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Pa. court addresses nuclear liability issue / 3

Illinois suing insurer in racketeering case / 3

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December 9, 2002

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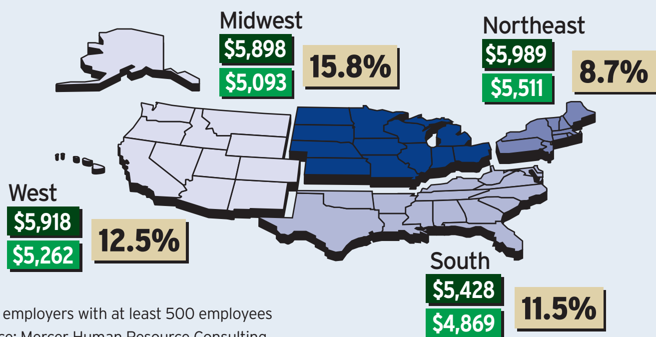

Survey predicts more big increases

Health care costs rising unabated

By JERRY GEISEL

Group health care plan costs increases continue to accelerate, with no end to double-digit annual cost hikes in sight.

As providers demanded and got big increases from health plans, and as plans passed those increases on to employers, group health plan costs for active employees jumped in 2002. Such costs rose by an average of 14.7%, to $5,646 per employee, according to a survey of nearly 2,900 employers released today by benefit consultant Mercer Human Resource Consulting in New York.

Total health plan costs for large employers—defined as those with at least 500 employees—rose by 11.5%, to $5,758 per employee. Costs for smaller employers grew by a staggering 18.1%, to $5,492 per employee.

In the Mercer survey, total health plan costs include employer and employee premium contributions for medical, dental, prescription drug, mental health and vision care.

This year's cost increases are the highest since 1990, when costs increased 17.1%, and they are about seven times higher than the overall increase in the consumer price index, which is expected to rise by just over 2% in 2002.

Although employers enjoyed several years of cost stability during the mid-1990s, when managed care plans had greater leverage over medical providers and the plans competed fiercely for market share, the current situation could not be more different. Health care plan costs now have increased for five consecutive years, and the increases have grown each year.

Health care plan costs increased by an average of $722 per employee in 2002, compared with $494 per employee in 2001 and $333 in 2000.

And employers do not expect cost increases to abate any time soon. Next year, they expect costs to rise by an average of 14%.

"The threshold of pain is being reached," said Blaine Bos, a Mercer consultant in Minneapolis

See COSTS/page 18

Backstop details leave questions

Buyers face cover decisions

By MICHAEL BRADFORD

Enactment of the federal terrorism coverage legislation has the commercial insurance market scrambling to work out coverage and pricing questions.

The Terrorism Risk Insurance Act of 2002, signed Nov. 26 by President Bush, creates a backstop that would allow the government to share some of the insurance industry's losses for future acts of terrorism.

The backstop would be activated after the appropriate federal authorities certified that an act of terrorism had occurred. Each participating insurer would pay claims within a deductible based on a percentage of its direct written premiums for the previous calendar year. The federal government would cover 90% of insured losses above the insurer deductibles, which would increase over the three-year program (*BI*, Nov. 25). Property/casualty insurers must offer terrorism coverage, though they are free to price it as they see fit (see story, page 18).

As insurers begin issuing quotes to policyholders for coverage that includes the terrorism protection, brokers and risk managers are working to understand the practical implications of the legislation.

"The next 45 to 60 days will be the ultimate shakeout period," said Alexandra Glickman, area executive vp with Arthur J. Gallagher & Co. in Los Angeles. "Not only will the carriers be notifying their insureds, insureds have to make decisions" about coverage they need and the price they are willing to pay, she said.

What to do with coverage already in place is one of the first questions that some risk managers face.

"That's a question for my broker," said Lance J. Ewing, executive director of risk management at Park Place Entertainment in Las Vegas. "They have to go back to the carrier and say, 'Now that they've paid the

See TERROR/page 18

Technology offers help on mass torts

By JOANNE WOJCIK

Risk managers at companies deeply entrenched in mass tort litigation are turning to technology to help allocate the costs among numerous insurers and policies, some of which are decades old.

Because the average risk management information system isn't built to handle the volume of claims and coverage data associated with mass tort cases, though, companies usually must outsource this function or hire a consultant to help build an allocation system from scratch. Outsourcing may be unacceptable, though, for risk managers who want hands-on involvement, and building is often too expensive.

As a result, some risk managers are asking their brokers for help, and, in response, some brokers are enhancing their existing RMIS technology.

See RMIS/page 14

Late News

Government approves cash balance pay credits

Cash balance pension plans that provide the same pay-related credits to all participants do not violate federal age discrimination laws, according to proposed Treasury Department and Internal Revenue Service regulations that will be released this week. The rules endorse the basic design feature of most cash balance plans currently operating. Under that design, each plan participant's account balance is credited with an amount equal to a certain percentage of his or her salary. Cash balance critics hold that the credits older employees receive would purchase a smaller annuity at normal retirement age than would those received by younger employees.

PHOTO: GETTY

Workers clean out an office building in Van Wert, Ohio, after the tornadoes of Nov. 9-10. The storms likely will cost insurers $460 million.

Tornadoes cost insurers $460 million: PCS

Tornadoes and thunderstorms that swept through seven states Nov. 9-10 will likely cost insurers about $460 million. The estimate of insured property losses by the Property Claims Services unit of Insurance Services Office Inc. includes insured damages of $160 million in Tennessee and $125 million in Ohio. Alabama also was hard hit, with insured losses estimated at

See LATE NEWS/next page

Benefit Management Takeout

EMPLOYEE BENEFITS COMMUNICATION AWARDS

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TOP EMPLOYEE BENEFIT COMMUNICATION SYSTEMS

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NEWSPAPER

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Inside

IRS rules permit multiple 401(k) loans

Employees in 401(k) plans can take multiple loans from the plans each year, under final Internal Revenue Service regulations published last week. Page 4

High court to tackle scope of punitives

The Supreme Court has another opportunity to clarify how much is too much where punitive damages are concerned, in a case involving claims-handling practices. Page 6

9th Circuit ruling on the money

A federal appeals court was right to rule that state juries should only consider conduct that occurred within their borders as they weigh punitive damages, one of this week's editorials says. Page 8

Risk managers must improve image

Risk managers need to polish their image a bit if they want to become respected members of their organizations' brain trusts, Senior Editor Joanne Wojcik says in her Commentary. Page 12

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REPORTING WEEKLY ON CORPORATE RISK, EMPLOYEE BENEFIT AND MANAGED HEALTH CARE NEWS

Business Insurance (ISSN 0007-6864) Vol. 36, No. 49, is published weekly by Crain Communications Inc., 360 N. Michigan Ave., Chicago, Ill. 60601-3806. Periodicals postage is paid at Chicago and at additional mailing offices. POSTMASTER: Send address changes to Business Insurance Circulation Department, 1155 Gratiot Ave. Detroit, Mich. 48207-2912. $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). Canadian Post International Publications Mail Product (Canadian Distribution) Sales Agreement No. 0293512, GST No. 136760444, Printed in U.S.A. Copyright © 2002 by Crain Communications Inc.

CONTINUED FROM PAGE ONE
$95 million. Insurers have received around 86,000 claims from residential and commercial policyholders, according to PCS.

Mattel covered for D&O settlement

Mattel Inc. and its directors and officers liability insurers will pay $122 million to settle a shareholder lawsuit. The toy company also agreed to negotiate certain corporate governance procedures with plaintiffs' attorneys. The lawsuit was filed following a sharp decline in Mattel's share price after its 1999 acquisition of software company The Learning Co. Inc. Mattel itself will pay $25.5 million on a pretax basis, consisting of the uninsured portion of the settlement and legal and professional fees.

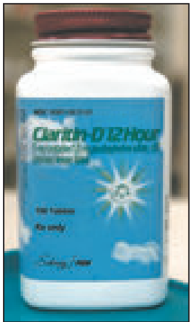
PBGC faces $1.1 billion plan termination loss

The Pension Benefit Guaranty Corp. intends to take over seven underfunded pension plans sponsored by National Steel Corp. of Mishawaka, Ind., which is in Chapter 11 proceedings. The plans have promised $2.8 billion in benefits to their 35,000 participants, but have only $1.3 billion in assets. The PBGC, which guarantees most but not all promised benefits, estimates its loss at about $1.1 billion. National Steel, according to the PBGC, already has failed to make $150 million in federally required contributions.

Late News

Over-the-counter Claritin to bring savings: PBM

Last month's decision by the Food and Drug Administration to make Claritin available as an over-the-counter drug will lead to significant savings for employers, according to pharmacy benefit manager Medco Health Solutions Inc. Medco estimates that its 1,500 employer clients could save up to $500 million a year as a result of the move. The move greatly affects employer spending not only on Claritin but also on all similar nonsedating antihistamine drugs, according to Medco.



Humana to cut 2,300 jobs

Humana Inc. said it will lay off 2,300 workers and take a charge of up to $145 million to cover severance costs and other expenses related to restructuring. The layoffs, amounting to about 17% of its workforce, will lead to a pretax charge in the fourth quarter of 2002 of between $75 million and $110 million. In addition, the company will close three of its seven customer service centers and take a pretax charge of between $25 million and $35 million for related expenses.

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 this week:

- More than 40 **searchable directories** provide easy access to resources and services.
- **Commentary** from Joanne Wojcik as well as *Business Insurance*'s other columnists.

Japanese insurers merge, spin off liabilities

Sompo Japan Insurance Inc. and its Taisei Fire & Marine Insurance Co. subsidiary have merged. The merger was the latest step in a rehabilitation plan for Taisei, which failed last year after being hit with large claims from the Sept. 11, 2001, terrorist attacks. Before the merger, Taisei spun off its reinsurance liabilities into a Bermuda-based trust company, Taisei Reinsurance Fire & Marine Insurance Co. The move was made to protect Sompo from reinsurance obligations related to the failed company.

Briefly noted

Endurance Specialty Holdings Ltd. has formed a London-based subsidiary, **Endurance Worldwide Insurance Ltd.**, which will write commercial insurance and reinsurance. EWIL, a unit of Bermuda-based Endurance Specialty, has received approval from the Financial Services Authority and will focus on U.K. property risks and European treaty business. EWIL was formed with £140 million ($218.0 million) in capital....**Ohio Insurance Director Lee Covington** resigned at the end of last month "to pursue career options in the private sector," according to an Ohio Insurance Department statement. Gov. Bob Taft appointed Holly Saelens as interim director of the department. She previously was the director for policy and legislation.

Proposal would bar states from tapping unemployment benefits for child care

Leave financed by jobless funds may end

By **MICHAEL PRINCE**

WASHINGTON—The U.S. Department of Labor is proposing elimination of a 2-year-old regulation that allows states to use their unemployment compensation funds for workers taking leave to care for the birth and adoption of children.

The Labor Department, which is conducting a department-wide review of all regulations, said the earlier rule, was "poor policy" and a misapplication of federal unemployment compensation law that results in payments to people that do not qualify for unemployment compensation.

Under the original rule, states were permitted to use money in their unemployment funds for workers who took time off to care for their newborn infants and newly adopted children. While that rule took effect with widespread publicity, no states have, in fact, yet launched such a program.

The department notes in its proposed regulation that eliminating the program will have a minimal impact. "The only effect of the removal of the regulations is that it reduces state flexibility" because states could no longer elect to use their unemployment funds to pay workers taking leave, the proposed regulation states. The proposed regulation was published in the Dec. 4 issue of the Federal Register.

The Labor Department proposal cited declining unemployment funds as a major reason no state has created a program. Since the original rule was put in place two years ago, many states' unemployment funds have been drained by rising unemployment, making it impractical to use the money for workers on leave, the department states.

The proposal stresses that elimination of the rule does not prevent states from passing paid-leave laws, provided they do not use unemployment funds.

In September, California enacted legislation mandating paid time off for California workers with new children and sick family members. Beginning July 1, 2004, a worker in California will be able to take leave and receive 55% of his or her pay for up to six weeks to take care of a new child or a seriously ill child, spouse or parent. Money for the program will come not from the state's unemployment compensation fund but from a newly established fund within the state's existing disability insurance program (*BI*, Sept. 30).

Employers, in general, were op-

See **LABOR**/page 19

PHOTO: FRANCES M. ROBERTS

Unemployment offices such as this one in New Jersey have seen an increase in claimants during the past year.

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Retirees likely to shoulder more health care burden

But survey shows most employers will continue to provide benefits to their current retirees

By JERRY GEISEL

Amid soaring costs, retirees can expect their former employers to raise cost-sharing for health care coverage, but most current retirees are likely to retain coverage, according to a new survey.

The survey of 435 employers with at least 1,000 employees, conducted jointly by Hewitt Associates Inc. and the Henry J. Kaiser Family Foundation, found that, on average, retiree health plan costs increased by 16% between 2001 and 2002.

That growth rate outpaces the average increase for active-employee health plans, according to several surveys.

This year, retiree health care plans offered by surveyed firms will cost an estimated $14.5 billion in total, with health plan costs averaging $95 million among employers with at least 20,000 employees and $4 million among employers having between 1,000 and 4,999 employees.

On an individual-retiree basis, the survey reveals just how expensive coverage is and the huge financial burden that under-65 retirees face without employer-subsidized coverage. For example, the total monthly premium cost for such an individual with a spouse is $729 this year, with employers paying, on average, $401, or 55% of the premium.

Total premium costs for retirees who are at least 65 years old, while much less because Medicare provides the bulk of coverage, still are substantial. For example, monthly premiums for a Medicare-eligible individual who retired on or after Jan. 1, 2002, and needs coverage for a spouse as well averaged $406, with the employer paying $241, or nearly 60% of the premium.

As health care costs escalate, retirees can expect to shoulder more of the burden. More than 80% of respondents said it is somewhat or very likely that they will increase retiree health premiums in the next three years, while 75% said it is somewhat or very likely they will raise plan deductibles.

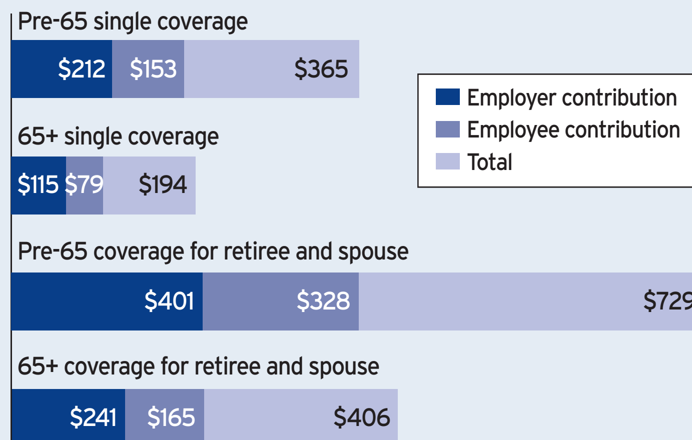
Still, nearly all employers will maintain their coverage programs for current retirees, with just 5% saying that elimination of coverage is somewhat likely or very likely in the next three years.

"Employer-subsidized coverage is not collapsing, but it is eroding,"

See KAISER/page 19

COST PER RETIREE

Average monthly premium costs for retiree health plans*



* For employees retiring on or after Jan. 1, 2002

Source: Kaiser/Hewitt

GRAPHIC BY ADAM DOI

Pa. ruling favors nuclear processors

Injury manifestation triggers cover

By SALLY ROBERTS

PITTSBURGH—With no precedent to guide it, a state appellate court has followed asbestos litigation in ruling that the manifestation of bodily injury triggers coverage under nuclear energy liability insurance policies.

The Superior Court of Pennsylvania's decision in *Babcock & Wilcox Co. et al. vs. American Nuclear Insurers et al.* is the first appellate ruling regarding coverage under nuclear energy liability policies for claims alleging radiation-related bodily injury, attorneys say.

The coverage dispute arises from pending litigation in federal district court in Pennsylvania in which more than 300 people are suing the Babcock & Wilcox Co. and Atlantic Richfield Co., alleging they became sick after being exposed to radioactive materials emitted from two nuclear fuel processing facilities.

ARCO operated the facilities until 1971 when it sold its subsidiary—Nuclear Materials Equipment Co.— to Babcock & Wilcox. New Orleans-based B&W subsequently assumed NUMEC's liabilities when it merged NUMEC into itself in 1974.

The vast majority of the injuries are various types of cancer, according to court papers.

Coverage for injuries from nuclear radiation was the focus of a recent Pennsylvania appeals court case.

Since 1958, Hartford, Conn.-based insurance pool American Nuclear Insurers and its predecessors have provided separate nuclear energy liability policies for the facilities. Limits under each policy initially totaled $3 million but increased over the years through endorsements; in 1979, each policy reached limits of $160 million.

B&W and ARCO contended that the manifestation of the alleged cancer is the triggering event under the policy and that, because most of the plaintiffs were not diagnosed with cancer until after February 1979, the facilities have $160 million in coverage limits available to pay the claims.

Conversely, ANI argued that, according to policy language, the triggering event was the date the radiation allegedly caused the cancer and not when the

See NUCLEAR/page 16

Raids on trust funds, bogus stock swap alleged

Decision lets Illinois proceed with Alpine racketeering case

By DOUGLAS McLEOD

CHICAGO—A federal judge has let stand a racketeering complaint in which Illinois insurance regulators charge the former operators of a defunct Illinois insurer with looting the company of $19 million over several years.

The Illinois Insurance Department filed the suit last year against several former officers and corporate affiliates of Alpine Insurance Co., a surplus lines insurer that was ordered liquidated in 2000. Regulators allege that former Alpine Chairman Peter J. O'Shaughnessy and others carried out a series of fraudu-

lent transactions—including raids on premium trust funds and a bogus stock swap—that drained Alpine's assets.

Mr. O'Shaughnessy and the other defendants filed extensive motions to dismiss the complaint on a variety of grounds, among them that regulators had failed to support claims under the federal Racketeer Influenced and Corrupt Organizations law.

In a Nov. 26 ruling, though, U.S. District Judge Amy J. St. Eve rejected virtually all of the motions, finding that the Illinois Insurance Department has backed up RICO and other claims sufficiently to proceed to trial.

"Basically, she sustained the complaint in its entirety, and I think it came as a huge surprise to the folks on the other side," said Jeffrey N. Cole, a partner with Cole & Staes Ltd. in Chicago representing the Illinois Insurance Department.

See ALPINE/page 17

Benefits cost-shifting calls for changed communications role

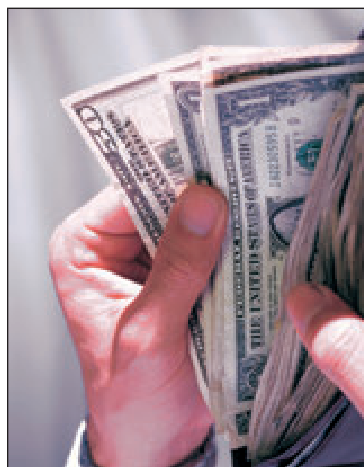
By MICHAEL PRINCE

As benefits programs move toward putting more responsibility onto employees, employers are putting more effort into helping workers make decisions and less into telling them what to do, benefit managers and consultants say.

"The communication role changes from telling what is there to helping you understand what's there," said Nicole Kelly, a principal with Buck Consultants Inc. in Pittsburgh.

Replacing the paternalistic communications of the past are more-explanatory missives that treat employees more as partners than as underlings, benefit managers and consultants say.

No longer can employers say to employees, "Here's the deal," said



Janet Raubach, director-communication consulting at Aon Consulting Inc. in Chicago. That approach is "not effective this year," she said.

The past year has seen significant changes in health plans, as employers look for ways to address sharply rising costs.

One major change has involved employers shifting a greater portion of health care costs onto employees. To do this without creating a backlash, though, requires a determined communications effort, benefit managers and consultants say.

Employers are "trying to get people to accept whatever the change is," Ms. Raubach said.

Educating employees

The big challenge this year has been educating employees about the costs of health care and about why they are paying more for coverage, said Colleen Corey, benefits and employment manager at Bio-

See BENEFITS/page 12

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IRS scraps limit on number of loans from 401(k) plans

By JERRY GEISEL

WASHINGTON—Employees in 401(k) and other defined contribution plans will be permitted to take multiple loans from the plans each year, under final Internal Revenue Service regulations issued last week.

The regulations, published in the Dec. 3 Federal Register, formally eliminate a highly criticized limit of two loans per year that the IRS proposed two years ago.

Critics, the IRS noted, said there was no statutory basis for limiting the loans to two per year. In addition, opponents of the limit said there were situations, such as plan participants having several children in college, that could create a legitimate need for multiple borrowings during a year.

Benefit experts welcome this liberalization in the final loan rules, which, for the most part resemble the regulations the IRS proposed two years ago.

"Having loans available is a good thing, as it leads to higher plan participation rates," said Michael Weddell, a consultant in the Southfield, Mich., office of Watson Wyatt Worldwide.

Roughly 80% to 90% of 401(k) plans offer loans, and, at any given point, roughly 20% of participants have loans outstanding, benefit consultants say.

Borrowing from a 401(k) plan can be more attractive to employees than borrowing from a commercial lender, because the overhead costs are lower and the approval process usually is much quicker, Mr. Weddell said.

Another attraction is that the interest charged on the loan goes back into the employee's account balance, instead of being paid to a third party.

> **'Having loans available is a good thing as it leads to higher plan participation rates.'**
> *Michael Weddell*
> *Watson Wyatt Worldwide*

Loans also can be more financially advantageous than hardship withdrawals, under which the employee is assessed income taxes, plus a 10% penalty tax. No taxes are imposed on plan loans as long as they are repaid on time.

Still, although the final IRS rules remove the proposed two-loan annual limit, federal law restricts the actual amount of money participants can borrow from their accounts. Under law, plan participants can borrow the lesser of $50,000 or half of their vested account balance.

The final rules also make clear that the maximum amount of interest that can be charged on an outstanding loan while an employee is on leave for military service is 6%.

The 6% cap is included in a 1942 law, but the earlier regulations didn't specifically mention that figure.

And, like the proposed regulations, the final rules from the IRS allow employees on leave for military service to extend the period of time they have to repay a loan by the length of their military service.

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Errors & omissions

- Because of incorrect information supplied to *Business Insurance*, a Dec. 2 ranking of the largest risk management information systems omitted Computer Science Corp.'s RISKMASTER software. Based on 6,000 installations in corporate risk management departments, CSC's software would rank as the second most widely used RMIS.

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Punitive damages limits at issue in high court case

By MARK A. HOFMANN

WASHINGTON—The Supreme Court has another opportunity to clarify how much is too much where punitive damages are concerned when it hears oral arguments this week in a case dealing with insurance claims-handling practices.

The case the justices will hear on Dec. 11—*State Farm Mutual Automobile Insurance Co. vs. Curtis B. Campbell and Inez Preece Campbell*—covers some of the same ground as the high court's 1996 landmark decision in *BMW of North America vs. Ira Gore*. In that case, which involved an automobile paint job, the court's majority held that a punitive damage award of $2 million over an underlying compensatory award of about $600 was so excessive as to violate the Constitution.

The justices declined, though, to provide any "bright line" or mathematical formula that would indicate where the acceptable becomes constitutionally invalid.

Business groups hope that the State Farm case will give the Supreme Court a chance to refine its earlier ruling.

"It's a continuing series of cases; obviously, the Supreme Court is aware of the importance of the issue, and we hope that they will provide a clear rule that will largely solve this problem once and for all," said Quentin Riegel, vp-litigation for the National Assn. of Manufacturers in Washington.

"It is unusual for any case to draw as many as 18 amicus briefs from the business community—which indicates that it has implications far beyond the concerns of both parties," said Victor Schwartz, a partner in the Washington office of the Kansas City, Mo.-based law firm of Shook, Hardy & Bacon L.L.P. Mr. Schwartz prepared an amicus brief for the Reston, Va.-based Product Liability Advisory Council.

"Punitive damages are, obviously, a central issue to our agenda. Putting aside the underlying facts, you have a $1 million case, and then a $145 million punitive damage verdict. The whole line of cases leading to *BMW* has created an orderly process, as well as clear constitutional limits on punitive damages. To allow this punitive damage verdict to stand would completely undermine that whole line of cases," said Sherman Joyce, president of the American Tort Reform Assn.

The State Farm case began in 1981, when the Campbells were involved in a fatal auto accident. They subsequently sued State Farm, claiming the insurer had failed to resolve a third-party claim against them and thus exposed them to a judgment that exceeded the $50,000 limit on their auto liability policy. Although State Farm later paid the entire judgment, the case continued.

In 1996, a Utah state jury awarded the Campbells $2.6 million in compensatory damages and $145 million in punitive damages after reviewing the insurer's national claims-handling practices and its alleged misconduct. Two years later, an appeals court reduced the punitive damage award to $25 million and the underlying compensatory award to $1 million.

The Utah Supreme Court, though, while leaving the lowered amount of $1 million in compensatory damages untouched, reinstated the full punitive damage award of $145 million in October 2001. In their opinion, the court's majority charged, the insurer had "repeatedly and deliberately deceived and cheated its customers" through its claims-handling practices. In reinstating the award, the state high court also took note of State Farm's net worth.

State Farm appealed to the Supreme Court, which agreed to take up the case this spring. Business groups see the high court review as a chance to right several wrongs.

"This case is the poster child for what is wrong with the punitive damages system. The award is grossly disproportionate, unconstitutionally excessive, punishes out-of-state and dissimilar conduct, considers a company's net worth and shows just how a jury can be whipped into a frenzy of retribution," said Robin Conrad, senior vp at the National Chamber Litigation Center Inc. in Washington. The center handles litigation for the U.S. Chamber of Commerce.

"This is a blockbuster," said the NAM's Mr. Riegel. "The subject matter is extremely important, because the potential liability is so great. This case, in particular, deals with fundamental constitutional limits on punitive damages, including limits under the full-faith-and-credit clause. It concerns the ability of one state to punish activity that affects its own jurisdiction—its own citizens and activities occurring within that state. And if one state—in this case, Utah—can impose punitive damages for conduct that occurs all over the country, that will necessarily impinge on the decisions of other states on the same issues."

"The plaintiffs in the case have tried to accumulate every possible grievance against State Farm from around the country and packaged it into one case," said ATRA's Mr. Joyce. "That's the basis for this extremely large punitive damages verdict. Our view is that the court needs to limit its view to the specific and particular type of conduct that was at issue."

"Its importance goes to how punitive damages cases are going to be tried against large companies that may or may not have committed an alleged multiplicity of sins. Are they simply going to be punished for the sin they committed against the plaintiff or alleged sins they may have committed against people in other states?" asked Mr. Schwartz.

"I believe that punitive damages, as a matter of history and tort law policy, should be related to a particular plaintiff. A defendant is placed in an impossible position if it has to defend mere allegations of conduct that is out of state and has nothing to do with the alleged harm to the plaintiff," Mr. Schwartz said.

Not surprisingly, the insurance industry sought Supreme Court review as well. In an amicus brief filed this summer, four insurer trade groups argued that the Utah courts had allowed the jury to act as a "national insurance regulator" (*BI*, Aug. 26). The Utah Supreme Court's action, argued the insurers, permits one jury in one state "to award punitive damages based on an assessment of the lawfulness of an insurer's practices outside of the state, including practices that have no similarity whatsoever to the controversy before the jury."

Allowing such an action would "radically transform" the role of the jury from "that of factfinder in a particular dispute into a national insurance regulator," according to the insurance groups.

The Alliance of American Insurers, the American Insurance Assn., the National Assn. of Independent Insurers and the National Assn. of Mutual Insurance Cos. joined in the brief. State Farm belongs to NAMIC.

California damages reversed

9th Circuit bars jury's consideration of national acts

By ROBERTO CENICEROS

SAN FRANCISCO—Punitive damage awards for wrongs committed in one state must apply only to those particular actions, rather than address nationwide conduct, a federal appeals court has ruled.

In *Ginny V. White vs. Ford Motor Co.*, a split 9th U.S. Circuit Court of Appeals found that a federal jury in Nevada violated Ford's due process by punishing the manufacturer for out-of-state conduct.

Plaintiffs' attorneys had encouraged the jury to award damages large enough to hold Ford responsible for wrongs nationwide, court records show. The attorneys introduced evidence based on Ford products sold across the country.

In addition, the trial court had rejected Ford's request to instruct the jury to consider only conduct affecting Nevada citizens and not to award damages relative to the sale of vehicles in other states.

In a 2-1 decision, the appellate court panel's ruling reverses and remands a $150 million jury award that subsequently was reduced by the trial judge to $69 million.

The case stems from the October 1994 death of a 3-year-old boy. The child died when a pickup truck that had been parked on a sloped driveway rolled over him. At issue was a potential brake problem for which Ford issued a recall order that did not go out until after the boy's death, court records show.

"The district court's refusal to limit the jury to consideration of Nevada's interests, combined with the plaintiffs' lawyers exhortations to let the decision resonate across the country, compels us to conclude that the jury was permitted to engage in a due process violation," Judge Andrew J. Kleinfeld wrote for the majority.

Judge Kleinfeld also said that one state cannot impose its laws on another state concerning punitive damage caps, product innovation and duties to warn consumers about defective products. The Nevada jury's award, for example, exceeds a punitive damages cap in Alaska, he noted.

But Judge Susan P. Graber disagreed with the majority and said jury instructions satisfied Nevada law. She found that "the degree of reprehensibility of defendant's conduct is high" because Ford intentionally failed to warn consumers about a defect that could result in death.

The decision remands the case to a jury to hear punitive damage arguments. Jurors will consider only the damages required to vindicate Nevada's interests in punishment and deterrence. The jury is to be told not to impose damages to protect people or punish harm outside of Nevada.

The appellate ruling is a significant victory because it restricts future plaintiffs' arguments for damage awards in cases where a company's conduct extends nationwide, said Andrew L. Frey, a partner at Mayer, Brown, Rowe & Maw in New York. Mr. Frey argued Ford's case before the appeals court in San Francisco.

But it is unlikely the decision will stand on appeal because it deviates from established jurisprudence, said Shanin Specter of Kline & Specter in Philadelphia. Mr. Specter, who represented the plaintiffs, said he plans to appeal the 9th Circuit's ruling.

Ginny V. White vs. Ford Motor Co., 9th U.S. Circuit Court of Appeals; No. 99-15185.

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Paul Winston

Editor Paul Winston's weekly column will resume in the Dec. 16 issue

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COMMUNICATIONS: New York: 212-210-0132
SUBSCRIPTIONS: Detroit: 888-446-1422

Business Insurance is published by Crain Communications Inc.

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Editorial

High court should follow 9th Circuit

WE DON'T ALWAYS AGREE with the reasoning of the 9th U.S. Circuit Court of Appeals, a skepticism that's often shared by the U.S. Supreme Court when it reviews decisions from that appellate court.

But a three-judge panel of that circuit court recently handed down a decision concerning punitive damages with which it's hard to argue. And the decision in *Ginny V. White vs. Ford Motor Co.* is a very timely one, too, for the Supreme Court will hear the latest in a series of cases involving damages this Wednesday as it considers the constitutionality of a Utah punitive damage award that is 145 times that of the underlying compensatory award. As we report on Page 1, that case, *State Farm Mutual Automobile Insurance Co. vs. Campbell*, has drawn an unusual amount of attention from the business community, and rightly so.

One of the questions raised in both the *White* and *State Farm* cases is whether a jury in a single state can levy punitive damages on a defendant for alleged wrongs committed in other states. Advocates of punitive damage reform have long argued that to allow juries in one state to penalize defendants for alleged misconduct beyond that state's borders is unconstitutional.

And that's just what the majority of the three-judge appellate panel reviewing the *White* case thought. As Judge Andrew Kleinfeld wrote for the majority, a lower court's refusal to limit the Nevada jury hearing that case to wrongs allegedly committed by Ford in Nevada "combined with the plaintiffs' lawyers exhortations to let the decision reverberate across the country, compels us to conclude that the jury was permitted to engage in a due process violation."

We couldn't agree more. Allowing a jury in a single state to de facto set national policy through punitive damages makes a mockery of federalism. In the *State Farm* case, a Utah court basically became a national insurance regulator by punishing State Farm for a variety of claims-handling practices carried out across the country, including practices that had nothing to do with the case at hand. While we're no big fans of state insurance regulation as currently practiced, we're appalled that a single state court should be allowed to override state regulation and, via punitive damages, set policy for the nation as a whole.

The Supreme Court can rectify that situation by following the trail blazed by the 9th Circuit and hold that state juries should limit themselves to considering conduct that occurred within their borders as they weigh punitive damages. There's nothing in the Constitution to allow a single jury in a single state to set national policy by using the club of punitive damages. Indeed, the Constitution has much to forbid it.

New tool for class actions

AT A TIME when many companies are facing an onslaught of class-action lawsuits, risk managers may have a new tool for tapping insurance coverage.

As we report on page 1, some risk managers are expanding their risk management information systems to track mass tort claims and the historical insurance policies that might respond. Coverage for mass tort claims, such as asbestos liability suits, often is sought from policies dating back several decades—well before such information was stored on computers.

With the help of brokers and consultants, savvy risk managers can assemble allocation systems to help find coverage for long-tail claims. What company today can afford not to seek such coverage, if it's available?

To be sure, assembling allocation systems for mass torts is not a simple task. Most risk management information systems are not designed to handle the massive volumes of data associated with mass tort claims. And decades-old policy information may be hard to locate, much less analyze with modern computer technology.

The effort and expense of creating such systems from scratch are significant, but so are the potential benefits of doing so. A policyholder facing asbestos litigation, for example, could use an allocation system to tap excess coverage by showing that underlying policy limits had been exhausted. Such proof could enable the policyholder to avoid the costly and time-consuming step of taking its insurers to court.

Demand for customized mass tort allocation systems is low, but it is bound to increase. Until tort reform changes the current legal environment, companies' exposure to class-action suits won't abate any time soon. Risk managers would do well to consider how technology could help.

Schillerstrom

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Ask a Casualty Actuary

Claims-practice changes and reserve analysis

Q: How should the effects of changes in claims practices be taken into account in projecting loss reserves?

A: Changes in claim practices can substantially distort commonly used loss-reserve projection methods. The type of distortion depends on the type of change. Let's consider some common situations.

Suppose your claims staff or that of your claims administrator changes the basis on which it estimates individual case reserves. For instance, where the claims staff or claims administrator previously did not build in a provision for future inflation in its estimates, it now does. Or suppose that the claims staff or claims administrator switches from estimating case reserves on the basis of the minimum amount for which the claim could be settled to the "expected" or the "worst case" amount.

Given either of these situations, a naive application of an incurred-loss development method would likely produce overstated estimates of reserve needs. Conversely, if any of these shifts occurred in the opposite direction, incurred projections would likely be understated.

Two approaches are commonly used to deal with such situations. First, if none of the changes in practices affects the rate of settlement of claims, then relying largely or entirely on paid-loss development projections could be the solution. Second, it may be possible to approximately adjust the history of incurred losses to what it would have been had the new practice been used all along. Or, you could try both of these approaches and compare the results.

Let's look at another common type of change in claims practices.

Suppose that claims are now settled much more slowly than in the past. This could be the result of understaffing in the claims area. In that case, a simplified application of a paid-loss development method would likely produce understated reserve needs.

Again, two common approaches are often used to deal with such a problem. First, if there have been consistent practices in estimating case reserves, then relying largely or entirely on incurred-loss development projections could be the solution. Second, it may be possible to approximately adjust the history of paid losses to what it would have been had the current practice been in effect all along. Again, you could try both approaches and compare the results.

Basic methods for applying such adjustments were presented in a paper written by James Berquist and myself in the late 1970s. These reserving methodologies, known as "Berquist Sherman" adjustments, are commonly used today.

Both adjustment techniques are based on the availability of accurate, consistent claims data. For example, changes in the percentage of reported claims that are closed at different ages of development for different accident years could be used to revise histories of paid losses to approximately what they would have been assuming the current percentages of claims closed. Once the paid-loss triangle has been adjusted to a consistent basis, the standard development method can then be applied.

Alternatively, case reserves carried during past periods could be adjusted to current adequacy levels by taking current average outstanding claims and adjusting them back to prior periods based on reasonable inflation assumptions. Once the entire triangle of incurred losses has been adjusted to a consistent basis, the old straightforward method can be applied.

Some of the hazards of applying these adjusted methods are mentioned in the late 1970s paper. The results of projecting adjusted incurred losses are highly sensitive to the rate of inflation that is used. And the results of projecting adjusted paid losses can be severely distorted if the relative proportion of very small claims shifts noticeably over time. The latter situation could, for example, create the illusion that claims are being settled faster when, in reality, all that has happened is that a growing percentage of claims are of the quick-settling type.

It is not uncommon for an actuary or analyst attempting to estimate loss reserves to be advised by claims staff that they are now reserving cases more adequately than in the past, or that they are now settling claims more quickly than was previously the case. Such statements may be:

- True.
- A reflection of the natural human tendency to believe that one's performance is improving over time.
- The result of an effort to influence the results of the reserve analysis in a desired direction.
- Some combination of these.

Understandably, it is important to review various statistics to determine whether there is evidence that the claimed changes have actually taken place.

All of this can be a rather complex process, suggesting that it is best left to those with substantial experience in performing such analyses.

Copies of key portions of the above-mentioned paper appear on the Web site *www.richardsherman.com.*

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

This month's column on actuarial issues in the casualty field is written by Richard E. Sherman, president of Richard E. Sherman & Associates Inc. in Ashland, Ore.

Address your questions to ASK, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Coverage suit dismissed over inconvenient forum

Legal briefs

The Court of Appeals of Arkansas has upheld a lower court's dismissal of a suit brought by Wal-Mart Stores Inc. seeking business interruption damages from its insurers for loss at a retail store in another state.

In December 1996, a large boulder fell from a rock face behind a Wal-Mart store in Dickson City, Pa., damaging the rear of the store. An engineering firm and construction company told Wal-Mart that a dangerous situation existed because of unstable cracks in the rock face that could cause further damage. Because of the extent of the recommended remedial measures, Wal-Mart decided to abandon the store. In January 1997, it resumed operations at a smaller, temporary location, and in 1998, Wal-Mart opened a new, permanent location. During this period, Wal-Mart said it incurred relocation expenses and experienced lost sales, which together totaled nearly $5 million. Wal-Mart's property and business interruption coverage was written by U.S. Fidelity & Guaranty Co. and Lexington Insurance Co., and it sought coverage from those insurers for its losses. The insurers denied coverage. Wal-Mart, whose corporate headquarters were in Benton County, Ark., sued the insurers in Benton County, seeking coverage for its losses. Both insurers requested the Benton County court to dismiss the suit, arguing that Pennsylvania was the more convenient forum for the lawsuit. The trial court agreed with the insurers and dismissed the suit.

On appeal, the court said that a trial court may decline to hear a case when it would be in the interests of the parties and the public to try the case in another forum. Here the court noted that the location of Pennsylvania witnesses and the relative inconvenience that would ensue from attempting to compel their attendance in Benton County, Ark., weighed in favor of having the trial in Pennsylvania. The trial court decision was affirmed.

Wal-Mart Stores vs. U.S. Fidelity & Guaranty Co., Court of Appeals of Arkansas, April 24, 2002 (*BI*/02/D.-$10).

CGL exclusions bar coverage for claims against tobacco firm

The Supreme Court of Delaware ruled that tobacco and "your products" exclusions of commercial general liability insurance policies issued to a cigarette manufacturer barred coverage for liability to smokers, governments and third-party payers, such as health insurers.

The Liggett Group Inc., a Delaware-based corporation, manufactures tobacco products in North Carolina and distributes them throughout the United States. Liggett has been sued in more than 1,000 cases filed by plaintiffs seeking to hold it liable for a broad range of personal injuries and property damage arising out of the use of tobacco. Liggett filed suit in Delaware against 33 insurance companies to determine its rights and the insurers' obligations under more than 100 CGL insurance policies sold to it by the various companies from 1970 through 2000. Liggett sought defense coverage for the underlying tobacco lawsuits. Each of the primary CGL insurance policies included a broad exclusion for tobacco-related health claims. The policies excluded coverage for "bodily injury or property damage included within the products-completed operations hazard." That hazard encompassed "all bodily injury and property damage…arising out of 'your product.'" In addition, "your product" was defined as "any goods or products, other than real property, manufactured, sold, handled, distributed or disposed of by…you." The trial court ruled for the insurance companies, concluding that the policies did not provide coverage for the underlying tobacco claims. Liggett appealed.

The appellate court agreed with the trial court that the underlying complaints, fairly read, alleged injuries arising from the use of Liggett's tobacco products. "Such allegations are clearly excluded from the primary CGL policies, absolving the insurers of any duty to defend," the court said. Furthermore, the court said that the personal injury coverage did not apply to smokers' claims of mental injury, anguish and humiliation, nor was smokers' alleged emotional distress within the advertising injury coverage. The trial court decision was affirmed.

Liggett Group Inc. vs. ACE Property & Casualty Insurance Co., Supreme Court of Delaware, May 16, 2002 (*BI*/03/D.-$10).

Worker's limitation not deemed 'substantial' under ADA

The 9th U.S. Circuit Court of Appeals ruled that an employee's inability to engage in continuous keyboarding or handwriting did not constitute "substantial limitation" on performing manual tasks under the Americans with Disabilities Act.

Jacalyn Thornton sued her former employer, McClatchy Newspapers Inc., in state court alleging disability discrimination in violation of the Act. The former employer had the case removed to the federal courts. Ms. Thornton maintained that her inability to engage in continuous keyboarding or handwriting constituted "substantial limitation" on performing manual tasks under the act.

The trial court ruled against Ms. Thornton. The appeals court affirmed the decision, in part, but subsequently issued a clarifying opinion again ruling against the plaintiff.

The 9th Circuit conceded that Ms. Thornton's life had been diminished by her inability to engage in continuous keyboarding or handwriting. The court said, however, that diminished is different from "substantially limited."

Judge Marsha S. Berzon dissented, stating that there was sufficient evidence to conclude that if the impact on Ms. Thornton's professional life was given some weight along with the impact on her personal life, a jury could decide that the limitation on her ability to perform the manual tasks of keyboarding and handwriting was substantial.

Thornton vs. McClatchy Newspapers Inc., 9th U.S. Circuit Court of Appeals, June 11, 2002 (*BI*/03/J.-$10).

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

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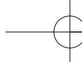
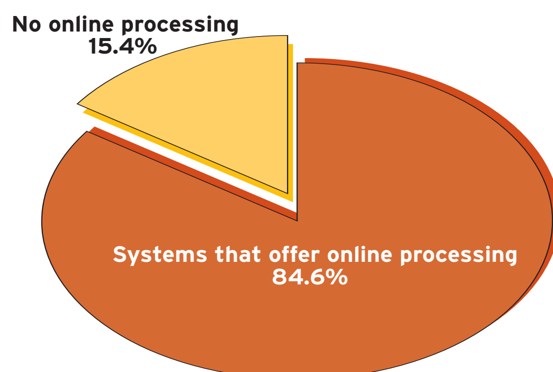


ONLINE PROCESSING

Percentage of systems that offer online processing



Source: *BI* survey

MOST COMMON FEATURES

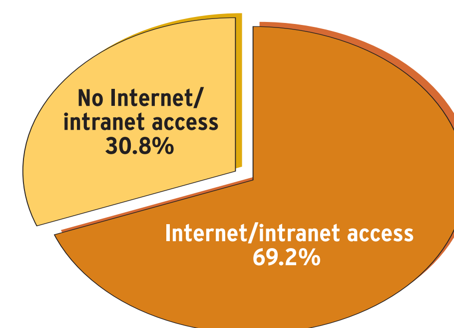
Ranked by percentage of employee benefit communication systems offering the feature

Feature	Percentage
Benefit plan descriptions	92.3%
Personalized benefit information	84.6%
Generation of reports	84.6%
Benefit option/selection adjustment	76.9%
Benefit modeling/projections	76.9%
Benefit option information/advice	76.9%

Source: *BI* survey

INTERNET ACCESS

Percentage of systems offering Internet/intranet access



Source: *BI* survey

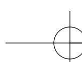
Benefit communication systems

Ranked by number of installations in corporate employee benefit departments

Rank	Software name	Company/Address	Phone/Fax/Web site	Number of installations	First installation	Officers
1	DOS Taxdemo 5.7	Human Resources Consulting Group Inc. 1202 E. Dover Drive Provo, Utah 84604	801-765-4417 Fax: 801-765-4418 *www.hrconsultinggroup.com*	5,565	1983	Rob J. Thurston, president
2	Benergy	OnlineBenefits 333 Earle Ovington Blvd., Suite 210 Uniondale, N.Y. 11553	516-414-7000 Fax: 516-414-5103 *www.onlinebenefits.com*	2,167	2001	Alan Cohen, president/CEO
3	Connection Server	Beacon Global Solutions Inc. 2 Worlds Fair Drive Somerset, N.J. 08873	732-560-9960 Fax: 732-560-9961 *www.beaconglobalsolutions.com*	100	1990	Andy Kelly, director-sales
4	whereiwork	BenefitAmerica 2221 Broadway St. Redwood City, Calif. 94063	650-299-9091 Fax: 650-299-9095 *www.benefitamerica.com*	50 [1]	2000	Howard Koenig, CEO
4	Campus	BenefitAmerica 2221 Broadway St. Redwood City, Calif. 94063	650-299-9091 Fax: 650-299-9095 *www.benefitamerica.com*	50 [1]	2000	Howard Koenig, CEO
6	Benefit Selections	Employee Technology Solutions Inc. 875 N. Michigan Ave., Suite 1900 Chicago, Ill. 60611	312-202-6617 Fax: 312-280-5650 *www.benefitselections.com*	19	1998	John Harney, COO-Near North Insurance Brokerage
7	BenefitsAccents	Employee Technology Solutions Inc. 875 N. Michigan Ave., Suite 1900 Chicago, Ill. 60611	312-202-6617 Fax: 312-280-5650 *www.benefitselections.com*	16	1998	John Harney, COO-Near North Insurance Brokerage
8	FACTS Web	FACTS Services Inc. 1575 San Ignacio Ave., Suite 406 Coral Gables, Fla. 33146	305-284-7400 Fax: 305-661-6710 *www.factsservices.com*	15 [1]	2000	Robert S. Graham Jr., Michael R. Graham, presidents
9	FACTS IVR	FACTS Services Inc. 1575 San Ignacio Ave., Suite 406 Coral Gables, Fla. 33146	305-284-7400 Fax: 305-661-6710 *www.factsservices.com*	10 [1]	1997	Robert S. Graham Jr., Michael R. Graham, presidents
10	Online Total Compensation Statements	Hay Group Inc. 100 Penn Square E. Philadelphia, Pa. 19107	215-861-2569 Fax: 215-861-2106 *www.haygroup.com*	6	2000	Bernd Schneider, CEO/managing director

1 Estimated
Source: *BI* survey

The 2002 Directory of Benefit Communication Systems is available in the directory area of *www.businessinsurance.com*. The directory is searchable by company name, corporate benefit clients, system name and system type, among other information. If your company provides employee benefit communication or information systems and would like to be listed in the online directory, contact Directory Editor Kevin Edison at 312-549-5279 or *kedison@crain.com* to obtain a questionnaire.



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Benefits: Strategies changing

Continued from page 3

Rad Laboratories Inc. in Hercules, Calif.

For example, Bio-Rad's senior management sent out a letter explaining that rising health care costs are requiring employees to share in the costs as well. And the company's cost-shifting efforts sparked little resentment from employees, "because we laid the groundwork and people understand now that this is a hot issue," Ms. Corey said.

Bio-Rad won an Award of Excellence in the benefits newsletter category of the 2002 *Business Insurance* Employee Benefits Communication awards (see story, page T7).

Employees have also been demanding more information from their employers, Ms. Kelly said.

"Employees are really looking for knowledge" to help them make better decisions with regard to both health care and retirement, she said.

One response to this demand has been growth in the number of Internet portals that provide benefits information to employees, she said.

And increasingly, employers are encouraging a two-way communication flow, accepting ideas from employees on the method and content of benefit communications. To that end, employers often work with employee focus groups to ascertain from the workers themselves what they want to see in communications, Ms. Raubach said.

"We're testing with the audience more this year than in previous years," she said. "We're trying very hard to get them involved, to get their acceptance."

More and more, benefits communication is being linked to an employer's overall health care strategy. A big movement this year has been toward creating a so-called "consumerist" mentality among employees with regard to health care. Such an approach in part seeks to make employees more aware of the costs of health care, encouraging them to be more judicious in their utilization and spending.

As part of this effort, some employers have designed communication campaigns to fundamentally change employees' way of thinking about health care, said Susie Albrecht, director of employee communications at Charles Schwab & Co. Inc. in San Francisco.

"We like to put more effort in helping our employees become more educated consumers of health care services," Ms. Albrecht said.

Charles Schwab won Best of Show for a traditional print program in the special-project category of *BI*'s EBC awards (see story, page T11).

"It's about changing culture, not just launching a campaign," said Ms. Raubach.

Fostering a consumerist mentality means more than just teaching employees about a new consumer-driven health plan. For example, benefit consultants suggest that an employer stress to employees that copayments do not represent the total cost of their health care and that the employer pays the bulk of the costs.

"That is not something we had focused on in the past," Ms. Albrecht said. "We want people to understand what they can do to control their own costs."

Some of the employer interest in consumer-driven strategies stems from a realization that many of the tools of managed care are increasingly ineffective in controlling health care costs, said Jean Schauer, senior communication consultant for Watson Wyatt Worldwide in Minneapolis.

"It's about getting employees in the game," she said.

To start this effort, employers are spending more time educating employees about their health plans and costs and then "asking them to be accountable for the services they use," said Ms. Schauer.

Online approaches

With Internet use continuing to grow, it's not surprising that employers have put more communications online.

"The medium of communication is shifting," Ms. Kelly said. Online communication not only has the information but also has links and tools built in to make it a much more complete education experience, she said.

Bio-Rad, for example, has gone virtually paperless with its open enrollment system. This year, the company put its enrollment book entirely on the Web, with the exception of one newsletter that introduced employees to the new online enrollment process, Ms. Corey said.

"We used it to drive people to the system," she said.

This success has led Bio-Rad to consider putting most of its future communications online, Ms. Corey noted.

Charles Schwab has also reduced its paper communications this year. For the first time, the company did not distribute to employees an open enrollment booklet. Instead, it sent out a four-page summary of the open enrollment process and put all other information on the company's intranet. This move saved Charles Schwab about $70,000, Ms. Albrecht said, and was well received by employees.

"No one really missed it," she said of the old booklet.

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Commentary

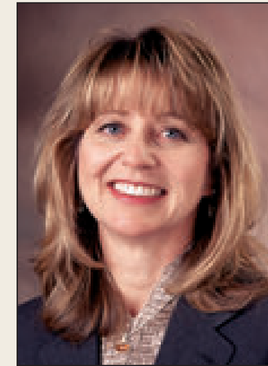
Risk managers must better image

Risk managers need to polish their image a bit if they want to become respected members of their organizations' brain trusts.

Take the risk manager who complains that his chief financial officer regards him as little more than a glorified workers comp claims administrator. Instead of seeking the risk manager's advice on the company's other risk- and coverage-related issues, the CFO goes to the firm's general counsel. But the general counsel, having very little expertise in these areas, consults the risk manager, who, in turn, provides the answers that the general counsel takes to the CFO, pretending he came up with them.

It reminds me a little bit of Cyrano de Bergerac, the homely soldier who wrote beautiful poetry that another man used to woo a fair maiden.

When I asked this risk manager if he weren't perhaps doing himself a disservice by handling the situation this way, he replied: "Oh, no. The general counsel knows that, without me, he'd be lost. So he'll make sure I'm always around to feed him the information he needs."



Joanne Wojcik

Surely this is no way to ensure job security.

In fact, many risk managers are becoming casualties of the hard market, primarily because they are seen as an extra expense as insurance costs are skyrocketing.

I recently spoke with one risk manager who was laid off even though he was in the midst of negotiating a Sept. 11-related business interruption claim. He explained that his department had been steadily shrinking over time until it finally became absorbed by the legal department, and the company's top executives decided to cut from the payroll any position that paid above a certain threshold.

This kind of economic decision-making seems very myopic to me, particularly given the current need for good risk management. What if another Sept. 11-type event occurred? Does the average CEO really believe the company's lawyers could mitigate the impact of such a catastrophic loss?

Business Insurance Editor Paul Winston recently wrote in his weekly column about the insurance industry's need for image-building, suggesting that the poor public perception of insurers was part of the reason the industry had so much trouble getting terrorism backstop legislation passed.

Well, insurers are not the only ones who need to enhance their public relations skills.

If they want to survive the next wave of downsizing, risk managers must shed their image as the Rodney Dangerfields of corporate America and get a little respect.

In an effort to get some free advice for these struggling risk managers, I called a friend of mine who specializes in crisis PR.

First and foremost, she said, risk managers must demonstrate their value to their organizations, both internally and externally.

"They should align themselves with their internal public relations departments to leverage their expertise within their organizations," recommended Ellen Blattel, president of San Francisco-based Blattel Communications. Too often, the PR department is viewed as an organization's external mouthpiece, but "it's as much internal as it is external," Ms. Blattel explained. For example, the PR department may produce an internal newsletter for which the risk manager could write an article focusing on issues such as loss control or injury prevention.

She suggested that risk managers also could make themselves more visible internally by attending upper-management meetings, perhaps even becoming part of the agenda by providing periodic risk management reports.

Ms. Blattel also suggested that risk managers clip articles from industry trade magazines and send them to upper management with their own synopses attached. This shows not only that risk managers are on top of the issues but also that they have an enterprisewide understanding of such matters.

Risk managers can also gain recognition by writing articles for trade magazines, being quoted in the press and speaking publicly, according to Ms. Blattel. The "publish or perish" adage often applied in academic circles easily transfers to almost any profession, she said. And to make upper management aware of these accomplishments, risk managers should send them copies of their articles, as well as brochures from their public appearances.

"It's all about proving they're providing something to their organizations that no one else is qualified to provide," she said.

Senior Editor Joanne Wojcik's commentary appears occasionally in Business Insurance and on www.businessinsurance.com. She can be reached at jwojcik@crain.com.

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RMIS: Tech tools used in mass torts

Continued from page 1

nology to try to meet this need.

Meanwhile, as class-action lawsuits proliferate, the technology is certain to catch up, experts predict, especially since computerized mass tort allocation systems often are helpful in "finding" additional coverage by providing proof to excess insurers that underlying limits or self-insured retentions have been exhausted.

"Because companies were running out of coverage, they were looking for other places to find it," said Andrea Tecce, a principal at Peterson Asbestos Claims Enterprise in Washington. PACE provides mass tort administration services to companies on an outsourced basis. Among its clients were the Asbestos Claims Facility and its successor, the Princeton, N.J.-based Center for Claims Resolution.

But there aren't a lot of other companies providing this service to defendants in mass tort cases, much less offering them as part of a RMIS application, industry experts say.

"The class-action industry and mass tort industry is fairly small. On a regular basis, we run into probably two other firms," said Jim Prutsman, vp of information technology at Poorman-Douglas Corp. The mass tort claims administrator based in Beaverton, Ore., also provides its services on an outsourced basis. Its clients include Exxon Corp., Dow Corning and Louisiana-Pacific Corp.

"Sometimes, you'll see some other people trying to get into the business," he said. But, of those, only a few are "legitimate competitors to ourself. It comes down to a matter of having the expertise to do it."

Indeed, "when this issue does arise, there are very few choices out there, and those choices that are out there technologically need a lot of customization, manual intervention and a lot of data management support," concurred Neil Harrison, director of risk information consulting at Aon Corp. in New York.

He added that it's also "really not something that we see as generic functionality within most of the products we work with on the RMIS side."

One reason there may be no off-the-shelf solution on the RMIS market is the lack of widespread demand, Mr. Harrison suggested.

"We have seen more inquiries or discussion over the issue over the last year or so than we have previously," Mr. Harrison said. "But it's still not something that comes up very often."

But that may change with the increasing number and types of defendants in mass tort litigation, some industry experts predict.

Widening exposure

Today, almost every organization is susceptible to class-action lawsuits, points out Bill Diaz, senior vp at Marsh Inc. in Chicago. In response to client requests, Mr. Diaz has been overseeing enhancements to the broker's STARS system to do mass tort data administration.

"About three years ago, we worked with a client who was looking at a more traditional RMIS, taking TPA data and consolidating it. And, in that process, we talked about some greater business issues, and this one was brought up. Their company was knee-deep in mass tort litigation and had built a system internally a couple of years prior to that to try to manage and distribute this information. The application was failing. It wasn't built to handle the volumes of information," he said.

After building a system that worked for this initial client, Marsh found that other customers were interested in such a product, Mr. Diaz said.

"There really wasn't a vendor that was supplying this type of system," he said. As a result, clients "were always having to go out to these independent consultants to try to build these systems from scratch, which can be very costly. And then there's the ongoing support, upgrades, changes to technology, etc. So when we started talking to them about what we did for this client, there was more and more interest."

Marsh now has five clients from various industries using the mass tort administration enhancement to STARS. St. Louis-based chemical company Solutia Inc., which was spun off from Monsanto in 1997, is one of them.

"We had been doing this with this makeshift system internally here. The problem was, it was a very manual process. Secondly, there were not all of these checks and balances," said David Jones, manager of risk management at Solutia.

Perhaps the biggest challenge is "you're asking a company like Monsanto, that's been around since 1901, to go back in time and accumulate all this data back to the 1950s on claims," he said. "First off, computers weren't used back then. Then you start getting into the 1960s and '70s when they were used, but they were very antiquated. The data that was maintained was very different and much less detailed than what you now maintain due to memory restrictions and today's analysis requirements." Furthermore, "all of these things about billing historical insurers were not even thought of until the late '80s," Mr. Jones added.

Solutia ended up having to obtain policy records from Monsanto's former insurers and load that information into the STARS system, Mr. Jones said. By using technology, Solutia may be able to recover additional insurance payments by proving that some of the underlying coverage limits in certain years have been exhausted, he said.

The need to manually enter reams of historical data into an RMIS is one of the challenges in using such systems for mass tort claims.

"For Solutia, it's millions of dollars we've been bringing in the door," he said. It allows the company "to pursue our historical insurers more accurately and systematically for recovery of dollars spent. Otherwise, we would have no means of tracking exhaustion of underlying limits for long-term exposure claims through the allocation of payments to various historical policies."

Besides proving exhaustion of primary coverage or self-insured retentions to tap excess layers, mass tort allocation systems also can be programmed to find additional coverage by reclassifying certain claims, PACE's Ms. Tecce said.

Policyholders have been billing their asbestos claims on their product-liability limits, but now they're realizing that their liability policies "have a separate no-aggregate limit for non-products," she said. "So even though you've consumed $2 million, you actually have another $2 million available for some other type of liability that's coming in your door."

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New solvent runoff schemes flourishing

Cutoff programs popular among insurers, but policyholder impact debated

By MEG FLETCHER

LONDON—ING Groep N.V.'s plan to cut off books of mostly long-term liability business through a scheme of arrangement in the United Kingdom illustrates the growing global popularity of this closure mechanism as a means for solvent insurers to exit lines of business, proponents say.

Cutoff schemes of arrangement are a variation of the runoff approach that is widely used elsewhere, especially by financially troubled and insolvent insurers.

For policyholders, the main difference is that cutoff schemes typically result in more prompt payment of known and anticipated claims but offer no payment for claims that arise after the scheme's deadline date. Runoff schemes typically take more time, giving unknown claims more time to surface but making full payment less certain.

Critics say, though, that cutoff schemes may benefit insurers ceding reinsurance to the scheme proponents while placing individual policyholders at a disadvantage. That, they say, is because policyholders may be less able than insurers to accurately quantify their incurred-but-not-reported losses.

Creditors of Amsterdam, Netherlands-based ING are due to vote on a scheme of arrangement for several of the insurer's solvent units on Dec. 11. The proposal involves five insurers, four Dutch and one Australian.

The proposed scheme is currently being reviewed by a London court, which is expected to approve it effective Dec. 23, according to Dan Schwarzmann, a partner in the London office of PricewaterhouseCoopers who is one of the scheme's primary advisers.

The scheme is unusual because it involves insurers that are not based in the United Kingdom, though they have established operations there, Mr. Schwarzmann said. Dutch law does not allow for such programs, he said.

The specific insurers are: Assurantiemaatschappij "De Zeven Provincien" N.V., which is known in the United States as The Seven Provinces Insurance Co. Ltd.; "Transatlantica" Herverzekering Maatschappij N.V.; Nationale-Nederlanden Schadeverzekering Maatschappij N.V.; National-Nederlanden Internationale Schadeverzekering N.V.; and Mercantile Mutual Insurance (Australia) Ltd.

According to ING spokesmen, most of the companies' claimants are ceding insurers but the group includes direct policyholders. They face claims totaling tens of millions of dollars, including asbestos and pollution-related claims.

If approved, the claimants will receive prompt, full payment for claims, including undiscounted payments for verified incurred-but-not-reported losses, Mr. Schwarzmann said.

The 93-page proposal cites advantages of the scheme of arrangement that include cost-efficient handling of liabilities "without protracted litigation," although it notes that there is a process for resolving disputed claims.

In addition, the proposal says, the scheme allows creditors "to achieve finality" without the worry that the now-solvent insurers might face financial problems in the future.

Disadvantages, though, include the fact that claims not filed by the cutoff date are barred. In addition, claimants may receive lower amounts than they would if the insurers went through a traditional runoff.

The scheme also includes the requirement that it obtain a permanent injunction order under Section 304 of the United States Bankruptcy Code, which will prevent litigation in the United States

See ING/ next page

Runoff reinsurer sees U.S. increase in asbestos claims

By SARAH VEYSEY

LONDON—Equitas Ltd., in announcing its six-month results, said that it is seeing a continued increase in asbestos-related claims from the United States.

Equitas, the runoff reinsurer for Lloyd's of London's pre-1993 long-tail liabilities, paid out £451 million ($708.1 million) in claims in the six months to Sept. 30, compared with £798 million ($1.18 billion) for the same period in 2001.

Equitas attributed the drop to two large commutation deals done during the first half of 2001.

Mr. Crall

Although Equitas did not provide exact figures, the runoff reinsurer said in a statement that "during the first half of this year, asbestos claims filings in the United States and the average amounts paid by some policyholders to resolve asbestos claims have continued to rise."

The reinsurer said that it is encouraged by the impact of documentation requirements introduced in 2001 that require claimants to provide evidence of asbestos-related impairment before claims are paid (*BI*, May 7, 2001).

"However, despite the group's efforts to limit the financial impact of asbestos claims, it may be necessary to increase asbestos reserves at the end of the financial year following the comprehensive actuarial review," Equitas said in the statement. The reinsurance company pointed out that additional organizations are now being targeted by asbestos claimants.

At March 31, Equitas' asbestos reserves stood at £8.0 billion ($11.52 billion) net of reinsurance.

Equitas also reported an investment return of £556 million ($872.9 million) for the six months, up 158.6% over the comparable period last year.

In addition, Equitas announced that its chief executive officer, Michael Crall, will retire in November 2003. He will be replaced by Claims Director Scott Moser but will remain on the Equitas board in a nonexecutive capacity.

Overall capacity still adequate, survey finds

European buyers' captive use growing

By SARAH VEYSEY

Four in 10 large European companies currently are operating a captive, according to a study by Aon Ltd. in London.

In the Benelux countries and the United Kingdom, the percentage

rises to 50%, Aon said. Aon surveyed more than 100 large European companies in 13 countries for its "Aon European Risk Management Survey 2002-2003."

Of those companies operating captives, 45% said they were "integral to their risk management and insurance program," according to the study.

Other matters addressed by the survey include risk managers' perceptions of the adequacy of capacity in the insurance market and the severity of recent rate increases.

Patrick Thomas, European development director of Aon International in London, said that "perhaps slightly differently to anecdotal evidence, the survey reveals that risk managers are confident there is enough (insurance) capacity for their requirements." Some 68% of respondents surveyed said they thought that sufficient capacity is available to meet their needs. But they ranked business interruption, physical damage and general liability as the main risk areas where "the purchase of adequate insurance cover [is] a concern."

Respondents said they had, on average, experienced a 30% increase in property premiums in 2002 and expect a further 15% increase at the 2003 renewals. For casualty lines, respondents said average price in-

See SURVEY/next page

World Updates

Berkshire Hathaway buys into aviation pool

Berkshire Hathaway Inc. has bought a 25% stake in the aviation underwriting pool managed by London-based Global Aerospace Underwriting Managers Ltd. from London-based Royal & SunAlliance Insurance Group P.L.C. RSA said it was reducing its 50% shareholding in GAUM to 10.1% as part of a restructuring announced in November. RSA sold pool shares to Zug, Switzerland-based Converium Ltd., Munich Reinsurance Co. and Northern States, a Berkshire unit. Converium, Berkshire and Munich Re now each hold 25% stakes in the pool, which manages over $1 billion in premiums annually.

Benfield planning London stock listing

Benfield Group Ltd. plans a London Stock Exchange listing in the first half of 2003. In October, the broker redomiciled to Bermuda from London to give Benfield the choice of a U.S. or U.K. initial public offering, the company said in a statement. Benfield said that while it "can meet the necessary requirements in either jurisdiction, the board considers that the rapidly moving regulatory environment in the U.S., with its inevitable cost implications, is not attractive for a public listing of the group's shares at this time."

Munich Re posts profit increase

Munich Reinsurance Co. reported profits of 3.2 billion euros ($3.18 billion) for the first nine months of 2002, up from an 85 million euro ($84.5 million) profit a year earlier, which reflected the Sept. 11, 2001, terrorist attacks. Nine-month gross premiums for 2002 rose 14.7% to 29.6 billion euros ($29.43 billion). For the third quarter, Munich Re reported an 859 million euro ($854.2 million) loss, largely due to investment losses. The reinsurer also reported flooding-related losses of 500 million euros ($497.2 million) in the quarter.

Centre to cease writing credit enhancement

Zurich Financial Services Group said Centre Group, part of ZFS' global asset business division, will cease writing new credit enhancement business. Zurich, Switzerland-based Centre will continue its structured finite risk insurance and reinsurance business and will support its existing book of credit enhancement business, ZFS said in a statement. ZFS declined to comment on the size of its credit enhancement business. Centre, which had been an independent unit, will report to the Zurich North America division.

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ING: Cutoff schemes flourish

Continued from previous page

from interfering with the plan.

In addition to being one of the first international schemes of arrangement, the proposal excludes one specific creditor of Seven Provinces—Employers' Surplus Lines Insurance Co., which is now in runoff. Excluding such a creditor is unusual, according to Mary Cannon Veed, a reinsurance attorney with Peterson & Ross in Chicago.

Previously, Commercial Union Insurance Co., as a successor to ESLIC, successfully sued Seven Provinces for breaching a reinsurance agreement and committing an unfair trade practice under Massachusetts law, essentially "for constantly shifting objections to payment," according to a 1st U.S. Circuit Court of Appeals decision in July 2000.

The scheme documents said ESLIC was excluded because it "was seeking to put itself in a special position." ING and ESLIC would not comment on the exclusion.

Observers say the proposed ING scheme raises some issues, including forum shopping and the ability of individual policyholders to protect themselves.

"The forum-shopping aspect of the scheme makes it really unusual," Ms. Veed said. "I would be somewhat concerned that the U.S. courts would not issue a (Section) 304 order under the circumstances. The U.S. court might be concerned they are using U.K. and Australian laws because they don't like the law of their home countries."

In addition, the ability of creditors to protect their interests varies significantly, depending upon whether they are policyholders or cedents, some observers say.

> **'The could be a truly awful idea for any direct policyholders or captives with long-tail risks.'**
>
> *Mary Cannon Veed*
> *Peterson & Ross*

Many individual policyholders may lack the legal resources and sophistication "to adequately protect their own self-interest when it comes to obtaining appropriate claims payment," said Dale Stephenson, president of the National Conference of Insurance Guaranty Funds in Indianapolis.

"This could be a truly awful idea for any direct policyholders or captives with long-tail risks," Ms. Veed said. "It is very difficult to fairly allocate IBNR—which refers to the statistical probability that losses will develop in the future, though they are not yet known—among people who, if they have a claim at all, will only have one or two. Either they get paid when they don't have any claims or, if they do have a claim, their share is way too small."

But PWC's Mr. Schwarzmann countered that "this reorganization plan has been designed to be fair to policyholders. We want to pay their present and future claims in full."

He also noted that insurers in previous schemes of arrangement essentially used their own calculations of IBNR claims and proposed how the monies should be allocated among claimants. Under the ING scheme proposal, though, claimants would provide the initial IBNR estimates.

A recent boost to the globalization of such scheme arrangements came earlier this year; in June, Rhode Island became the first U.S. jurisdiction to allow the use of such schemes for insurers domiciled there.

"It is envisaged that companies will redomesticate to that state to avail themselves of the statute," said Ipe Jacob, head of the financial markets group for Grant Thornton, an accounting firm in London.

Survey: More captive use seen

Continued from previous page

creases this year were 25% and a further 15% increase is expected next year.

Respondents in Germany and Austria said they expected the highest increase in property rates—30%—for 2003, while Scandinavian respondents expect the lowest, at 5%. Germany and Austria also expect the highest increase in casualty rates—40%—next year. Scandinavia again expects the lowest increase, at just 6%.

Aon said that "the fact that more companies are taking premium out of the market and putting risks into captives, or reducing costs by retaining more risks," would likely have the effect of slowing rate increases in the coming year.

The survey showed that 8% of respondents were now carrying a property deductible of 10 million euros ($9.9 million) or more and that 42% of respondents expected to take a 500,000 euro ($497,200) property deductible in 2004. "We expect to see a significant number of companies with deductibles that, in Europe, would never have been dreamed of three or four years ago," Mr. Thomas said.

And in the survey, risk managers ranked business interruption, loss of reputation, and product liability and tampering as the top risks faced by business. But only 22% of respondents said they had instituted risk management plans for brand and reputation risk, and just 24% had such plans for product tampering risks, according to the survey.

Aon surveyed companies in Austria, Belgium, Denmark, Finland, France, Germany, Italy, Netherlands, Norway, Portugal, Spain, Sweden and the United Kingdom.

Copies of the survey are available by contacting James Wood at 44-207-216-3205.

Products & Services

Web-based rehab program offered

RICHMOND, Va.—General Management Solutions Inc. has developed a Web-based return-to-work software program designed to help get injured employees back on the job.

The program, called YnotReturn2Work, links risk managers, treating physicians and case managers, allowing decisions to be made quickly with regard to return-to-work issues. For example, a treating physician can view job descriptions online and suggest modifications to accommodate an injured worker. In some cases, the doctor can issue a work release in minutes.

The software is especially helpful to risk managers who are responsible for multiple locations with employees under the same job classification, according to Richmond, Va.-based GMS.

More information is available from Mark Willis or Michael Leep at GMS at 888-561-6282.

Claims materials available online

HARTFORD, Conn.—Risk managers can access claims reporting materials electronically with a new Web-based application from Travelers Property Casualty Corp.

The new application allows large Travelers policyholders to use a single customized site that contains their reporting information and state and network provider information.

The site provides detailed claims information for each of the policyholder's coverages. Electronic sharing among all the client's locations is available, as is a link to the insurer's network medical provider directory and other services.

More information is available from Leslie Marshall at 860-954-5729.

Hartford launches work/life program

HARTFORD, Conn.—The Hartford Financial Services Group Inc. has launched an employee assistance and work/life program called GuidanceResources.

The program offers an array of services that employees and their families can use to overcome problems that affect their personal and work lives.

One offering, elder care services, is expected to appeal to parents raising children while caring for their own parents. Child care services, drug and alcohol programs, legal assistance, financial counseling and other services are also offered.

More information is available at the press room site at *www.thehartford.com.*

ARAG helps guard against identity theft

DES MOINES, Iowa—ARAG Group is including identity theft protection in its group legal insurance plan.

ARAG, a legal advisory plan administrator in Des Moines, Iowa, offers several services as part of its program to help plan members deal with identity theft. A member can receive advice on thwarting identity theft and legal help if he or she is victimized.

A specialist can help plan members identify at-risk areas, explain personal liability, provide information to credit agencies, monitor resolution of the situation and offer other help.

Information is available at 800-888-4184.

Nuclear: Ruling follows asbestos litigation

Continued from page 3

cancer manifested.

Because there is a lengthy latency period for many cancers caused by radiation, ANI contended most of the underlying claims are covered by policies in effect before April 1974, when B&W and ARCO's combined coverage never exceeded $40 million.

In affirming a lower court judge's opinion, the Superior Court of Pennsylvania ruled Nov. 25 that the date of the manifestation of the injury is the appropriate date for determining the applicable policy and coverage limits.

In his opinion, Judge R. Stanton Wettick Jr. relied on the 1993 asbestos case *J.H. France Refractories vs. Allstate*. In that case, the Pennsylvania Supreme Court ruled that, under the language of J.H. France's commercial general liability policies, coverage for asbestos-related injuries is provided if any of three events—exposure, progression, or manifestation—occurred during the term of the policy.

"Both the CGL policies and the ANI policies use the same 'causation' language," the superior court wrote in its recent decision. "The present case involves the development of diseases that, for purposes of coverage issues, is similar to the development of asbestos-related diseases. Consequently, J.H. France's interpretation of the CGL policies governs this litigation."

"It's a case of first impression with respect to the interpretation and application of nuclear policies to personal injury claims," said Neil R. Brendel, a partner with Kirkpatrick & Lockhart L.L.P. in Pittsburgh who represents B&W. "We think it's an interpretation that is consistent with the intent of the policies and consistent with the broad indemnity protection that is to be afforded under these policies," he said.

Roberta D. Anderson, an associate with Kirkpatrick & Lockhart added: "The significance for policyholders is that it shows courts are not going to latch on to the slight nonmaterial differences in policy language to achieve coverage-restricting results."

The superior court also upheld the trial judge's opinion that ANI is obligated to pay for independent counsel to represent the separate interests of B&W and ARCO in connection with the underlying claims rather than fund joint counsel.

ANI attorney Andrew S. Amer, a partner with Simpson, Thacher & Bartlett in New York, said his client is considering whether to seek an appeal from the Pennsylvania Supreme Court.

The Babcock & Wilcox Co. et al. vs. American Nuclear Insurers et al., No. 1916 WDA 2001; Superior Court of Pennsylvania.

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Alpine: Illinois to proceed with racketeering case

Continued from page 3

"They gave it their all in these motions to dismiss, and they lost on every single ground."

"We believe that the original suit was about 95% inaccurate," Mr. O'Shaughnessy replied, adding that he will pursue arguments that the RICO claims are barred by a statute of limitations, even though Judge St. Eve rejected this contention.

The other defendants and their lawyers either declined to comment or could not be reached.

Alpine, which wrote $145 million in gross premiums from 1992 to 1996, was a unit of Transco Syndicate #1 Inc., a now-defunct Illinois Insurance Exchange syndicate. The insurers were, in turn, owned by Exstar Financial Corp., a Solvang, Calif.-based holding company that Mr. O'Shaughnessy controlled.

Illinois regulators charge that former Alpine Chairman Peter J. O'Shaughnessy took more than $5 million in diverted premiums, improperly using Alpine and Transco money to support an 'extravagant lifestyle.'

Illinois regulators initially acted on concerns about Alpine's solvency in 1996, requiring Illinois Insurance Department approval for certain transactions. Alpine pursued an abortive attempt to win a California license that year but was ultimately placed in conservation in Illinois in 1999 and ordered liquidated a year later.

Within a year of the liquidation order, Illinois regulators had filed their RICO suit, charging Alpine officials with systematically looting the insurer between 1987 and 1996. In addition to Mr. O'Shaughnessy and Exstar, the suit names:

- Three Exstar affiliates: TCO Holdings Inc., an intermediate holding company incorporated in Delaware; California-domiciled TCO Insurance Services; and Illinois-domiciled TCO Insurance Services Inc. TCO Insurance Services and TCO Insurance Services Inc. provided underwriting management and other services to Alpine and Transco Syndicate.
- Steven Shinn, Craig Rice and John Clark, all officers of Alpine, Transco, Exstar and the TCO companies.

Illinois regulators cited a variety of alleged schemes by which the defendants diverted Alpine's funds.

The TCO management companies, for example, were supposed to maintain Alpine and Transco premiums in separate trust accounts but instead commingled the money with TCO funds and diverted almost $9 million to other affiliates over several years, the suit alleges.

Mr. O'Shaughnessy himself took more than $5 million of the diverted premiums, improperly using Alpine and Transco money to support an "extravagant lifestyle," regulators charge. Among other things, he caused Alpine and Transco to buy $4.8 million in real estate that he owned, including $2.5 million for his California home, which he then leased, the complaint says.

Mr. O'Shaughnessy also engineered a stock swap deal aimed at funneling premiums to Exstar without arousing regulatory scrutiny, the complaint alleges. Under the deal, Transco—Alpine's parent—paid $15 million for preferred stock of Concord General Corp., a Concord, Calif.-based company owned by Jeffrey Beresford-Wood, an associate of Mr. O'Shaughnessy. At the same time, one of Mr. Beresford-Wood's companies paid $15 million for preferred shares of Exstar.

The net effect of the deal was to shift $15 million of Alpine and Transco premiums to Exstar, regulators charge. If Transco had simply paid a $15 million dividend to Exstar, the transaction would have triggered Insurance Department review, the suit notes.

The defendants ultimately exchanged Transco's Concord General stock for a promissory note from another Beresford-Wood company. Alpine—which assumed the note—was owed $14 million in 1997 but discharged the debt for a payment of $2.3 million, the suit says.

The complaint seeks $19 million in actual damages—which could be tripled under the RICO law—along with $10 million in punitive damages.

Mr. O'Shaughnessy and the other defendants filed four separate motions to dismiss the complaint, arguing that the racketeering charges were time-barred, and that regulators had failed to cite facts that would sustain RICO allegations and state law charges of conspiracy, fraud and conversion.

In her ruling, though, Judge St. Eve largely rejected the motions. She dismissed one of four RICO counts against Exstar and TCO Holdings only, and dismissed the conversion count against all defendants, leaving the bulk of the RICO and state law charges standing.

While ruling that the complaint was specific enough in its allegations of mail and wire fraud under the RICO law, the judge ordered the Illinois Department to conduct additional discovery to add details on these charges and to file an amended complaint by Jan. 21.

No date has yet been set for a trial.

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"I teach continuing education classes for AIIA members, and I often bring (RLI Surety Representative) Wendell Merritt into the classroom and cite RLI as the ideal example of what an insurance company should be. They excel at explaining how a bond works, in helping me gain confidence in writing surety bonds. I'm amazed at how quickly I became an 'expert' at surety, and I thank RLI for that."

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Costs: Survey sees more increases

Continued from page 1

who is an author of the survey.

The drivers of the cost increases, including providers hiking their charges for services and increased utilization, have not changed, Mr. Bos said.

But Mercer found that employers, faced with the prospect of continued high annual cost increases, are beginning to take steps to combat those increases.

For example, whereas health maintenance organizations once imposed minimal cost-sharing requirements on enrollees, those days are ending as employers pressure HMOs to offer more affordable products. This year, for example, Mercer found that 45% of HMOs offered by employers included a hospital deductible—up from 35% two years ago—with the median deductible now $250.

In addition, employers are pruning the number of HMOs they offer their employees. This year, very large employers—those with at least 20,000 employees—had an average of 24 HMO contracts, down from 32 in 2000.

"In the 1990s, the ultimate cost-management strategy was to increase HMO enrollment. Now, employers are throwing out poor-performing HMOs, even if it means moving employees into less-managed plans," Mr. Bos said.

And that dual strategy—shifting more costs to employees and dropping the HMOs with the highest rates—appears to be helping to hold down costs. Large employers—those with at least 500 employees—held their HMO cost increase to 8.1%. By contrast, smaller employers, which have less bargaining clout and typically each offer only one HMO, were clobbered with a 25.9% increase in average HMO costs per employee.

Employers' move away from HMOs is reflected in the decline in the number of employees enrolled in the plans, which were once seen as the most promising plan model for holding down costs. This year, employee enrollment in HMOs slipped to 29% from 33% in 2001, while enrollment in preferred provider organizations climbed to 50% from 46%.

Employers also are taking steps to control prescription drug costs, which rose 16.9% in 2002. That increase was down slightly from last year's 17.8% rise and 18.3% in 2000.

Just over 50% of employers—up from 40% last year—currently offer a three-tier copayment design. Under that model, an employee pays the least for a generic drug, a higher amount for a brand-name drug listed on the plan's formulary and the most for a brand name not on the formulary.

And bigger design changes are coming down the road. More employers, Mr. Bos says, will be moving to consumer-driven health plans, which are plans with very high deductibles linked to employer-funded reimbursement accounts, which pay only a portion of employees' out-of-pocket expenses.

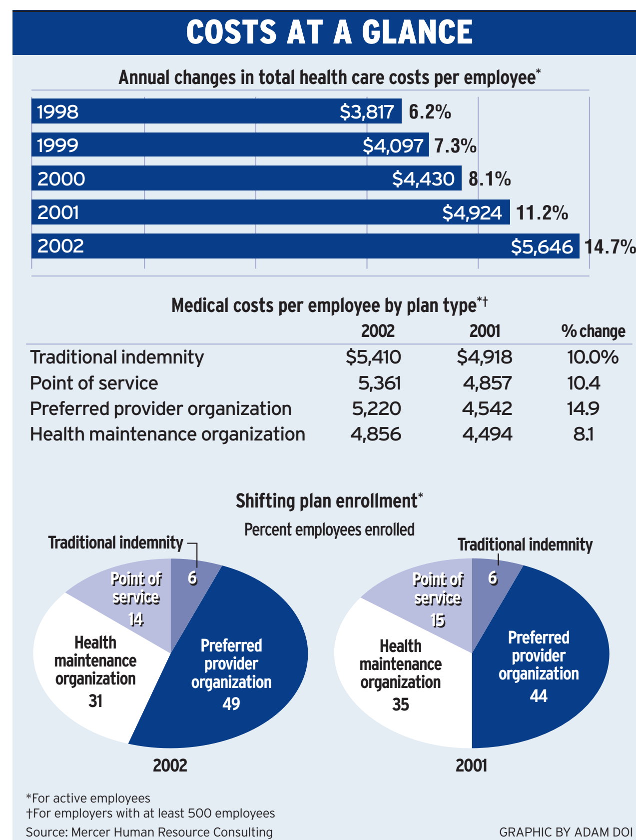
Indeed, 15% of very large employers reported that they are likely to offer a consumer-driven health plan within the next two years.

Increased employee cost-sharing, whether through consumer-driven plans or through existing designs with higher deductibles, is certain to increase, Mr. Bos said. Such approaches seek to increase employees' exposure to costs and, as a result, prompt them to use services more judiciously, he said.

"With a $10 or $20 copayment, employees really are insulated from costs. We haven't done as much as we could on the demand side" of the health care equation, Mr. Bos said.

Other survey findings, all involving employers with at least 500 employees, include:

- Regionally, PPO costs were highest in the West, averaging $5,592 per employee, up 12.4% from 2001. PPO costs were lowest in the South, averaging $4,958 per employee, up 16.6% from 2001.
- HMO costs were highest in the Midwest, averaging $5,100 per employee, up 18% from 2001. The West had the lowest HMO costs, which averaged $4,704 per employee, up 7.5%.
- Point-of-service plan costs were highest in the West, averaging $5,960 per employee in 2002, up 19.9%.



Copies of the "National Survey of Employer-Sponsored Health Plans" will be available in mid-March by contacting Tara Lewis, Mercer Human Resource Consulting, 1166 Ave. of the Americas, 28th Floor, New York, N.Y. 10036; 212-345-2451. The cost is $500.

Treasury issues backstop help

By MARK A. HOFMANN

WASHINGTON—The Treasury Department has issued its first interim guidance on implementation of the Terrorism Risk Insurance Act of 2002.

The interim guidance was unveiled at a Dec. 3 press conference by Treasury Undersecretary Peter Fisher and National Assn. of Insurance Commissioners President Terri Vaughan. The Treasury Department expects to issue additional guidance in the future, "including how we intend to apply the law to captive insurers and other self-insurance arrangements," said Mr. Fisher.

President Bush signed the act Nov. 26, allowing creation of a federal reinsurance program to help insurers pay for future catastrophic terrorism-related losses.

The first interim guidance deals with how insurers can meet the act's requirement that they disclose to policyholders the availability of terrorism coverage. According to Mr. Fisher, insurers that use the NAIC model disclosure forms released late last month would be in compliance with the requirement.

In addition, the guidance spells out the meaning of the act's directive that insurers "make available" in all property/casualty policies coverage for insured losses and "make available coverage that does not differ materially from the terms, amounts and other coverage limitations applicable to losses arising from events other than acts of terrorism."

Insurers can comply with the "make available" provision by making a "formal offer of coverage to a policyholder that does not differ materially from the terms (other than price), amounts and other coverage limitations offered to the policyholder," according the guidance.

The guidance also lists the types of property/casualty coverage addressed by the program and how insurers should determine their direct earned premium for purposes of calculating the "deductible" they must reach before becoming eligible for government cost-sharing.

Mr. Fisher said the Treasury Department will also seek comment on the impact of the threat of terrorism on the availability of group life insurance.

The guidance will appear in the Federal Register and has been posted at *www.treas.gov/trip*.

Backstop: Insurers adjusting

Continued from page 1

premium, what do we do?'"

"We're recommending that if you've got coverage, check the cancellation procedures," said Jill Dalton, North American property practice leader with Marsh Inc. in New York.

By considering those provisions, risk managers can compare their stand-alone coverage with the terms and conditions that are being offered under the act, she explained.

If coverage that is in place can't be canceled, "we recommend that terrorism coverage is written as excess and differences-in-conditions over existing coverage," Ms. Dalton said.

As far as risk managers are concerned, "there's not a lot for them to do," said Gary Marchitello, New York-based managing director of Aon Corp.'s global property practice. Within 90 days, they will be notified of coverage terms and pricing, and will have 30 days to accept or reject the offer.

Impact on pricing

Quotes so far have varied widely.

"The (numbers) that we have seen are very low to very high," said Mr. Marchitello.

Ms. Dalton said prices are "all over the place. One is 100% to include the terrorism coverage and another is 2%. It's hard to say where it will settle in."

Insurers are facing a tricky pricing situation, Mr. Ewing pointed out. "Underwriters may price it at what, in their mind, is appropriate, but the marketplace may dictate whether anybody takes it at their price," he said.

Brian Duperreault, chairman and chief executive officer of ACE Ltd. in Hamilton, Bermuda, said it is not in insurers' best interest to seek unreasonably high premiums. "We want to have a spread of risk and not have adverse selection."

Randy Schreitmueller, vp-operations, sales and client services for Johnston, R.I.-based Factory Mutual Insurance Co., said the insurer will rely on risk assessment protocol to determine rates.

That approach considers the location of a property risk, its particular operation and whether more than one client is on the premises. As a result, at the insurer, which operates as FM Global, pricing "really will vary," he said.

Policyholders that had coverage before enactment of the backstop should not expect a marked reduction in rates under the federal program, said Dominic J. Frederico, president and chief operating officer of ACE. The risk of terrorism damage remains the same, he explained, and insurers still have substantial retentions.

Such statements don't sit well with the Consumer Federation of America, a nonprofit group that issued a statement saying commercial policyholders with coverage in place should demand sizable discounts because potential payouts are much lower than when the policies were written.

"My analysis shows that the typical business with terrorism coverage should get back about 40% to 50% of its premium for a full year, or 20% to 25% for a half year of remaining coverage," J. Robert Hunter, CFA's director of insurance, said in the statement.

Unanswered questions

The terrorism backstop act does leave some questions unanswered, industry sources agree.

Shared programs, for example, may be particularly tricky to renew, noted Suzanne Douglass, executive vp with Willis Risk Solutions in New York. Because the law says only that insurers must notify policyholders within 90 days of the bill's signing and buyers then have 30 days to respond, some risk managers are going to find themselves juggling response dates and trying to determine how their answers will affect a program's coverage written by other insurers.

Ms. Douglass said some underwriters apparently haven't read the legislation.

"As of yesterday," Ms. Douglass said a few days after the bill was signed, "we had a placement where three insurers said they were renewing, but with the terrorism exclusion....Some underwriters believe they can bind coverage with an exclusion, and we've had to tell them they are wrong."

Mr. Marchitello said there are questions on how the act will apply to non-U.S. insurers. The plan applies only to acts within the United States, except for losses involving aviation, U.S.-flagged vessels and properties with government operations.

"Carriers who do not operate in the states are almost all universally confused as to whether they are covered under the bill," he said. "Even if they are covered, they may not want to be. What enforceability does the U.S. government have over a foreign insurer?"

And, risk managers and brokers are waiting on clarification from the government as to how captives and self-insured employers will be treated under the act.

Insurance buyers are expected to benefit from an expanded market for stand-alone coverage.

Mr. Frederico of ACE said some companies may want to purchase the coverage for losses that fall below the $5 million threshold and for acts of terror committed by U.S. citizens, which are not covered under the bill.

Gavin Souter contributed to this report.

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For the Record

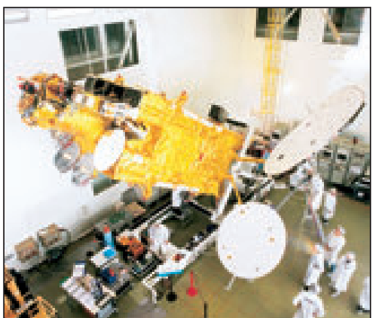
This roundup of news from the previous week is generated by *BI*'s Daily News reporting. To get breaking news as it occurs, log on to *www.businessinsurance.com*, or sign up online for free *BI* Daily News by e-mail.

Calif. health care exec proposes universal care

The head of Blue Shield of California is urging consideration of a public/private universal health care coverage plan for California residents. Blue Shield Chairman and Chief Executive Officer Bruce Bodaken's proposal calls for employers to offer insurance coverage for all workers or an equal amount of money toward "an essential benefit package for each employee," according to a statement.

Satellite loss likely despite recovery efforts

Satellite insurers likely face a huge loss despite successful efforts to stabilize the orbit of a telecommunications satellite stranded in a useless sub-orbit. The Astra 1K likely is no longer commercially viable, said a spokesman for the satellite's owner, SES Astra. He explained that the fuel consumed during the orbit corrections would considerably shorten the satellite's original 13-year lifespan even if the craft could be repositioned in its intended orbit. Numerous insurers cover the satellite, which is valued at $291.5 million euros ($289.8 million). The problem occurred when the launch rocket's second-stage burn failed.



Insurers face huge losses after this Astra 1K satellite, launched in August, failed to reach a usable orbit.

Industrial broker seeks third-party business

Industrieschutz Insurance Broker GmbH, a joint-venture insurance broker formed by Aon Corp. and Siemens A.G., will offer insurance brokerage services to industrial clients and affiliates of Siemens. The broker, which received approval from the European Commission last month, will be 51% owned by Siemens Financial Services and 49% owned by Aon Jauch & Huebener GmbH, Aon's German unit. Siemens and Aon will jointly manage IIB, which will be based in Mulheim, Germany.

Boat act doesn't bar state suits: High court

A federal boat safety law does not bar product liability suits brought in state courts, a unanimous Supreme Court ruled. The case, *Sprietsma vs. Mercury Marine U.S.*, involved propeller guards on recreational boat motors. The husband of a woman killed in an Illinois boating accident sued the boat's manufacturer in state court, claiming that the boat's design was dangerous. The court dismissed the case, holding that the 1971 Federal Boat Safety Act expressly pre-empted such state actions. The U.S. Supreme Court justices held that the federal law's pre-emption language did not apply to common-law claims for several reasons involving the precise wording of the law, such as the fact that the pre-emption refers to "a" state or local regulation, which the court held " implies a directness...that is not present in the common law."

Andersen seeks deal with captive creditors

Arthur Andersen L.L.P.'s Bermuda-based captive insurer, Professional Services Insurance Co. Ltd., has petitioned a Bermuda court to approve a solvent scheme of arrangement with its creditors. A meeting of creditors has been scheduled for Jan. 3. Andersen cited concerns about its captive's solvency earlier this year in backing out of an agreed $217 million settlement of litigation over its role as auditor of the defunct Baptist Foundation of Arizona. The accounting firm revived the settlement as a trial got underway.

Asbestos litigation costly to workers: Study

Workers at companies that are driven into bankruptcy by asbestos litigation end up suffering significant losses in both present and retirement income, according to a study prepared by Sebago Associates for the American Insurance Assn. The study says that workers at such firms suffered estimated average declines of 25% in their 401(k) plans due to bankruptcy. In addition, each displaced worker at a bankrupt firm will lose between $25,000 and $50,00 in wages over his or her career, according to the survey.

Briefly noted

The National Assn. of Insurance Commissioners membership is expected to formally adopt the proposed **Interstate Insurance Product Regulation Compact**, which is designed to speed the introduction of new products, at the organization's quarterly meeting in San Diego on Dec. 7-10, according to an NAIC statement....President Bush on Dec. 3 signed legislation that extends through Dec. 31, 2003, a 1996 **federal benefits parity law** that bars group health care plans from providing lower annual and lifetime dollar caps on coverage for mental disorders than for other medical conditions....Spanish insurer **Corporacion Mapfre S.A.** has named Ricardo Blanco Martinez to the newly created position of chief executive.

Labor: Program's end proposed

Continued from page 2

posed to the federal program, because it gave employees an incentive to take leave, often forcing companies to work short-staffed, said Veronica Hellwig, a senior consultant for Watson Wyatt Worldwide in Wellesley Hills, Mass.

Those that lauded the federal proposal blasted the Bush administration for proposing its repeal. "It's shocking that an administration that gives endless lip service to family values would withdraw this policy before its potential has been fully explored by the states," said Judith Lichtman, the president of the National Partnership for Women & Families, a family and health care advocacy group in Washington, in a statement. "It is a slap in the face to American women and men who are struggling to be responsible employees and responsible parents."

But Ms. Hellwig said the elimination of the policy makes sense; unemployment compensation funds, she said, should not be used for family leave. "It's unemployment compensation; it's not baby unemployment compensation," she said.

The move by the Labor department was applauded by the Society for Human Resource Management, which in 2000 filed a lawsuit to prevent implementation of the rules. The suit, which was brought in collaboration with the U.S. Chamber of Commerce, was dismissed this year.

"The DOL action is good public policy, especially given the status of so many state budget deficits. It protects the funds to ensure that those who are truly unemployed have the dollars necessary to make it through a transition period," said Deron Zeppelin, governmental affairs director for SHRM in Alexandria, Va.

The Department of Labor is accepting written comments on the proposed rule until Feb. 3, 2003.

Kaiser: Greater retiree burden

Continued from page 3

said Kaiser Family Foundation President Drew Altman, who spoke at a briefing on the report last week in Washington.

But future retirees may not be so fortunate. Twenty-two percent of employers said it is somewhat or very likely that they will eliminate coverage for future retirees within the next three years.

Randy Johnson, director-human resources strategic initiatives at Motorola Inc. in Schaumburg, Ill., who also spoke at the briefing, described the conflicting pressures employers face on the retiree health care front.

On one hand, Motorola wants to provide coverage to enable its employees "to retire with dignity," he said.

On the other, though, the company needs to control its costs in order to compete effectively, and many of Motorola's competitors do not offer retiree health coverage, Mr. Johnson said.

Motorola pays 80% of retiree health care premiums, though it does not offer subsidized coverage for employees hired as of Jan. 1.

While retiree health care costs are rising at a rapid pace, legislation Congress is likely to consider during the next session to add a prescription drug benefit to the Medicare program could reduce employers' retiree health cost burden considerably.

Indeed, 61% of surveyed employers said their firms would save money if Medicare were expanded to cover prescription drug costs.

For example, Motorola's Mr. Johnson said prescription drugs account for more than 50% of health care costs for its Medicare-eligible retirees.

Sixty-two percent of surveyed employers said that if Medicare were expanded to cover prescription drugs, they would revamp their plans to supplement what Medicare offers.

Free individual copies of "The Current State of Retiree Health Benefits: Findings from the Kaiser/Hewitt 2002 Retiree Health Survey" are available by going online to www.kff.org, or by calling 800-656-4533 and requesting publication #6061.

Online Poll [11/23 - 12/6]

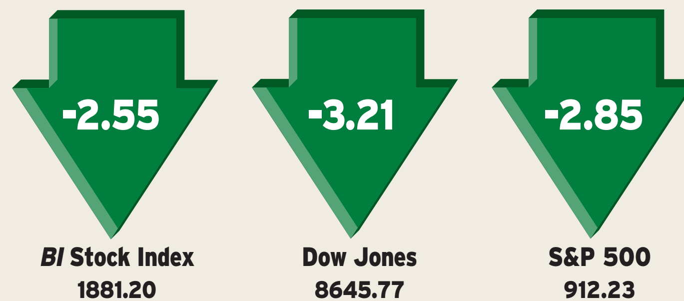
Should single-hulled oil tankers, like the vessel that broke up off Spain's coast, be outlawed more rapidly than 2015, as now scheduled?

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

BI Stock Index [12/2 - 12/6]

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

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



BI Stock Index	Dow Jones	S&P 500
1881.20	8645.77	912.23

Largest gains

Company	Change
SCOR	30.98%
Meadowbrook Ins. Group	16.29%
Gainsco Inc.	16.00%
Willis Group Holdings	10.13%
Sierra Health Services	9.61%

Largest losses

Company	Change
Vesta Insurance Co.	-10.93%
Allmerica	-8.56%
AXA-UAP Group	-7.17%
American Int. Group	-6.46%
Hub International	-6.20%

Weekly change by market segment

Segment	Change
Brokers	1.73%
Insurers/Reinsurers	-0.50%
Managed Care Organizations	3.51%

Source: CNET Investor (investor.cnet.com)

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Business Insurance

Special Take-Out Section

Benefits Management

December 9, 2002

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Business Insurance

Special Take-Out Section

Benefits Management

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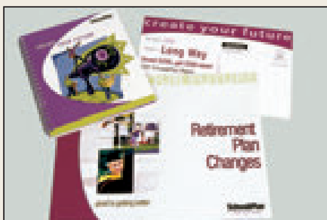

Best of Show - Charles Schwab & Co. Inc. **Page T11**

Steakhouse chain's handbook sizzles

Benefits booklet offers buffet of information for restaurant employees

By SALLY ROBERTS

As a means to consolidate all of its summary plan descriptions and to offer employees a quick reference for their benefits questions, Ryan's Family Steakhouses Inc. developed one large, easy-to-read, eye-catching benefits handbook.

Although the handbook cut down on the number of calls made to the benefits department of the Greer, S.C.-based restaurant chain, it also accomplished another important goal, according to Keith Bray, Ryan's director of risk management and benefits. "Primarily, we wanted to give employees something that would be beneficial to them and help them understand their benefits," he said. At the same time, though, "we feel we have one of the best—if not the best overall—benefits package in the restaurant industry, and we wanted to communicate that," Mr. Bray said.

"We have gotten so many good comments about how employees didn't realize how good their benefits were," he said. "It's done its job and met its objective from that aspect."

Ryan's Family Steakhouses' "Team Member Benefits Handbook," which was mailed out in early 2001 to approximately 5,000 employees enrolled in its benefits plan, won Best of Show in the *Business Insurance* 2002 Employee Benefits Communication Awards competition in the multisubject booklet category.

"Ryan's is a restaurant chain, so they don't have (human resource) people at every location and they don't have a huge HR staff with a huge call center to manage a lot of questions from employees," said Traci Turner, who served as the communications consultant on the handbook. "And it's hard to ask restaurant managers to be front-line HR people."

By providing one handbook that incorporates all of the restaurant's SPDs for each benefit offering in a legally compliant yet easy-to-read format, employees have quick access to information and the answers they are looking for, said Ms. Turner, a principal of Turner Dillon L.L.C. in Atlanta.

Throughout the handbook's 155 pages, employees can find a brief overview of each benefit, information about how to get claim forms and answers to coverage questions, phone numbers and Web addresses.

"One of the things this handbook has that has been so helpful to employees is a 'life events' section at the beginning of the handbook," Ms. Turner noted. This section gives employees information about what to do when getting married, having a baby, going out on disability leave or retiring, as well as other events, she said.

The blue- and peach-colored

See RYAN'S/next page

Connecticut meets 403(b) challenge

Enrollment guide successfully explains new investment options

By JUDY GREENWALD

The state of Connecticut faced a daunting challenge when it set out to design the 403(b) enrollment guide for the employees of its educational institutions.

The state was slashing the number of participating vendors—from more than 70 down to six—and had to describe the defined contribution plan program to all of its approximately 15,000 eligible employees, from custodians to professors.

The result was a 20-page booklet that was named Best of Show in the single-subject booklet category in the *Business Insurance* 2002 Employee Benefits Communication Awards competition.

The 403(b) program had been "in shambles," said Steve Weinberger, Hartford-based director of retirement and benefit services for the state of Connecticut. "We found ourselves with over 70 vendors that were actively in receipt of contributions, and it wasn't clear to us exactly what our employees were investing in for starters, so we really needed to shape up a legitimate program."

Mr. Weinberger said a key component of this entire process was the communications material "and the effort that we made to explain the new program and educate employees as investors, which I think was really being done for the first time."

One issue in approaching the project was the booklet's broad audience. "It was a very diverse group of people that we needed to communicate to," said Mr. Weinberger. "We have people eligible to participate who spend their whole lives as custodians, and actual real-life rocket scientists," he said.

Janice Cymerman, an associate principal with Buck Consultants Inc. in New York who worked on the project, said it was a question of "making sure the brochure would appeal to all different levels of understanding."

Mr. Weinberger said the designers sought "to approach this in a very realistic and comprehensible fashion so that, regardless of background or expertise, the communication is going to be effective insofar as explaining the program, the different investment choices inherent within it, the risk that they bring and the overall objectives of a 403(b) plan."

The booklet's cover features a letter from state Comptroller Nancy Wyman. Inside, colorful graphics, charts and illustrations are used to describe the 403(b) program. Each chapter is introduced on a page with gold lettering against a striped background. The booklet also features a pocket that holds brochures with information on the plan's six investment choices.

Mr. Weinberger said he regards the communication program, which cost between $55,000 and $65,000, as a success. "All things considered, recognizing that this a very vocal, demanding and some-

See CHALLENGE/page T5

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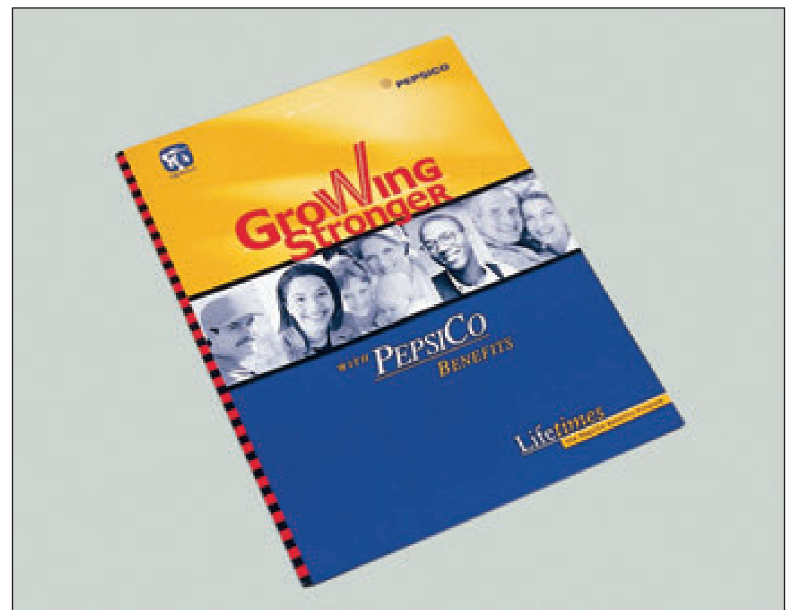
PepsiCo brochure explains merger's effects on benefits

Booklet eases transition for workers joining program



By SALLY ROBERTS

When PepsiCo Inc. merged with The Quaker Oats Co. in August 2001, the soft drink company wanted to ensure a smooth and successful transition for the 3,500 Quaker employees who would be joining PepsiCo's benefits program.

One key element to easing that change was a four-color brochure that not only informed Quaker employees about their transitional and new benefits, but also welcomed them to the PepsiCo team.

PepsiCo's "Growing Stronger with PepsiCo Benefits" won the Award of Excellence in the 2002 *Business Insurance* Employee Benefits Communication Awards competition in the multisubject booklet category.

"This was the first communication going out from PepsiCo to the Quaker audience," said Peter Dattilo, president of Dakota Group Inc., the Wilton, Conn.-based creative consulting firm that helped PepsiCo's benefits communication team develop the materials. "Like any other merger, Pepsi was sensitive to the first communication and how it would be received."

One of the challenges PepsiCo faced was that although Quaker employees were receiving some new benefits with PepsiCo, other Quaker benefits—namely, a lucrative employee stock ownership program—were being eliminated.

The goal of the communication project was to highlight the positive benefits changes and minimize the negative perception of other changes, Mr. Dattilo said.

The employers' 15-page brochure uses charts, graphs and photos to welcome employees to the company and to highlight and detail key benefit offerings. It also includes a calendar of events that clearly outlines what has happened in the merger and what employees can expect in the future with regard to their benefits.

"We wanted to keep it simple, and we also wanted to use bright colors to give it a positive, upbeat attitude," said Gerry Hawkings, creative director at the Dakota Group, who also worked on the project.

The approximate cost of producing the brochure, which was mailed to the employees' homes, was $30,000.

Ryan's: Benefits booklet

Continued from previous page

handbook uses old-fashioned restaurant graphics and plays on the restaurant theme throughout, Ms. Turner said. For example, each SPD contains a "Quick Bites" section at the beginning, which gives a brief overview of the benefit. And the message on the handbook cover reads, "How may we serve you today?"

"We want them to know that, from Ryan's standpoint...we are there to serve them if they have questions or issues or comments," Mr. Bray said of the message.

At the back of the handbook is a pocket in which employees can place the additional brochures and newsletters that are sent throughout the year to provide news and explain plan changes.

Mr. Bray said that he expects to have to update the handbook every two to three years.

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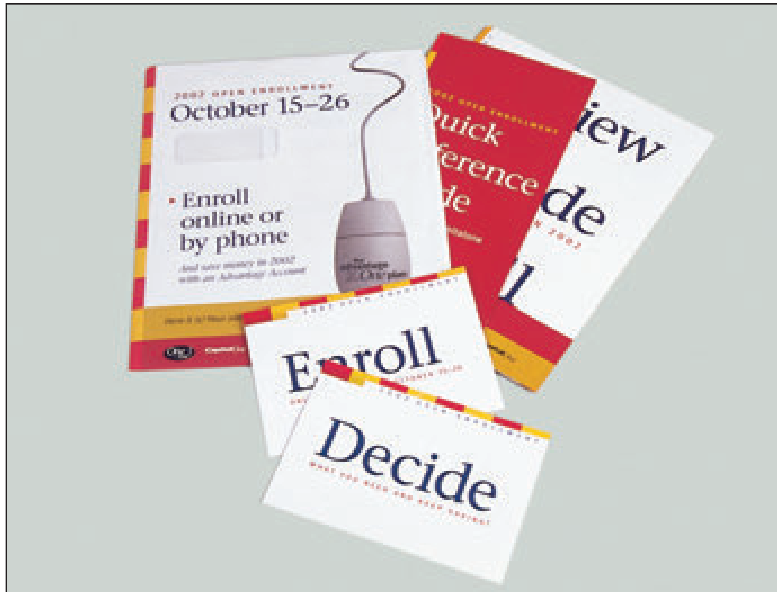

Capital One raises interest in online enrollment program

By JUDY GREENWALD

When Capital One Services Inc. launched a campaign last year to encourage its 15,000 employees to enroll in its benefits plan online, it anticipated, at best, a participation level of 50%.

Instead, to the delight of the campaign's organizers, 80% of employees enrolled using the Web during Capital One's open enrollment period. In fact, the program was so successful that the company has decided to enroll everyone online this year, said Steve Morawetz, group manager of human resources communications for the Falls Church, Va.-based consumer lending products firm.

The program, which included an enrollment kit, postcards and posters, was named the Best of Show in the total benefits category in the *Business Insurance* 2002 Employee Benefits Communication Awards competition.

Encouraging employees to enroll online was a big change for the company, Mr. Morawetz said. "In the past, we had been a pretty much traditional, paper-based enrollment company," he said; only in the last couple of years had they introduced the possibility of using an interactive voice response system for enrollment.

As a result, "the biggest challenge we had with our associates was convincing them that going online to enroll benefits was the way to go," he said.

First, "we had to make sure the experience was pleasant in terms of not having technical glitches," said Mr. Morawetz. A second issue was the cost, he said, noting that online enrollment costs less than doing so either by paper or phone.

The company was successful on both counts. In addition to achieving an 80% participation rate, "we were actually able to reduce the amount of expense from the prior year," by trimming the enrollment booklet to 16 pages from 32, said Mr. Morawetz.

He would not disclose the exact costs but said the overall communications program cost about 10% to 20% less than the previous year's program.

The front cover of the enrollment booklet reads: "Review your options," "Decide what you need in 2002" and "Enroll Oct. 15-26," with the first word of each phrase presented in large, bold type. Page one of the booklet advises, "If you read nothing else, read this page!" and then details the review, decision-making and enrollment process.

Postcards were also sent to employees' homes reinforcing these three steps. In addition, employees received reminders through the company's voice-mail system.

Capital One "tried to be very direct and simplify their message," said Julie Horner, a consultant with Hewitt Associates Inc.'s communications practice in Atlanta who helped put the materials together.

"People start zoning out after a while if books get too long. So we really wanted to try and be aware of how little time people had but also wanted to make sure that they covered all the important points so some of the nuances of enrollment didn't get lost," said Ms. Horner.

The designers sought to "mimic what people would see online." To do so, the company provided headline-style links that could be clicked on to get additional information, said Ms. Horner.

In terms of feedback, "this is a perfect case study of no news is good news," said Mr. Morawetz. Capital One can gauge the level of acceptance and determine whether the process was clear and understandable by the volume of calls seeking help, he said. The number of calls was "significantly below what we had anticipated," Mr. Morawetz said, "so that was a good sign in and of itself."

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Southwest Gas' branding effort gets benefits materials read

By RODD ZOLKOS

In trying to introduce new benefits and a new enrollment method to Southwest Gas Corp.'s 2,500 employees, one of the biggest challenges was simply to get employees to read the benefits materials.

"What I find is employees generally don't read what we give them," said Kim Smith, senior manager, corporate human resources, at Las Vegas-based Southwest Gas.

"A lot of it is because there's just too much text and a lot of it is just not easy to understand," Ms. Smith said. "It's almost legalistic."

But working with Mercer Human Resource Consulting, Southwest Gas solved the problem by developing a consistent set of icons to identify key benefits subject areas, making liberal use of color and graphics, and by being sure that material was written at an appropriate reading level for the company's various employees.

Ultimately, the efforts to communicate details of the FleXelect benefits program and direct employees to online benefits enrollment were successful, earning Southwest Gas an Award of Excellence in the total benefits program category of the *Business Insurance* 2002 Employee Benefits Communication Awards competition.

"We had a number of objectives," said Donna Jaffee, senior consultant at Mercer in Los Angeles. "First off, the materials Southwest Gas had been providing them had no consistency visually."

With the goal of creating a visual brand for the Southwest Gas human resources department, an illustrator was hired to develop icons for the various benefits groups. The illustrator also developed icons for the two ways employees could enroll, online and by telephone.

Those icons, a doctor's bag and stethoscope for medical benefits, a piggy bank for the flexible spending account, etc., now are associated with information on those subjects throughout Southwest Gas' print and online benefits communications.

Ms. Smith credits employees' increased understanding of their benefits due to the FleXelect communications with doubling the number of employees who enrolled online, to 60% this year from 30% last year. Next year, Southwest Gas plans to go completely to online enrollment.

The entire communication program cost $140,000, with print materials distributed to employees at the six Southwest Gas sites through internal mail.

Challenge: 403(b) options

Continued from page T2

times difficult audience, I would say that we hit a home run," he said. "This was the first time this audience is receiving a standard communication that presents information to them about the program in a regular, formatted fashion and gives them the essential information they need to be effective participants. So, from my perspective, this has really been a wonderful accomplishment."

About 6,000 of the approximately 15,000 employees are now participating in the 403(b) plan, "and I'm looking for that to steadily increase," said Mr. Weinberger. He noted that, despite the new program's introduction in a down market, "there has been steady growth."

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Kodak newsletter keeps workers focused on the benefits picture

Need to limit costs spurs creative approaches

By MEG FLETCHER

It seems only appropriate that a photographic and imaging manufacturer such as Eastman Kodak Co. should have an eye-catching employee benefits newsletter.

But creating a "fresh" looking newsletter that was also consistent graphically with other employee benefits communication materials was challenging due to budget constraints, according to Jan Peckham, the benefit communications manager for the Rochester, N.Y.-based company.

"Do more with less…has become an unavoidable mantra," at Kodak, which, like many major corporations, has a dwindling staff and budget for overhead functions, said Andree Mastrosimone, the president of Calm & Sense Communications, a communications and marketing consulting firm based in Kodak's hometown that participated in the project.

Judicious investments in two-color processing—such as the use of yellow and blue instead of the black and a single color used previously—produced a lively-looking newsletter that belied its cost-conscious approach.

As a result, the revamped "You & Kodak news" quarterly newsletter "achieved more impact with no additional printing cost," Ms. Peckham said.

In addition, the recurring appearance of a globe-like logo in a vertical box along the left margin of the page repeated the "Total Compensation" theme of other employee benefits materials, such as the company's kit for new hires and its retirement-planning workbook, Ms. Peckham said.

Kodak wanted a consistent approach to help all its employees recognize benefit-related information and keep them interested in reading about timely matters such as stock options, health care reimbursement accounts and enrollment deadlines.

An entry consisting of five recent newsletter issues won Best of Show honors in the benefits newsletter category of the *Business Insurance* 2002 Employee Benefits Communication Awards competition.

The revised quarterly newsletter, which was first distributed in May of 2000, was mailed to the homes of each of the company's approximately 30,000 employees in the United States.

The benefits department also was able to control mailing costs for the quarterly newsletter by inserting it into the same envelope used to send the company's more frequent general newsletter. In addition, by limiting design and writing costs to less than $1,000 per issue, the total cost of the quarterly newsletter was kept to $4,000 per issue, or $16,000 annually, Ms. Mastrosimone said.

The newsletter facelift met Eastman Kodak's goals by developing an appealing publication that encourages employees to read it, Ms. Peckham said. Kodak got positive feedback on its redesigned newsletter initially from a 30-employee communication advisory team. The team, she said, includes "a vertical slice" of employees, from supervisors to line workers.

In addition, hundreds of workers responded positively to an e-mail survey that was conducted after employees had received the first two issues, Ms. Peckham said.

Specifically, 92% of respondents agreed that the publication is well designed, 89% of respondents strongly agreed that the newsletter is interesting and easy to read, and 79% of respondents said that they read each issue of the newsletter from cover to cover.

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Communications down to a science

Bio-Rad newsletter a success in driving online enrollment

By MEG FLETCHER

Bio-Rad Laboratories Inc. realized that its new benefits newsletter was a winner when 87% of the company's employees enrolled in its benefits plan through the Bio-Rad benefits Web site the first time that option was offered.

"We were thrilled," because the level of response exceeded the 80% that is typical for first-time online enrollment, said Colleen Corey, corporate benefits and employment manager for the company, which is located in Hercules, Calif.

"The focus of the newsletter was to introduce employees to the new system and educate them about how to navigate it," Ms. Corey said.

The eight-page newsletter, which was designed in two versions to meet the needs of both union and nonunion employees, was mailed April 25 to the homes of the company's 2,100 employees in the United States. The total project cost approximately $20,000.

The version that was sent to the 90% of employees who are not union members won an Award of Excellence in the *Business Insurance* 2002 Employee Benefits Communication Awards, in the category of benefits newsletters.

While Bio-Rad sought to introduce the new enrollment technology, it was careful to preserve traditional options for employees, who were accustomed to receiving a 25-page booklet rather than logging on to a Web site for benefits information.

Few employees used low-tech approaches, though: Only 12.5% of employees enrolled using paper forms, and less than 1% enrolled by telephone, Ms. Corey said.

In addition, Bio-Rad's newsletter was designed to reflect the human resources department's new branding theme—"The people behind the science." Bio-Rad employees provide tools and services to clinical diagnosticians and to researchers in life-related sciences.

That theme was emphasized graphically in the newsletter with the department's new logo. The logo, which appears at the top of each newsletter page, features four photographs depicting workers' faces and the company's name.

"Everything from the design to content really worked well together to inform and educate employees about a completely new way to access benefits information," said Kathleen Renger, a San Francisco-based communications consultant with Aon Consulting in Chicago who also worked on the newsletter project.

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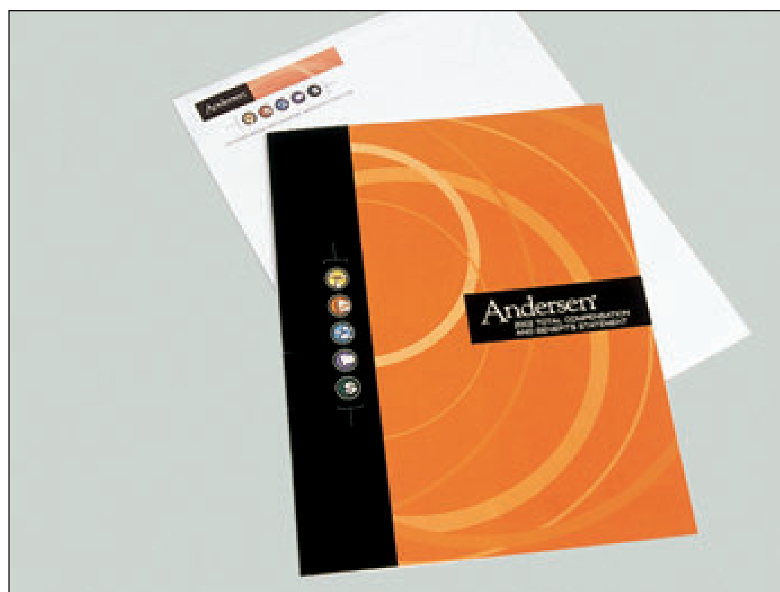

Andersen opens window to realizing benefits' worth

Statement tells total-package value

By RODD ZOLKOS

As at many companies, the benefits provided employees at Andersen Corp. represent a considerable portion of employees' actual total compensation.

So, learning that some employees didn't even know about certain benefits and were unaware of their value prompted the Bayport, Minn.-based manufacturer of custom windows and doors to look for a way to better communicate compensation and benefits details to its 5,700 benefits-eligible employees.

The resulting 2002 total compensation and benefits statement earned Andersen a Best of Show in the personalized correspondence category of the *Business Insurance* 2002 Employee Benefits Communication Awards competition.

Maureen McDonough, director of corporate communications at Andersen, said company-sponsored employee focus groups revealed that many employees "didn't even know they had a pension plan, and the pension plan is a huge piece of their total benefits. So we wanted to make sure they understood what their benefits were."

Also, because many employees had never worked anywhere other than at Andersen, they did not realize how favorably their benefits stacked up against those available elsewhere.

Assembling the total compensation and benefits statement was a complex challenge. "We had various sources of information that all had to be pulled together," Ms. McDonough said. "Another challenge would be making this understandable for the range of people we were trying to reach."

To communicate effectively with those various groups, the company produced three versions of the statement, one for general office and manufacturing employees, one for sales staff and another for executive-level employees. "The general language and the tone was slightly different for each of those versions," Ms. McDonough said. The company also produced a Spanish-language version.

According to John Ritz, senior vp, and Rochelle Helm, project manager, at Aon Consulting in Owings Mills, Md., who worked with Andersen on the compensation and benefits statement project, the company's goals were achieved by integrating concise, easy-to-understand language with employee-specific data into a personalized statement.

In addition to identifying the full scope of their benefits package and the benefits' value, the booklets provide employees with a useful financial and retirement planning tool, according to the consultants.

To further clarify benefits information, the total compensation and benefits statement used the same corporate branding introduced in Andersen's 2002 Benefits Open Enrollment Guide, linking the statement with Andersen's existing benefits education program.

Before the statements went to the printer, Andersen presented the new statement to employee focus groups to obtain their input. Once printed, the statements were mailed to employees' homes in April.

The total development of the statement took about six months, with the project costing under $90,000. The company has already begun developing the 2003 statement, with plans to deliver it to employees in late March, Ms. McDonough said.

"We've gotten really great feedback," Ms. McDonough said. "It's funny. Our company has a culture of not providing much positive feedback. If they like it, they don't say anything. But if they don't like it, you hear about it."

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Fox Entertainment document makes employee star of show

Statement highlights value of workers' benefits

By RODD ZOLKOS

In crafting a 2002 benefits statement, Fox Entertainment Group Inc. sought a document that would not only convey the necessary information but also appeal to employees throughout the company's diverse operations at 200 different sites.

"Fox Entertainment Group is a fairly large, diversified company with operations all across the country, though benefits are centralized" at the company's Los Angeles headquarters, said Lynn Franzoi, senior vp-benefits at Fox. "We know we have a very good benefits package, but our goal is make employees aware of the value of their benefits."

The result of those efforts is a movie-themed document that makes the employee the star of the show, earning Fox an Award of Excellence in the personalized correspondence category in this year's *Business Insurance* Employee Benefits Communication Awards.

"Total compensation statements often have a less well-defined mission than something that is more specifically targeted," said George Grimm-Howell, a senior consultant at Buck Consultants Inc. in St. Louis who worked on the Fox project.

The purpose of such statements is to build an appreciation for the value of the noncash compensation, Mr. Grimm-Howell said, using "some creative techniques to make the statement more interesting and engaging and create a 'splash effect' when they are released."

In previous years, the Fox statement used images of particular stars or stills from certain films, posing problems if stars fell from favor or the movie bombed. Such problems have, on occasion, forced last-minute changes in the document's design.

"The way we solved that problem was to move more to illustration and trying to go with something that was more conceptual and less literal," Mr. Grimm-Howell said.

Another challenge was to "present the information in a way that makes all the various employees at Fox feel included," something else the statement's design achieves, the consultant said.

"I think the design Buck came up with this year was a real attention-getter," Ms. Franzoi said. "It did fit in well with the company."

The statement was produced over about six months at a budget of $130,000, before being distributed to the homes of 8,000 benefits-eligible Fox employees in May.

The response to this year's statement has been very favorable, according to Ms. Franzoi, citing opinion cards returned by employees and the quality of the additional questions they're asking about their benefits.

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Meeting needs of an outspoken, diverse workforce

Battelle's 401(k) kit gives employees investor info at whatever level of complexity they seek

By JOANNE WOJCIK

When Battelle Memorial Institute changed 401(k) plan recordkeepers to The Vanguard Group in 2001, the research institute also needed a new enrollment and education communications program.

But developing a communications kit that would be sophisticated enough for Battelle's many highly educated researchers yet simple enough for all of its 8,000 employees in Richland, Wash., and Columbus, Ohio, posed a challenge, according to Sheila Beck, supervisor of benefits administration at Battelle.

"With our staff, you wanted to keep their attention, have something bright and colorful. But they're also analytical, and we wanted the information to be precise and clear," Ms. Beck said. Because most of Battelle's researchers are analytical types, "it had to be very, very correct. So we did a lot of checking before we put everything out on the Web site," she said.

Ms. Beck said it is clear that the online 401(k) enrollment kit Vanguard created for Battelle met both of these objectives, "because no news is good news, especially here." The company's employees can be "a very vocal group of people, especially when they're not happy," she said.

The kit was named Best of Show for electronic communication in the special project category of the *Business Insurance* 2002 Employee Benefits Communication Awards competition.

In fact, the recordkeeper change itself had been made in response to a survey conducted two years ago, in which the research institute's employees said they wanted more and varied investment options as well as more electronic communication about plan issues, Ms. Beck said. Under the previous plan, most benefits communication was conducted by phone, she explained.

"They wanted something online; they wanted more information," she said.

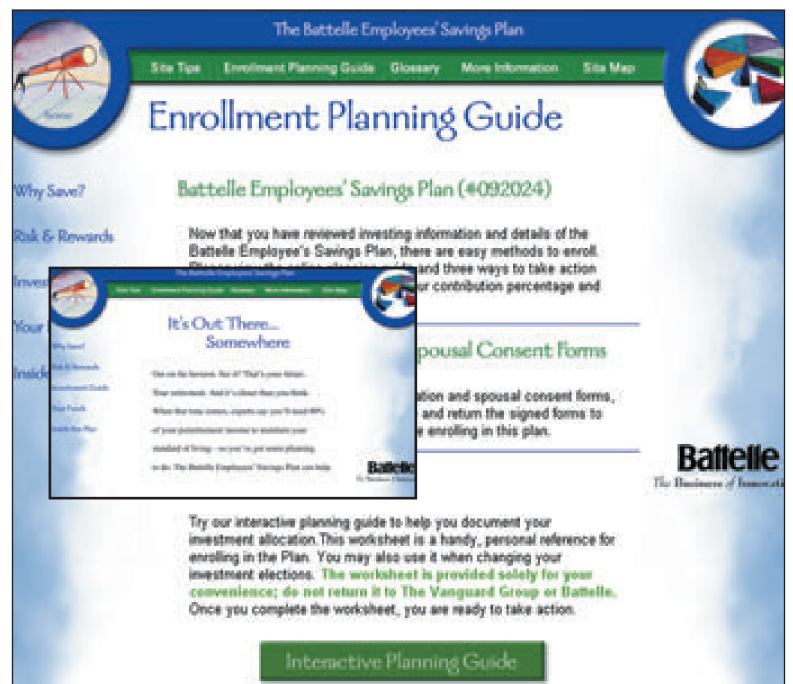
To meet the demands of Battelle's outspoken yet diverse workforce, "the Web site was set up so that people could gain access to the information they needed in the way that they needed it," explained Rich Dikeman, an education consultant at Vanguard in Valley Forge, Pa.

For example, though the text used throughout the online enrollment and education kit is intended for the novice investor, associated "Take a Closer Look" pieces provide in-depth information. In addition, for the highly experienced investor, connections are available to providers of advanced financial information services such as Financial Engines and Vanguard.com.

One indication of the success of the communications program is the lackluster demand Vanguard has seen for hard-copy kits, in contrast to a high number of Web site visits, according to Mr. Dikeman.

"The hard-copy kits are not depleting, which means people are turning to and relying on the electronic kit," he said. The Web site has received 1,288 unique visitors through Oct. 31, and the average visitor spends 9 minutes and 13 seconds on the site, he reported.

In addition, Battelle employees have become the biggest users of "e-meetings" for the Financial Engines resource, according to Mr. Dikeman. This service provides personalized financial planning information.



If this trend continues, the cost of updating the communications program will fall significantly, because making changes electronically costs less than reprinting booklets, Mr. Dikeman explained. Of the approximately $30,000 spent to create the program, most of the expense was related to printing the hard-copy kits, he said.

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BASF uses Web technology to explain new fund options

By JOANNE WOJCIK

When BASF Corp. introduced eight new investment funds to its 401(k) plan, it saw Web technology as the most cost-effective way to communicate the complex changes to plan participants.

Previously, "our plan was pretty generic. We had stable-value funds and equity funds and an asset allocation fund or two. This time, we actually were adding in for the first time three pure bond funds, which were totally foreign" to the company's 401(k) participants, explained Peter Pascarosa, manager of executive human resource services for the Mount Olive, N.J.-based chemical manufacturer. "So a good chunk of time…was devoted to (explaining) how bonds work."

But, he said, "we were under instructions from the steering committee that we had to do it leveraging some technology. We were not allowed to go on a road show at 40 manufacturing sites."

To keep the cost of the new communications program in check, Mr. Pascarosa enlisted the help of BASF's internal information technology department, as well as plan trustee The Vanguard Group, which provided some of the services at no additional cost.

As a result of the collaboration, BASF's active employees now can use the Internet to access three modules: an enrollment kit, an introduction to the new funds, and a refresher course on investment education and asset classes that also includes information on bond funds.

The program, which includes audio as well as visual elements, won the Award of Excellence for electronic communication in the special projects category of the 2002 *Business Insurance* Employee Benefits Communication Awards competition.

Mr. Pascarosa also used technology to spread news of the change, via e-mail to eligible employees. The message announced that a new icon on employees' computer start-up screens would provide entry to the communications program.

To measure the program's effectiveness, BASF monitored the number of visitors to the site—it saw about 3,000 hits in the first 10 days—as well as the extent of movement into the funds.

In the first month, $29 million—or approximately 2% of the plan's assets—was invested in the new funds, $16 million of which went into the bond funds. Three months later, $57 million had been moved into the new funds, with $21 million in bonds. And, after a year, $99 million was invested in the new funds, with $62 million in bonds.

"We saw a lot of flight to safety into our stable-value funds," Mr. Pascarosa said.

Business Insurance Employee Benefits Communication Awards

Schwab urges employees to 'create your future'

Theme of learning to work toward a richer retirement prompts plan participation

By MICHAEL BRADFORD

Retirement plan changes at Charles Schwab & Co. Inc. gave the company an opportunity to educate employees about the advantages of participation.

"Schwab was making fairly significant changes to the 401(k) plan," said Susie Albrecht, director, employee communications at the San Francisco-based financial services company. "Because of the extent of the changes, we felt this was needed."

Work on the benefits communication program began when Ms. Albrecht joined Schwab in February. She collaborated with Jillian Brege, a senior consultant at the time with Mercer Human Resource Consulting in San Francisco, to develop the package.

Their work helped the finished product earn a Best of Show for traditional print in the special projects category of the 2002 *Business Insurance* Employee Benefits Communication Awards competition.

Ms. Brege said one of the challenges was to "nail down a theme that captured that this was not just a change" but, rather, a way employees could learn to work toward a richer retirement. The aim, she said, was "getting them to really take another look at what they are doing."

The theme that emerged was "Create Your Future," and that message is displayed prominently on the materials that were distributed in desk drops and mailings. Schwab also used e-mail to inform employees of changes.

One of the biggest changes to the 401(k) was an acceleration of the matching feature. Under that change, an employee could contribute less money than was required under the old plan to become eligible for the full company match. Also, Schwab's employee stock option plan was discontinued and moved into the 401(k).

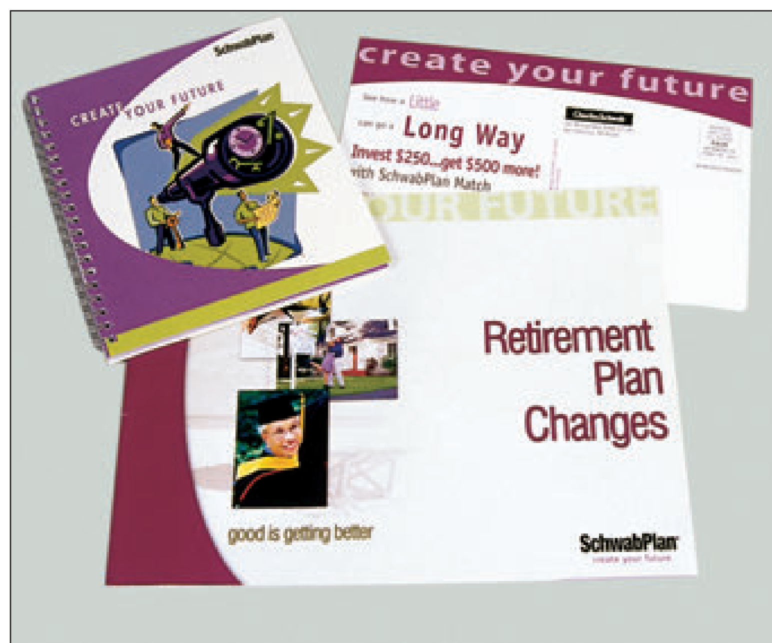
A colorful, 74-page spiral-bound booklet that was mailed to each worker details, in a straightforward, easy-to-understand fashion, how the 401(k) plan is structured.

Eligibility, vesting, the company match and a host of other information is covered. Charts show how compounding increases a plan's worth and highlight the value of contributing as much as possible to the plan. Some basics on investing are discussed, and a list of funds in which employees can invest is also provided.

The retirement plan changes are fully detailed in a separate booklet that was mailed to employees. Questions and answers relating to the changes were handled by e-mail.

"We also built a very robust Web site" where employees can learn about the changes, Ms. Albrecht said.

Ms. Albrecht said workforce demographics influenced the shape of the campaign. "We have a lot of employees under age 30," she said, "and that had an impact on the style we used, in terms of the writing and the design. We wanted it to be something that appealed to a younger audience without turning off the more seasoned employees."



One of the aims of the program was to ensure that there was no decrease in retirement plan participation—a goal that was met, according to Ms. Albrecht. The plan had strong participation before the campaign, with 84% of eligible employees participating.

By measuring the volume of e-mail following the distribution of the first material detailing the changes, Schwab found employee interest to be high. An 85.2% jump in e-mail to the company's Schwab Retirement Plan Services was seen as in indication of growing employee interest in the plan.

In the first month following the distribution of the spiral-bound "Create Your Future" booklet, there was a 61.1% decrease in e-mail volume, which Schwab saw as an indication that employees were comfortable with the details of the plan and were making adjustments to their accounts and investment strategies.