leaks to fix. Claim counts that average in excess of 200 are unmanageable; in fact, about 130 claims is the most an adjuster should have to handle. The high claim count results in only the largest leaks receiving the most attention. The combined smaller leaks force the ship to take on more water—liability consisting of unwarranted offers, bad-faith actions, punitive damages and high values to settle cases, all of which extend the life and expense of the

claim.

The claim adjusters work to the point of exhaustion with no overtime pay or any additional benefits. The more proactive claim adjusters, feeling that they are becoming burned out, abandon ship at the first port, to be rescued by any passing ship that offers better conditions and salary. The remaining adjusters, seeing the time pass, become even more disheartened, and the level of stress rises, killing creativity and efficiency. The claim adjusters just go through the motions, not caring anymore.

The claims manager has the dubious honor of assigning more work to an already less experienced and overburdened crew. This fosters resentment among the adjusters, who cannot possibly do the work they already have, and the ship takes on more water. The claims manager is then forced to keep the salary increases of the adjusters low so the department can reduce operating costs. This does not go over well with the crew and only adds to the number of crewmembers abandoning ship.

It gets to the point where the remaining adjusters have minimal experience to properly analyze new problems, are lacking skills or are simply unable to locate a passing ship to jump onto. Therefore, only the weak and exhausted crewmembers are left on board. This is now the claims manager's pool for promotions if any become available, as very few experienced sailors will want to jump onto a sinking ship.

Those that do come aboard have little experience or are coming from another sinking ship. This high turnover does not reflect well on the claims manager's

Perspective

management skills, and, in many instances, he or she also starts looking to abandon ship.

The vp—or captain of the sinking ship—may have a difficult job. He or she has to try to keep the admiral happy all the while trying to keep his or her claim expenses down. He or she has no say in what

Some vps will delegate responsibility to their officers and never check what they are doing. This can create fiefdoms... which, in turn, creates a micromanaged atmosphere, making life more difficult for the seasoned adjuster.

the sales/agent or underwriting department is writing. If the vp's management skills are poor or his or her ego gets in the way, it is a terrible burden on that individual's shipmates.

Some vps will delegate responsibility to their officers and never check what they are doing. This can create fiefdoms aboard the ship, which, in turn, creates a micromanaged atmosphere, making life more difficult for the seasoned adjuster, who has to deal with the new officer's ego problems.

I have also seen instances where the captain will promote a manager that has no management or people skills but is good at kissing up. Be on guard; this type of promotion will only cause more resentment in the ranks and lead to more adjusters abandoning the ship.

One thing I find very interesting is that when things have gone wrong and the captain is asked to resign or decides it is in his or her better interest to abandon ship, most likely the captain's new company never questions his or her background. Does your

company really need a captain who has run a ship aground?

The captain will always give you references that say what a great master of the vessel he or she was. Why not make a few calls and find out what this captain is really like? Can your company afford to have a captain sink your ship? Do you want to see your seamen start abandoning ship? I have seen it time and time again, where a captain, after sinking one ship, is hired to sail another.

There are many ways to keep your ship afloat. Be willing to take risks. If you make a mistake, learn from it. The following ideas are in no way all-inclusive but will help keep your ship heading in the right direction.

● Tighten your jib. The jib sail helps you navigate in the right direction. The first thing your officers need to do is jettison their egos, so the proper amount of trim is left.

First, establish goals and try to reach them. One goal might be to have your file room computerized with an electronic checkout system. Have each file bar-coded. Once a week, have a file room attendant use a handheld reader and check each file on your sailors' desks. This way you always know where your files are.

This also helps the adjuster who is unaware that a superior has removed the file for review. As an adjuster, nothing looks worse for your company than when you have to explain to the auditor that you cannot locate the file.

Another goal may be to open up your door to all employees. One way to do this may be with an anonymous suggestion box. What can it hurt to have such a box? You may receive some helpful suggestions.

● Trim your main sail. By trimming the main sail you reduce power. Sometimes you need to reduce power to make a better turnaround and then pick up speed. Try to maintain a flat management concept. Watch out for multiple layers of management, which weaken the directives.

I have seen director-level personnel micromanage senior adjusters to the point of checking

every letter written before going out. Unfetter adjusters from needless rules and regulations. Trim your main sail to have a more-efficient claims operation.

● Bail out the ship. To run your ship smoothly you need to patch up the hull and bail out the water. You need to emphasize to your seamen that they are appreciated and needed. In addition, they need to know what is going on.

Holding quarterly meetings with all staff to provide them with the direction your ship is taking will be appreciated. They have to feel that they are part of the team and that their ideas are important to the captain. Assign appropriate workloads so problems can be dealt with promptly and sufficiently, instead of jury-rigging at the last moment.

● Incompetent or unprofessional officers or managers with poor people skills need to go. Remember that good technical skills do not guarantee good managerial skills. If you do not wish to terminate individuals, place them in another position handling claims, but do not let them continue to manage people.

Nothing will sink your ship faster than a poor officer or manager who demeans and mistreats his or her subordinates. Aside from bringing potential harassment charges, the adjusters will want to jump ship or transfer out of that person's unit in a hurry.

One way to correct the problem of poor officers is to have their subordinates anonymously send in evaluations to the captain. The captain should review these evaluations with the manager or officer and, if need be, try to substantiate any major problems and correct them. How many captains actually do this? The captain needs to be aware of what is going on.

There are many ways to keep your ship seaworthy. Work together as a team and sail straight ahead!

Kevin R. Gallagher is a vp with Chilton International Inc., an insurance and reinsurance consultant, in Holmdel, N.J.

Trusted: Producers should be key advisers

Continued from page 22H

Trusted advisers, in contrast, have the confidence to look at things from their client's perspective, which is not an easy task, he said.

They also are very persistent.

"The people who are very effective, they literally create niches," Mr. Horan said. "They identify who are the clients or the process that they are going to go after. They are going to be aggressive. They are going to be focused. They are going to be relentless, and they are going to do everything it takes."

They engage their intended audience in strategic dialogue without allowing product or technical issues to dominate their conversations, he said.

Most people prefer asking safe questions that they may already know the answers to. They do so out of fear of the unknown or because they want to be liked, Mr.

Horan said. But trusted advisers ask questions that challenge others to think about difficult issues.

"Trusted advisers are very good at pushing, at stretching and creating uneasiness," Mr. Horan said. "And, as a result, both they and the client walk away with more insight."

While trusted adviser practices can help insurance producers develop and retain valued customers, they also are valuable within the agency, Mr. Horan said after his presentation to the IIABA. The same principles can be used to maintain close relations among an agency's officers and key employees.

The enhanced relationships can help an agency's owner understand and address its key employees' concerns. That way he or she can address those issues and maintain a productive working environment for those employees.

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INSURER TOPICS

IT briefs

XL names three to executive posts

HAMILTON, Bermuda—XL Capital Ltd. has appointed Don Baker, Hans Gmuender and Dennis Nishikawa to new executive broker and client relations positions in the company's insurance operations. The new positions are intended to increase the focus of XL's insurance operations on its distribution sources and on broker and customer issues.

Mr. Baker will serve as managing director of broker and client relations for insurance operations in Bermuda, in addition to his recently announced appointment as executive vp of XL Insurance (Bermuda) Ltd. Mr. Baker joined XL from the Bermuda branch of Zurich Insurance Co., where he has been chief executive officer since 2000. Mr. Baker is based in XL's world headquarters in Hamilton, Bermuda.

Mr. Gmuender will be managing director of broker and client relations for insurance operations in Europe, Asia and South America, in addition to his current role as deputy CEO of XL's commercial large account insurance business, known as XL Insurance Global

Risk. He has been employed by XL since its acquisition of Winterthur International in 2001. Mr. Gmuender is based in XL's insurance offices in Winterthur and Zurich, Switzerland.

Mr. Nishikawa will be managing director of broker and client relations for insurance operations in North America, in addition to his current role as director of North American sales and marketing for XL Insurance Global Risk. He joined XL in 2000 and is based in XL's offices in Los Angeles.

Blues to monitor affordability projects

WASHINGTON—The Blue Cross & Blue Shield Assn. and the Harvard Medical School have launched a partnership to monitor and evaluate local Blues plan initiatives to keep health care affordable.

The announcement was made as part of the launch of BlueWorks, a campaign to shed light on the best practices within the Blues system to keep health care affordable and encourage adoption of the most effective practices.

BlueWorks will publish quarterly reports, beginning in January 2004, to identify and provide reviews of innovative Blues plan initiatives that demonstrate promise in keeping health care affordable. In addition, BlueWorks will publish an in-depth analysis of how one

initiative has worked to keep health care affordable.

Blues plans have developed partnerships and programs with doctors and hospitals to encourage improved quality, many representing the types of best practices the Harvard partnership will identify and study.

Bankers group elects association president

WASHINGTON—Thomas D. Murray, managing director of BancorpSouth Insurance Services in Tupelo, Miss., has been named president of the American Bankers Insurance Assn. for the 2003/04 year.

As managing director of BancorpSouth Insurance Services, the insurance agency subsidiary of BancorpSouth Bank, Mr. Murray manages insurance operations in six states. Prior to his election as president of the Washington-based ABIA, he was vp of the organization since its creation in April 2001.

Lloyd's agencies using RMS models

NEWARK, Calif.—Risk Management Solutions Inc. has expanded its involvement in the Lloyd's market with the addition of three Lloyd's managing agents as RMS clients in the last three

months.

With the addition of AEGIS, Cathedral Underwriting and Catlin Underwriting Agencies, Newark, Calif.-based RMS now has relationships with 17 of the 20 largest Lloyd's managing agents, with RMS RiskLink catastrophe modeling software being used by 24 Lloyd's managing agents, representing 80% of the total Lloyd's market capacity. RMS also announced the development of a new data processing tool in response to requests from its Lloyd's clients that use risk models for commercial account underwriting.

AEGIS is licensing the RMS catastrophe modeling software for the United States and the RMS Offshore Platform Model for hurricane risk. Cathedral Underwriting is licensing software for the United States, Canada and the Caribbean, with the models to be used for its established treaty book and a start-up direct and facultative operation. Catlin is licensing for the United States and Japan.

Feedback from Lloyd's clients guided the development of a new data processing tool previewed at the RMS International Seminar in Paris in September and planned for market release in early 2004. The tool promotes efficiency in the creation and transfer of exposure data for commercial property accounts.

and midsize commercial insurers.

Mr. Klenow will be based in the Overland Park, Kan., headquarters of GE Commercial Insurance.

GE Commercial Insurance is a division of Employers Reinsurance Corp.

Vesta appoints two executives

BIRMINGHAM, Ala.—Thomas E. Mangold has been elected executive vp of Vesta Insurance Group Inc. In addition to his new role as an executive officer of the Birmingham, Ala.-based holding company, Mr. Mangold will continue his responsibilities as chairman and chief executive officer of American Agencies Holdings Inc., Vesta's nonstandard auto subsidiary.

Mr. Mangold joined American Agencies in 2000 from Bristol West Insurance Group, where he had been CEO.

Vesta also appointed Michael W. Lefler as president of Florida Select Insurance Holdings. Mr. Lefler has been vp and chief underwriting officer for Florida Select Insurance Co. since its inception in 1996.

Mr. Lefler replaces Stephen A. Korducki, who recently resigned to return to the reinsurance business.

TPA opens office in St. Louis

LOS ANGELES—David Morse & Associates, a national claims administration and independent adjusting company based in Los Angeles, has opened a new claims field office in St. Louis.

The office gives DM&A claims coverage in Missouri and southern Indiana. DM&A now has 36 offices in 16 states and large regional claims centers in Los Angeles; Battle Creek, Mich.; and New York.

Ralph Adams, who will be the claims supervisor for the new St. Louis office, spent the last 10 years as claims supervisor for DM&A's Tampa and Miami offices. The St. Louis office will offer all property and casualty claims services, as well as workers compensation fraud investigation.

Officers, board of directors named at 108th convention

NEW ORLEANS—F. Timothy Hegarty Jr. was elected 2003/04 chairman of the National Assn. of Mutual Insurance Cos. at the organization's 108th Annual Convention last month in New Orleans.

Mr. Hegarty is president and chief executive officer of the Norfolk & Dedham Group in Dedham, Mass. He has been with the Norfolk & Dedham Group for 19 years and has a long history of service to the industry.

Mr. Hegarty also is a board member of Excess Reinsurance Co. in Philadelphia; Dedham Co-Operative Bank in Dedham; Mutual Fire Insurance Assn. of New England in Peabody, Mass.; and Automobile Insurers Bureau and The Independent Property Casualty Insurers of Boston.

Other NAMIC officers for the 2003/04 year include: Wayne F. White, president/chairman of Home Mutual Fire Insurance Co., Conway, Ark., chairman-elect; Robert A. Wadsworth, president and CEO of Preferred Mutual Insurance Co., New Berlin, N.Y., vice chairman; and John T. Hill II, senior vp and chief financial officer of the Magna Carta Cos. in New York, secretary/treasurer.

NAMIC's 2003/04 board of directors includes Daniel E. Stone, president and CEO of Indiana Farmers Mutual

Insurance Co. in Indianapolis; John A. Bykowski, president and CEO of Secura Insurance in Appleton, Wis.; Brian Boyden, executive vp of State Farm



Insurance Co., Bloomington, Ill.; David C. Poling, secretary/treasurer/general manager of Farmers Mutual Relief Assn. in Upper Sandusky, Ohio; and David L. Anderson, secretary/manager, Farm Mutual Insurance Co. of Lincoln County in Canton, S.D.

Also serving on the 2003/04 board are: Barbara Baurer, executive vp/chief operating officer of Country Insurance & Financial Services in Bloomington, Ill.; L. Keith Birkhead, chairman/president/CEO of Farmers Alliance Cos. in McPherson, Kansas; Jo Ann Kushel, manager/secretary/treasurer, Boeuf & Berger Mutual Insurance Co. in New Haven, Mo.; and Philip E. Love Jr., executive vp/CEO of South Carolina Farm Bureau Mutual Insurance Co., Cayce, S.C.

Other board members include: James F. Pinnock, president of Stanley Mutual Insurance Co. in Stanley, New Brunswick, Canada;

Richard M. Raun, secretary/treasurer of Woodland Mutual Insurance Co. in Carlton, Minn.; Gerald P. Schmidt, president of Mutual of Enumclaw Insurance Co. in Enumclaw, Wash.; and Shawn Simpsen, claims manager at Carthage Mutual Insurance Co. in Colfax, Ill.

During the convention, Charles M. Chamness was officially appointed as Indianapolis-based NAMIC's president. Mr. Chamness succeeds Larry L. Forrester, who served the association for 33 years, the last 15 as president. Prior to being named NAMIC's executive vp in March, Mr. Chamness was the association's vp of public affairs from 1995 to 2003.

Also during the NAMIC convention, the Insurance Education Foundation celebrated its 15th anniversary by presenting "Lifetime Achievement Awards" to Mr. Forrester and IEF President Bob Harrison for their contributions to the foundation. Mike Pickens, the National Assn. of Insurance Commissioners' president and the Arkansas commissioner of insurance, presented the awards.

NAMIC's 109th convention will be held in Washington, Sept. 19-23, 2004.

GE ERC division names top actuary

OVERLAND PARK, Kan.—GE Commercial Insurance has appointed Jerry Klenow chief actuary for the medical professional liability product line in the company's health care division.

Mr. Klenow will be responsible for the rating and pricing of health care products, in addition to strategic planning and projection of revenue. Before joining GE Commercial Insurance, Mr. Klenow worked as an independent actuarial consultant, providing statements of opinion and consulting for health care professional liability insurers

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Fluor Hanford workers Fred Joost, left, and Henry Torres wear protective clothing as they prepare a container of spent nuclear fuel for a trip across a massive cleanup site in Hanford, Wash., where the fuel will be stored until a national storage facility is ready to receive shipments.



PHOTO: COURTESY OF FLUOR HANFORD INC.

Safety: Tool helps reduce exposure

Continued from page 22

identified in the AJHA process," he said. "It has provided greater certainty" that workers will not be exposed to harmful radiation, he said.

Overall, the software has provided "a cultural shift" in the way the company approaches safety, Mr. Hermanson said.

Fringe benefits to the process include greater productivity because of fewer "false starts" and work delays due to workers arriving at a job site with inadequate or inappropriate

equipment. In addition, opportunities for feedback after workers complete a project further refine best practices for future use.

"A recent innovation was the development of a portable feature," which lets a planner transfer the hazard analysis questions and related information to a hand-held personal computer, according to the joint statement. "This allows the user to take the AJHA record into the field during the job walk-through and answer the questions as the hazardous conditions are observed," it said. Another new feature is "the ability to digitally capture pictures of the work area and imbed those images with the AJHA record," it said. When the information is subsequently uploaded, workers and subject matter experts can view both text and photos, which allows for better planning.

The software also has garnered widespread recognition for the company.

Last month, Messrs. Jaeger and Hermanson won a national Innovation Award from the Voluntary Protection Programs Participants' Assn.

The national Voluntary Protection Programs, which are administered by OSHA and the U.S. Department of Energy, are a cooperative effort among labor, management and government. To be eligible for VPP status, companies must have safety and health programs that exceed OSHA's standards. Currently, more than 1,000 U.S. worksites are VPP participants and more than 750,000 U.S. workers are directly affected by the program, according to a VPPPA statement.

In addition, Fluor Hanford's safety measures have been heralded as "a national model of excellence" by Washington Gov. Gary Locke.

The U.S. Department of Energy also acknowledged the software's key role. "The AJHA provides a powerful and valuable tool to ensure integrated organizational functions are used to identify and control hazards, as well as providing streamlined logistical capabilities regarding work package development, worker involvement, approvals and feedback," it said in a report.

In addition, the software "can be adapted to just about any type of business application where you might experience industrial safety and industrial hygiene issues," Mr. Hermanson said.

Although Fluor and the U.S. Department of Energy have copyrighted the software, it is available free of charge through a licensing agreement. A wide variety of entities, ranging from other nuclear cleanup contractors to a school district, have implemented or expressed interest in the program.

For more information about the software, send e-mail to Mr. Jaeger at miles_b_jaeger@rl.gov or to Mr. Hermanson's address at mark_l_hermanson@rl.gov.

Information about the VPPPA program is available online at www.vpppa.org.

CVC Pharmacy
4 column x 10"

Careful integration, management of disabilities helps hospital trim millions from its comp costs

By MEG FLETCHER

Baystate Health System Inc. has saved millions of dollars in workers compensation costs during the past decade as it implemented programs to integrate its handling of disability management.

Attaining those rewards took time, though, because the health care company had to first tackle a variety of challenges, including a lack of manager involvement and a fragmented modified duty program, said Gary S. Mackey, director of disability management services for Springfield, Mass.-based Baystate.



**Baystate
Health System**

But Baystate's transition to an integrated disability management system also enabled it to explore new opportunities to minimize risk and control losses.

Throughout the process, Mr. Mackey said the strategic question has remained the same: "How do we balance the needs of the employee with the operational business needs of the organization?"

'How do we balance the needs of the employee with the operational business needs of the organization?'

*Gary S. Mackey
Baystate Health System Inc.*

Baystate is the parent corporation of a hospital-based health care delivery system that serves western Massachusetts. It includes an academic medical center and two community-based hospitals, which together have more than 700 beds.

Among its various operations and programs, Baystate also provides outpatient facilities and programs, home care and hospice services.

Baystate, which had \$1.2 billion in gross revenues last year, employs about 9,200 workers, including about 6,500 full-time equivalent employees. Most employees are not affiliated with unions.

Baystate self-insures and self-administers many of its insurance-related programs with assistance from BHS Insurance Co. Ltd., its Cayman Islands-domiciled captive. BHS insures Baystate's long-term disability, primary workers comp and other property/casualty coverages, said Pamela K. Burger, Baystate's corporate director of risk management and chief compliance officer.

Baystate began the transformation of its programs in 1990 by integrating and bringing in-house the

administration of workers comp, long-term disability and health benefits. In addition, several services were brought in-house, including claims and medical case management, and utilization review.

Baystate employees also received ergonomics assessments, vocational rehabilitation services and "a proactive safety and wellness program," which included management of diseases such as hypertension, Mr. Mackey said.

Initial challenges

One challenge Baystate faced in implementing its program was that managers previously lacked clear roles regarding the management of workers compensation claims, and no one felt truly accountable for them, he said.

Under the new plan, workers comp costs are allocated to each department in which they occur, so managers are now much more aware of costs, he said.

In addition, previously "cryptic" reports that were difficult to interpret have been replaced by data in a more useable format, Mr. Mackey said.

Among the challenges Baystate faced in integrating its disability management program was the health system's "fragmented modified duty program," he said.

Previously, the company was motivated to bring employees back to work "at almost any cost," though that might create a situation in

which a nursing unit had so many staff members working with medical restrictions that it was hard to get some work done, such as lifting patients, Mr. Mackey said.

In addition, employees on modified duty were not centrally managed, and reviews of their progress in returning to full duty were conducted too infrequently, he said.

Baystate now views modified duty as "a bridge" that seeks to guide a disabled worker back to

Continued on next page

**"Yes, that
stomach**

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Continued from previous page
work within a specified time period, usually no more than six months, he said.

The case files of workers on modified duty are now reviewed frequently, though Baystate is very careful to abide by Family and Medical Leave Act requirements that mandate that a person's job be kept open for 12 weeks, he said.

Helping to implement this new approach is a new advocate on staff, who helps a worker unable to return to his or her regular duties find appropriate work within Baystate. If the worker's new job pays less than his or her previous one, the worker typically receives 60% of the difference in pay as a temporary partial workers comp payment for five

years, he said.

Preferred providers

The integrated disability program provided Baystate with the opportunity to formalize a preferred provider arrangement to ensure that its injured workers received prompt and appropriate care, Mr. Mackey said. While the arrangement includes about 600 physicians in its area, Baystate primarily uses about 20 to 30 of them, he added.

Massachusetts' law helps an employer such as Baystate by allowing an employer to refer a workers comp claimant for his or her first visit, excluding emergency room treatment, Mr. Mackey said. Employee satisfaction with medical

care is "high," and fewer than 10% of them subsequently seek care elsewhere, he said.

Physicians are encouraged to participate in the program because Baystate reduced the administrative complexity of handling workers comp claims and pays them higher fees than those required by the state's low fee schedule, Mr. Mackey said. In addition, it reimburses providers within 10 days, which is faster than the norm, he said.

In return, though, Baystate requires that the physicians see patients within 72 hours, be committed to returning patients to work and share their office notes with the employer, to the extent possible under privacy laws.

Rewarding new ideas

Another approach Baystate introduced in 1991 to help control losses was to establish an in-house grant program that gives money to test the viability of employees' ideas for loss control and quality programs.

Baystate's captive budgets about \$100,000 annually for such grants, which must survive a rigorous screening process. Grant awards have ranged from less than \$2,000 to the full annual amount, although there is no requirement that the entire sum be allocated each year, Ms. Burger said.

About one-third of the grants are awarded to programs that are related to reducing or controlling disability costs, Ms. Burger said. For example, \$15,000 was allocated to a hospital with limited security to train staff members in nonviolent crisis intervention so they could cope with difficult patients.

In addition, some grant projects—such as a "lift team" of persons specially trained to move bedridden patients—are so successful that the concept eventually becomes part of the hospital's regular staffing plan, she said.

"The primary motivation is loss control and quality," Ms. Burger said. The general consensus is that the money is well spent, she added.

Lower comp costs

The success of Baystate's overall integration program is seen in the company's ability to reduce its workers comp costs as a percentage of payrolls, Mr. Mackey said.

It reduced that figure from 2.6% in 1993 to 0.7% in 2002, which, Mr. Mackey noted, is less than half the industry average of 1.5% during that period. In 2002 alone, when Baystate paid \$2.5 million in workers comp costs on its \$350 million payroll, its costs were \$2.8 million less than the industry average.

Other measures of improvement include a decrease in the incurred costs of workers comp claims from \$3.7 million in 1990 to \$1.4 million in 2002, while the number of open claims more than one year old dropped from 320 in 1991 to 132 in 2002.

"We are an example of a successfully integrated company," Mr. Mackey said, though he acknowledged that he would like to do more about addressing the indirect costs of workers comp claims and absences.

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David Williamson
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Property and Liability Insurance

Chiropractors: Blamed for higher costs

Continued from page 10

visits workers compensation claimants may have.

"In California, employees can sign up to use chiropractors as a comp doctor," she said. Under state law, an employee can pre-designate whom he or she would like to have as a treating physician when the individual is injured.

And even in cases where the employee did not pre-designate a physician, "the employer has only 30 days of control," she said, after which the injured worker is free to "doctor shop" until finding one he or she likes.

"There are some people who can get better faster with manipulation," observed Dr. Charles Kelley, who heads up the workers compensation program at Outrigger Enterprises Inc. "On the other hand, there are some chiropractors who use long-term manipulation as a therapy, and that just adds to the cost," said Dr. Kelley, who is director of sales-special markets at Outrigger in Honolulu.

"If you have a patient who has an underlying need for attention and medical care and perhaps they have some underlying personality disorder, they can get into the hands of a

provider who's being paid to treat them, and it could go on forever," he said.

But not all chiropractors are bad actors, asserted Tara Schilling, senior vp at Keenan & Associates in Torrance, Calif., a broker that provides third-party administration services for workers compensation.

"Everybody is jaded on chiropractors, and all you'll hear is horror stories; and there are a lot of them," she said, "but there are chiropractors that help people."

Ms. Schilling cited two "success stories" to support her assertion.

In one, an injured worker who

was getting no relief after five weeks of physical therapy was referred to a chiropractor. The chiropractor treated the claimant for two weeks, and the claimant returned to work. The temporary disability savings amounted to \$1,508, and avoiding litigation saved the employer an estimated \$5,000.

"He was threatening to go to a lawyer," she explained.

In another instance, a claimant seeing an orthopedic specialist whose prescribed treatment included wearing a back brace, medication and physical therapy was referred to a chiropractor.

"He had two adjustments and was back to work the following week," said Ms. Schilling, adding that the temporary disability savings to the employer amounted to approximately \$3,500.

"There are clearly subsets of chiropractors out there who are overutilizing, and this overutilization of care, does, in fact, drive up the cost of workers compensation claims," said Dr. David Deitz, national medical director at Liberty Mutual Insurance Co. in Boston. "I think what's a mistake is to automatically assume that all chiropractors are practicing the same way. There are chiropractors in the United States who practice appropriately and who do good physical medicine treatments and take good care of claimants."

While moves by states such as California and Florida to limit chiropractic visits may offer a partial solution to the problem, they are not the cure, according to Dr. Deitz.

'There are chiropractors in the United States who practice appropriately and who do good physical medicine treatments and take good care of claimants.'

*Dr. David Deitz
Liberty Mutual Insurance Co.*

"It's a quick fix to a complex problem. It's certainly worked in Florida, where costs have been reasonably well managed with their regulatory solution," he said.

In Florida, where chiropractic visits were limited by law to 18 visits over eight weeks, medical costs per claim average 20% less when chiropractors are directing care than when physicians are in charge, according to the WCRI study.

But the Florida Chiropractic Assn. has since successfully lobbied to raise the limit to 24 visits over 12 weeks.

Perhaps a more effective way to ensure claimants are receiving appropriate chiropractic care is to monitor the treatment, intervening where necessary, and measure outcomes, according to Dr. Deitz.

"When we find that we have people whose treatment plans are off track and are involved with multiple visits and things like that, we try to move those cases not only to case management but, if necessary, to medical peer review, as quickly as we can," he said.

Ms. Schilling concurred.

"As a third-party administrator, what we do is put a nurse case manager on the case," she said. "They facilitate the injured worker's getting to a permanent and stationary status. And that's critical, because medical treatment—whether it's chiro or orthoped—runs rampant."

Using prescreened network chiropractors can also ensure quality treatment, said Fred Scardellette, vp of product development and marketing in disability management at Intracorp in Philadelphia.

"Use of a network can result in unit cost reductions of 10% to 25%," he said. "For best results, a network must include providers of the most-utilized treatments."



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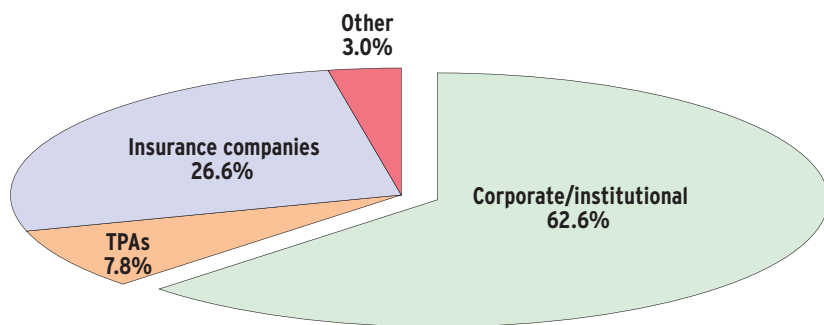
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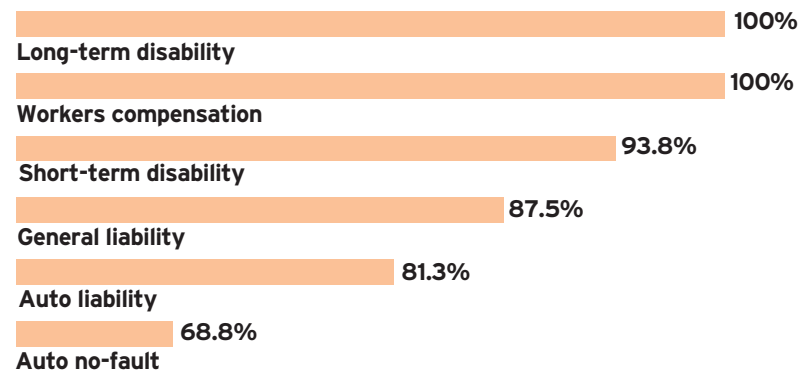
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BREAKDOWN OF CUSTOMERS

Source: BI survey

SERVICES BY COVERAGE LINE

Percentage of surveyed companies providing services for each



Source: BI survey

Largest rehabilitation service providers

Ranked by revenues from rehabilitation services provided directly to employers in 2002*

Rank	Company/Address	Phone/Fax/Web site	Revenues from rehabilitation services in 2002	Professional staff	Total customers	Cases closed in 2002	Independent medical exam cases	Expert opinion cases	Principal officer
1	Concentra Inc. 5080 Spectrum Drive, Suite 400W, Addison, Texas 75001-4648	800-232-3550 Fax: 972-387-0550 www.concentra.com	\$212,219,000	3,154	3,500	122,703	225,000	0	Daniel J. Thomas, CEO
2	Intracorp 1601 Chestnut St., Philadelphia, Pa. 19192	215-761-7100 Fax: 215-761-5538 www.intracorp.com	\$152,200,000	1,088	657	247,757	3,500	191	Thomas Crowell, president
3	CorVel Corp. 2010 Main St., Suite 600, Irvine, Calif. 92614	949-851-1473 Fax: 949-851-1469 www.corvel.com	\$135,000,000	1,350	1,100	55,000	45,000	5,500	Gordon Clemons, CEO
4	GENEX Services Inc. 440 E. Swedesford Road, Suite 1000, Wayne, Pa. 19087	610-964-5100 Fax: 610-964-1919 www.genexservices.com	\$101,000,000	1,188	1,300	92,000	0	0	Peter C. Madeja, president/CEO
5	Crawford & Co. 5620 Glenridge Drive, Atlanta, Ga. 30342	404-589-0830 Fax: 404-845-3142 www.crawfordandcompany.com	\$66,611,000	487	1,736	67,260	10,041	2,043	Grover Davis, chairman/CEO
6	Cascade Disability Management Inc. 4601 N.E. 77th Ave., Vancouver, Wash. 98662	360-713-5118 Fax: 877-477-3720 www.cascadedisability.com	\$20,719,009	151	387	6,999	0	0	David Buonviri, president
7	GatesMcDonald 3455 Mill Run Drive, Hilliard, Ohio 43026	800-336-4733 Fax: 614-777-3142 www.gatesmcdonald.com	\$16,000,000	184	6,715	15,000	8,000	4,000	Danny Fullerton, president/COO
8	MedInsights Inc. 4360 Chamblee Dunwoody Road, Atlanta, Ga. 30341	770-457-2400 Fax: 770-457-1500 www.medinsights.com	\$12,300,000	96	202	31,520	187	202	Joe Zubretsky, CEO
9	CareSys 15 River Road, Suite 200, Wilton, Conn. 06897	203-761-7333 Fax: 203-761-7311 www.caresys.net	\$6,300,000	33	15	20,000	150	0	Peter Hotz, president/CEO
10	The ASU Group-Recovery Unlimited 2173 Commons Parkway, Okemos, Mich. 48864	800-968-2417 Fax: 517-349-1332 www.asugroup.com	\$6,239,000	51	198	1,720	0	0	Tara LaRose, executive vp

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

Source: BI survey

The entire Directory of Rehabilitation Service Providers is available online in the directory area of www.businessinsurance.com. The searchable directory allows users to locate rehabilitation service providers by company name, revenues and services provided, among other information. PDF copies of the directory can be purchased by calling the Crain Information Center at 312-649-5476.

HealthSouth: Hartford seeks to rescind coverage

Continued from page 4

apply to provide coverage to any directors or officers.

Meanwhile, the House Energy and Commerce Committee's Subcommittee on Oversight and Investigations launched hearings into the HealthSouth fraud last Thursday, taking testimony from several current and former company executives.

Former HealthSouth Chairman and Chief Executive Officer Richard M. Scrushy appeared at the hearing but invoked his 5th Amendment right against self-incrimination in refusing to answer questions. In interviews, though—including a segment on the CBS News program "60 Minutes," portions of which were shown at the hearing—Mr. Scrushy blamed subordinates for HealthSouth's false financial reports.

Mr. Scrushy has not been charged criminally but has been sued for fraud and insider trading by the Securities and Exchange Commission and named in multiple shareholder lawsuits.

FBI agents raided the Birmingham offices of HealthSouth, an operator of health care clinics, in March, and several executives soon after agreed to plead guilty to charges related to the company's financial reporting. Fifteen former officers to date have reached plea agreements and have promised to cooperate with federal prosecutors.

According to SEC and other court filings, HealthSouth senior officers launched a scheme in the 1990s to compare the company's actual unreported earnings to stock analysts' estimates and to "fix" any shortfall by recording bogus earnings to meet expectations. Executives participating in the alleged scheme referred to themselves as "family members" and to company meetings at which the "fixes" were discussed as "family meetings," the SEC alleges.

Two Chubb Corp. units and Royal Insurance Co. of America, HealthSouth's primary D&O insurers from 2001 to 2003, sued the company and dozens of its current and former officials in Alabama and Delaware state courts in April to rescind their policies. Several excess insurers followed suit, with most filing rescission actions in Birmingham federal court. They include Travelers Casualty & Surety Co., ACE American Insurance Co., Continental Casualty Co., Gulf Insurance Co., Zurich American Insurance Co. and St. Paul Mercury Insurance Co.

Twin City—which wrote \$10 million excess layers in both the 2001-2002 and 2002-2003 policy years—became the latest of these, filing suit Oct. 3 against HealthSouth and 44 company directors and officers.

The insurers generally charge that the defendants knowingly concealed the company's true financial condition in applying for coverage and that the policies should thus be voided. If courts do not grant rescission, the insurers also seek declarations that the defendants have no

coverage for dozens of securities fraud, shareholder derivative and fiduciary liability lawsuits filed in 2002 and 2003, as well as for costs arising from the SEC and criminal investigations.

HealthSouth and many of the defendant directors and officers, meanwhile, have filed counterclaims charging the insurers with

breach of contract, bad faith and fraud.

HealthSouth, for example, argues that it was "a known and insurer-accepted risk" that some of its financial statements might be false. Some insurers renewed existing D&O policies despite being on notice of several 1998 securities fraud class-action suits charging the com-

pany with inflating its stock price and several federal "whistleblower" suits charging it with filing false Medicare reimbursement claims, HealthSouth alleges.

Under Alabama law, the company also contends, insurers may not rescind coverage for false statements in a renewal application, and may not rescind unless the applica-

tion and policy set out grounds for rescission.

A Birmingham federal judge has consolidated the federal D&O suits in a single proceeding. The judge has also stayed discovery proceedings against former HealthSouth officials who have pleaded guilty to criminal charges and are awaiting sentencing.



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Structures: Liability concerns to influence M&A deals

Continued from page 4

boards, you're not going to see your company acquire another company that has old liabilities."

That's because corporate boards of directors will want "representations and warranties" that an acquisition target's reserves are adequate and that the seller will guarantee it, Mr. Kramer said. Sellers will be unwilling to make such commitments, he said, because they are trying to sell the company and rid themselves of liabilities, he said.

With two sides unable to agree, "you're not going to see mergers of insurance companies," Mr. Kramer predicted. Instead, "you're going to see sales of books of business," he suggested.

"What that will do," Mr. Kramer said, "is leave the stub" of the company to likely be placed in runoff. "For those of you in the runoff business," he told conference attendees, "this will probably be a boom time."

Meanwhile, insurers that are staying in the business are changing their reinsurance buying strategies, in part, because of liability issues, said Anthony Taylor, president and chief executive officer of Hamilton, Bermuda-based Montpelier Reinsurance Ltd. Mr. Taylor spoke at a separate session during the conference.

"I've noticed since the beginning of this year the propensity of global insurers to purchase increasing amounts of reinsurance," Mr. Taylor said.

'You may be authorized, you may be licensed to underwrite anywhere in the world, but lose your rating and you won't do the business. Right now, a rating is equivalent to a de facto license.'

Donald Kramer
ACE Ltd.

One insurer he examined is spending more than 40% of its gross written premiums on reinsurance after spending less than 30% of that amount five years ago. While that alone doesn't seem a large increase, it does seem significant after taking into account that the insurer's gross premiums have "risen by 10-fold in those five years," Mr. Taylor noted.

Other cedents are also significantly increasing the amount of reinsurance protection they are buying, he said.

One of the main reasons why insurers are increasing the amount of reinsurance they buy is a fear of increased losses from casualty business, Mr. Taylor said.

Also, insurers have impaired capital because of investment losses and some have substituted reinsurance protection for lost capital, he said. The reinsurance also helps them meet the requirements of the rating agencies, Mr. Taylor said.

The influence of rating agencies has increased substantially over the

past several years, said ACE's Mr. Kramer.

"They absolutely control the industry, because you may be authorized, you may be licensed to underwrite anywhere in the world, but lose your rating and you won't do the business. Right now, a rating is equivalent to a de facto license," he said.

Rating agencies have downgraded "the entire reinsurance industry," which presents a problem for insurers as well, Mr. Kramer noted.

They have to seek out the strongest reinsurers and consider the risk of ceding too much coverage to any single reinsurer, he said.

As insurers keep more of their risk as a way to avoid that scenario, the effect trickles down to primary policyholders.

When insurers write closer "gross to net" premiums, Mr. Kramer explained, they reduce the limits they will offer and risk managers have to shop harder to find the coverage they need.

17th International Reinsurance Congress

Bermuda meeting draws 215 to island

HAMILTON, Bermuda—Bermuda welcomed its first insurance industry conference since Hurricane Fabian stormed the island last month.

About 215 registrants signed up for 17th International Reinsurance Congress, sponsored by London-based Hawksmere P.L.C. The meeting was held Oct. 8-10 at the Fairmont Hamilton Princess. The hotel sustained some damage from Fabian, but the problems had no

effect on the meeting.

Attendees heard from a number of industry experts who dis-



cussed tort reform, regulatory issues, the future of the reinsurance market and other topics.

New this year was the Commutations Rendez-Vous sponsored by Cavell Management Services.

The Commutations Rendez-Vous gives insurers and reinsurers a place to meet, negotiate commutations and discuss other matters.

The 18th Reinsurance Congress is set for Oct. 6-8, 2004, at the same location. More information is available from Hawksmere at 44-207-881-1899 or www.hawksmere.com.



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17th International Reinsurance Congress

U.S. insurers have weathered a tough time

By MICHAEL BRADFORD

HAMILTON, Bermuda—Insurers have weathered years of economic storms in good shape, but some dark clouds still loom, a U.S. insurance regulator says.

Speaking at the 17th International Reinsurance Congress in Bermuda earlier this month, Iowa Insurance Commissioner Therese M. Vaughan said the United States has recently emerged from what is possibly the "most dramatic economic environment since the Great Depression of the 1930s."

"Many people have referred to this as the perfect storm. We've had record-high credit defaults, we've had nearly record lows in interest rates, dramatic declines in equity values and, of course, the unprecedented losses of Sept. 11, 2001," she said.

Those conditions, combined with problems related to asbestos and toxic mold litigation, hit at a time when property/casualty insurers' balance sheets were weakened by losses from underpriced business written in prior years, Ms. Vaughan pointed out.

"Together," she said, "these converging developments" have subjected the industry to what could be called "an extreme tail event."

Despite taking a beating from many angles, U.S. insurers have, overall, survived in good shape, Ms. Vaughan said.

There were 30 insolvencies among U.S. insurers last year, she said, up from 15 the previous year but well off approximately 80 per year that were recorded in the late 1980s and early 1990s. "So, in terms of the number of insolvencies, we have not seen any cataclysmic effects from this extreme tail event."

Another measure of insurer health can be seen in how often insurers have triggered regulatory action by falling below thresholds required for risk-based capital, Ms. Vaughan noted. The percentage of companies that have triggered such action fell to 5% at the end of last year, from 5.7% in 2000, she said.

Still, Ms. Vaughan warned, the good news comes with some caveats.

"There could be a lag between the troublesome economic conditions and actual insolvencies," she suggested. "There could be some financial-statement engineering going on."

Further, "risk-based capital could be missing major areas of risk that could be growing and almost certainly are," Ms. Vaughan said.

But, "the bottom line," she emphasized, "is this: The U.S. (insurance) industry has faced an extreme tail event and weathered it. Defaults are coming down; interest rates are going up; the stock market is going up; the industry is better managing its underwriting exposures, including terrorism risk; nonlife insurance rates have risen dramatically" and reserves have been strengthened.

"Finally," Ms. Vaughan mentioned, "after years of steady decline," U.S. insurers increased their surplus in the first six months of

this year.

"The industry has gone through a period of nearly unprecedented economic turmoil and come out of it still standing," she said. "And, actually, I would say standing reasonably tall, given the circumstances."

Insurers' resilience, Ms. Vaughan suggested, speaks well for their "risk management practices and the current regulatory system."

Such plaudits aside, though, "there are things that keep regulators awake at night," she said.

Life insurers, for example, are reporting losses on guaranteed bene-

fits and life and annuity contracts, Ms. Vaughan pointed out. "And it's reported that reinsurance for some of these guarantees has dried up. There's a reasonable question as to whether life companies have adequately quantified, managed and priced for this risk."

Asbestos-related problems continue to "loom large" for insurers, she noted, and there are concerns about the adequacy of insurers' reserves, particularly as they pertain to asbestos liabilities.

"Reinsurance recoverables are way up, amounting to 60% of in-

dustrywide surplus, and virtually every major reinsurer has been downgraded" by rating agencies, according to Ms. Vaughan.

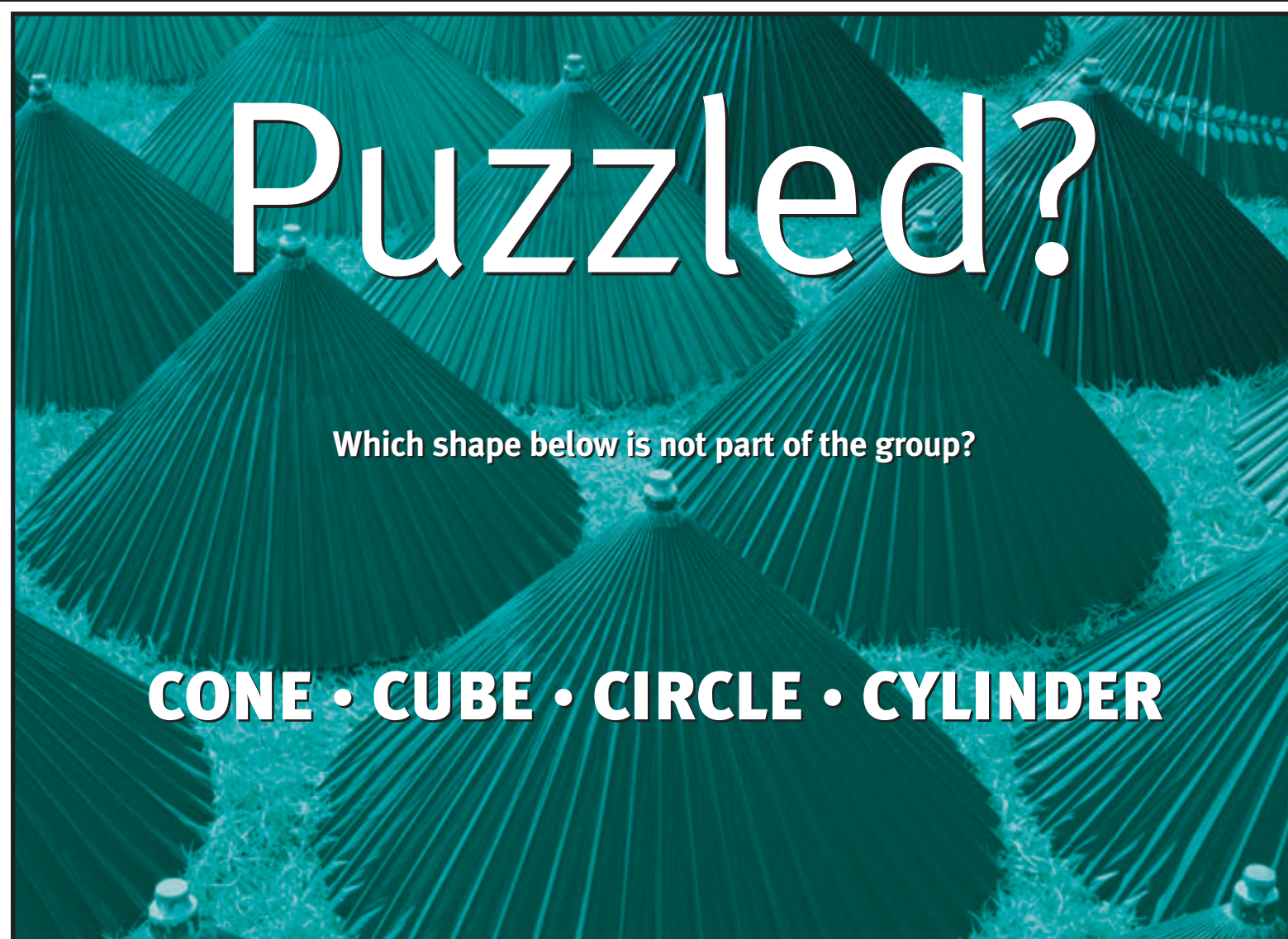
Those issues that keep regulators from sleeping are familiar ones, she said. "They are virtually the same things that regulators were paying attention to in the late 1980s and early 1990s," she said. "That is oversimplifying, of course, because while the issues are fundamentally the same, in many ways the industry has changed."

Investment strategies are more complex today, marketing practices

have changed, there are more publicly traded insurers, competition is coming from banks and others outside the industry and there is a "virtually infinite variety of complicated guaranteed life and annuity products today," Ms. Vaughan explained.

With it all, though, regulators must do their jobs with the same fundamental questions in mind that were posed in the 1980s and 1990s, she said.

"Are the companies (properly) pricing and underwriting the products that they sell?" she asked. "Do they understand the risks that they are assuming in those products, and are they managing them properly? And, are they investing the money backing those policies prudently?"



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Comings & Goings

Insurers

John Cavoore has been named to the additional post of chief executive officer of OneBeacon Insurance Group Ltd., a Boston-based subsidiary of White Mountains Insurance Group Ltd. Mr. Cavoore will continue as president of OneBeacon.

Uni-Ter Underwriting Management Corp., an Atlanta-based specialist in property/casualty insurance for long-term care facilities, has named **Kathleen Cavallo** as

president of the newly formed Uni-Ter Risk Management Services. Before her promotion, Ms. Cavallo was vp, clinical services.

Endurance Specialty Insurance Ltd., a subsidiary of Hamilton, Bermuda-based Endurance Specialty Holdings Ltd., has made two senior-level appointments. **Maria Costello** and **Mary Lou Douglas** have both been named senior vp and team leader. Before their promotions, Ms. Costello and Ms. Douglas both held the title of vp, professional lines.



Mr. Herman



Mr. Bishop

Alan J. Kreczko has been named senior vp and deputy general counsel of The Hartford Financial Services Group Inc., based in Hartford, Conn. Previously, Mr. Kreczko served as acting assistant secretary for population, refugees and migration for the U.S. Department of

State.

Hamilton, Bermuda-based insurance company ACE Ltd. has made two senior-level appointments, effective Jan. 1.

• **Mark Herman** has been appointed president of ACE Global Professional Lines. Mr. Herman currently is president and CEO of ACE Bermuda.

• **Andrew Kendrick** has been appointed president and CEO of ACE Bermuda, subject to approval by the Bermuda Department of Labour and Immigration. Mr. Kendrick is currently president of ACE Global Markets.

Also at ACE, **Chris Fisher** has been named senior vp of ACE Bermuda Insurance Ltd., replacing **Klaus Gebhardt**, who was recently appointed chief underwriting officer of ACE Latin America.

Chicago-based CNA Surety Corp. has named **John F. Corcoran** as chief financial officer and senior vp. Previously, Mr. Corcoran was senior vp and senior financial officer for CNA Insurance Cos.

New York-based AIG Aviation Inc., a subsidiary of American International Group Inc., has named **John Myers** as chairman and CEO. **Steve Blakey**, formerly executive vp of AIG Aviation, will replace Mr. Myers as president.

Reinsurance

General Electric Co.'s Employers Reinsurance Corp., based in Overland Park, Kan., has appointed **David Bassi** as the new global risk and underwriting leader for GE ERC's property/casualty reinsurance unit. Previously, Mr. Bassi was global risk manager-casualty reinsurance.

Willis Re, the New York-based reinsurance brokerage unit of Willis Group Holdings Ltd., has named **Eugene F. Mason Jr.** as senior vp, working out of the New York and Farmington, Conn., offices. Before joining Willis, Mr. Mason was global professional liability product leader and second vp at General Electric Co.'s Employers Reinsurance Corp.

Managed care

Hartford, Conn.-based Aetna Inc. has named **Charles M. Cutler** as national medical director for quality management. Dr. Cutler, who previously served as chief medical officer of the Washington-based American Assn. of Health Plans, will be based in Aetna's offices in Blue Bell, Pa.

Magellan Health Services Inc. has named **Rene Lerer** as president. Dr. Lerer also serves as chief operating officer of the Columbia, Md.-based behavioral managed care company.

Heidi Kunz has been named executive vp and CFO of Blue Shield of California. Before joining San Francisco-based Blue Shield, Ms. Kunz was executive vp and CFO for Gap Inc.

Other suppliers

Trumbull Services L.L.C., based in Windsor, Conn., has named **Sean Moore** as the national director of alternative market services. Previously, Mr. Moore was responsible

for the Eastern regional outsourcing services.

Allenbrook Inc., a Brunswick, Maine-based provider of property/casualty insurance automation services, has named **Charles M. Peck** as president. Before joining Allenbrook, Mr. Peck was CEO of the-globe.com.

The American Assn. of Insurance Services, a national insurance advisory organization that develops policy forms, manual rules and rating information, has made two senior-level appointments:

• **Dennis Lofgan**, who formerly was an independent commercial lines product consultant for Kemper Professional Insurance Co. and Arch Insurance Co., has been named senior product development specialist for commercial property at the Wheaton, Ill.-based organization.

• **Sheila Morris** has been named senior product development specialist for inland marine. Previously, Ms. Morris was assistant vp of underwriting for Combined Specialty Insurance Co.

Michael Bishop has joined Minneapolis-based Pelto Group Inc. as senior vp of claims operations for the claims management and consulting company. Mr. Bishop was formerly the national director of claims operations for National Car Rental, Alamo Rent a Car and Car Temps USA.

The Segal Co., a New York-based employee benefit consulting firm, has appointed four to the post of senior vp.

• **Deborah J. Marcotte**, previously an actuarial manager, will provide consulting services and supervise actuarial work.

• **Darrin Owens**, previously a vp, will work with large collectively bargained, multiemployer health and welfare clients.

• **David R. Shock**, a former vp, will work with national multiemployer clients.

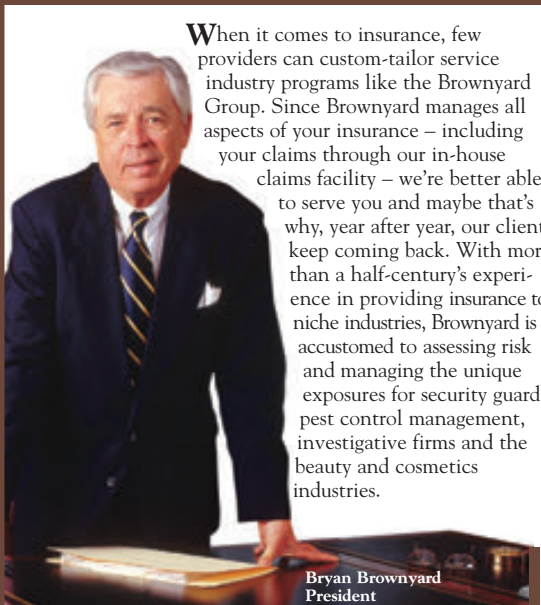
• Former Vp **Louis Giallonardo** will focus on public-sector health care for regional and national organizations.

Cozen O'Connor has named **Linda S. Kaiser**, a former Pennsylvania insurance commissioner, as a senior member in the law firm's insurance regulatory practice group. Before joining Philadelphia-based Cozen O'Connor, Ms. Kaiser was a partner at the law firm of Saul Ewing L.L.P.

Kevin J. Walsh has been named partner in the law firm of Lord, Bissell & Brook L.L.P. of Chicago, where he will focus on litigation and arbitration of insurance and reinsurance disputes. Before joining Lord, Bissell & Brook, Mr. Walsh was a partner in the New York-based law firm of Kelley Drye & Warren L.L.P.

Business Insurance would like to report on senior-level changes at commercial insurance companies and service providers. Please send news of recently promoted, hired or appointed senior-level executives to: Joe Walker, Business Insurance, 60 N. Michigan Ave., Chicago, Ill. 60601-3806; jwalker@crain.com. Photos should be sent to: Kathy Barnes, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; kbarnes@crain.com.

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Commentary

Ease into fitness through cycling

The summer vacation in Holland went as planned. What I took away from it wasn't.

I recommend the trip to every employee benefits manager, who, I think, could quickly and inexpensively turn their experience into programs that could further help their organizations' overweight employees slim down and cut back their health care spending. Considering that the U.S. surgeon general estimates that 61% of American adults are overweight or obese and that associated health problems cost the economy \$117 billion annually, there is still more work to be done.

The vacation was a buddy biking trip through the Dutch countryside. Over eight days, our 365-mile excursion took us through sweeping pastures and farmland, thick woods, quaint villages of brown brick homes topped with high-pitched roofs and large cities.

I never will forget those images. Or the one of a 15-foot-high statue of a young, thin Elvis in front of a small home near Amsterdam.

But Holland's cycling culture made the greatest impression on me. Although I knew that cycling is an important mode of transportation in Holland, being immersed in that culture is an incredible experience. On village streets, bicycles outnumber cars. Even in bigger cities, bicycle traffic is significant. Lots near town squares and at commuter train stations are packed with parked bikes.

People of all ages—from septuagenarians to schools of school-age kids—bicycle. One afternoon, I saw a young mother riding with her 3-year-old son, who, incredibly, was pedaling his own tiny two-wheeler.

So, while I was on holiday in a foreign land, this culture turned my thoughts to employee benefits—specifically, the potential advantages of promoting cycling.

The United States, of course, is not Holland, where several dynamics propel—if not compel—cycling. There, fuel prices are much higher, and a vast network of bike paths criss-cross the country. The terrain is flat, and the climate is relatively temperate.

Still, as some American employers have found, even modest biking-promotion programs can draw their employees into cycling, which has some advantages over weight-reduction programs.

For example, cycling allows employees to ease into a healthier lifestyle. A spokesman for the League of American Bicyclists points out that a cyclist riding at 12 mph can burn off at least a super-sized cheeseburger in an hour. Significantly, that pace "is below the sweat level," noted the

spokesman, whose observation echoes the sales pitches for those no-sweat fitness gizmos advertised on TV.

But, unlike those contraptions and other, more traditional exercise regimens, cycling could be a convenient activity for unfit employees who cannot find time to exercise regularly. That's because many unfit employees could incorporate cycling into their daily routines without changing their schedules much.

For example, the city of Portland, Ore., for years has paid \$25 monthly rewards to employees who bike to work. Less than 5% of eligible employees participate, but another program designed to curtail traffic-subsidized rapid transit fares—may be holding down participation.

Regardless, given that federal government statistics show that half of the nation's population works just five miles or less from home, there is great potential for other employers to make such a program work.

The city of Santa Barbara, Calif., this year took a different approach and has had promising results. The city purchased a fleet of 10 specially designed transportation bicycles at \$500 each for a segment of its staff to use to get around downtown. Dru van Hengel, the city's alternative transportation planner, says employees of all fitness levels use the bikes and that more city departments want to join the program.

Before hopping on the saddle, employees had to take a course on riding safely in traffic, which resulted in an unexpected benefit, Ms. van Hengel noted. More than half of the 50 eligible employees did not ride regularly before, but many report they plan to ride more—including to work—now that they know how to ride safely, she says.

Like the concept but not those programs? There are lots of places to go for other ideas. Links to various cycling organizations are available at www.thunderheadalliance.org.

John Doidge, who co-founded SimpliCity Cycle Co. of Sausalito, Calif., with mountain biking visionary Joe Breeze to produce transportation bicycles, is available as a consultant.

Of course, even the most successful bicycling promotion program likely will have only limited success in a vacuum. We also have to stop sucking down those cheeseburgers.

Senior Editor Dave Lenckus can be reached at dlenckus@crain.com.



Dave Lenckus

Testing: Not an issue

Continued from page 4

have to file complaints with the EEOC before any legal action could occur, and awards would be limited to \$300,000, as they are under Title VII of the Civil Rights Act, pointed out Joanne Seltzer, an attorney in the New York office of Jackson Lewis L.L.P.

Insurers, meanwhile, would not be permitted to use genetic information to deny coverage, and would be required to treat genetic information like other confidential information, as governed by existing privacy rules. Enforcement of the act as it impacts health insurance would be the responsibility of the Departments of Labor and of Health and Human Services.

Employer-backed organizations question what the legislation would accomplish.

"We do feel that it is somewhat a solution in search of a problem," said Maria Ghazal, director-health policy for the Washington-based American Benefits Council.

"Our members tell us that they are not using it, and insurers tell us they are not using it. Once the Senate came to a consensus that they were going to act on this this year, we were focused on improving the bill," Ms. Ghazal said. "One of our key concerns was the remedy section. They did make significant improvements. At the end of the day, though, we are still concerned that complying with this will divert valuable resources from health plans and only exacerbate the situation of making health insurance unaffordable for more Americans."

A health-care policy expert for the National Assn. of Manufacturers agreed that the final version of the bill was an improvement on previ-

ous versions.

"To one extent, the fact that we worked so hard in trying to find less-onerous alternatives to an earlier Democratic bill, we feel a certain sense of accomplishment," said Neil Trautwein, director-employment policy for NAM in Washington.

"On the other hand, we have to worry about initiating new litigation even in more-measured fashion. There's really not a substantial record of discrimination to prompt this legislation, so what we're dealing with is legislation by anecdote, fear and perception."

"I don't think we have any research evidence" that employers were using genetic information to make employment decisions, said Linda Bergthold, a senior consultant with Watson Wyatt in Universal City, Calif.

"The larger employers had already taken steps even before HIPAA to establish a firewall between employment decisions and medical plan decisions," said Ms. Bergthold, who is national director-health-care compliance for Watson Wyatt. "HIPAA had employers document what they were doing, but when we did HIPAA consulting, we found that employers had separated employment files from files with any medical plan information and restricted the use of any information from the medical plan files to people who didn't make employment decisions."

There is simply "no research base to show that genetic discrimination is widespread," said Ms. Bergthold, who noted that there was one highly visible case that had drawn national attention to the general issue of an employer using genetic information.

In the first case of its kind, Burlington Northern Santa Fe Corp. agreed last year to pay \$2.2 million to 36 workers who claimed that they'd been genetically tested without their permission (*BI*, May 13, 2002). The EEOC had sued BNSF in 2001, claiming that its genetic testing program—which purportedly was intended to explore whether there was a genetic link to carpal tunnel syndrome—violated the Americans With Disabilities Act (*BI*, Feb. 19, 2001).

Jackson Lewis' Ms. Seltzer noted that the legislation has a long way to go before it becomes law, particularly since three separate House committees have jurisdiction over some portion of any genetic nondiscrimination legislation. But if the Senate bill or something close to it does become law, any ban on employers seeking genetic information could cause significant troubles for them, she said.

"This turns into a problem where you have a job that's going to require exposure to chemicals that trigger certain genetic conditions," she said. "If you don't allow the employer to get genetic information, is there a possibility on the other end that the employee can sue the employer for not having notified them of this potential danger? It always turns around and comes back and bites," said Ms. Seltzer.

Watson Wyatt's Ms. Bergthold said that while the measure adds a "layer of compliance," for employers, it could actually prove beneficial to them by setting a national standard.

"I think the main benefit is basically superceding state laws and making a consistent federal law. For large employers who operate in many states, it makes it easier for them to be compliant because they only have to comply with one standard," she said.

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Business Insurance

UMP contends its financial health is restored

Australian med mal insurer seeks to exit liquidation

By ELIZABETH FRY

SYDNEY, Australia—The Australian medical professional liability crisis took another turn last week when the country's largest medical malpractice insurer sought court approval to come out of liquidation.

The move came just days after the Australian government had postponed its plans to impose a special levy on doctors and hospitals to make up for the \$460 million Australian (\$311.9 million) in claims the government is due to pay resulting from the collapse of Sydney-based professional liability insurer United Medical Protection Ltd. (BI, Oct. 13).

The New South Wales Supreme Court is expected to rule Oct. 27 on UMP's petition to exit provisional liquidation. UMP, which insured about 60% of the nation's doctors, was placed in provisional liquidation in April 2002 as result of escalating medical malpractice losses. David Lombe, a partner at Deloitte Touche Tohmatsu in Sydney, was appointed provisional liquidator.

To make up for the incurred-but-not-reported liabilities it had agreed to assume from UMP, the Australian government had planned to impose an IBNR levy on hospitals and doctors.

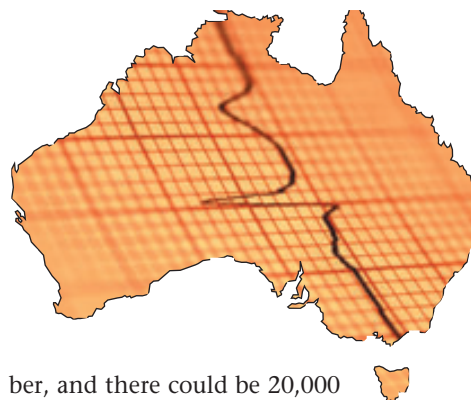
That levy, which could have totaled more than \$250,000 Australian (\$169,550) for some doctors, was postponed after thousands of health care providers threatened to quit practicing medicine rather than pay the levy.

"The levy was the last straw. The high insurance premiums were difficult enough to cope with, but now, with the latest levy and ever-increasing practice costs, financial issues are overwhelming," said Dr. Mukesh Haikerwal, vp of the Australian Medical Assn.

Shortly after the government announced its decision to postpone the levy's introduction, UMP applied to exit provisional liquidation.

If the court allows UMP to exit provisional liquidation, the insurer still would not be responsible for the \$460 million Australian in liabilities assumed by the government, a Deloitte spokeswoman said.

If the court refuses to allow UMP to come out of liquidation, there will be a flood of doctors looking for alternative sources of professional liability coverage, said Mark Valena, chief financial officer of the Medical Defence Assn. of Victoria, another malpractice insurer. "The UMP members are left with a decision to make—whether they stay or leave UMP. Renewals are due in Decem-



ber, and there could be 20,000 medicals all come on the market looking for a new insurer."

Mr. Valena pointed to a recent Deloitte Touche Tohmatsu report that said that UMP's swift recovery was largely due to the support from its loyal members.

"The UMP group is solvent, and the value of its net assets has increased by \$80.2 million in the last financial year, to a net asset position of \$78.9 million," the report says.

UMP's members stayed with the insurer after it was placed in provisional liquidation, in large part because they had no alternative, said Dr. Haikerwal of the AMA.

"There was no point in doctors leaving. They had no choice; they would have had to buy tail cover, which a new insurer might not take on, and in the current climate they might not find total cover," he said.

At its June 2002 financial year-end, UMP reported consolidated revenues of \$192.4 million Australian (\$108.3 million), an 18.4% decrease from 2001.

World Updates

Royal & SunAlliance completes share issue

Royal & SunAlliance Insurance Group P.L.C. has raised around £960 million (\$1.60 billion) in a share issue. RSA said in September that the proceeds from the issue would be used, in part, to boost its U.S. reserves. RSA plans to exit most of the U.S. market by selling the renewal rights to its U.S. property/casualty accounts to Travelers Property Casualty Corp.

Bermuda-based Aspen slated to hold IPO

Aspen Insurance Holdings Ltd. is planning an initial public offering of its shares on the New York Stock Exchange. The Bermuda-based company, formed in 2002, was known as Wellington Re until March 2003. Lloyd's of London-based insurer Wellington Underwriting P.L.C. holds a 20% stake in the company.

Van Santen to continue as FERMA president

Thierry Van Santen, director of risk management for French-based Danone Group, has been re-elected president of the Federation of European Risk Management Assns. for a further two years. Mr. Van Santen has been president of FERMA since 2001. Ralf Oelssner, chairman of the German risk management association Deutscher Versicherungs-Schutzverband e.V. and director of corporate insurance for Deutsche Lufthansa A.G., has been elected vp of the association, FERMA announced. Paul Taylor, the vp of FERMA from 2001 to 2003, was unable to take up the post of president of the association.

Omni Whittington to buy Reliance unit

Guernsey-based runoff specialist Omni Whittington Investments (Guernsey) Ltd. is to buy London-based Reliance National Insurance Co. (Europe) Ltd. RNICE, which ceased underwriting in 2001, wrote marine and aviation, property, third-party liability, reinsurance and accident and health business in Europe.

Sykes, Dufraise take posts at Aon units

Paul Sykes has been named director of Aon Insurance Managers (Guernsey) Ltd. with responsibility for White Rock Group, the Aon arm set up to provide services to protected cell companies. In addition, Alain Dufraise has been appointed director of White Rock Gibraltar, reporting to Mr. Sykes.

France pulls out of settlement over ELIC sale

PARIS—The French government has pulled out of a \$585 million preliminary settlement with U.S. authorities over the 1991 purchase of failed insurer Executive Life Insurance Co. by French bank Credit Lyonnais.

U.S. prosecutors charged that Credit Lyonnais, which at the time was owned by the French government, illegally purchased the assets of Executive Life at artificially low prices and concealed its involvement in the deal. At the time, U.S. law prohibited banks from owning an insurance company.

A settlement in principle was reached earlier this month between the French government and U.S. prosecutors, under which France could have avoided federal criminal charges by paying \$585 million in a settlement to compensate California policyholders who claim they were short-changed by the deal.

But late on Oct. 15, French Finance Minister Francis Mer said the settlement had fallen through. No further details were given.

Earlier this month, the U.S. attorney's office in Los Angeles requested the extradition of four French individuals who were involved in the Executive Life deal.

The French Ministry of Justice refused the request on the grounds that it is not French policy to extradite French citizens.

The U.S. attorney's office in Los Angeles declined to comment.

Credit Lyonnais was acquired by French bank Credit Agricole earlier this year.

—Sarah Veysey

European Parliament proposes new rules

European insurers oppose quarterly reporting plan

By SARAH VEYSEY

BRUSSELS, Belgium—A proposal under consideration by the European Parliament that would impose new reporting requirements on publicly listed financial services companies in the European Union would impose an "excessive burden" on insurance companies, an insurer group argues.

The Brussels-based Comite Europeen des Assurances says it welcomes European Commission moves to harmonize the European Union's financial services sector. However, the CEA said that the current proposal for a directive on the transparency of information about publicly held companies could impose excessive and onerous reporting requirements on insurers.

Amendments to the current proposal are expected from the Legal Affairs Committee and the Economic and Monetary Affairs Committee of the European Parliament, which is currently debating the proposals. The Council of the European Union will then consider the European Parliament's comments, and the proposal may be passed back to the Parliament for a second reading or formulated into a draft directive.

One area of concern for insurers is a proposal that would require listed companies throughout the European Union to report their results quarterly, according to a CEA report on the current proposals.

Such a requirement, the CEA says, "will create an excessive burden, both in costs and time, on insurance undertakings, whilst adding disproportionately small value to investors' information."

Yannis Samothrakis, assistant manager for economics and finance at the CEA, said that the organization maintains that quarterly reporting might be appropriate for some companies but should not be a universal requirement. The CEA hopes that quarterly reporting will remain voluntary and not be made mandatory by any E.U. di-



PHOTO: BBC/NEWSCAST

The European Parliament in Brussels is considering new reporting rules as part of proposals to streamline financial regulation.

rective on transparency, he said.

Insurance is a long-term business, said Mr. Samothrakis, and is therefore managed on a long-term basis. The introduction of a quarterly reporting requirement would be misleading and would prompt managers to take a short-term view of their business, he said.

The issue of quarterly reporting is unlikely to be of much interest to policyholders, he said, except to buyers of reinsurance, who probably already understand the complexity of insurance company reports.

See CEA/page 39

Munich Re aims to boost capital by \$4.5 billion

MUNICH, Germany—Munich Reinsurance Co. is planning to raise about 3.8 billion euros (\$4.48 billion) of capital through a share issue at the end of this month.

The company said in a statement that it would use the additional



capital to take advantage of growth opportunities in reinsurance.

In August, Standard & Poor's Corp. downgraded Munich Re to A+ from AA- because of concerns over the group's capital adequacy, among other factors.

Stephen Searby, credit analyst at S&P in London, said the announcement of the capital-raising move was "consistent with S&P's expectation that the group's capital-adequacy ratio will be improved to the AA range by the end of 2004."

Munich Re will issue about 50.9 million new shares during a subscription period between Oct. 28 and Nov. 10. On Oct. 16, Munich Re shares closed at 98 euros (\$116) on the German stock exchange.

—Sarah Veysey

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NOTICE OF COURT HEARINGS

KINGSCROFT INSURANCE COMPANY LIMITED (Formerly Kraft Insurance Company Limited, Dart And Kraft Insurance Company Limited And Dart Insurance Company Limited)
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WALBROOK INSURANCE COMPANY LIMITED
and
EL PASO INSURANCE COMPANY LIMITED
and
LIME STREET INSURANCE COMPANY LIMITED (formerly Louisville Insurance Company Limited)
and
MUTUAL REINSURANCE COMPANY LIMITED ("Mutual Re")
(together "THE KWELM COMPANIES")

NOTICE IS HEREBY GIVEN that the KWELM Companies have applied to the High Court of England and Wales and, in relation to Mutual Re only, to the Supreme Court of Bermuda for directions relating to the convening and conduct of meetings (the "Meetings") of the KWELM Companies' Scheme Creditors ("Scheme Creditors").

The Meetings are proposed to be convened under Section 425 of the Companies Act 1985 of Great Britain and, in the case of Mutual Re only, under Section 99 of the Bermudian Companies Act 1981, for the purpose of enabling the Scheme Creditors to consider and, if thought appropriate, approve an Amending Scheme of Arrangement (the "Amending Scheme") in respect of the KWELM Companies and their respective Scheme Creditors.

Should the Amending Scheme become effective, it will amend and restate the terms of the Scheme of Arrangement presently in force in respect of the KWELM Companies dated 8 September 1993 (the "Original Scheme").

The Amending Scheme will introduce a mechanism for the closure of the Original Scheme by utilisation of a bar date for submission of claims together with an actuarially based estimation methodology, where appropriate, to evaluate and quantify liabilities (including contingent and future insurance and reinsurance liabilities) notified under the Amending Scheme owed by and to the KWELM Companies. Such a mechanism will facilitate the making of a substantive and ultimate distribution to Scheme Creditors earlier than would be the case under the Original Scheme.

At these directions hearings (the "Hearings"), the KWELM Companies will request that the English Court, and in respect of Mutual Re only, the Bermudian Court convene separate meetings of each of their respective:

(i) Protected Scheme Creditors (being Scheme Creditors whose claims are eligible for protection under the applicable provisions of the Policyholders Protection Act 1975 by the Financial Services Compensation Scheme Limited); and

(ii) General Scheme Creditors (being Scheme Creditors in respect of claims which are not Protected Scheme Claims).

Scheme Creditors who wish to attend and make representations in connection with the composition of the Meetings at the Hearings at 10.30am on 28 November 2003 in the High Court of England and Wales and, in relation to Mutual Re only, at 9.30am on 2 December 2003 in the Supreme Court of Bermuda, should contact the Scheme Administrators as soon as possible.

If the Courts give directions to convene the Meetings, the KWELM Companies will, in due course, make available to all Scheme Creditors copies of the Amending Scheme and Explanatory Statement at the same time as formal notice is given of the Meetings. In the meantime, the latest drafts of those documents, the Scheme Administrators' letter to the Scheme Creditors dated 17 October 2003 notifying Scheme Creditors of the Hearings and a more detailed notice of the Hearings, the English and Bermudian Court applications and draft Court Orders setting out the proposed directions can be downloaded from www.kwelms.com. Alternatively, hard copies can be obtained from the Scheme Administrators. In the event the Courts give leave to convene the Meetings and the Scheme Creditors vote in favour of the Amending Scheme at the Meetings, we would expect the bar date to be toward the end of September 2004.

CJ HUGHES and IDB BOND
 Address for correspondence of the KWELM Companies
 Scheme Administrators, John Stow House, 18 Bevis Marks, London EC3A 7JB, United Kingdom.
 Tel: +44 (0) 20 7645 4991. Fax: +44 (0) 870 600 7588.
 Cadwalader Wickersham & Taft LLP, 265 Strand, London WC2R 1BH, United Kingdom (Ref RG/AJOW/KA)
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PUBLIC NOTICE
 NOTICE OF MEETINGS OF SCHEME CREDITORS
 IN THE HIGH COURT OF JUSTICE
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 NO 6366 OF 2003
 IN THE MATTER OF
BLACK SEA AND BALTIC GENERAL INSURANCE COMPANY LIMITED
 (PROVISIONAL LIQUIDATORS APPOINTED)
 AND IN THE MATTER OF
 THE COMPANIES ACT 1985

NOTICE IS HEREBY GIVEN that by an Order dated 10 October 2003 made in the above matter, the Court has directed that meetings (the "Scheme Meetings") of the Company's Scheme Creditors (as defined in the Scheme (as defined below) of Black Sea and Baltic General Insurance Company Limited (the "Company") be held together on 2 December 2003 at The Chartered Insurance Institute, The Insurance Hall, 20 Aldermanbury London EC2V 7HY, United Kingdom commencing at 3.30pm. All Scheme Creditors are requested to attend at such place and time either in person or by proxy.

The purpose of the Scheme Meetings will be to consider and, if thought fit, to approve (with or without modification) a scheme of arrangement proposed to be made between the Company and the Scheme Creditors pursuant to s425 of the Companies Act 1985 (the "Scheme").

A downloadable file of the proposed Scheme, Explanatory Statement and Appendices are available on the Company's website at www.blacksea.co.uk. Should an email or a printed copy be required, please send your request to the Joint Provisional Liquidators at their Plumtree Court address below, and one will be sent to you.

Copies of the notice of the meetings, the proxy and voting form, the short-form Explanatory Statement, the Scheme document and the long-form Explanatory Statement can be obtained from the Joint Provisional Liquidators at their Plumtree Court address below or their Solicitors.

The Scheme Creditors may vote in person at the Scheme Meetings or they may appoint another person, whether a Scheme Creditor or not, as their proxy to attend and vote in their place.

It is requested that proxy and voting forms be lodged with the Joint Provisional Liquidators, Black Sea and Baltic General Insurance Company Limited, c/o PRO Insurance Solutions Limited, One Great Tower Street, London EC3R 5AH, fax number +44 (0) 20 7623 3318, not less than three working days before the time appointed for the Scheme Meetings. A faxed copy of the proxy and voting form will be accepted if legible.

By the same Order the Court has appointed Dan Schwarzmann of Plumtree Court, London EC4A 4HT, United Kingdom or, failing him, Nigel Rackham of Plumtree Court, London EC4A 4HT, United Kingdom to act as Chairman of the Scheme Meetings and has directed the Chairman to report the result of the Scheme Meetings to the Court.

The Scheme of Arrangement will be subject to the subsequent approval of the Court.

Dated this 15th day of October 2003
RICHARDS BUTLER
 Beaufort House, 15 St Botolph Street, London EC3A 7EE, United Kingdom (Ref: JLT/0150788)
 Solicitors for the Joint Provisional Liquidators of Black Sea and Baltic General Insurance Company Limited

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CEA: Opposed to quarterly reporting

Continued from page 37

A spokeswoman for the Assn. of British Insurers said the London-based trade organization was "generally in agreement with the CEA."

She said that the ABI opposes quarterly reporting out of concerns that the requirement could lead to "ad hoc reporting" and making short-term changes to improve quarterly results.

According to the Comité Européen des Assurances, producing a detailed half-yearly management risk report would be extremely burdensome.

Another area of concern to the CEA is a proposal to make companies publish a management report on a half-yearly basis. This report would have to include "all significant uncertainties and risks which may affect the development of the company" for the remainder of the financial year, according to the CEA's paper.

But because of the complexity of insurers' business, producing such a detailed risk report twice yearly would be extremely burdensome, said Patricia Plas, the CEA's director of economics and finance.

This process would be both costly and time-consuming for insurers, the CEA argues in its paper, and "the resulting expenses will greatly outweigh the benefit of additional information for shareholders."

The CEA would prefer companies to be asked to provide a half-yearly update on significant changes within the company or sector, which would give shareholders pertinent news.

An additional proposal would require companies to report year-end results within three months of the year's close. This, the CEA argues in its position paper, is an extremely difficult deadline for insurers to meet, given that financial results must be audited.

"Though timely reporting should be the objective, it is crucial that sufficient time is allowed to ensure quality of information," the paper says. "A deadline of four months is a more-workable timeframe, in view of the director's objectives."

Lloyd's: Regulation deemed OK

Continued from page 3

U.K. government's regulation of Lloyd's dating back to the 1970s. The report, which the overwhelming majority of members of the European Parliament had approved, stemmed from complaints by names who charged their massive underwriting losses were caused by a U.K. failure to adopt E.U. regulations governing the adequacy of reserves.

In the E.C. statement, Internal Market Commissioner Frits Bolkestein said, "As regards the situation before the introduction of the U.K.'s Financial Services and Markets Act 2000 legislation, we have always and repeatedly made clear to complainants that any action seeking damages for alleged incompatibility under the former regime must be undertaken exclusively before U.K. courts."

Mr. Bolkestein also said that the commission's inquiry has effectively ensured that U.K. regulation is in compliance with E.U. directives.

The inquiry, he said, had "a strong influence in the development of a new legal framework in the U.K. for the regulation and supervision of Lloyd's that is in line with the requirements of the E.U. insurance directives."

But one U.K. name blasted the commissioner's conclusions.

"It was ridiculous for Bolkestein to refer complaints to national courts knowing that names have no chance of succeeding with legal actions in the U.K.," said John Pascoe, a former name.

"Furthermore, by saying that the infringement proceedings have pushed the U.K. authorities to ensure compliance is an admission that the regulatory regime did not comply before the commission took action. The whole thing is ludicrous," said Mr. Pascoe.

Mr. Pascoe said he intends to take his case for regulatory negligence to the European Court of Justice, the E.U.'s highest appeals court.

A spokesman for Roy Perry, the member of the European Parliament who drew up the critical report on the regulation of Lloyd's, said the European Parliament also believes there is unfinished business.

Parliament still expects the commission to answer its request by Nov. 15 for E.C. comment on a parliamentary finding that the United Kingdom was not in compliance with E.U. laws in earlier decades.

The commission began an investigation into the regulation of Lloyd's in 2000. In December 2001, the commission sent the U.K. authorities a letter of formal notice identifying its concerns with the regulatory and supervisory regime for Lloyd's then in force.

The U.K. government replied on April 30, 2002, pointing out that, under the Financial Services and Markets Act 2000, its supervision of Lloyd's met E.U. standards.

The commission sent a supplementary letter of formal notice in January 2003 asking for clarification on solvency arrangements at Lloyd's and issues relating to its self-regulatory powers. The U.K. authorities completed their responses by May 27.

A spokesman for the U.K. government said: "We are very pleased that the commission has given Lloyd's a clean bill of health. We were always confident that it would do so because we believe that the regulatory system in place fully meets European and international standards."

A spokeswoman for Lloyd's said, "We are pleased to note that the commission has found that the current U.K. government regulatory regime of Lloyd's complies with E.U. law."

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MONDAY, NOVEMBER 17, 2003

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World Captive Forum Golf Tournament
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3:00 PM - 6:00 PM
Opening Workshops
Track 1: Captive Basics: The Expanding Horizons
Track 2: Employee Benefits in Captives: The Opportunities and the Imperatives

6:00 PM - 7:30 PM
Welcome Reception with Exhibitors
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TUESDAY, NOVEMBER 18, 2003

7:30 AM - 9:00 AM
Breakfast in the Exhibit Hall
Sponsored by Dempsey Myers & Co.

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

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

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

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

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

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

3:00 PM - 5:00 PM
Networking Poolside Break
Sponsored by Watson Wyatt Insurance & Financial Services, Inc.

7:00 PM - 10:00 PM
Captive Cabaret featuring the internationally known *Jimmy Keys*

WEDNESDAY, NOVEMBER 19, 2003

7:30 AM - 9:00 AM
Breakfast in the Exhibit Hall
Sponsored by Barbados Investment & Development Corporation

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

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

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

11 AM - 12:30 PM
Tax and Legal Developments

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

1:30 PM - 2:30 PM
Conference Round-Up

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Asbestos: National trust fund clears major hurdle

Continued from page 1
 from Senate Majority Leader Bill Frist, R-Tenn., calling for a larger contribution (BI, Oct. 13). But last week, after examining the latest proposal from Sen. Frist, they agreed to the larger contribution, provided that all of their other criteria for participating in the fund are met.

Among other things, these principles include that non-U.S. entities be held accountable for contributions on the same basis as domestic insurers and reinsurers, that insurers provide no contingency funding of the program if it should prove in-

adequate to pay claims, and that the program provide collateral source offsets of awards from the fund.

The full Senate has not yet begun consideration of the measure. In addition, no companion bill has been introduced in the House of Representatives.

Insurers' contribution to the proposed fund had initially been capped at \$45 billion. However, last-minute amendments to the bill in the Senate Judiciary Committee raised their minimum payout to \$52 billion, with the possibility of tens of billions of dollars in additional levies should the fund prove inadequate to meet claims.

On Oct. 15, both insurers and manufacturers agreed to Sen. Frist's latest funding proposal, and the lawmaker responded in a statement that he was "very encouraged" by the developments. "While many other details still remain to be worked out, clearly this is a significant and meaningful step forward between two major parties to the

larger asbestos negotiations," he said in his statement.

However, one key player—organized labor—has not endorsed the current trust-fund proposals, noted Julie Rochman, senior vp at the American Insurance Assn. in Washington.

'The trial bar is basically irrelevant, because they're going to be against anything you do.'

Julie Rochman
 American Insurance Assn.

Ms. Rochman dismissed the importance of the plaintiffs' bar to the negotiations. "The trial bar is basically irrelevant, because they're going to be against anything you do," she said. "They just don't want a trust fund."

But "labor's key, obviously—we go nowhere without labor supporting this bill," she said.

"People were sort of obsessing on the funding (but) there are other equally important issues that are still outstanding. First and foremost, the fund has to be an exclusive remedy; all asbestos-related claims must come to the fund," she said.

"There are two overwhelming reasons to go with the trust fund—one is finality and the other is certainty," Ms. Rochman said. She said that a last-minute amendment to the bill, offered by Sen. Joseph Biden, D-Del., "destroys any hope of certainty, because it basically says if at least 95% of claims aren't paid within any calendar year, then the fund blows up and everybody immediately returns to tort."

"The next step now that we've gotten past this hurdle on the funding is to start taking on these other chunks of the bill and resolving them satisfactorily. We made it clear we reserve the right to oppose the overall bill unless these other issues are satisfactorily resolved," Ms.

Rochman said.

Another insurance industry representative also stressed that the insurers' core principles, as outlined in an Oct. 7 letter to Sen. Frist, have to be incorporated into any bill.

"The industry gave tentative approval to the alternative funding proposal conditioned on acceptance of the remaining core principles as outlined in the Oct. 7 joint trade letter," said Julie Leigh Gackebach, assistant vp-government relations for the National Assn. of Independent Insurers in Washington. "The unity of industry behind the core principles enabled us to get a stronger and more equitable funding scheme, and we look forward to continuing to work with the congressional leadership to develop a final package that ensures certainty, finality, equity and efficiency."

In addition to AIA and NAI, the Alliance of American Insurers, the National Assn. of Mutual Insurance Cos. and the Reinsurance Assn. of America developed and endorsed the principles.

PBGC deficit increases to \$8.8 billion

By JERRY GEISEL

WASHINGTON—The financial condition of the employer-funded federal agency that guarantees pension benefits continues to deteriorate.

The Pension Benefit Guaranty Corp. as of Aug. 31 had a record \$8.8 billion deficit, compared with a shortfall of \$5.7 billion as of July 31. The deficit marks a huge change from two years ago, when the agency reported a \$7.7 billion surplus in its single-employer insurance fund.

PBGC Executive Director Steve Kandarian told the Senate Aging Committee Tuesday that the rise in the PBGC's deficit stems from sever-

al factors, including changes in interest rate assumptions, asset values, new claims and probable termi-



Deprived of a revenue base, a federal bailout of the PBGC might be necessary.

Steve Kandarian
 Pension Benefit Guaranty Corp.

nations from financially distressed employers.

Indeed, the PBGC over the last year has been hit with the biggest losses in its 30-year history, including the \$3.9 billion benefit liability it took on last December when it terminated the pension plan of failed steel manufacturer Bethlehem Steel Corp.

Mr. Kandarian warned that, in the absence of reforms such as legislation to im-

prove pension funding, the PBGC's deficit could grow so large that the size of the premium increase it would need to impose to pay those obligations would be intolerable to employers with defined benefit plans, who would terminate their plans.

Deprived of a revenue base, a federal bailout of the PBGC might be necessary, Mr. Kandarian warned.

Currently, employers with defined benefit plans pay a base annual premium of \$19 per plan participant, while employers with underfunded plans pay an additional \$9 per \$1,000 of plan underfunding.

401(k), other pension limits to rise in 2004

WASHINGTON—Employees will be able to contribute more to their 401(k) plans next year, while maximum contribution and benefit levels in other retirement plans also will increase.

Next year, employees will be able to defer \$13,000 to their 401(k), 403(b) and 457 plans, up from the 2003 limit of \$12,000. In addition, employees 50 or older participating in such plans will be able to con-

tribute \$3,000 in "catch-up" contributions, up from this year's \$2,000 maximum.

Other changes include raising to \$205,000 from \$200,000 the amount of employee compensation that can be considered in computing pension benefits and contributions; boosting to \$41,000 from \$40,000 the maximum contribution that can be made to an employee's defined contribution plan account; and increasing to \$165,000 from \$160,000 the maximum annual benefit that can be funded through a defined benefit plan.

The changes, announced last week by the Internal Revenue Service, generally were mandated under tax legislation—the Economic Growth and Tax Relief Reconciliation Act—Congress passed in 2001.

Meanwhile, Social Security taxes will be increasing next year, as will Medicare cost-sharing requirements.

Effective Jan. 1, 2004, the

amount of an employee's wages subject to Federal Insurance Contributions Act taxes will increase to \$87,900 from \$87,000. Employers and employees each pay a 7.65% FICA tax.

In addition, the Medicare Part B premium, which covers physician services, will increase to \$66.30 per month, up from \$58.70 in 2003. Between 5% and 10% of employers pay all or part of the Part B premium for their retired workers.

In addition, the Medicare deductible for the first 60 days of a hospital stay will increase to \$876 from \$840. The daily copayment for extended hospital stays—61 through 90 days—will increase to \$219 from \$210, while the daily copayment for stays exceeding 90 days will rise to \$438 from \$420.

The level of Medicare deductibles and copayments is relevant to employers with retiree health plans that pay health care costs not covered by the federal program.

—By Jerry Geisel



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TRIA: Coverage available

Continued from page 4

as having met the definition of "terrorism" in the act before any payout can be made. Annual payouts are capped at \$100 billion, under the law.

While insurers are meeting their requirement to offer policyholders such coverage, the lack of U.S. Treasury Department pricing guidelines means that the premiums charged are "all over the map," Ms. Dalton said.

In addition, "approximately half of property insurers are offering 'noncertified' coverage to policyholders in addition to TRIA," she said. Those policies may cover non-U.S. locations as well as acts of "domestic" terrorism, she said.

Another alternative is a "stand-alone policy" that can wrap around an "all risk with TRIA" policy and fill its gaps by covering domestic terrorism as well as non-U.S. locations, she said.

Several major insurers are offering about \$1 billion total in stand-alone coverage, though their individual capacity varies, according to Ms. Dalton. Berkshire Hathaway Inc. is taking the lead by offering \$500 million, while underwriters at Lloyd's of London are offering \$200 million. American International Group Inc. and AXIS Specialty Ltd. are each offering \$150 million, while ACE USA is offering \$100 million, she said.

Terrorism protection also is avail-

able through other blends of stand-alone and noncertified coverages, though protection from nuclear, biological and chemical risks is limited, she said. Terrorism coverage also may be available through other government-sponsored programs in Australia, France, Germany, India, Israel, South Africa, Spain, Sri Lanka and the United Kingdom.

In addition, using a captive "may be an excellent way to reduce premiums and deductibles while limiting a dollar trade with insurers," Ms. Dalton said.

As of July, Marsh reported that 20 existing captives added TRIA coverage, one new captive was formed for that purpose and at least 13 companies were considering captive-relat-

ing plans to survey insurers and policyholders about the TRIA program for a report to Congress, she said.

All those who receive questionnaires should respond, urged Robert R. Cohen, national policy counsel for the National Assn. of Real Estate Investment Trusts. Mr. Cohen moderated the panel.

The symposium was organized by the Risk & Insurance Management Society Inc. and five real estate-related organizations—the National Council of Real Estate Investment Fiduciaries, the National Assn. of Real Estate Investment Trusts, the National Assn. of Real Estate Investment Managers, the National Multi-Housing Council and The Real Estate Roundtable.

A "major question" is whether reinsurance will follow the term of the primary policies or end on Dec. 31, 2004 or 2005, Ms. Dalton said. The Treasury Department is mak-

Real Estate Risk Management Symposium

Property market improving

By REGIS COCCIA

CHICAGO—After two years of steep price increases and curtailed capacity, commercial real estate owners are starting to see insurance market conditions improve, brokers say.

Speaking at the Real Estate Risk Management Symposium earlier this month in Chicago, sponsored by the Risk & Insurance Management Society Inc., a panel of four brokers discussed market developments and underwriting trends.

"Real estate buyers are paying about 100% more for property coverage" than the general industry since the Sept. 11, 2001, terrorist attacks, said Kevin Madden, managing director of the national real estate practice at Aon Corp. in New York.

Mr. Ruane called the current market "confused," noting that while rates should be adequate to ensure economic viability, several high-profile insurers have exited the market in recent years. Major property insurers that have lost their A-level ratings and subsequently left the market include Reliance Insurance Co., The Home Insurance Co. and Kemper Insurance Cos.

Another topic the panel addressed was how risk managers can get underwriters' attention, particularly on terrorism coverage.

The free market for terrorism insurance is "going back to what it was before 9/11," said Alexandra S. Glickman, managing director and practice leader of Gallagher Real Estate & Hospitality Services for Arthur J. Gallagher & Co. in Glendale, Calif.

"Price depends on how aggressively your program is being marketed," Ms. Glickman said. "You can't take the first answer, you can't take the second answer—you have to go back over and over" to underwriters.

She said capacity is available and noted that a Gallagher client was able to secure \$200 million in terrorism limits recently from Boston-based Lexington Insurance Co., a unit of American International Group Inc.

"We're seeing a greater need to look at portfolios in their entirety," Ms. Glickman said.

Underwriters are looking closer at real estate exposures, and pricing "depends on if you have iconic assets, trophy assets. You'll be paying more" if the real estate portfolio in-

cludes high-profile properties in central business districts in major cities, she said.

"How do you differentiate your account?" Marsh's Mr. Schake asked rhetorically. He advised risk managers to "treat underwriters like lenders. They're a capital source, so treat them as such."

Willis' Mr. Ruane said real estate buyers have long had a reputation with underwriters as price shoppers, which seems to be changing now. "Sophisticated buyers are within this community. I think educating underwriters is important. Buyers of real estate are sophisticated and looking for long-term relationships," he said.

While the percentage of clients that buy terrorism coverage is between 20% and 25%, on average, some panelists said more than half of the clients that buy terrorism coverage are in the real estate industry.

The Terrorism Risk Insurance Act of 2002, which requires insurers to offer coverage for certain terrorist attacks (see story, page 4), "is not perfect, but it has created a market," said Mr. Schake.

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Labor: Cost-shifting a contentious issue

Continued from page 1

tain good quality benefits in the future."

With health care costs rising faster than the rate of inflation, labor problems will continue for the foreseeable future, said Joe Martingale, national leader for health care strategy at Watson Wyatt Worldwide in New York.

"It puts pressure on the system and stresses labor and employee relations," Mr. Martingale said of health care inflation. "It's not just when there is a union involved," he added, noting employers also are requiring nonunion workers to contribute more of their salaries to help offset rising health care costs.

Grocery workers strike

In Southern California, current labor actions involve tens of thousands of grocery store workers, bus mechanics and Los Angeles County sheriff's deputies.

Union members last week walked picket lines in front of hundreds of grocery stores after workers for Pleasanton, Calif.-based Safeway Inc.'s Vons stores walked off the job Oct. 11. They did so after talks between the stores and the United Food & Commercial Workers broke off over the issue of contributing toward the cost of health care benefits. Currently, the union employees pay nothing under most of the health care plans they are offered.

On Oct. 12, Boise, Idaho-based Albertson's Inc., and Cincinnati-based Kroger Inc.'s Ralphs stores in Southern California locked out their unionized workers, who are governed by the same master con-

tract as the Safeway workers.

The three grocery chains were trying to negotiate a new joint contract with the union. The strike and lockout affected about 70,000 workers in southern and central California.

Members of the UFCW subsequently walked out on Kroger stores in Kentucky, Ohio and West Virginia on Oct. 13. UFCW members also are on strike in St. Louis in a dispute over health insurance contributions with grocers there.

Grocery stores in Southern California say they will continue to provide their workers with competitive benefits but must share the burden of rising costs.

Skyrocketing health care costs are a key issue in the labor disagreement, a Safeway spokeswoman said. The stores say the cost of providing health care benefits shot up more than 50% during four years of a labor contract that expired on Oct. 5.

Those costs are expected to continue rising in the years to come while they face growing competition from low-cost stores that do not provide health and welfare benefits, the stores say.

"As responsible companies, we are seeking nothing more than a fair contract that will help us to remain competitive in the face of soaring health care and benefit

costs and increased competition from lower-cost operators," John Burgon, president of Los Angeles-based Ralphs, said in a statement.

Under the expired UFCW contract, workers for the three companies did not contribute to premiums and paid only a \$10 copayment for each doctor visit under their health plans. Under an HMO plan offered to the workers, there was no premium, no copayment and no deductible.

The stores say they will continue to provide competitive benefits but must share the burden of rising costs. They are asking current employees to pay weekly premium costs of \$5 for single coverage and \$15 for family coverage, a spokeswoman for Albertson's said.

A 2003 annual survey of employer-provided health benefits conducted by the Menlo Park, Calif.-based Kaiser Family Foundation found that most workers pay a portion of premiums for their health coverage.

The percentage of premiums paid by employees remained statistically unchanged over the past two years at 16% for single coverage and 27% for family coverage, according to Kaiser.

But the food workers' union contends the cost impact on members of the grocery chains' proposed contract would be greater than simply introducing copayments.

The union and the stores jointly oversee a trust fund that administers worker health benefits paid for with store contributions, a union spokeswoman said.

The union contends that the stores also want to cut their contri-

butions to the trust fund by about \$1 billion over three years, which would slash the level of benefits available for employees, the spokeswoman said.

None of the grocery store chains would comment on the trust fund changes.

Bus mechanics strike

Just a few days after the grocery workers went on strike, about 2,000 mechanics represented by the Amalgamated Transit Union also went on strike against the Metropolitan Transportation Authority in Los Angeles.

Disagreement over the size of the MTA's contributions to a union health care trust fund and over control of the union-managed fund stalled negotiations. The MTA currently deposits about \$17 million annually into the fund to pay for medical coverage for the mechanics and retirees, but because of soaring costs the union wants the MTA to increase its funding.

The mechanics have been paying nothing for individual health coverage and only \$3 per month for a spouse and \$6 a month for a family, according to a statement by the MTA.

To pay for those benefits, the MTA provides the fund with \$533 a month for each active employee, with additional funding for retirees, said Dane Sheldon, vp of ATU Local 1277 in Los Angeles.

The MTA's contribution amount has not changed since 1994, Mr. Sheldon said. But the cost of providing benefits to union workers has increased 57% just in the last

three and one-half years, he said.

The union contends it would require another \$300 a month per employee to maintain the current level of benefits. The union also says it is willing to increase workers' contributions to cover some of the increase but that in a recent bargaining proposal the MTA offered to increase its contribution by only \$85 per employee per month, according to the union.

An MTA spokesman said he could not comment on negotiations or how much the transit authority would contribute to health benefits.

The fund is on the verge of bankruptcy, in part because of mismanagement by the union, the MTA alleges. To help improve the fund's financial outlook, the MTA has proposed giving the union fund a one-time contribution of \$3.74 million.

But the MTA also wants a more-direct role in managing the fund, at least temporarily, until its financial outlook improves, the MTA spokesman said.

Sheriff's deputies protest

Los Angeles County Sheriff's Department deputies, most of them assigned to county jails, are staging a series of "sickouts" over higher health care costs.

A state court judge ordered the deputies back to work, but the wildcat strikes continue, in protest of the lack of an agreement between the deputies' union and county officials over salary and health benefits. The deputies want the county to provide them with pay raises that are generous enough to help offset health care costs that were passed on to them in January 2003, when their contract expired.

Deputies now pay about \$90 a month for family coverage under an HMO plan, whereas they paid nothing for the coverage last year. The traditional indemnity plan the county makes available to deputies now costs about \$250 more a month than a year ago.

Safety: Few are implementing standards

Continued from page 1

espousing, but also a recognition of the inevitability of public demand for accountability—that it is no longer acceptable for hospitals to refuse to disclose what they're doing in the areas of quality and patient safety," she said.

Thirty-eight of the 49 urban and suburban hospitals targeted by Leapfrog in Wisconsin provided patient safety data for the study.

The showing was even more impressive in Minnesota, where 90.5% of the 42 hospitals targeted by Leapfrog responded. In fact, Minnesota was among the states where a large number of hospitals not on Leapfrog's list provided information, according to Carolyn Pare, chief executive officer of the Buyers Healthcare Action Group in Minneapolis, another Leapfrog Group member.

Under encouragement from the BHAG and the Minnesota Hospital Assn., many of the rural Minnesota hospitals responded to provide information on other types of patient safety efforts besides those tracked by Leapfrog, Ms. Pare explained.

So far, all of the Leapfrog's standards have focused on the kinds of patient safety efforts most likely to be applied in urban and suburban

hospitals, which generally have larger patient volumes.

"We need better knowledge about ways to improve patient safety in rural hospitals," Ms. DeMars said.

While participation rates may have been impressive in some states, they were disappointing in others. In Illinois, for example, just 8.1% of hospitals reported data for the patient-safety study. This lackluster participation may be due in part to Illinois only recently being added to Leapfrog's roster, whereas Minnesota was among the first regions targeted when the survey began in 2001, according to Ms. Pare.

While the increased participation overall was encouraging, the findings themselves were somewhat disappointing, though not surprising, several Leapfrog Group members said.

"Leapfrog practices are on the cutting edge of quality improvement, and very few hospitals have implemented them all," Ms. Delbanco said.

Furthermore, "we may be getting a more accurate picture as more and more hospitals fill out the survey as to what the true implementation of these practices is," she added. "It

would be different if we had the ability to mandate that every hospital fill out the survey."

For example, while nearly 40% of the hospitals responding to the survey say they have implemented at least one of Leapfrog's recommended patient-safety practices, only 4.1% have fully implemented computerized physician order entry, and just 22.3% have fully implemented intensive care unit physician staffing with intensivists.

Leapfrog measured the percentage of hospitals using recommended evidence-based treatments for several high-risk conditions. It found that:

- 13.2% have met the group's standard for coronary artery bypass graft surgery.
- 12.0% met the standard for percutaneous coronary interventions.
- 16.2% met the standard for abdominal aortic aneurysm repair.
- 13.7% met the standard for pancreatic cancer resection.
- 6.5% met the standard for esophageal cancer surgery.
- 38.2% meet Leapfrog's specifications for neonatal intensive care units.

"We've got a long way to go," acknowledged Ms. DeMars.

"We're pleased that a greater number of providers and hospitals have voluntarily chosen to submit the information, and on the downside, yes, there doesn't seem to be as consistent an implementation of systems to meet the goals," observed Geoff Schick, regional manager of health care in Kenosha, Wis., at Leapfrog Group member Daimler-Chrysler Corp.

"This is profoundly important and useful and admirable," said Brian R. Klepper, executive director of the Center for Practical Health Reform of Jacksonville, Fla. "Hospitals have taken a real step forward in recognizing that this kind of transparency is essential to get quality and cost under control."

As for the findings, Mr. Klepper said he was not surprised, because they illustrate why health care is in a crisis stage.

"Part of the reason we have lousy numbers is because health care processes have been invisible. Until you shine a light on it, there's no reason for people to gasp," he said.

More information on Leapfrog's patient-safety study is available at www.leapfroggroup.org.

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Late News

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Best said the reinsurer's future earnings are unlikely to support an A++ rating, particularly given their drop from historic levels. Best noted that although Swiss Re's existing



risk-based capital base could be rated as A++, the rating

agency is concerned about the reinsurer's reliance on "lower quality" or "soft" capital, such as deferred acquisition costs, present value of future profits and hybrid debt. A spokesman for Swiss Re said: "We do not comment on the assertions of ratings agencies."

Aetna to offer FSA debit system

Aetna Inc. is introducing an automatic debit system for its 2.5 million members with flexible spending accounts. Starting next year, participants with drug coverage will be able to have out-of-pocket prescription drug expenses,



such as copayments, automatically taken out of their FSAs at the time their prescription is filled at any one of more than 52,000 participating pharmacies. Aetna executives say Aetna is the first national health insurer to offer the feature to FSA participants. The program will be available to both fully insured and self-insured employers that use Aetna to administer their FSAs.

Kane to lead XL drive into primary casualty

XL Capital Ltd. has hired Dennis P. Kane as executive vp to lead the expansion of its XL Insurance Global Risk unit into the primary casualty insurance market. Mr. Kane, who



formerly served as president of Kemper Casualty Co., will be responsible for XL's effort to target U.S.-based Fortune 2000 companies as buyers of general liability, automobile liability and workers compensation coverages. He will be based in New York.

Labor Department repeals paid-leave rule

The Department of Labor has repealed the federal regulation allowing states to use unemployment insurance funds to provide paid employee leave. The final rule, published in the Oct. 9 Federal Register, takes effect on Nov. 10. The controversial rule was published in June 2000. It allowed states the freedom to provide workers taking leave to care for new babies with compensation from that state's unemployment insurance fund. Once the rule was published, it came under legal assault by employer groups seeking to stop its implementation.

W.R. Berkley forms underwriting manager

W.R. Berkley Corp. has formed an underwriting management company. Berkley Risk Solutions Inc. will provide insurance- and reinsurance-based financial solutions to insurers and self-insured employers in several markets, including the United States and London. The unit will write business on behalf of various W.R. Berkley domestic and international insurance subsidiaries, the company said. Jeffrey E. Vosburgh, former president of Cologne Re Managers, has been named president of Berkley Risk Solutions.

Willis recruits Marsh team

Willis Group Holdings Ltd. is beefing up its executive risk practice in San Francisco with the hiring of a professional liability team from Marsh Inc. Brenda Shelly, former managing director and FINPRO

practice leader for Marsh in San Francisco, is the new executive vp and Western region leader for Willis' Executive Risk Practice Group based in San Francisco.



Joining Ms. Shelly from Marsh is Andrew Legge, former vp-sales, who is now vp and Pacific Northwest team leader for Willis; Michael Mahoney, former assistant vp, now a vp at Willis; Jennifer Houser, who maintains her title as executive assistant; and Amy Jeter, who maintains her title as vp-claims advocate.

Travelers posts nine-month gains

Travelers Property Casualty Corp. posted nearly \$1.21 billion in net income for the first nine months of this year, a 57.5% increase over the



year-earlier period. Travelers' net income for the first nine months of 2002 included a cumulative aftertax charge of \$242.6 million resulting from changes in accounting for goodwill. Net premiums written for the nine-month period totaled \$9.81 billion, up 10.5%.

UnitedHealth Group profits, revenues up

UnitedHealth Group Inc. reported a 35.5% increase in net income for the nine months ended Sept. 30, to \$1.32 billion. For the third quarter, the



UnitedHealth GroupSM

company reported a 34.8% increase in net income, to \$476 million. Revenues for the nine-month period increased 16.2%, to \$21.3 billion, while for the third quarter they increased 15.9%, to \$7.24 billion. The

company said its third-quarter results were driven by strong operating performance across its various operations.

Treasury issues rules for implementing TRIA

The Treasury Department has issued two new final rules for implementing the Terrorism Risk Insurance Act. One of the highly technical rules clarifies the extent to which state residual market insurance entities and state workers compensation funds must participate in the program; the other deals with terminology used in the disclosure and "make available" requirements imposed upon parties to the insurance action. The full text of both rules is available at www.treasury.gov.

Briefly noted

Glen Allen, Va.-based **Hilb Rogal & Hobbs Co.** is acquiring London-based reinsurance broker Alexander, Brooks & Stevens Ltd. Terms were not disclosed....**Kemper Services**, a former unit of Kemper Insurance Cos., has been renamed **Broadspire**. The risk management and administration services unit was bought by Platinum Equity L.L.C. earlier this year....The Occupational Safety and Health Administration has issued a bulletin on how to prevent **mold growth** and how to protect workers involved in the prevention and cleanup of mold. The bulletin is available at www.osha.gov....**Marsh Inc.** has signed a letter of intent to buy Brady & Co. Inc., an Anchorage, Alaska-based brokerage. Terms of the deal were not disclosed.

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

[10/13-10/17]

How important do you think the property/casualty insurance industry's unified opposition to the Senate asbestos reform bill will be in determining the fate of the measure?



Very Important	30.8%
Somewhat important	22.3%
Not important	30.8%
Don't know/Don't care	16.1%

BI Stock Index

[10/13 - 10/17]

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 ↑ 1.37
2052.97

Dow Jones ↑ 0.49
9721.79

S&P 500 ↑ 0.12
1039.32

Largest gains

Trenwick Group Ltd.	9.09%
SCPIE Holdings Inc.	7.64%
PXRE Corp.	6.20%
Argonaut Group	6.10%
AFLAC Inc.	5.78%

Largest losses

Gainsco Inc.	-9.09%
Axis Capital Holdings	-6.73%
XL Capital Ltd.	-6.15%
Selective Insurance Group	-5.10%
Fairfax Financial	-3.40%

Weekly change by market segment

Brokers	1.56%
Insurers/Reinsurers	0.80%
Managed Care Organizations	1.29%

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

FM Global: \$325 million to be distributed

Continued from page 3

cyholder-owners. The insurer reported net income in two of the last three years, recording \$244 million of net income in 2002, a net loss of \$132 million in 2001 and net income of \$354 million in 2000. On a consolidated basis, FM Global reported a \$215 million net loss in 1999, following a \$37.5 million loss a year earlier.

As of Sept. 30, FM Global reported \$2.8 billion of policyholder surplus. From year-end 1998—on a consolidated basis—through 2001, the insurer's surplus fell from \$2.4 billion to \$2.0 billion. By year-end 2002, it had grown to \$2.1 billion.

Mr. Subramaniam also said that FM Global hopes the credit boosts its policyholder retention level, which typically has been in the 90% range.

The insurer plans to distribute the credit between Jan. 1 and Dec. 31, 2004, as policyholders' coverage

With approximately 3,000 policyholders, typically large multinational accounts, the credit amounts to around \$108,000 per risk on average, with the insurer's long-term policyholders receiving larger portions.

renews. The few policyholders with multiyear policies that do not renew next year would receive their credit on their policy anniversary date.

With approximately 3,000 poli-

cyholders, typically large multinational accounts, the credit amounts to around \$108,000 per risk on average. But the insurer's long-term policyholders would receive larger portions than other policyholders.

A policyholder's credit would equal a prescribed percentage of the premium and fees the policyholder had paid for all of its coverages and loss control services in effect as of Sept. 30, 2003.

In that calculation, FM Global will not include premiums paid for coverage written by or on behalf of two divisions—stock company Affiliated FM Insurance Co., which serves the middle market through brokers, and reinsurer Mutual Boiler Re. The insurer also will not include premiums paid for surety and cargo coverage. In addition, premium cessations that the insurer paid to fronting companies, program part-

ners and captives will be excluded.

The percentage of premium that policyholders receive as a credit would be based on the policyholder's longevity with the insurer. Policyholders that have been with the insurer 20 years or longer would be entitled to a 15% credit. Those with the insurer from five to 19 years would receive a 12% credit, and policyholders that have been with the insurer fewer than five years would receive a 6% credit.

Mr. Subramaniam said the nature of the credit differs in a couple of important ways from the dividends that some mutual insurers pay their policyholders. He said those dividends usually are "institutionalized" annual expenses that are not driven by the insurers' profitability. In addition, all policyholders' dividends are equal per \$100,000 of premium they have paid, he said.