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$4

IRS, Treasury OK cash balance design

But rules threaten other hybrid plans

By JERRY GEISEL

WASHINGTON—Proposed pension plan nondiscrimination rules issued jointly by the Treasury Department and Internal Revenue Service give the government's seal of approval to cash balance pension plans, but other pension hybrids may not fare so well.

The proposed rules, which fill a long regulatory vacuum on the issue, make clear that the very core of cash balance design—crediting employees' accounts with a percentage of pay and crediting the accounts with interest—does not violate federal age discrimination law.

By issuing the rules, regulators are saying that "the basic design of cash balance plans is perfectly permissible," said Scott Macey, senior vp and director of government affairs with Aon Consulting in Somerset, N.J.

"If you have designed a reasonable cash balance plan, which is what most employers have

See CASH BALANCE/page 22

U.S. lawsuits challenge Equitas status, claims handling

By DAVE LENCKUS

LONDON—Former New York Insurance Superintendent Ed Muhl recollects the frenetic late-hour conference calls the night in September 1996 when negotiations over the creation of Lloyd's of London runoff reinsurance organization Equitas Ltd. reached a critical point.

That was the night when Mr. Muhl, who then was the primary U.S. regulator of Lloyd's, signed off on the transaction that saved the loss-burdened 300-year-old insurance market from insolvency. Under its Reconstruction and Renewal plan, Lloyd's remained solvent by fully reinsuring its pre-1993 nonlife liabilities into Equitas.

Six years later, Equitas has paid more

See EQUITAS/page 20

Ignorance, denial, lack of government guidance to blame

Few employers at work on HIPAA compliance

By MICHAEL PRINCE

After months of watching and waiting, many employers have only in recent weeks turned their attention to complying with the privacy regulations contained in the federal Health Insurance Portability and Accountability Act.

"Generally, employers are either in the dark or denial" about compliance, said Lisa Murphy, a member of the Washington law firm of Miller & Chevalier.

Ms. Murphy said that only a small number of employers have moved aggressively toward compliance; many others have, until recently, taken a wait-and-see attitude.

Part of the delay stems from anticipation by many employers that the federal government would change the regulations to eliminate the need for employers to comply.

"A lot of people expected to see a significant revision to how the law would be applied," said Katherine Klug, director of HIPAA services in New York-based Buck Consultants Inc.'s Minneapolis office.

Under the regulations developed by the Department of Health and Human Services, any employer that sponsors a health plan and possesses privately identifiable health information about its employees must implement policies and procedures to protect that information and

keep it confidential. In general, the policies and procedures must be in place by April 14, 2003. Some exemptions exist, though, and small employers—those with less than $5 million in premiums, or $5 million in claims for self-insured employers—have an extra year to comply, consultants and lawyers say.

HIPAA provides for financial penalties for noncompliance, though consultants and legal experts said the government plans to help employers comply rather than penalize them at the outset.

"Virtually every employer is covered by the

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International

U.K. SUIT FOCUSES ON FILM FINANCING

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Late News

Lloyd's to have record $22 billion capacity

Lloyd's of London will have capacity of £14.25 billion ($22.46 billion) in 2003, the most in the market's history, Lloyd's Chief Executive Nick Prettejohn announced. In 2002, Lloyd's had capacity of £12.30 billion ($17.91 billion). "It is testimony to the unique features of a genuine and enduring marketplace. It is a new record which clearly demonstrates the Lloyd's businesses have been successful in attracting new capital," Mr. Prettejohn said.

Appeals courts to hear WTC coverage case

The 2nd U.S. Circuit Court of Appeals has agreed to review lower court rulings on the question of whether the Sept. 11, 2001, terrorist attack on the World Trade Center was one occurrence or two. WTC leaseholder Silverstein Properties Inc. is appealing a decision that a Willis Group Holdings Ltd. policy form defines the loss as a single occurrence, along with a separate ruling denying summary judgment on whether a Travelers Property Casualty Corp. form allows the two-occurrence theory.

Aon-Giuliani alliance takes on school risk

Aon Corp. and Giuliani Partners L.L.C. have begun the first crisis management project under a strategic alliance the two companies announced in October. In the pro bono project, the companies are working with a Chicago public school to develop procedures designed to protect students and the school in the event of a terrorist attack in Chicago. The alliance's efforts at the Walt Disney Magnet School will focus on the security of the school and its students following an attack.

Missouri sues KPMG over General American

The Missouri Insurance Department is suing KPMG L.L.P., charging that it failed to follow professional auditing standards, which contributed to the 1999 financial collapse of General American Life Insurance Co. and its mutual holding company parent. The lawsuit alleges that

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

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CONTINUED FROM PAGE ONE

KPMG allowed misrepresentations in the insurers' statements. It also charges that the accounting firm did not reveal to outside board members and others the risky nature of General American's popular "stable-value contracts," which were essentially guaranteed-investment contracts, according to a Missouri Insurance Department spokesman.

American Airlines settles DVT case

American Airlines has settled a deep-vein thrombosis case in the United States. A spokesman for the airline would not provide other details. The case was similar to a lawsuit filed in the United Kingdom by 56 victims of the so-called "economy-class syndrome" and their families. That suit claims that airlines failed to adequately warn passengers about the risks of DVT, a blood-clotting condition that claimants say is caused by sitting in cramped conditions, such as aircraft cabins, for long periods.

Health care quality initiative announced

Three leading health care groups are launching a voluntary initiative to advance quality care. The initiative focuses on three conditions—heart attack, heart failure and pneumonia—using a common set of measures and priorities. The initiative will report on how 10 quality measures affect outcomes. The American Hospital Assn., the Assn. of American Medical Colleges and the Federation of American Hospitals are the initial sponsors of the quality effort.

Late News

PHOTO: AFP

Stephen Friedman, left, speaks after President Bush named him the top White House economic adviser.

Bush taps Marsh exec as top economic adviser

President Bush has named Stephen Friedman, a senior principal of the MMC Capital Inc. unit of Marsh & McLennan Cos. Inc., as the administration's top economic adviser. Mr. Friedman will head the Bush administration's National Economic Council. He replaces Lawrence Lindsey, whom the administration ousted last week. Mr. Friedman, 64, retired in 1994 as chairman of Goldman, Sachs & Co., and later joined MMC Capital, Marsh's insurance and reinsurance equity unit.

N.Y. regulator urges use of cat reserves

The federal terrorism backstop is a positive development for insurers and policyholders, but it should be followed by government action to allow insurers to set up some form of catastrophe reserves, said Gregory V. Serio, New York's superintendent of insurance. "Catastrophe reserving is essential," Mr. Serio said at the 2002 Annual Executive Conference for the Property/Casualty Industry. Insurers should be granted some form of tax credit to establish reserves in case they suffer multiple catastrophes over short periods, or to allow them to pay for terrorism-related losses after the Terrorism Risk Insurance Act of 2002's provisions expire in three years, he said.

Mr. Serio

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.
- The **Datebook** calendar lists upcoming industry meetings and events and lets you add your own.
- New **Commentary** from Paul Winston joins the work of *BI*'s other columnists.
- The **Online Forum** allows readers to exchange ideas and information.

Briefly noted

The Australian House of Representatives has received a bill that would create the Australian Reinsurance Pool Corp. to **provide insurance for future terrorist attacks**. Australian officials first described in detail how the pool would work in October (*BI*, Oct. 28)....London-based **Royal & SunAlliance Insurance Group P.L.C.** plans to launch an initial public offering for its operations in Australia and New Zealand during the first half of 2003. In November, RSA said it would spin off most of its Asia-Pacific arm, resulting in a reduction in premiums of about £1 billion ($1.56 billion)....**Sir Howard Davies** will leave his post as chairman of the Financial Services Authority in October 2003 to become director of the London School of Economics. He had been due to remain at the U.K. regulator until January 2004. No successor has been named.

Judge blocks CIGNA settlement in Illinois

Slams as 'underhanded' effort to avoid consolidated case

By MICHAEL PRINCE

MIAMI–A federal judge in Miami blasted CIGNA Corp.'s settlement of a physician class-action suit in Illinois last month as an "underhanded" attempt to elude a massive consolidated class-action suit before his court that names CIGNA and other large managed care organizations.

In a sharp rebuke of the insurer, U.S. District Court Judge Federico Moreno approved a request by plaintiffs in the Miami suit to enjoin CIGNA and its attorneys from moving forward with a settlement the company reached with a separate set of plaintiffs and attorneys in Illinois last month (*BI,* Dec. 2).

"How CIGNA can, with a straight face, argue to this court that its maneuvering is agreeable to the usages and principles of law, is incredulous," the judge's Dec. 12 order states.

Since 2000, Judge Moreno has presided over multidistrict class-action litigation brought by more than 700,000 physicians against nearly every large managed care organization claiming the companies have shortchanged the doctors on payments.

In late November, though, Philadelphia-based CIGNA, one of the defendants in the Miami case, agreed to a settlement totaling at least $200 million with physician plaintiffs in federal court in Illinois.

The Illinois case originally was brought in state court, but over a five-day period last month was amended to include federal claims, then removed to federal court, where a settlement was submitted by both parties and preliminarily approved by the court. Because CIGNA settled essentially the same claims, the plaintiffs in Miami would be bound the Illinois deal and CIGNA could not be sued again for the same charges.

Plaintiffs in Miami, who were not party to the Illinois case, immediately asked Judge Moreno to enjoin the settlement.

Judge Moreno said that CIGNA's Illinois settlement is the first such attempt he could find of a party trying to get around the jurisdiction of a multidistrict litigation court.

"The case law is sparse, if nonexistent, in situations where part of a consolidated MDL federal case was settled in a different federal court," the order states.

While acknowledging the rare circumstances of one federal court enjoining another, Judge Moreno said that action clearly is needed to protect the parties in the Miami suit.

"This court is well aware of the strong public interest favoring settlements. However, it cannot turn a blind eye to the underhanded maneuvers CIGNA took to obtain this settlement. CIGNA snookered both this court and Judge Murphy in Illinois in an obvious attempt to avoid this court's jurisdiction. CIGNA settled the claims of this court's plaintiff class and yet seeks approval from another judge in Illinois without informing that judge, apparently, of the proceedings in this case," the order states.

If the court allowed CIGNA to proceed with the Illinois settlement, all the other defendants could negotiate their own settlements outside of the Miami action. "What then, would be the point of consolidating all of the cases here and certify a class," Judge Moreno's order states.

The Miami plaintiffs' co-lead attorney, Archie Lamb in Birmingham, Ala., said CIGNA's tactic is unprecedented in multidistrict litigation.

"They overreached and did it under the cover of night," he said. "This is about a sneaky a tactic in major legislation that I could ever imagine," he added.

CIGNA did not view Judge Moreno's order as a setback. In a written statement the company said the order does not affect the terms of its settlement. "What is at issue is which federal court will review and oversee the settlement," the insurer states.

Mr. Lamb agreed that the settlement still stands and the next step is determining which judge will determine its fairness. Regardless of the judge, Mr. Lamb said he intends to object to CIGNA's settlement as inadequate.

TRENWICK GROUP LTD.

Revenues and net income (in millions of dollars)

	9/30/02	2001	2000	1999
Revenues	$829.8	$1,030.8	$361.6	$161.1
Net income (loss)	($187.7)	($154.4)	$9.5	($2.8)

Source: *BI* survey

Trenwick leaps credit hurdle but faces more

Backing aids Lloyd's unit

By DOUGLAS McLEOD

HAMILTON, Bermuda—Trenwick Group Ltd. has cleared a crucial financial hurdle in securing lenders' backing for its Lloyd's of London underwriting operations, but it still faces the challenge of renegotiating debt that comes due early next year, insurance analysts say.

Trenwick announced that its banks have agreed in principle to renew $182.5 million in letters of credit to capitalize its Lloyd's operations for the 2003 underwriting year. Along with added capital from Trenwick and $156.4 million of previously announced backing from Berkshire Hathaway Inc.'s National Indemnity Co. unit, Trenwick's underwriting capacity at Lloyd's will total about $500 million next year, the insurer reported.

Trenwick also said last week that it will cease writing specialty insurance business through its London-based Trenwick International Ltd. unit, the latest in a series of restructuring moves that have pared down its U.S. and London operations. With the restructuring, Trenwick's main sources of revenue will be its Lloyd's unit and a recently announced facility through which it will produce business for Chubb Re Inc.

With Trenwick's restructuring, the insurance holding company's main sources of revenue will be its Lloyd's unit and a newly formed facility through which it will produce business for Chubb Re.

The insurer needed to close the Lloyd's financing deal with its lenders to ensure a flow of revenue that will allow it to manage its debt obligations, including a $75 million senior note that matures April 1, 2003, industry observers say.

"It's a positive development for the company and provides them with a little more time to work on the refinancing of the senior debt," noted Karole Dill Barkley, an analyst with Standard & Poor's Corp. in New York.

"They needed to get the Lloyd's deal done," agreed Keith Lennox, an analyst with A.M. Best Co. in Oldwick, N.J. "It's one of the ways they can start to generate some cash flow."

In announcing the LOC renewal, Trenwick also reported that it has hired Greenhill & Co. L.L.C., a merchant bank with offices in New York and London, to advise it on restructuring its outstanding debt and preferred equity.

Alan Hunte, Trenwick's chief financial officer, confirmed that the $75 million note is one of the obligations Greenhill will examine but declined to comment on possible restructuring options for Trenwick's debt or preferred shares. The insurer suspended dividend payments on its preferred and common stock last month.

Trenwick's financial struggles accelerated in October when Best downgraded several of the insurer's units be-

See TRENWICK/page 22

Universal health care proposals gathering support in California

By ROBERTO CENICEROS

SACRAMENTO, Calif.—The problem of California's large uninsured population is giving rise to some unconventional thinking about how coverage should be provided in the state.

Earlier this month, new legislation was unveiled that would require employers to help fund a universal health care coverage system. In addition, the chief executive of Blue Shield of California has called for the creation of a universal health care system for the state that would rely largely upon employer-sponsored coverage.

The attempt to mandate business' participation is expected to draw employer opposition, though supporters of the proposal argue that the costs of health care services provided to the uninsured ultimately are passed on to employers and insured individuals, through higher premiums.

In addition, observers say, the bill may have trouble attracting much legislative support because of California's current budget problems, including a deficit of more than $20 billion.

PHOTO : AP/WIDE WORLD

State Sen. Jackie Speier, left, and Blue Shield of California CEO Bruce Bodaken have expressed support for universal health care.

The language in S.B. 2 thus far provides few details about how the insurance-based universal care system would work. But the bill does state that "it is the intent of the legislature to develop an employer-based health care coverage system that provides health insurance to every employee."

Observers familiar with the legislation say it intends to create a "play-or-pay system."

Under such a system, employers would be required to provide health insurance for all of their employees or to pay into a state-run fund that would provide care for employees not covered under employer-sponsored plans.

The unemployed would receive care through government programs.

Sen. Jackie Speier, D-San Francisco,

See HEALTH CARE/page 23

Pension fund manager settles suits

By JOANNE WOJCIK

PORTLAND, Ore.—A federal judge in Oregon has issued a settlement order governing the return of approximately $300 million to former clients of Capital Consultants L.L.C., including more than 60 collectively bargained union pension and welfare plans.

Funds from the court-approved settlement will be distributed by the receiver of the Portland, Ore.-based investment firm, which was accused in more than 20 ERISA suits filed in 2000 and 2001 of mismanaging assets, resulting in nearly $500 million in losses (*BI*, April 30, 2001).

The sum includes $11.4 million that Segal Advisers, a unit of New York-based benefit consultant The Segal Co., has agreed to pay to resolve a separate lawsuit related to the collapse of Capital Consultants. Segal served as an investment consultant to nine union pension plans.

"Segal Advisors believes that it acted properly and did nothing wrong and, in the absence of a settlement, would have vigorously defended itself," a company spokeswoman said in response to the settlement.

The settlement also includes $15.8 million recovered by plan participants who filed several class-action lawsuits against trustees.

Other contributors to the $300 million settlement include Capital Consultants principals, trustees for the pension plans and several lawyers and consultants that worked with the investment company. They are:

- Certain Capital Consultants officers and Wilshire Credit Corp. entities: $40 million. Between 1994 and October 1998, Capital Consultants provided $160 million in loans to Wilshire, a subsidiary of Wilshire Financial Services Group engaged in the business of acquiring and servicing loan portfolios. Wilshire defaulted on the loans.
- Lane Powell Spears Lubersky, Capital Consultants' principal law firm: $25 million.
- Moss Adams L.L.P., an accounting firm that provided auditing and accounting services for Capital Consultants: $17 million.
- Stoel Rives L.L.P., Wilshire's principal law firm: $12.5 million.
- O'Melveny & Myers L.L.P.: $8 million. Capital Consultants hired the law firm for advice and guidance on significant ERISA-related issues.
- McCarter & English, a law firm representing a Capital Consultants' borrow-

See CAPITAL/page 19

Commissioners divided on interstate regulation model

NAIC compact drawing criticism

By MEG FLETCHER

SAN DIEGO—The National Assn. of Insurance Commissioners is facing criticism from both inside and outside its organization over a new model interstate compact adopted during its winter meeting last week in San Diego.

If states enact the Interstate Insurance Product Regulation Compact, it would establish a commission to act as a central clearinghouse to provide regulatory review of life insurers' proposed products, including group or individual annuities, life insurance, disability insurance and long-term care insurance.

"While improving industry competitiveness and the 'speed to market' of new insurance products, a formal IIPRC will provide a 'one-stop-shop' filing process for insurance products while maintaining the existing state-based regulatory system," the NAIC said in a statement. Currently, life insurers seeking to market a new product must get approval on a state-by-state basis.

The compact's leading advocate, outgoing NAIC President Terri Vaughan, said that she considered it "critical" that the NAIC adopt the measure, which has been in the works for the past 10 months. The interstate compact approach is part of "an evolutionary process" to modernize regulation to benefit consumers, insurers and regulators, said Ms. Vaughan, who is Iowa's insurance commissioner.

The vote came after a lengthy and sometimes contentious debate that saw several efforts to amend the model, nearly all of which were rejected.

The proposal ultimately passed on a 37-to-13 vote, with Hawaii abstaining. "No" votes were cast by the commissioners from Arizona, California, Delaware, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Montana, Nevada, New Mexico, South Dakota and Washington.

The 16-page model compact probably would have faced more opposition had it not been successfully amended to require that it be circulated to state officials—including lawmakers and policymakers—for their review and input, according to regulators at the meeting.

While other state officials may want to consider amending the model, Ms. Vaughan said that, eventually, any state wishing to participate in the commission must adopt a uniform version of the measure. Although some state legislatures have expressed interest in considering the proposal immediately, others may need a few years to become comfortable with the concept, she said.

Adoption of the proposal represents the NAIC's first formal effort to modernize state insurance regulation using the well-established mechanism of an interstate compact, which is an agreement

See NAIC/page 18

Supreme Court considers punitive award limits

By MARK A. HOFMANN

WASHINGTON—Drawing a "bright line" that would determine the precise ratio at which punitive damages become unconstitutionally disproportionate to underlying damages could backfire, a Harvard law professor told the Supreme Court last week.

Laurence Tribe's warning came as he argued the position of Curtis B. Campbell and his wife Inez in *State Farm Mutual Automobile Insurance Co. vs. Campbell*. The case stems from the Utah Supreme Court's decision to reinstate a punitive damages award of $145 million against State Farm, which had been ordered to pay $1 million in other damages to the Campbells as result of its handling of a 1981 insurance claim (*BI*, Dec. 9).

The state Supreme Court cited alleged misconduct State Farm had engaged in outside Utah over a 20-year period, as well as State Farm's net worth, in reinstating the award.

State Farm appealed to the U.S. Supreme Court, holding that the punitive damage award was so disproportionate to the compensatory damages that it violated the Constitution's 14th Amendment due process guarantee.

The case has drawn considerable attention from the business community, which views it as yet another opportunity for the Supreme Court to rein in what many employers regard as an irrational and capricious system for awarding punitive damages. In fact, State Farm's position drew 18 amicus briefs—largely from business groups—while the Campbells' drew only six.

In a discussion of the case at the Washington Legal Foundation a few days before the oral argument, Philip K. Howard said that the current system's harm lies not the number of punitive damage awards made but, rather, in the number of punitive damage award sought. Mr. Howard is a partner in the New York office of Washington-based Covington & Burling and the author of "The Collapse of the Common Good."

"It's as if the prosecutor for a misdemeanor could always seek the death penalty," Mr. Howard said. The rampant pursuit of punitive damages turns the judicial system into a form of extortion, he said.

Even though businesses' briefs concentrated on the Utah Supreme Court's emphasis on alleged out-of-state—and, in some cases, only tangentially related—conduct in reinstating the award, as well as the fact that the punitive damage award was 145 times the compensatory award, the question of whether there should be an exact formula for determining a punitive damage award's constitutionality was clearly on the justices' minds.

State Farm's attorney—Sheila L. Birnbaum, a partner with the law firm of Skadden, Arps, Slate, Meagher & Flom L.L.P. in New York—said during Dec. 11 oral arguments, "We're not asking you to draw a bright line. It would be helpful, but I don't think this court is prepared to do this."

The question of whether there should be an exact formula for determining a punitive award's constitutionality was clearly on the justices' minds.

In previous cases, the high court has stopped short of drawing such a bright line but has indicated that a punitive damage award four times the underlying award approached the limits of constitutionality.

"Suggesting a number would be arbitrary," said Mr. Tribe. If the court drew a bright mathematical line, defendants could factor punitive damages into the cost of doing business rather than modify their behavior, he said.

Associate Justice David Souter had asked Ms. Birnbaum that if punitive damage awards four times underlying damages were acceptable and 145 times were not, how did awards of 80, 60 or 20 times the underlying damages fare?

Would the court have "to pick a number?" Justice Souter asked, wondering aloud whether it had any business doing so.

"Runaway" punitive damages are not good for the legal system, said Justice Anthony Kennedy, after Mr. Tribe said that punitive damages in an individual case could take into account the harm done to the community as a whole by a defendant's misconduct.

In reply, Mr. Tribe asked whether it was "the mission of this court to redesign" the legal systems of all 50 states.

A decision in the case is expected next year.

Errors & omissions

● A story in the Dec. 2 issue, "Deductibility of Captive Premiums a Taxing Question," incorrectly attributed a remark on captives obtaining regulatory approval to lend funds to parent companies to C. Jeffery Triplette, vp of risk management-insurance at Duke Energy Corp. in Charlotte, N.C. The comment was made by James R. Cameron, a partner with the Baker & McKenzie law firm in New York.

Comings & Goings: Buyers

Lance J. Ewing has joined Park Place Entertainment Corp. in Las Vegas as executive director of risk management.

Mr. Ewing, 41, who serves as first vp of the Risk & Insurance Management Society Inc. and is in line to assume the group's presidency next year, previously worked as senior director of legal/risk management at GES Exposition Services Inc. in Henderson, Nev.

Mr. Ewing

In his new position, Mr. Ewing is responsible for all aspects of domestic and international risk management at Park Place. Park Place Entertainment owns, manages or has an interest in 28 gaming properties operating under the Caesars, Bally's, Flamingo, Grand Casinos, Hilton and Paris brand names, with a total of approximately 2 million square feet of gaming space, 29,000 hotel rooms and 55,000 employees worldwide, according to the company.

Mr. Ewing reports to Harry Hagerty, Park Place's chief financial officer.

Mr. Ewing earned a bachelor's degree in criminal justice from Mercy Hurst College in Erie, Pa., a master's degree in occupational health and safety engineering from Columbia Southern University in Orange, Ala., and a master's degree in law and justice from the University of Pittsburgh.

He holds the Associate in Risk Management and Certified Risk Manager designations.

We'd like to report on staff changes in your risk management, safety and employee benefits departments. Please e-mail announcements to Michael Bradford, at mbradford@crain.com.

Big employers avoid biggest hikes in group health care rates: CIAB

Large employers are experiencing slightly smaller group health insurance premium increases than are their midsize or small counterparts, according to a survey by the Council of Insurance Agents & Brokers.

The "CIAB Employee Benefits Fall Market Survey" is based on the responses of 80 independent insurance agents and brokers across the country. Seventy-eight percent of the respondents reported that small accounts—covering 50 or fewer employees—had experienced group medical plan premium increases of 10% to 30% since May, with 14% of the respondents reporting increases of 30% to 50% for such accounts, and 1% reporting increases of between 50% and 100%.

For medium accounts, those with 51 to 500 employees, increases were similar. Seventy-four percent of the respondents reported increases of 10% to 30%; 12% reported premium hikes of 30% to 50%. None reported any higher increases.

Large accounts, those with more than 500 employees, fared the best in a difficult market. Seventy-four percent of the respondents reported increases of 10% to 30%, but only 3% reported increases of 30% to 50%, the highest increases cited.

In a statement accompanying the survey, CIAB President Ken Crerar said that the study showed that "employer-sponsored heath insurance is under stress as never before due to the seemingly unstoppable escalation in the cost of medical care. It is critical that players on all levels come together and address this problem."

—By Mark Hofmann

Paul Winston

Putting a premium on catching rogues

A lot of attention is being paid to a federal antiterrorism law that gives the government new surveillance powers over citizens.

The law—dubbed the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001—gives law enforcement agencies easier access to business records, medical records, educational records and even library records in an effort to fight terrorism. The law also provides broader powers to tap phones, Internet usage and other electronic communications.

A more obscure provision of the USA PATRIOT Act requires insurance companies and other financial institutions to screen their clients—policyholders and claimants—against government-provided lists of suspected terrorists, drug dealers, money launderers and other undesirables.

Paul Winston

When insurers begin to comply with the law, I can imagine critics complaining that it just provides them with another excuse for denying otherwise valid claims. But that kind of bellyaching is un-American, by jingo!

Everyone knows that terrorists and felons in general file far more insurance claims than law-abiding citizens and thereby drive up premiums for everybody. Besides, if you are not a terrorist, drug dealer, money launderer or other undesirable, you have nothing to fear!

The aim of requiring insurers to perform these kinds of background checks is to trip up dangerous people as they perform routine transactions, such as purchasing car insurance or filing a health care claim. Much of this process will be automated, so it's not as if you'll have to stand by while your name is screened against a stack of rap sheets.

But even if the method of cross-checking names is streamlined, I have to wonder just how many criminals the law will catch.

In spite of Martin Frankel's best efforts, insurance is not a particularly elegant means of money laundering—at least on the customer's end.

And it's just a guess, but I don't think drug dealers buy much in the way of personal or commercial insurance. Ditto for terrorists.

I can picture it now:

Insurer: Hello, this is the Patriotic Insurance Co., how may I help you?

Claimant: I need to get a broken crown replaced. How do I file a claim?

Insurer: I need your name and policy number, sir.

Claimant: Osama bin Lad...er, I mean, John Smith. My policy number is 123-456-789.

Insurer: OK, just a moment while I access your records, sir. OK, I have it now. Hmmmm. Sir, will you please hold a moment?

Claimant: Hurry up!

Insurer: I'm back, sir, and I'm sorry but we cannot cover your crown replacement.

Claimant: Infidel! You will pay!

Insurer: Sir, no need to be rude. Your policy does not cover this procedure because...

Claimant: What kind of capitalist swindle is this? I give you hundreds of dollars in premiums to pay for this!

Insurer: Yes, sir, but the type of policy you bought doesn't cover this claim.

Claimant: You are a thief!

Insurer: No need to get huffy, sir. Because you are enrolled in the dental HMO, you only get one crown or bridge every 12 years, and you had one installed two years ago. This is how we keep your premiums low.

Claimant: But my tooth is broken!

Insurer: Well, sir, if you had opted to pay more for the premium dental plan, you would be eligible for coverage of more frequent and costly dental procedures.

Claimant: Oh, I get it now. I see what you are up to, devil claims person!

Insurer: Sticks and stones, sir.

Claimant: It's because I'm a terrorist, isn't it?

Insurer: Sir, state law prevents us from discriminating on any basis, including criminal tendencies.

Claimant: I shall declare a jihad against your company!

Insurer: Sir, if you wish to file a complaint, I can give you the mailing address of the insurance commissioner's office.

Claimant: You cheat! I know where you live! I will lay waste to your home, to your town!

Insurer: I'm hanging up now, sir.

Claimant: You Americans are all the same.

Insurer: American? Sir, I should tell you that as part of the Patriotic Insurance Co.'s efforts to keep your premiums low, it has outsourced its claims services.

Claimant: So?

Insurer: So it would be too costly if I were in America. Actually, I am in India. Have a nice day, sir.

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Business Insurance

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Editorial

Rising health costs not inevitable

FOR HOW LONG CAN health care costs keep rising at their current rates?

While that's a question that no one can answer with precision, we can say definitively that one day even the biggest and most financially well-heeled employer will not be able to afford to provide coverage to its employees unless costs are gotten under control.

Just how serious the cost situation has become is underscored by a recent survey by Mercer Human Resource Consulting. Costs, on average, increased nearly 15% this year, which was an astounding seven times more than the overall increase in the consumer price index and the fifth consecutive year of increased costs.

To be sure, there are some forces that are driving up costs—most notably the increased leverage of providers—about which buyers can do little.

But it would be incorrect to say that rising costs, at least at this rate, are inevitable and that there is nothing employers and insurers can do about them.

Certainly, plan design, which is completely under the control of employers, has played a role in the escalation of costs.

Many employers, for whatever reason, were asleep at the switch in designing cost-sharing arrangements. Plans that have $5 or $10 copayments, as many still do, for office visits do not promote the careful use of health care services.

To be sure, cost sharing should not be set at levels so high as to discourage employees from receiving needed services. But $5 or $10 copayments no longer are realistic if one's goal is appropriate use of health care services.

Another area, also very much under the control of employers and insurers, is management of chronic care. Too many employers still lack adequate programs to ensure that employees with chronic problems such as diabetes and high blood pressure receive the maintenance care they need, resulting in neglect of conditions and, ultimately, much higher treatment costs that could have been avoided.

On a broader front, we wonder how many insurers and others that have established preferred provider organizations—which have become the dominant way in which health care services are delivered—are including providers on the basis of quality of care and not just price.

Quality of care—meaning services provided right the first time—may, in fact, be the least-expensive care. Those providers that can do it right should be the first ones managed care vendors should be looking to include in their networks.

Making these kinds of changes won't be easy, but they're more than necessary. To allow the current cost spiral to continue unchecked is a sure way to price the employment-based health care system out of existence.

HIPAA deadline nears

EMPLOYERS ARE RESPONDING in various ways to an approaching deadline for compliance with privacy provisions of the Health Insurance Portability and Accountability Act. Some are acting now to meet the deadline, while many are waiting to see what will happen, and others are seeking ways to sidestep the regulations.

In any case, benefit consultants and attorneys are warning that employers are running out of time. As we report on page 1, most employers will need to take steps by April 14, 2003, to protect employees' private health care information and keep it confidential.

The warnings about HIPAA compliance are not unlike those proclaimed three years ago about the looming Y2K computer problem. In 1999, there was much ado about the millennium bug, which turned out to be almost nothing. Failure to comply with HIPAA regulations, though, carries financial penalties. And an employer's inadvertent or intentional release of sensitive personal information could spark litigation.

Employers and benefit experts have complained that the federal government so far has not provided adequate guidance on complying with the law. Some are suggesting that the Department of Health and Human Services will focus less on penalizing employers and more on helping them comply.

Such help undoubtedly would be welcome, though employers shouldn't wait around for it. Many employers may find that relatively simple actions will ensure the safeguarding of information covered by the HIPAA regulations. For employers with more-complex situations, postponing action until closer to April won't make problems easier to solve.

As with most deadlines, forewarned is forearmed. Employers need not panic about complying with the HIPAA privacy rules, but they should act sooner rather than later.

Schillerstrom

Letters to the Editor

Act should alleviate terror insurance crisis

To the editor: In response to the Dec. 9 article "Backstop Details Leave Questions: Buyers Face Cover Decisions," the Risk and Insurance Management Society Inc. acknowledges that pricing terrorism losses continues to be extremely difficult but strongly believes that, with the passage of the Terrorism Risk Insurance Act, premiums should become more reasonable, capacity should expand and limits should be available to cover buyers' needs.

RIMS member companies, nearly 4,000 commercial policyholders, expect implementation of the TRIA on a reasonably prudent basis. This critical act will go a long way toward restoring our members' faith in the ability of the insurance and reinsurance markets to provide effective safeguards for both policyholders and insurers should future catastrophic terrorist events occur.

The society and its membership are counting on insurers to set fair rates for this new catastrophic risk, which threatens all sectors of our economy and the security of our world. It is critical that insurers act fairly and reasonably, considering all the assistance the buying community has given the underwriting community in securing this legislative remedy.

Christopher E. Mandel
President
Risk & Insurance Management Society Inc.
New York

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Structural flaws imperil health care system

By Brian R. Klepper

Many health plans may be having a banner year, but it would be foolish indeed to ignore employers' and consumers' pain over premium costs.

It's clear now that unrelenting cost is driving American health care into a true crisis. If we don't confront and correct our insidious structural flaws, they'll almost certainly bring on the system's failure. Our safety net will be overwhelmed, and we'll lose billions of dollars invested over decades in those institutions. Employers will retreat from coverage sponsorship, and the government will intervene into the business of health coverage more broadly than ever before. Our health system will change dramatically, and many of us won't particularly like the new order.

We've reached a threshold of affordability. Health costs have risen at twice the general inflation rate over the last 20 years, but, recently, the slope has steepened alarmingly. Last year, premiums rose by an average of 12.7%—the largest rise in 12 years—a breathtaking eight times the 1.6% rate of general inflation and four times the 3.4% wage gains of nonsupervisory workers. This year, the situation is even worse, with costs up 16% or more on average. Small businesses are paying 30% to 70% more for coverage that often is narrower than before. Nobody sees these trends moderating any time soon.

For perspective, consider Wal-Mart Stores Inc.'s 2001 net earnings of $5,079 per worker. Now compare this with overall average per-employee health benefits expenditures for all employers of $5,456 in 2002, up $656 from the previous year. For many companies, health benefit costs are outstripping the average employee's contribution to the bottom line.

Such dynamics are, of course, unsustainable, and the ramifications are fearsome. In the teeth of an economic downturn, many firms are transferring much of the additional cost to employees for the first time. Some are dropping health benefits entirely. If one in seven of the 142 million Americans who previously received employer-sponsored coverage is forced out of the system, the number of the uninsured could spike by 50% or more, to at least 60 million. The uncompensated care load on safety-net hospitals—which are already stretched beyond capacity—would increase dramatically, and many facilities would face failure. A sizable percentage of funding would be removed from the system, affecting the entire health industry. And because health care employs one in 11 workers and represents $1 in every $7 in the economy, the disruptions would resonate throughout all U.S. economic sectors. There almost certainly would be a public outcry for government intervention, followed by a free-for-all among the more than 1,000 health care special interests, each with its own reform agenda.

It's no wonder we can't control costs. Despite huge advances throughout health care, much about performance remains invisible to managers and to the public. Not all organizations collect data, few use that information in meaningful ways, and fewer still share it. We haven't yet agreed on compatibility standards within health care technology, so information exchange remains difficult and, in some cases, impossible. Providers remain resistant to adopting evidence-based guidelines, and the majority of health plans are just as stubborn,

Health costs have risen at twice the general inflation rate over the last 20 years, but, recently, the slope has steepened alarmingly. Last year, premiums increased by an average of 12.7%—the largest rise in 12 years—a breathtaking eight times the 1.6% rate of general inflation.

continuing to use varying protocol sets. Worse, every level of the system lacks accountability for performance.

Because we can't assemble comprehensive, population-level data, the identification of evidence-based best practices remains a clinical concern rather than a more broadly based statistical imperative. And without regional and national performance data on practitioners and institutions, it is difficult to compare clinical or financial performance across providers/vendors or over time.

These issues—information, standardization and accountability—are the major barriers to controlling cost in an increasingly complex and commercialized arena. Unwilling to collaborate and unable to measure, we can't manage effectively.

In the name of competition, the health care industry has systematically fought against these measures. Aside from being self-defeating, our intransigence has baffled and alienated the rest of progressive American enterprise. For the most part, they incorporated these tools long ago and know their numbers. They wonder why we in health care haven't and don't.

If modern health care is to remain viable, policies and programs must be adjusted to facilitate practice changes while moderating cost. Information, standards and accountability are central to that reform, because they are the keys to effective cost management in complex systems. The stakes are enormous, so we'll either do it or it will be done by others.

Currently, the National Quality Forum appears to be the most promising multistakeholder effort to develop a standard national measurement set. This is a groundbreaking project that is in all our interests.

Recently, Health and Human Services Secretary Tommy Thompson said our health system has "the symptoms of a swiftly advancing disease." As it becomes critically ill, the special interests will "unfreeze," fostering greater collaboration and compromise, and making meaningful health care reform possible. This must be a national effort that brings everyone together around a common vision of what health care ought to be, as well as a plan to get us there. For those willing to directly address the symptoms' root pathologies, a unique and positive challenge awaits.

Brian R. Klepper is executive director of the Atlantic Beach, Fla.-based Center for Practical Health Reform, a multiconstituency, nonpartisan effort to stabilize and improve health care service delivery and finance.

Rich understanding of comp costs needed

By Joseph Paduda

Rapid increases in loss ratios driven, in large part, by medical trend rates over 10%, have driven many workers compensation insurers and third-party administrators to re-examine their managed care programs.

For many, this examination has been disconcerting, at best. Case management expenses appear to deliver little return on investment, few procedures are altered as a result of precertification, and preferred provider organization savings and penetration rates are showing marginal, if any, improvement.

Those payers that have turned to their internal managed care staff for answers have found that those operations, trimmed to the bone after the longest soft market in memory, offer little opportunity or capability of delivering additional expense reduction. All this at a time when medical providers are again flexing their muscles, obtaining more-favorable reimbursement rates from even the strongest health maintenance organizations. At times like these, what's a workers compensation payer to do?

The first priority is to understand the problem. And the most important concept to grasp is that, in workers comp, medical expense is not a monolithic problem with a monolithic solution. In fact, analyses by the Workers' Compensation Research Institute of Cambridge, Mass., show that not only are there tremendous variations in medical expenses among states, but that problem areas in some states are not problem areas in others. It is no wonder that generic managed care programs are failing to deliver returns. It is a safe bet that they are directing resources to attack problems that don't exist, while ignoring areas that are much more problematic.

Studying the WCRI's CompScope reports provides several excellent examples of the differences in medical expense profiles in various areas. One of the areas that is highlighted in these reports is physical therapy, and the broader category of physical medicine. Accounting for almost a quarter of medical expenses, physical medicine is involved in the majority of lost time claims and is associated with the relatively few claims that drive most of the loss cost. Historically, workers comp payers dealt with physical therapy expenses through a combination of broad-based discounted PPOs and, occasionally, utilization review and precertification.

PPOs typically contract with facilities, individual clinics and hospitals for physical therapy at percentages off the fee schedules, ranging from 10% to 20%. While these "discounts" seem reasonable at first blush, the "savings" they deliver is illusory.

The problem with physical therapy is not the price per service but the amount of services delivered, something generic PPO arrangements can't control. Typically, physical therapy treatment courses can run from 12 to 18 visits. At $75 per visit post-discount, total costs can easily hit $900 to $1,350 per case.

The most important concept to grasp is that, in workers comp, medical expense is not a monolithic problem with a monolithic solution.

Unfortunately, because the cost per service, or even per day, in physical therapy is low, many payers don't believe it pays to require precertification of physical therapy.

Those that do often find that the ROI is marginal at best. The reason again has to do with the application of generic solutions to what are very different problems.

For example, the CompScope report shows there is wide variation in the delivery of physical medicine around the country. In Florida, physical therapy utilization in nonhospital settings is a comparatively minor contributor to medical costs. Hospital-based physical therapy, though, is quite expensive on a cost-per-service basis. By comparison, physical medicine expense in Texas is primarily a utilization issue. The number of services delivered in Texas is significantly higher than in eight other states in the CompScope analysis. This high utilization correlates with higher costs for physical medicine: Texas' costs are 99.4% above the average.

With a richer and deeper understanding of the problem, we can now develop solutions that are going to deliver the results we need. To continue with the example above, while it may not pay to precertify nonhospital physical therapy in Florida, the ROI on pre-certification for physical therapy provided by a hospital should be quite good. In contrast, given Texas' expense picture, precertification appears to be very attractive. Unfortunately, Texas workers comp laws are not particularly supportive, making it difficult to enforce reductions in care.

Physical therapy is but one example of the diverse and dynamic problem that is workers comp medical expense management. Similar variations are present concerning hospital expenses, pharmacy costs and the use of surgery and radiology—in fact, the entire scope of medical services. Successful workers comp payers will recognize that, in order to control these costs, they have to broaden and deepen their understanding of the components of the medical dollar.

Joseph Paduda is principal of the Madison, Conn.-based consulting firm Health Strategy Associates.

Bad times are good for Kroll's restructuring service

By LISA FICKENSHER

Security and investigation firm Kroll Inc. is going through an identity crisis—and loving every minute of it.

For most of its 30 years, New York-based Kroll was known as the go-to company for investigating corporate crime and high-profile cases. Its bread and butter was handling everything from chief executives being stalked to governments looking for hidden assets—Kuwait hired Kroll 11 years ago to locate Saddam Hussein's investments abroad.

These days, Kroll is just as likely to get a call from a company that's liquidating its assets or restructuring. One of its executives, Stephen Cooper, is the acting chief executive of Enron Corp.

Long known as the go-to firm for investigating corporate crime, Kroll these days is just as likely to get a call from a company that is liquidating its assets or restructuring.

And, in a year when most companies are downsizing, Kroll is growing like never before. A series of acquisitions—including the purchase of restructuring firm Zolfo Cooper—means that revenues this year should reach $285 million, up 38%. The company is expected to report a profit of $19.8 million, or 61 cents a share, compared with a loss of $21 million last year.

This year, only 18% of Kroll's revenues have come from investigations, compared with nearly 40% last year and nearly 100% just a few years ago.

"We want to be a company that is fine in good times and bad times," said Michael Cherkasky, who has been president and chief executive of Kroll since May 2001.

Part of Kroll's recent success is due to timing. Since the Sept. 11, 2001, terrorist attacks, there is more demand for security services and intelligence. The other part is due to its corporate reinvention.

"We really look at ourselves as a new company," Mr. Cherkasky said.

In 1997, an armored car manufacturer named O'Gara-Hess & Eisenhardt acquired Kroll, a private firm founded by Jules Kroll. The new entity, called Kroll-O'Gara Co., was traded on the Nasdaq. But the marriage was uneasy: The companies, which were managed separately from two different headquarters, were plagued by internal bickering.

After four years, the Kroll side took control and sold the O'Gara portion, pocketing $53 million in cash. It used its windfall to help pay down $76 million in debt. The remaining debt was turned into unsecured convertible notes, which Kroll executives now expect will be converted into equity because the firm's stock price has risen. Its shares are up 29% since the end of last year, trading at about $19.50 today.

Driving the company's growth and its future potential are two acquisitions made this year. In June, Kroll bought OnTrack Data International Inc., the nation's largest data recovery firm, and in September, it acquired Zolfo Cooper.

"Getting a well-recognized name in corporate restructuring is a feather in its cap," said Ben Perks, chief financial officer of Denver-based Navigant Inc., a Zolfo Cooper rival.

In fact, Navigant itself had hoped to acquire Zolfo Cooper. "It was a coveted boutique," said Mr. Perks.

The corporate restructuring business is booming because of the large number of troubled firms. Furthermore, companies like Kroll are likely to be able to grow by acquiring rivals or groups of specialists, since accounting firms will have to jettison their units that perform restructuring work.

"You are starting to see a spinning off of these specialized businesses, like bankruptcy reorganization," said Mr. Perks.

The payoff can be substantial. In just one month, Zolfo Cooper generated $7 million in revenues for Kroll. It also brings Kroll more financial predictability: Its work with Enron, for example, will keep money flowing in for at least another four years, Mr. Cherkasky said.

That's a good thing, because Kroll's revenues from investment banks and law firms involved in IPOs and mergers and acquisitions dried up 18 months ago. While this loss of due diligence work is painful, it's not crippling, insists Mr. Cherkasky, since no single client represents more than 3% of

See KROLL/next page

Insurer recovery tougher than many had assumed

Prolonged soft-market pricing, long-tail exposures help slow return to profits

By Myron M. Picoult

Notwithstanding a pricing environment that is clearly stronger and broader based than was expected by industry observers, the earnings recovery for many underwriters is proving to be more difficult to achieve. This would seem to explain the dearth of smiles on the faces of most CEOs and CFOs. The stresses of the overall marketplace and the inability to meet earnings expectations—which, in hindsight, were permitted to rise to unreasonable levels—are taking their toll.

It took a long time to for the property/casualty industry to get into this mess, and it will take a long time to get out. Two years of price increases will not make everyone whole. With every quarter, it becomes increasingly clear that business written between 1998 and through most of 2001 was more poorly priced than management realized.

Taking stock

Exacerbating the pricing shortfall is that fact that terms and conditions were horrendously compromised. Adding fuel to the fire are the ongoing difficulties of old asbestos and environmental writings that continue to haunt insurers. Balance sheet integrity, for most of the industry, was undermined by the use of feckless reserving standards. As 2002 progressed, virtually all insurers were forced to lower their earnings guidance.

Indeed, the decline in earnings put considerable pressure on the old savior—net investment income. Nonetheless, the fact remains that basic reserves were woefully understated. Underwriters have begun to correct the situation, but some companies still have not gotten the message.

Industry executives rail on rating agencies as being reactive. The fact is that someone has to hold management's feet to the fire. The bottom line to all of this is that investors should be prepared for some 2002 fourth-quarter charges as management rushes to clean up balance sheets and attempts to restore credibility to their financials.

Continued on next page

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Another problem industry executives have to deal with is rebuilding the underwriting talent pool. Good underwriters do not grow on trees, and it will take years for the industry replenish lost talent. This complicates the process of "sculpting" books of business to take advantage of underwriting prowess.

Furthermore, there has to be a better balance between strategic growth and mindlessly going after steep price increases. On the latter point, it should be noted that the alternative risk transfer market is more sophisticated today than it was in the mid-1980s. Hence, we may be on the edge of more growth in that market, which could limit some of the needed pricing recovery. Once business flows into that market, it rarely comes out. This further erodes the industry's pool of quality business and the overall flow of business.

A simplistic crunching of the numbers seems to imply that, in order to achieve a 15% ROE, insurers have to produce combined ratios that are in the higher 80s to the lower 90s. Most insurers have never been in that territory.

Then, we have the return-on-equity fantasy. Many carriers have prognosticated ROE figures that appear to be unrealistic given current industry operating dynamics.

A simplistic crunching of the numbers seems to imply that, in order to achieve a 15% ROE, insurers have to produce combined ratios that are in the higher 80s to the lower 90s. Most insurers have never been in that territory. That does not mean that they can't get there, but it would appear to be quite a challenge, given the lack of net investment income growth, the pressure to make balance sheets whole, and the need to unwind some past financial transactions. The last of those relates to a new focus on earnings transparency and legitimacy. It should also be noted that with the new focus on transparency and legitimacy comes more earnings volatility.

Finally, we come to the bottom line and whether current analyst expectations are still too high. Some tempering would still seem to be in order. Eventually, accident-year results will overtake the charges of the current calendar years. We are just not there yet.

As if the aforementioned factors were not enough, the fact remains that the industry, as a whole, is capital constrained. Recent small but successful capital raising efforts, with the funds being split between balance-sheet repair and capital enhancement, underscore the point. Indeed, some entities are operating under an umbrella of "disabled capital" and are unable to take full advantage of the current pricing environment. As Charles Dickens wrote, "It was the best of times, it was the worst of times." It just depends on which side of the fence you're sitting on.

Myron Picoult is an adviser to Lazard Freres & Co. in New York. He is a past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts. An archive of Mr. Picoult's columns for Business Insurance is at www.businessinsurance.com.

Kroll: In high demand

Continued from page 11

the company's revenues.

Because Kroll no longer relies on any one business line to carry it, analysts' ratings are unanimously positive. Goldman Sachs and Credit Suisse First Boston initiated coverage within the past couple of weeks, assigning "market outperform" ratings. While cash reserves of $67 million gives Kroll financial strength, the bullish ratings are mostly based on its ability to pick up more business from existing customers and to add more clients like Enron, which will be a source of revenue for many years.

Mr. Cherkasky is well aware of what Wall Street expects from Kroll. He said he is focusing on capitalizing on new customer relationships and cross-selling services. Only 50 of Kroll's largest 100 clients buy more than one service from the company, he said. "There is an enormous opportunity," he said.

But even some of Kroll's boosters are worried about its rapid growth. It has acquired 14 companies since 1998, and experts see the need for another layer of management to help digest so many parts.

In the near term, however, another good year seems almost certain. Equity research firm Sidoti & Co. is predicting that Kroll will post a 150% increase in earnings in fiscal 2003, reaching $49 million.

"Kroll has business now that can help in an up cycle or a down cycle," said David Gold, an analyst with Sidoti.

Lisa Fickensher is a reporter for Crain's New York Business, a sister publication of Business Insurance.

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Systems help hospitals ensure patient, staff security

Management must overcome objections to electronic positioning monitor

By MARK TAYLOR

Scott Rolfe, clinical manager of emergency services at University Medical Center in Las Vegas, can, with the click of a computer mouse, locate the emergency room nurses, doctors and other members of his 125-person staff anywhere in the 28,000-square-foot facility at a moment's notice. He can track their movements on a monitor, call them directly using a microphone on his computer without a noisy systemwide page and communicate rapidly and privately when needed.

Although 504-bed UMC has nearly 200 video cameras throughout its 25-acre, eight-building campus, this Orwellian scenario doesn't require video cameras to monitor the comings and goings of hospital staff. It relies on local positioning technology—similar on a small scale to the satellite-based global positioning system—included in state-of-the-art hospital security systems. Those systems, which promise to keep out intruders and prevent infant abductions, also are capable of logging in when employees arrive for work and leave the hospital as well as tracking when they go into a restroom or step out for a smoke.

Fifteen months after the Sept. 11, 2001, terrorist attacks, America remains a nation consumed by worries about safety and security. Hospitals, which serve both as potential targets for criminals and terrorists and as healing institutions for victims of crime and terror, have invested millions of dollars in high-tech security systems.

Joseph Freeman, chief executive officer of Newtown, Conn.-based market research and consulting firm J.P. Freeman Co., said that though the hospital security market is highly fragmented, spending will increase to $272 million this year, up 13% from 2001. That figure does not include guard or investigation services but does include burglary, access-control video surveillance, closed-circuit TV, biometrics and locator product spending.

Sales of radio frequency-based tracking systems have skyrocketed in the past few years to nearly $21 million this year, from about $1.8 million in 1999, according to New York-based consulting and research firm Frost & Sullivan.

The latest health care security systems typically include multiple video cameras and monitors, access-control systems with automatic door locks, employee and patient identification software, and baby-matching systems that make it nearly impossible to abduct a newborn or accidentally assign an infant to the wrong parents.

Hospital risk managers and facilities directors say the new systems reduce the risk of theft, wandering patients and potential attacks against patients and employees, while protecting both groups and improving productivity. So why aren't more U.S. hospitals installing these programs?

Clearly, one obstacle to hospitals purchasing and implementing such programs is their price; most of the sophisticated tracking programs cost at a minimum in the low six figures and can exceed $1 million for full-hospital or system installation. But another big factor is employee and physician concerns of potential privacy violations and objections that the programs could be used as spying tools to support disciplinary actions.

High-tech drawbacks

Hospital administrators and boards face a dilemma; the programs work so well that they frighten key hospital constituencies, particularly unions and physicians. Some fear the intrusion of an unseen Big Brother and question whether the systems function as just another way of disciplining employees, tracking their time away from their stations or punishing vocal union members.

Page Gravely, a health care defense lawyer with the Richmond, Va., firm Crews & Hancock who specializes in hospital risk-management issues, said that the technology can be a double-edged sword. "But you have to be absolutely clear what your reasons are for implementing it," Mr. Gravely said. "It's important not to put technology before your people or the policy-development process."

Mr. Gravely said the decision to purchase a security system is often incident-driven, prompted by a baby abduction, a shooting in the ER or a fire claiming patient lives.

"Buying this sophisticated technology can be a wise investment, but administrators need to clarify their expectations and be prepared to deal with the secondary risk issues posed by the systems," he said.

'Buying this sophisticated technology can be a wise investment, but administrators need to clarify their expectations and be prepared to deal with the secondary risk issues posed by the systems.'

Page Gravely
Crews & Hancock

For example, he said, hospital security and staff must be better trained to respond if a weapons-detection system detects a gun. The technology alone won't disarm potentially harmful visitors. Added training and even more security staff may be needed, at higher costs. And if the hospital advertises its state-of-the-art system to the public, it could face a higher standard of liability in negligence or wrongful injury suits if that system fails.

Carl Mogavero, president of the Glendale Heights, Ill.-based International Assn. for Healthcare Security & Safety, agreed. His organization has 1,700-members, mostly hospital security system directors. Mr. Mogavero, who is director of security services at 181-bed Cook Children's Healthcare System in Fort Worth, Texas, said hospital managers must conduct risk assessments before shopping for security systems.

Mr. Mogavero said hospital security officials face a delicate balancing act among safety and security, privacy, risk management and cost-effectiveness concerns. "Legally, there are certain areas where we can't set up video monitors or tracking systems, like employee locker rooms and toilets, but there are some areas we have to keep an eye on. And reasonable people can come to an agreement about what they do and do not want."

Facing the unknown

Deborah McKay, a University Medical Center nurse, said there were some concerns when the system first was proposed.

"People will always resist the unknown," Ms. McKay said. "But they assured us it wouldn't be installed in restrooms. And once the system was up and running, we immediately saw how beneficial it was for us. We can show patients and family members when there's a question or complaint when we were there. And if a doctor needs me, he can call me in the room, as opposed to having somebody going into every room looking for me. It saves a lot of time and helps us address patient needs better and faster."

Officials at hospitals that installed the programs, which are produced by industry systems-control companies and medical equipment manufacturers such as Andover, Mass.-based Andover Controls Corp.; Fairfield, Conn.-based General Electric Co.; Batesville, Ind.-based Hill-Rom Services Inc.; and Morris Township, N.J.-based Honeywell, say top management and boards must initiate the effort and seek cooperation from all affected parties.

UMC CEO William Hale said his management team and board made safety its No. 1 priority. "There was some screaming from unions about Big Brother, but we were able to educate everyone that we weren't doing this to spy on them but to protect our patients and employees," Mr. Hale said.

He acknowledged the hospital has not yet documented tangible savings from the installation of the high-tech security systems. But he noted that safety was the top priority, not return on investment.

"We're still young in the process," said Mr. Hale, who noted that UMC earned $10.1 million in net income on fiscal 2001 revenue of $359.4 million. "Our medical-error rate has fallen since we installed our prescription drug-monitoring system. In the long run, we expect this will save us money from a liability standpoint. We hope to see lawsuits and employee accidents going down."

Chris Roth, UMC's director of facilities, said the life-safety system includes components from multiple vendors integrating fire and smoke detector alarms, access-control systems that include automated door and elevator locks, nearly 200 video cameras controlled by a state-of-the-art monitoring multiplex, heating and air conditioning controls, a nurse-locator system that relies on local positioning technology in the ER and intensive-care unit, and a baby-matching and abduction-prevention system.

"Our first priority is protecting the lives of patients and the people who work here," Mr. Roth said. "All of our systems are automated but can interface manually and are buffered by backup generators. On a computer screen, a technician can pull up floor maps of each building, floor, wing and room. The level of detail and specificity is amazing."

For example, if a piece of missing equipment is tracked to the garage, security can prevent the thief from leaving the parking lot.

Mr. Roth said UMC spent $500,000 to install the Hill-Rom nurse-locator system in about 20% of the facility and has budgeted about $2.5 million to complete the job.

In addition, the hospital has spent another $2 million on its infant-security program and on integrating its fire alarm and heating and air conditioning-control system. He said the move to purchase and install high-tech hospital secu-

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Monitors: Objections overcome

Continued from page 14

rity systems was driven by the administration of the county-owned hospital and supported by its board of trustees, who also serve as Clark County commissioners.

He said the systems were introduced with the promise that they would not be used for disciplinary purposes and would not monitor restrooms.

Winning over skeptics

The hospital's three emergency rooms—pediatric, adult and trauma—logged a combined 111,000 visits last year. Emergency services manager Mr. Rolfe said the new 59-bed adult ER alone is triple the size of the old facility and bigger than many hospitals.

"In our old ER, we were on top of each other and people were easier to reach and communicate with," Mr. Rolfe said. "But emergency room physicians and nurses are extremely independent people, and the new system presented an issue. It was an issue we were prepared to address multiple times. We showed the staff how separated we would be in the new facility and pointed out that we wanted this to provide better patient care. Before we moved in, we gave them a chance to try it out and play with it."

Mr. Rolfe said he uses the access-locator system to find doctors, nurses, staff and equipment. He said the new system decreases overhead paging, a constant annoyance, because he can locate a nurse and talk directly with him or her. "We don't have time to waste looking for staff members in the emergency department," he said.

Mr. Rolfe said nurses put up the most initial resistance. "They wondered why we wanted to watch them and follow them, and we were kind of taken aback," he recalled. "We said we were just trying to make it easier for them to do their jobs."

He cited as an example a patient's relative complaining that no hospital staff had responded to the patient after repeated requests for help. The relative filed a formal complaint. "We were able to pull up documentation that proved someone had arrived within 35 seconds and we were able to dispute" the complaint, he said.

Mr. Rolfe said the ER has attached tracking locators on valuable equipment and telephones needed for patient care. "I can find out quickly that the ventilator I need is in bed 8," he said. "That's been a big benefit."

The nurses 'wondered why we wanted to watch them and follow them, and we were kind of taken aback....We said we were just trying to make it easier for them to do their jobs.'

Scott Rolfe
University Medical Center

The hospital formed a committee several years ago to study the problem of infant abduction after a baby's kidnapping at a neighboring hospital garnered national headlines. Staff learned that since 1986, 187 babies have been abducted from hospitals, but, in the same time, more than 25,000 babies were mismatched, Mr. Roth said.

"We felt very good about our infant abduction-prevention system, but we were not doing anything about baby and mother matching," he said, pointing out that more than 450 babies are born each month at UMC. "We decided that was a void we needed to fill. So we took a good system and made it better, integrating our existing card access-control system and camera monitors with a baby-matching system."

That security system was installed this year in the hospital's seventh-floor tower housing labor and delivery units. Immediately after delivery, mothers and babies are fitted with matching identification bands containing identical matching tracking devices. The security system, which combines infrared detectors and radio frequency antenna, is integrated into the floor's elevators and doors.

"If a baby presents without being discharged, or leaves with someone other than its mother, it will be trapped on the floor," Mr. Roth said. "Elevators will remain open and doors will be locked shut and escape prevented. Red lights flash on the floor and security is alerted."

Mr. Roth said another benefit of the nurse-locator system is it makes it possible to track staffing needs.

"If people aren't responding timely to patient calls, we can record that and increase staff when it's needed," he said. "This can be a very valuable management tool."

Mr. Roth said that many intangible benefits probably go unrealized.

"A secure environment doesn't always show a return on investment," he said. "It's hard to quantify the impact of nurses or doctors being unable to find needed equipment quickly or somebody unauthorized walking out the door with a laptop. I think we'll save money lost through theft. But we're trying to quantify the savings, and we're documenting our tangible savings. It's not just about the dollars, though."

Mark Taylor is a reporter for Modern Healthcare, a sister publication of Business Insurance.

Comings & Goings


Ms. Lindenmayer


Mr. Gandolfo


Mr. Bailey

Brokers:

Former risk manager **Judy M. Lindenmayer** has joined Hobbs Group L.L.C. as a senior vp and will relocate from the broker's Boston office to its Atlanta headquarters Jan. 1. She serves as a national resource for Hobbs, specializing in alternative risk financing and enterprise risk management. She retired earlier this year as vp-fidelity insurance and risk management for Boston-based FMR Corp., where her risk management program earned her the 1997 *Business Insurance* Risk Manager of the Year award. Hobbs is a unit of Hilb, Rogal & Hamilton Co.

Fred Podolsky and **Suzanne Murray** have joined Glen Allen, Va.-based HRH to expand its directors and officers liability, professional liability and transactional liability capabilities. Mr. Podolsky will be managing director of the Executive and Transactional Risks Practice Group, and Ms. Murray will be the D&O and professional liability leader of the new unit. Previously, Mr. Podolsky was CEO of Willis Global Financial & Executive Risk, a unit of Willis Group Holdings Ltd. Ms. Murray was Willis' national D&O practice leader.

Jerome H. Bailey was named chief financial officer of Marsh Inc. in New York, where he will be responsible for global finance and technology. He previously was executive vp and CFO of Dow Jones & Co. Inc.

Insurers:

The Seibels Bruce Group of Columbia, S.C., has promoted **Franklin D. Hutchinson** to senior vp, insurance operations. He will be responsible for personal and commercial lines, including regulatory affairs, pricing and filing. He formerly was vp, regulatory relations and product development. Seibels Bruce also has promoted Controller **Bryan D. Rivers** to the additional post of treasurer. He has served as the holding company's controller since 1999.

Other suppliers:

Vincent Gandolfo has joined Palmer & Cay Consulting Group as a principal in the firm's New York office. The former senior managing director at Frank Crystal & Co. Inc. will be responsible for the growth and management of Palmer & Cay's benefits consulting division in New York and New England.

U.S. law creating confusion in London

By SARAH VEYSEY

LONDON—Insurers in London are grappling with the implications of the U.S. Terrorism Risk Insurance Act of 2002, the federal terrorism backstop measure passed by U.S. lawmakers last month.

In the London market, where Lloyd's of London syndicates and mutual insurance pools often involve multiple underwriters, the act's requirement that insurers provide quotes for terrorism coverage for U.S. property/casualty policies is proving logistically difficult.

The sending out of quotes and notices of the availability of coverage is a "coordination nightmare," particularly in a subscription market such as Lloyd's, according to Heidi Lawson, counsel at the New York law firm of Debevoise & Plimpton and chair of the Committee on Insurance Law of the Assn. of the Bar of the City of New York.

"This is a U.S. piece of legislation designed for U.S. business and, thus, U.S. insurers," said Tim Press, specialist in political risks and trade finance in the special risk department of London-based broker Miller Insurance Group. "But London is a subscription market. And the larger property policies tend to be subscription."

One complication is that the act does not make clear whether, on a subscription piece of business, all underwriters on the slip must offer quotes for terrorism coverage or whether only the lead underwriter must do so, market sources point out.

"Normal London market leading-underwriter agreements that appear on most slips would not have given the leader any authority to effectively add a peril, which the act does," said Martin Roberts, technical executive of the Lloyd's Market Assn.

In addition, as of Nov. 26, when it was passed into law, the act nullifies terrorism exclusions in existing policies according to a definition of "terrorism" outlined in the act. But this definition is not one typically used by Lloyd's and London underwriters, Mr. Roberts explained. Therefore, he said, established London market terrorism exclusions are "partially nullified" by the act.

Furthermore, the act gives insurers 90 days to give notice to insurance buyers of the coverage they would offer and at what price, and buyers then have 30 days to respond. But sources say

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U.K. court to hear charges of fraud in film financing

By CAROLYN ALDRED

LONDON—A unit of Jardine Lloyd Thompson Group P.L.C. failed to win a court dismissal of allegations that it failed in its duty of care when placing film finance coverage for a series of Hollywood flops.

In a decision last month, a London High Court judge ruled that Lexington Insurance Co., the insurer of the film finance deals, could pursue allegations that JLT Risk Solutions Ltd. was guilty of a pattern of fraudulent conduct when it placed the coverage for the transactions.

The decision came as part of a dispute in which the trustee of film bondholders are suing Lexington, which is a subsidiary of American International Group Inc. of New York, and JLT over Lexington's refusal to pay more than $76 million under film financing insurance contracts. Under these policies, an insurer agrees to repay bank loans if a movie fails to earn back its budget within a defined period after its completion.

This case is the latest in a wave of litigation surrounding six film funding bonds issued by London-based film company Flashpoint Ltd. in the late 1990s (*BI*, June 11, 2001).

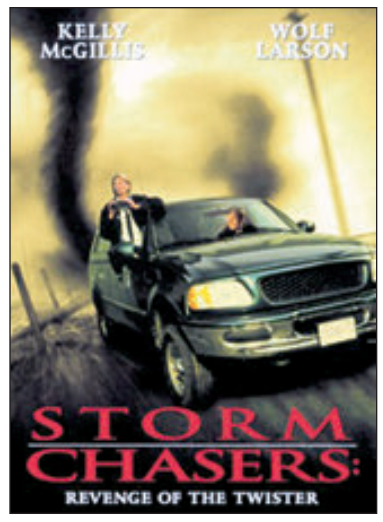
Claims totaling $48 million made for the bond Hollywood Funding No. 5 Ltd. and $33.6 million for Hollywood Funding No. 4 Ltd. are in dispute following Lexington's refusal to pay out in January 2001. The insurer claimed that the number of films made under each funding agreement was not as agreed in the contract.

The bondholder's trustee, originally Law Debenture Trust Corp. (Channel Islands) Ltd., but replaced this month by Jersey-based Hollywood Realisations Trust Ltd., claims that Lexington is in breach of the contract in its refusal to pay. However, if Lexington succeeds in its defense, the trustee charges that JLT was in breach of its duty.

Lexington claims that varying the number of films financed by each bond increased the risk transferred to the insurer and made a loss more likely. Reducing the number of films would reduce the revenue and lead to larger claims under the insurance contracts, and increasing the number of films would reduce the quality of the films and make them less likely to be successful, according to court papers. Under one of the projects, five films were produced rather than the specified four and in the other only three of a specified six were made. Lexington claims that JLT failed in its duty of care to the trustee by not advising the trustee that varying the number of films discharged Lexington of its liability.

JLT sought to strike out allegations in Lexington's defense that representations made by JLT and

See FILM/next page



"Storm Chasers," a 1998 film, is among several financial failures that spurred coverage disputes.

AUSTRALIAN LIABILITY RATING OUTLOOK

Survey respondents indicated the rate increases they experienced during the 12-month period ending June 2002 and their expectations for future rate increases in both insurance and reinsurance.

	2002	2003	2004
Public & product liability	**51%**	**23%**	**13%**
Public & product liability	**39%**	**22%**	**16%**
Professional indemnity	**51%**	**27%**	**13%**
Professional indemnity	**49%**	**53%**	**18%**
Directors & officers liability	**32%**	**21%**	**11%**
Directors & officers liability	**45%**	**45%**	**22%**

■ = Insurance ■ = Reinsurance

Source: Deloitte Touche Tohmatsu and J.P. Morgan Securities Australia Ltd. 2002 General Insurance Industry Survey

Aussie rate hikes at peak: Study

By EDWIN UNSWORTH

The steady rise in Australian commercial insurance premiums will likely last at least two more years, a survey concludes.

The "2002 General Insurance Industry Survey," conducted jointly by Deloitte Touche Tohmatsu and J.P. Morgan Securities Australia Ltd., said that rate increases across commercial lines ranged, on average, from 30% to 50% over the 12 months ending June 2002. The report forecasts rate increases averaging 27% in 2003 and 13% in 2004.

Factors contributing to the hard market include a shortage of capacity, insurers pricing at more "technically correct" levels and higher reinsurance costs, the survey says. Another contributing factor was the collapse of Australian insurer HIH Insurance Ltd. and the subsequent shift in insurance capacity.

The steepest hikes were seen in public liability, product liability and professional liability coverage. Public and product liability rates rose an average of 51% in 2002 and are expected to rise by 23% in 2003 and 13% in 2004, on average. Professional indemnity rates increased, on average, by 51% in 2002 and are forecast to rise by 27% in 2003 and 13% in 2004.

The survey of underwriters, reinsurers and brokers also showed that the "overwhelming" majority believe the hard market will last at least another 18 months, with an average expectation that it will continue for two to three years.

However, sharply rising commercial pricing will not result in a quick return to profitability for insurers, the survey says. The combined ratio for commercial lines will not result in an acceptable level of profitability until 2004, it says. This is partly because liability classes have been adversely affected by the need to increase reserves for prior years, although the survey's respondents believe this process is now largely complete.

The survey's authors conclude that one positive effect of the commercial insurance market's consolidation is that it will reduce the volatility and severity of the next cycle.

An executive summary of the survey can be downloaded at the Web site www.deloitte.com.au.

World Updates

Pension plan closures increase in U.K.: Survey

The number of occupational defined benefit pension plans that closed to new entrants nearly doubled from 2001 to 2002, according to a survey conducted by the National Assn. of Pension Funds. NAPF surveyed 970 U.K. occupational pension plans and found that 84 employers had closed their defined benefit pension plans to new entrants in 2002, compared with 46 in 2001.

U.K. trade regulator studying liability rates

The United Kingdom's Office of Fair Trading is launching a review of the U.K. liability insurance market. The regulatory body plans to examine the public liability, product liability, professional liability and employers liability insurance markets. The study will explore why rates are increasing significantly in those areas, the OFT said in a statement. The OFT said it would publish a report in the spring of 2003.

Australian court orders retrial in tobacco case

An Australian appeals court has ordered a retrial of landmark case where a tobacco manufacturer was ordered to pay $700,000 Australian ($374,360) to a smoker suffering from lung cancer. In April, Rolah McCabe won Australia's first court ruling finding a tobacco company liable for a smoking-related illness. Ms. McCabe, who has since died, claimed that the Australian unit of London-based British American Tobacco P.L.C. should be liable for knowingly selling an addictive product. The trial court judge disallowed British American Tobacco Australia Service Ltd.'s defense after he ruled that it destroyed evidence. But the appeals court ruled that BAT's defense should be heard.

U.K. survey sees drop in workplace deaths

Workplace deaths in Britain declined in the 2002/01 reporting year, but 32.9 million working days were lost to work-related ill health and 7.3 million to work-related injuries, according to a study by the U.K. Health and Safety Commission. While workplace deaths fell 14.7% to 249 in the 2002/01 year compared with 2001/00, the number of major workplace injuries remained fairly steady at 27,477, compared with 27,524 in 2000/01, the HSC reported. The HSC said that an estimated 32.9 million days were lost to work-related ill health in 2002/01, up from 18 million in the most recent comparable survey, conducted in 1995.

Film: Fraud case can proceed

Continued from previous page

Flashpoint that both were "reliable and trustworthy" were false and fraudulent and that JLT and Flashpoint were guilty of a pattern of fraudulent conduct in placing coverage for film finance transactions.

JLT refused to comment on the litigation.

AIG would not comment directly on the Hollywood 4 and 5 litigation. An AIG briefing paper on the use of insurance film finance securitizations notes that "it may well be that noteholders in the film-financing transactions expected that the policies in question were the functional equivalent of financial guarantees" of the type normally issued in the United States, which provide "an unconditional and absolute obligation to make immediate payment of any claim," rather than a property/casualty insurance policy.

Meanwhile, litigation involving more than $100 million in claims from another film financing bond, Hollywood Funding No. 6, which also involves Lexington and JLT, is awaiting outcome of the Hollywood 4 and 5, according to lawyers involved in the litigation.

In separate film finance litigation, a House of Lords ruling on a preliminary issue is expected soon on whether film finance insurers may rescind their contracts if they can show that policyholder Chase Manhattan Bank or its broker, Heath Group P.L.C., fraudulently or negligently misrepresented film finance risks. The ruling will have a bearing on many other ongoing film finance disputes, the lawyers said.

Terror: Law creates confusion

Continued from previous page

that, in a subscription market, this could result in insurance buyers receiving notices at various times during that 90-day period, depending on how soon all the affected underwriters are able to identify and price the risks.

On top of this confusion, the market is already extremely busy with Jan. 1 renewals, Mr. Press noted.

In an attempt to help Lloyd's brokers and underwriters through these difficulties, the LMA has proposed a one-time market agreement that would enable the Lloyd's leader on a slip to issue the notice on behalf of the following market and the first two Lloyd's leaders to determine the rate, Mr. Roberts said. "Then the leader would actually issue the notice (of coverage given or offered) required by the act," he said.

This agreement has been approved by virtually all of the roughly 100 Lloyd's syndicates—including runoff syndicates—represented by the LMA, Mr. Roberts said.

Lloyd's brokers will now assist underwriters in identifying policies affected and will negotiate terms before notifying the other underwriters on the slip, explained Mr. Roberts.

But he stressed that the agreement is unique and will not be repeated. It "only applies to those policies that were in force on the 26th of November; it does not apply to new or renewal business," he said.

The passage of the act has also increased the workload of underwriters in the London company market at an already-busy time, according to Dave Matcham, director of operations of the International Underwriting Assn. The IUA represents members of the company market in London.

The IUA has been advising its members "as quickly as we can and as clearly as we can," Mr. Matcham said.

The IUA is exploring the possibility of a market agreement for the company market similar to that introduced by the LMA, Mr. Matcham noted.

A report on the aviation insurance and reinsurance industry by London-based broker Benfield Group P.L.C. highlighted a further potential problem posed by the act for London underwriters.

"For some Lloyd's syndicates, the additional premium charged for providing terrorism coverage under the act on policies already issued may result in their premium income exceeding their underwriting capacity," according to the report. "In addition, to the extent that insureds opt to purchase the additional cover, Lloyd's underwriters' increased liability for surplus lines funding will need to be funded in the Surplus Lines Trust Fund."

Under U.S. law, Lloyd's is required to hold in trust funds to ensure its ability to pay its U.S. liabilities.

NAIC: Compact plan drawing criticism

Continued from page 3

among states to accomplish a specific purpose. A few states previously adopted a non-NAIC sanctioned compact to resolve problems with interstate receiverships, though it has been essentially inactive.

Meanwhile, the NAIC will work under Ms. Vaughan's direction to develop uniform standards that regulators will use in evaluating products covered by the compact, said newly elected NAIC President Mike Pickens, the Arkansas insurance commissioner.

"I really feel that this is the right thing to do for consumers and regulators," Mr. Pickens said.

It remains to be seen, though, how state officials and legislatures will respond to the NAIC's controversial model law.

Several critics, who tried to postpone the vote last week, hold that the compact proposal is flawed for several reasons, including its inappropriate delegation of state regulatory authority, its lack of standards and its failure to allow for adequate consumer input.

For example, a letter signed by 44 members of the National Assn. of Attorneys General urged delaying the vote because of "serious legal and policy concerns," including what it sees as the compact commission's pre-emption of aspects of state consumer-protection laws.

Maryland Insurance Commissioner Steve Larsen echoed those concerns during the debate and sought to amend the measure to eliminate what he considers overly broad pre-emption language. Vesting too much authority in the commission could tie a state regulator's hands, Mr. Larsen argued.

Also opposing the compact proposal was California Insurance Commissioner Harry Low, who said he could not support the measure because it does not include California's standards. California consumer advocates have argued that their state's long-term care standards offer a high level of protection for consumers, and they fear that the yet-to-be developed compact standards would be weaker.

Other critics included more than two dozen consumer organizations, who complained in a letter that the compact would likely lower product standards and reduce accountability to the public.

Given that NAIC support for the measure "was pretty lukewarm," consumer representatives will continue to voice their concerns to state legislators, said Birny Birnbaum, an NAIC-funded consumer representative from the Center for Economic Justice in Austin, Texas.

"We will work against it in every state that it is introduced," said Kevin Hennosy, executive secretary of Spread the Risk Inc., a consumer-oriented publication based in Kansas City, Mo.

But supporters of the measure were encouraged by the NAIC's endorsement.

"I think it is a very positive development, but supporters of it (the compact) face a long, hard road before it becomes a reality," said Ann Henstrand, vp-government and industry affairs for Metropolitan Life Insurance Co. in New York. If the NAIC fails, it is only reasonable to assume that life insurers may explore a federal alternative, she said

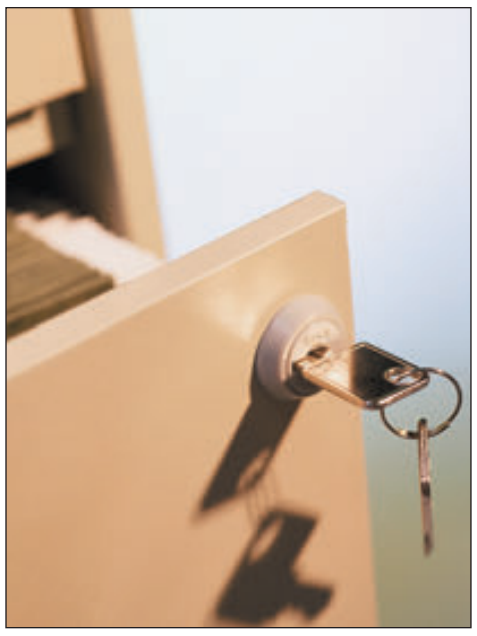
HIPAA: Few employers moving toward compliance

Continued from page 1

regulations," said Serena Simon, another member of Miller & Chevalier in Washington.

Many employers assume that, because a third-party administrator handles all their claims, they possess no protected health information, Ms. Klug said. But in fact, she said, many employers advocate on behalf of employees for disputed medical claims and thus obtain lots of protected information.

As a result, some employers are choosing to stop receiving any data, "to get as far away from protected health information as possible," Ms. Klug said.



But before making that decision, an employer should weigh the need for such information against the obligations outlined in HIPAA. If the information is not being used, the employer can stop soliciting it, shedding itself of the HIPAA privacy requirements, Ms. Simon said. "The less information you have directly coming to you, the less you have to do," she said.

For employers that elect to continue to receive health information, an important next step "is changing the philosophy of how health information is used," said Kathy Bakich, national director of health care compliance in the Washington office of New York-based The Segal Co. The new philosophy, she said, should ensure that the private information is available only to selected—and specially trained—staff members of the benefits department.

For example, access to computerized health information should be limited to the selected personnel through the use of passwords and firewalls, and paper files should be kept under lock and key, Ms. Bakich said.

Complicating the situation further is that HIPAA does not pre-empt state privacy laws. In fact, HIPAA states that the more stringent law should be followed.

"If states enact laws that give more protection to individuals, then covered entities have to follow them," Ms. Murphy said.

As a result, a multistate employer must check the applicable state laws to see if any are more restrictive than is HIPAA. And it has to make the determination whether to follow the law for the most restrictive state in regard to its entire workforce or just in regard to those work sites located in that state, Ms. Murphy explained.

'Employers are still waiting for clear guidance on what their obligations are under the regulations. ... So that burden of interpretation falls on employers.'

Paul Dennett
American Benefits Council

This multiple-law issue is the one that is of greatest concern to employers, said Paul Dennett, vp of health policy at the American Benefits Council in Washington. Mr. Dennett noted that federal regulations have not provided employers with instructions on how to negotiate the various laws.

"Employers are still waiting for clear guidance on what their obligations are under the regulations," Mr. Dennett said. "So that burden of interpretation falls on employers."

While many employers have only recently focused on the issue, others have been looking at it for a while. NCR Corp. in Dayton, Ohio, has been monitoring the changes in the law for the past few years; in 2002, NCR began working with attorneys, consultants and internal experts to put together its privacy plan, said Michael Kriner, the company's director of benefits. Other large employers he has been in communication with have also been moving along, Mr. Kriner said.

Another employer that has aggressively moved forward with implementing the privacy regulations is American Express Co. in New York, said Arleane Soto Baltrusitis, the company's vp of benefits.

American Express has completed its plan and will begin training and communicating the newly developed policy to employees early next year.

The biggest challenge, Ms. Baltrusitis said, was "trying to understand who are the protected entities and what it all meant." Compounding the issue is the lack of guidance from the federal government, she noted.

The company turned to outside attorneys for guidance in determining which employees need to be included in HIPAA compliance efforts. The situation is especially complex because the company has numerous onsite health clinics.

"It was costly in both time and money, as the guidelines were just not there," Ms. Baltrusitis said.

But for those that have put the issue onto the back burner, the April deadline looms.

"It's time to really pull up the boot straps and get started. Don't wait any longer," Buck's Ms. Klug said. "It's not too late, but the clock is ticking."

Ms. Baltrusitis acknowledged that few other companies have moved as aggressively as American Express on this issue. And for those that have lagged, it's time to get started.

"You're really behind an eight-ball and better move real quick," she said.

Capital: Pension fund manager settles lawsuits

Continued from page 3

er: $2.5 million.

- Weiss Jensen Ellis & Howard P.C., an additional law firm used by Capital Consultants: $2 million.
- Deloitte & Touche L.L.P.: $1.8 million.
- C.F. Credit L.L.C.: $1.35 million. C.F. Credit is a formerly defunct limited liability company based in California that was reformed in 1996 as a conduit to provide loans from Wilshire entities.
- Barclay Grayson, the former president of Capital Consultants who recently pled guilty to crimes related to the scandal and is now serving a prison sentence: $500,000.
- PriceWaterhouseCoopers L.L.P.: $200,000.
- Bear Stearns, a former lender to Wilshire: up to $100,000 to defray the cost of mailing notices.

Additional sums could be added to the settlement if the plan trustees decide to pursue claims against other financial advisers and are successful, according to attorneys involved in the litigation.

The trustees are represented by Bullivant Houser Bailey P.C. in Portland, which spearheaded the mediation that led to the $300 million settlement.

Insurance is expected to cover a large part of all of the settlements, attorneys say. Specific coverage information is not being made public, though.

Capital Consultants is insured for errors and omissions by American International Specialty Lines Insurance Co., a unit of American International Group Inc. in New York. Policy limits were not disclosed.

The trustees have fidelity bond coverage, as is required under the Employee Retirement Income Security Act. Many of them also have fiduciary liability coverage, according to the plans' Form 5500 filings with the U.S. Labor Department.

The other firms' errors and omissions coverage also will respond to the settlement, the attorneys say. Defendants contacted declined to provide coverage information.

Approximately $140 million of the settlement will come from the liquidation of Capital Consultants' assets, attorneys say.

The Labor Department froze the assets of Capital Consultants in the fall of 2000.

The Capital Consultants' suits, which have been consolidated under U.S. District Judge Carr King in Portland, charge that the firm "imprudently" invested pension plan assets in risky loans to Wilshire Capital. Its parent company, Wilshire Financial Services Group, filed for reorganization under Chapter 11 of the U.S. Bankruptcy Code in March 1999.

Capital Consultants, founded in 1969, had grown into one of the nation's top money managers, with $1 billion in assets in February 2000.

The Capital Consultants lawsuits: A settlement timeline

February 2000: Capital Consultants L.L.C. manages more than $1 billion in assets for employment trusts and private investors.

September 2000: The U.S. Department of Labor and the Securities and Exchange Commission place Capital Consultants into receivership. Suits are filed on behalf of investors, seeking the recovery of losses.

May-August 2001: Formal mediation of the case against Capital Consultants.

September 2001-March 2002: Defendants agree to a series of settlements.

May 2002: A settlement is reached with the receiver that will return about 57% of the lost monies.

December 2002: The final distribution order to investors is announced.

Equitas: Runoff reinsurer's status, practices disputed

Continued from page 1

than $20 billion of claims, much of it to U.S. policyholders.

But, according to some policyholder attorneys, Equitas is approaching a crossroads of its own.

They question Equitas' financial wherewithal and object to its claims-handling practices. Indeed, one ceding insurer is suing Equitas over the asbestos claims cost controls the facility implemented this year.

Other legal actions raise questions about U.S. and U.K. regulatory oversight of Equitas.

Some attorneys, led by a U.K. barrister, even are proffering the theory that policyholders can and should avoid dealing with Equitas and instead seek coverage directly from Lloyd's for losses covered by pre-1993 policies.

Financial strength issues

The common thread, though, leads back to Equitas' financial strength.

In reviewing Equitas' March 2002 year-end results, top facility officials noted that, despite a drop in surplus and rising asbestos liability clams, the facility's solvency margin had improved and a reserve boost for asbestos liabilities was unnecessary.

But as in previous years, independent auditor PricewaterhouseCoopers qualified the results because of uncertainties surrounding Equitas' long-tail liabilities. Equitas Chairman Hugh Stevenson stated, "Asbestos claims continue to be the greatest single threat to the stability of Equitas."

And, in the Dec. 4 review of Equitas' six-month results ending Sept. 30, facility officials noted that rising asbestos liability claims might force the runoff reinsurer to boost its asbestos loss reserves by the end of its fiscal year on March 31, 2003.

Some policyholder attorneys contend that Equitas can report it is solvent only because it assumes it will earn a much higher return on investments than is reasonable and then discounts its liabilities accordingly. Equitas increased the discount rate on its claim liabilities a quarter-point this year, to 5.25%.

Policyholder attorney Robert M. Horkovich characterized Equitas' investment assumptions as "unduly optimistic," given the current environment of low interest rates, stock market malaise and restrictions on insurer investments in equities.

Equitas would be insolvent if it made more-realistic investment assumptions and discounted its liabilities 3.7% or less, said Mr. Horkovich, a partner at Anderson Kill & Olick P.C. in New York.

Policyholders' uncertainty about Equitas' future is helping the runoff reinsurer, according to several attorneys. Claims negotiators for the facility in the past year have been using policyholders' concerns to gain coverage concessions, including heavy discounts on the value of future claims, the attorneys contend.

Conceptually, if Equitas were to collapse, U.S. policyholders could seek to recover their losses from Lloyd's U.S. trust funds if they obtained court judgments against Lloyd's. But current Lloyd's members might not be willing to prop up the funds—as the market contemplated doing as part of its R&R plan—if an Equitas insolvency was massive, Lloyd's market observers say.

So policyholders agree to "less than desirable" settlements because of "their fear of the future," said policyholder attorney John Sylvester, a partner with Kirkpatrick & Lockhart L.L.P. in Pittsburgh.

Representatives of several policyholders that have settled with Equitas would not comment, were unavailable or did not return calls.

Several leading brokers either did not respond to requests for comment about their clients' claims negotiating experience with Equitas or said they do not discuss their relationships with insurers.

Equitas officials acknowledge the financial pressure that asbestos claims have created for the facility, but they remain cautiously optimistic about Equitas' ability to meet all of its liabilities. They point to Equitas' rising solvency margin and increasingly effective claims management strategy; they downplay a 3% drop in surplus during the last fiscal year and a strong six-month investment return that still fell £82 million ($129.0 million) short of expectations reflected in the discount taken on liabilities.

Surplus slid "due to technical additions to reserves" in several areas, Mr. Stevenson explained.

A spokesman denied that Equitas' discount rate is subjective and overly optimistic. "The discount rate, as computed, is a direct function of market yields at the date of the balance sheet and is not a function of anything else," he said.

Equitas officials acknowledge the financial pressure that asbestos claims have created for the facility, but they remain cautiously optimistic about Equitas' ability to meet all of its liabilities.

The spokesman said Equitas' investment assumptions reflect the relatively stable, high interest rates that have been available on the long-term bonds in which the facility invests as it matches its investments against the claims payments it expects to make many years in the future.

He pointed out that Equitas, as allowed by U.K. regulators, invests a portion of its surplus in equities. Such investments traditionally generate the greatest long-term returns but can result in shorter-term losses, as they did during the first six months, he said.

The first half of the fiscal year marked the first time that investment returns did not exceed expectations for Equitas, the spokesman said. Aggregate investment earnings previously had surpassed the expectations reflected in the liability discounting by £500 million ($788.0 million), he said.

As for the negotiating tactics of Equitas representatives, the spokesman said that "no one is authorized, much less encouraged, to make any statements inconsistent with the information" contained in the facility's financial reports. He also said that resolving the highly complex claims Equitas often faces "usually requires a good deal of negotiation."

Equitas' concern about asbestos liabilities centers on the health of asbestosis claimants seeking damages. Equitas does not want to cover ceding companies' or direct buyers' asbestos losses if the claimants only fear they will become ill but do not meet certain medical criteria currently.

Some attorneys estimate that 80% to 90% of new claimants are unimpaired.

The U.S. Supreme Court is reviewing a case in which the justices have been asked to bar such claims (*BI*, Nov. 4).

In addition, the U.S. Senate this fall began considering, with the support of some asbestos claimant attorneys, limiting court access to claimants who meet specified medical criteria (*BI*, Sept. 30).

And lawmakers in Mississippi, which has been one of the most attractive U.S. venues for asbestos plaintiffs, passed reforms this year designed to prevent lawsuits on behalf of plaintiffs who do not live or never worked in the state.

Tougher claims standards

But Equitas is not waiting for any judicial or legislative help. It already has begun requiring policyholders to prove that asbestos claimants meet minimum bodily injury and asbestos exposure standards before the facility will cover asbestos losses.

"No contract wording requires insurers to pay or reinsurers to reimburse invalid claims," the Equitas spokesman said.

But California courts ultimately may determine the future of that claims-management strategy.

In a lawsuit filed in Los Angeles Superior Court against Equitas and others, Markel Corp. subsidiary Associated International Insurance Co. of Woodland Hills, Calif., argues that the documentation requirements violate the conditions of the excess insurer's reinsurance policies.

The reinsurance policies that Lloyd's underwriters wrote for Associated International and other insurers give ceding insurers sole authority to determine the validity of claims they will cover, the plaintiff argues in court papers. As an excess insurer, Associated International depended on and abided by primary insurers' claims management decisions, the lawsuit asserts.

Complying with Equitas' documentation requirements would create huge, unanticipated administrative costs for Associated International and would expose it to wrongful claims-handling charges by policyholders, the insurer argues.

Policyholder attorney Scott Gilbert of Gilbert Heintz & Randolph L.L.P. in Washington said Equitas' documentation requirements amount to "unilateral tort reform that is fundamentally inconsistent with insurer policy obligations and, in many cases, insurer/policyholder settlement agreements."

Regulation questions

Another legal action filed in New York state court against Equitas and New York insurance regulators challenges more than claims-management tactics. San Francisco-based policyholder organization United Policyholders demands that New York regulators require Equitas to obtain a reinsurance license and an insurance adjusting license to operate in the state (*BI*, Nov. 18).

If the policyholder group succeeds, then the facility would have to meet New York solvency requirements, said Mr. Horkovich of Anderson Kill, which represents United Policyholders.

The Equitas spokesman said the U.K. Financial Services Authority is responsible for regulating Equitas and that the facility does not conduct business in the United States. He added that no state has asked to regulate the facility.

The FSA potentially faces legal trouble from the European Commission over the agency's supervision of Equitas and Lloyd's. The commission is investigating whether the agency has properly enforced an E.U. law requiring insurers to maintain adequate loss reserves.

Equitas reports $9 billion of gross undiscounted asbestos reserves.

Meanwhile, London-based barrister Richard Astor is advancing the theory, supported by some U.S. policyholder attorneys, that Lloyd's had no authority to move its pre-1993 liabilities to Equitas and that policyholders still have the right to recover 100% of their losses from Lloyd's.

Mr. Astor, a consultant to U.S. attorneys and policyholders on Lloyd's and Equitas law, said U.S. policyholders could tap various Lloyd's funds set up to pay claims by filing suit in the United States against unnamed underwriters and serving Lloyd's U.S. attorneys with the lawsuit.

After a final judgment, coverage proceeds would be distributed from the relevant Lloyd's funds, including its U.S. trust funds. Policyholders would not have to collect from Lloyd's members individually, he said.

U.S. policyholder attorney Marc S. Mayerson agreed. Suing Equitas in a U.K. court for coverage "cuts you off from the Lloyd's U.S. trust funds and puts you at risk to how protective London courts might respond," said Mr. Mayerson, a partner with Spriggs & Hollingsworth in Washington.

Not every attorney critical of Equitas' claims management, however, sees this as a useful tactic for all policyholders battling the facility over coverage. Policyholder attorney Laurence J. Eisenstein of Eisenstein Malanchuk L.L.P. in Washington said he would be concerned that smaller policyholders could not afford a legal battle with Lloyd's.

A Lloyd's spokesman said that policyholders with pre-1993 losses "have no contract with Lloyd's of London; their contract is now with Equitas."

The Equitas spokesman said the runoff reinsurance facility would be obliged to indemnify any Lloyd's member who faces a judgment if his or her liabilities had been moved to Equitas.

Cash balance: Nondiscrimination rules unveiled

Continued from page 1

done, you have not, in the view of government agencies, violated age discrimination laws," said Dan Schwallie, a consultant in the Cleveland office of Hewitt Associates Inc.

Employee benefit consultants have maintained that cash balance pension plans don't discriminate against older employees ever since the first such plan was established in 1986. However, numerous suits have been filed over the years charging that the plans are discriminatory, leading to conflicting decisions.

Those suits argued that the credits older employees receive would purchase a smaller annuity at normal retirement age than would those received by younger employees.

The government's proposed rules reject that theory, however, which benefit experts say is a victory for common sense.

"If everyone gets the same pay credits and interest, how could that possibly be viewed as age discrimination?" asked Larry Sher, a principal and director of research at Buck Consultants Inc. in New York.

The proposed rules also make clear that employers converting traditional pension plans to cash balance plans can avoid violating age discrimination law by taking one of two approaches in handling employees' accrued benefits.

In one approach, employers—as many have done—can convert the accrued benefit to an opening cash balance account balance, as long as reasonable actuarial assumptions are used. In the other approach, the accrued benefit in the old plan is kept separate, and the employee starts out with a zero balance in the new plan.

But, as benefit experts had expected, the rules do not stipulate what approach employers should use in determining the value of plan account balances when employees leave and take their benefits. Employers and their advisers maintain that participants are entitled to just their account balances, but under a legal theory the IRS unveiled in 1996 but never formally proposed, there could be situations where participants would be entitled to greater benefits. That issue will be addressed in future regulations, Treasury Department officials said earlier.

While benefit experts welcome the government endorsement of cash balance plans, they are dismayed about how the proposed rules appear to affect other hybrid or nontraditional plans.

In a cash balance pension plan, 'if everyone gets the same pay credits and interest, how could that be possibly be viewed as age discrimination?'

Larry Sher
Buck Consultants Inc.

partment set out specific rules for cash balance plans, the same was not done for other hybrids, most notably so-called pension equity plans. In many cases, those plans—which get their names because their accrual rates are smoother than those in cash balance plans or traditional final-average-pay plans—would be subject to the same nondiscrimination rules that apply to more traditional plans. Because of their unconventional design, pension equity plans would have difficulty passing such rules.

As a result, benefit experts say that, without a massive and not necessarily logical overhaul of formulas, most of the existing pension equity plans would be considered discriminatory.

"Most (pension equity) plans will not satisfy these regulations," warns Ethan Kra, chief actuary for Mercer Human Resource Consulting in New York.

"They are outlawing compromise designs and forcing design extremes," added Eric Lofgren, director of the benefits consulting group at Watson Wyatt Worldwide in Philadelphia.

Indeed, Mr. Lofgren maintains that the impact goes beyond pension equity plans, of which approximately 100 have been established. Many of the nation's largest employers, including Dow Chemical Co. and Ameritech Corp., operate pension equity plans. That compares with the several hundred cash balance plans that have been established.

"They have outlawed all compromise approaches. This will stifle plan innovation, and this must change. You can have front-loaded or back-loaded plans" but not something in between, he said.

It is unclear, in the absence of official explanation, why other pension hybrids did not receive the same favorable treatment as cash balance plans. Some speculate, though, there is animus within the Treasury toward many hybrid designs.

"We believe it was an intentional decision on the part of government officials, some of who view these plans as discriminatory," Mr. Kra said.

That, if true, is "ridiculous," said Mr. Lofgren, noting that there could be many situations in which older employees could earn richer benefits in a PEP plan compared with a cash balance plan.

Benefit experts say they expect to wage a long campaign to convince government regulators to provide more favorable rules for hybrids other than cash balance plans.

"A lot of work will be required between proposed and final regulations to avoid burdening defined benefit plans….The hard work is just beginning," said Richard Shea, a partner with Covington & Burling in Washington and a former Treasury department official.

Trenwick: Credit deal helps but more hurdles remain

Continued from page 3

low A-, triggering a default under the $226 million LOC facility capitalizing Trenwick's Lloyd's unit for the 2002 underwriting year. That facility expired Nov. 22, but lenders agreed not to act on the default—for example, by demanding cash collateral for the outstanding balance—while negotiations to renew the facility went forward.

In response to the downgrade, Trenwick America Reinsurance Corp. entered into a deal in which it will produce up to $400 million in U.S. reinsurance business for Chubb Re. Stamford, Conn.-based Trenwick America will reinsure 100% of any losses in excess of the collected premium and take two-thirds of any profits on the business, while Chubb Re—which maintains underwriting and claims authority—will earn a 5% fronting fee and take one-third of the profits.

Trenwick also announced it would cease writing U.S. specialty program insurance, a book of business that accounted for $311.5 million, or 23.9%, of its nine-month 2002 gross written premium volume of $1.31 billion. Last week, the insurer also halted specialty insurance underwriting at London-based Trenwick International, which produced another $132.3 million, or 10.1%, of nine-month gross premiums. Trenwick's specialty business comprised a variety of property/casualty risks from general liability to long-haul trucking and professional liability coverages.

Existing U.S. and London specialty business will be run off, and Trenwick said it will record a fourth-quarter charge against earnings for expenses of the London underwriting shutdown.

Another blow came last month, when Trenwick reported a $90.7 million reserve increase and a resulting $187.7 million net loss for the first nine months of this year. This prompted a second rating downgrade from Best, which now rates Trenwick America and several other Trenwick units B-. Best does not rate Trenwick's Lloyd's syndicate 839.

Meanwhile, though, Berkshire Hathaway increased its backing of Syndicate 839 for the 2003 underwriting year, and Trenwick last week won an agreement in principle from its lenders to renew $182.5 million of the Lloyd's LOC facility for next year.

In addition to a 5% cash fee, Trenwick's lenders are to receive 15% of the insurer's Lloyd's profits for 2002 and 2003, along with interest-bearing notes and warrants and a pledge of all of Trenwick's equity interests, assets and property to secure the LOC obligations, the company reported.

The backing lets Trenwick 'support those portions of our business which we believe will produce the best results for our policyholders, creditors and shareholders.'

W. Marston Becker
Trenwick Group Ltd.

The backing of Berkshire and the banks "allows us to continue to support those portions of our business which we believe will produce the best results for our policyholders, creditors and shareholders," W. Marston Becker, Trenwick's acting chairman and chief executive officer, said in a statement.

Syndicate 839 and the Chubb Re facility are now Trenwick's main ongoing operations. Trenwick will continue a process already underway to shift certain specialty business to Lloyd's from units that have ceased underwriting, according to Mr. Hunte, who would not comment on how Trenwick's overall premium volume may change with the restructuring.

While noting the positive news on the LOC renewal, analysts are waiting to see whether Trenwick performs well enough to regain its financial footing.

A key issue, S&P's Ms. Barkley noted, is the level of Trenwick's earnings. The insurer will be sharing its Lloyd's earnings with Berkshire and its U.S. reinsurance earnings with Chubb Re, and the question is whether its share of those earnings will prove sufficient to meet its debt obligations, she said.

Syndicate 839, which underwrites aviation, casualty and marine risks, should produce good results: "The market pricing is good and they should be able to write a good 2003 year of account at Lloyd's," Ms. Barkley said.

Market response to the Chubb facility, however, remains to be seen, she said.

"The profitability of the Chubb business will be important," Best's Mr. Lennox said.

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Issue of December 16

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.

Medco makes ERISA lawsuit settlement offer

Medco Health Solutions Inc. will pay $42.5 million to settle five class-action lawsuits that alleged the pharmacy benefit manager failed to pass on rebates from drug makers to its clients. Several groups of employers alleged that Medco's actions violated its fiduciary obligations under the Employee Retirement Income Security Act. Medco also agreed to better inform clients of the wholesale price of drugs, the amount of discounts and rebates it receives, changes to drug formularies and the availability of generic drugs.

RIMS creates category for retirees

The Risk & Insurance Management Society Inc. has created a reduced-rate membership category for retired members. Deputy and associate members of RIMS who have retired will pay a $100 annual membership fee, compared with regular membership fees that start at $400 per year. Retired members' benefits will be the same as those of working members. Olen M. Stewart Jr., who retired as risk manager of Southern States Cooperative Inc., is the first member in the new category.

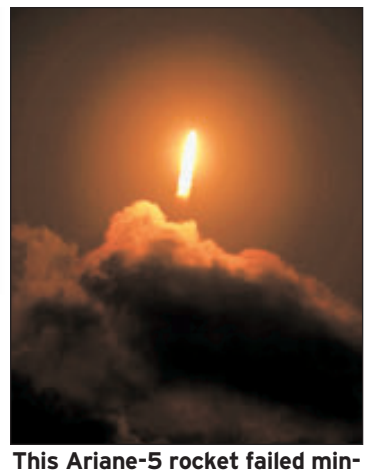

PHOTO: AFP

This Ariane-5 rocket failed minutes after its Dec. 11 launch.

Satellite insurers face large losses

SES Astra gave up its efforts to rescue an Astra 1K satellite that had been stranded in a useless suborbit since its Nov. 26 launch and crashed it into the Pacific Ocean. The satellite was valued at 291.5 million euros ($294.4 million) and was covered by numerous insurers. Munich Reinsurance Co. had the largest share of the program. Meanwhile, insurers face a loss of about $13 million from the failed launch of two satellites on an Arianespace Ariane 5-ESCA rocket that exploded shortly after takeoff on Dec. 11 from Kourou, French Guiana.

SVB Syndicates to exit U.S. liability reinsurance

Lloyd's of London managing agency SVB Syndicates Ltd. will withdraw from underwriting U.S. liability reinsurance in 2003. SVB said U.S. liability reinsurance would account for about £50 million ($78.8 million) of its 2002 premium volume. "The board of SVBS believes that this premium income can be replaced with other, more-attractive business, given the exceptional conditions prevailing in direct insurance markets," SVB said in a statement.

Link between benefits and corporate strength

Chief financial officers believe there is a link between the quality of companies' health care benefits and their financial strength, but they can't prove it, according to a survey by the Integrated Benefits Institute. Ninety-three percent of respondents said they believe the link exists, but few CFOs are able to measure the impact of benefits on profits because the criteria used to evaluate benefit programs, such as employee satisfaction and employee retention, are not all expressed in financial terms, the study said.

Briefly noted

The American Assn. of Insurance Services is posting online commercial lines endorsements and disclosure notices developed to aid compliance with the Terrorism Risk Insurance Act of 2002. The materials are available at *www.aaisonline.com* but are copyrighted. Companies not affiliated with AAIS wishing to use the materials should contact Joyce Tignino, vp of marketing and industry relations, at 800-564-2247....**Aetna Inc.** plans to cut 690 jobs in an effort to reduce costs. The health insurer, which will have about 27,500 employees after the layoffs, will take a $30 million fourth-quarter charge related to severance costs.... A Tillinghast-Towers Perrin survey found that insurers are increasingly interested in **enterprise risk management** for operational, strategic and financial exposures. Of 94 insurer chief financial officers, chief risk officers and chief actuaries, 49% have some form of enterprise risk management in place, and 38% are considering adopting it.

Health care: California proposal

Continued from page 3

introduced the legislation Dec. 2—the first day of the current legislative session. Sen. Speier's bill says it aims to address the health care needs of 6.3 million uninsured Californians, or one in five state residents.

Sen. Speier's measure states that more than half of the uninsured adults in California were employed during 2001 and that California employers trail the nation in providing employee health coverage.

Nationwide, 59% of employees receive health care coverage from employers, according to the Kaiser Family Foundation, a Menlo Park, Calif.-based research organization. In California, 53% of employees receive employer-sponsored health coverage. Kaiser data also shows that 14% of the nationwide population is not insured through any means, compared with 19% in California.

S.B. 2 states that greatly reducing the number of uninsured Californians would lower the average per-employee cost of health care coverage. That is because the uninsured often put off seeking care, explained Michael Ashcraft, an aide to Sen. Speier. When they do finally receive care, their conditions often have worsened, and the higher cost for that treatment ultimately gets passed on to the insured population, Mr. Ashcraft explained.

But not all employers are likely to be swayed by that reasoning.

The California Chamber of Commerce has yet to take a position on S.B. 2 but is likely to oppose the measure, said Cher Gonzalez, a legislative advocate for the chamber in Sacramento.

Other interest groups, though, support the concept of universal care.

The Sacramento-based California Medical Assn., for example, is working with Sen. Speier to further develop S.B. 2, although the CMA has not yet fully endorsed the bill, a CMA spokeswoman said.

And a day after Sen. Speier introduced her legislation, Bruce Bodaken, chairman and chief executive officer for Blue Shield of California in San Francisco, made a similar recommendation. In a speech delivered in San Francisco, Mr. Bodaken proposed creating a universal care system based on employer-provided insurance.

'A lot of (health plans) may be cautious of pushing universal coverage, because it probably means the imposition of a mandate on employers to buy insurance, and employers are plans' customers.'

Walter Zelman
California Assn. of Health Plans

Universal care could alleviate many current problems plaguing California's health care system, Mr. Bodaken said. Those problems include rising insurance rates, a trauma system "on the verge of collapse," and a state government too broke to provide adequate health care for the poor.

Under Mr. Bodaken's recommendation, all employers except small businesses would have to provide health insurance to their employees, or they would have to contribute "the financial equivalent toward an essential benefit package for all their employees."

Unemployed Californians without insurance would be required to purchase health insurance if they have the means to do so, while eligible uninsured people lacking the means to buy insurance would receive coverage from federal- and state-funded programs. Medical professionals would determine what would be "an essential benefits package," with a minimum level of coverage that health plans would have to meet.

For the time being, Blue Shield will finance an academic study evaluating the financial options for funding such a program, Mr. Bodaken said in his speech.

Many health plan leaders recognize the advantages of universal health insurance, though few have publicly support such proposals, said Walter Zelman, CEO and president of the California Assn. of Health Plans in Sacramento.

"A lot of (health plans) may be cautious of pushing universal coverage, because it probably means the imposition of a mandate on employers to buy insurance, and employers are plans' customers," Mr. Zelman said.

But the growing problem of the uninsured is prompting other prominent health care figures to raise the issue of universal coverage.

For example, William W. McGuire, chief executive of Minnetonka, Minn.-based UnitedHealth Group, in April wrote to every member of Congress, urging the government to lead an effort to develop a "basic health benefit package" that could be delivered to everyone. Once that minimal coverage level had been determined, it would fall to the private sector and the government to make the benefits available as cost effectively as possible, Mr. McGuire wrote.

Online Poll [12/9 - 12/13]

Who is responsible for crisis planning in your organization:

Risk management department	25.0%
Information technology department	5.3%
Building management department	11.8%
Combination of the above	43.4%
Other	14.5%

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

BI Stock Index [12/9 - 12/13]

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
-2.07	-0.58	-0.43
1842.23	8433.85	889.50

Largest gains

Meadowbrook Ins. Group	14.49%
CNA Financial Corp.	7.91%
Zenith National Ins.	6.37%
MetLife	5.71%
RLI Corp.	4.21%

Largest losses

Trenwick Group Ltd.	-27.05%
Unico American Corp.	-12.05%
Gainsco Inc.	-10.34%
ACE Ltd.	-8.21%
AEGON N.V.	-6.71%

Weekly change by market segment

Brokers	-0.07%
Insurers/Reinsurers	-1.39%
Managed Care Organizations	-0.46%

Source: CNET Investor (investor.cnet.com)