

Business Insurance

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**401(k) PLAN ADMINISTRATORS
MAY FACE MORE COURT BATTLES
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**LINDSAY LOHAN'S WOES
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ON MOVIE RISKS / PAGE 3**

**ARCH HITS BACK AT GEN RE
IN FIGHT OVER DEFECTION
OF SPECIALIST TEAM / PAGE 3**



In Brief

NOAA reduces storm forecast

The National Oceanic & Atmospheric Administration's Climate Prediction Center has scaled back the number of named tropical storms it is forecasting for the 2007 Atlantic hurricane season to 13 to 16, down from 13 to 17 predicted in May. According to NOAA, seven to nine of the named storms are expected to grow to hurricanes; and three to five could become major hurricanes, packing sustained winds of at least 111 mph.

Heath Lambert exploring options

London-based Heath Lambert Group said last week it has appointed corporate finance advisory firm Hawkpoint Partners Ltd. to look at the broker's long-term financing

See **IN BRIEF** page 26

BENEFITS MANAGEMENT

CONSUMER-DRIVEN HEALTH PLANS



Employers fine-tune their consumer-driven health plans; takeup rate estimates for preventive care options differ; more employers

consider offering only CDHPs; health care debit card providers unlikely to exit the marketplace.

Page 11



CHINA:
Product liability market stays competitive; recent product recalls.
Page 25

China recall crisis underscores risks

Better supply chain management urged

By **DAVE LENCKUS**

While better risk management controls cannot prevent all product liability claims—such as those linked to U.S. companies' suppliers in China—they can help the producer whose brand reputation is at risk resolve claims faster and recover damages from culpable suppliers.

Since March, numerous U.S. producers and importers have recalled a wide range of food products and consumer goods because of contaminants or dangerous defects blamed on their suppliers in China (see chart, page 25).

The defective products include snack foods, toys, pet food, tires, toothpaste and fish. In one of the most highly publicized incidents, toymaker Mattel Inc. of El Segundo,

Calif., earlier this month recalled 967,000 Fisher-Price toys that a supplier in China contaminated by using lead paint.

Individual lawsuits and litigation seeking class action status have been filed against many of the U.S. producers of those products. The lawsuits also typically name every party involved in the products' distribution chains.

In court, blaming a rogue supplier is not helpful, because producers are strictly liable for the products they introduce into the U.S. distribution stream, plaintiffs and defense attorneys agree.

Therefore, producers should take more measures before their products are distributed to protect themselves, experts said.

See **CHINA** page 25

Marsh, N.Y. alter pact to permit insurer fees

Broker gets OK to collect payment for services

By **SALLY ROBERTS**

NEW YORK—Marsh Inc. soon will begin accepting certain fees from insurers for brokerage transactions under an agreement with New York Attorney General Andrew Cuomo and Superintendent of Insurance Eric Dinallo.

The Aug. 3 agreement amends Marsh & McLennan Cos. Inc.'s \$850 million 2005 settlement with New York authorities, which limited its form of compensation to fees from clients and commissions from insurers in brokerage-related transactions.

It is the fourth amendment (see box) that has been made to the agreement MMC reached more than two years ago to settle charges that it rigged bids and steered clients to insurers that paid the highest contingent commissions. Most recently, Marsh gained authorization to accept additional profit-based commissions from insurers on business in which it acts as a

managing general agent or underwriting manager (*BI*, Aug. 28, 2006).

The Risk & Insurance Management Society Inc., which in June called for a prohibition on all "placement fees" paid to brokers by insurers, has given Marsh's latest agreement its stamp of approval.

Chicago-based Aon Corp. and London-based Willis Group Holdings Ltd., which reached similar agreements and subsequent amendments with New York, say they expect to reach a similar agreement regarding the insurer fees.

"Aon has been in discussion with regulators in New York over these same issues, and they have assured us that they are prepared to extend identical treatment to Aon and others," a spokesman said.

As for Willis, "Any enhanced regulatory flexibility that we may be granted will be applied against our unwavering principles," Joe Plumeri, chairman and CEO of

See **SETTLEMENT** page 24

IRS issues guidance on flex benefit plans

Proposed regulations clarify how to conduct discrimination tests

By **ROBERTO CENICEROS**

WASHINGTON—Proposed Internal Revenue Service regulations provide employers specific guidance for the first time on certain practices for operating and administering Section 125 flexible benefit plans, consultants say.

Because the IRS is likely to use the guidance as a springboard for future audits, its proposed regulations also are likely to bring greater uniformity among employer practices, consultants add.

The proposed rules, released Aug.

3, apply to the wide array of coverages offered through flexible benefit plans. Those benefits can include health insurance, flexible spending accounts, health savings accounts, disability coverage, group term life insurance and dependent care benefits.

While providing new guidance, the IRS also generally confirms that employers should continue many "good faith" practices they have adopted so far, the consultants said.

"It's always good when you get definitive guidance one way or the other so you know how you are doing," said J.D. Piro, an attorney at Hewitt Associates Inc. in Norwalk, Conn. "It is even better when it confirms the direction you have

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How can you reduce medical costs in workers' compensation?

Ask Aon.



With the medical component of workers' compensation soaring, many organizations see no end in sight. However, there are strategies that have proven effective in the group health arena that could also

have a dramatic effect on the medical and pharmacy components of workers' comp. Visit **www.aon.com/ask** to learn more about cost-containment strategies that can help your workers' comp program.

– Heidi Mader,
assistant vice president in Aon Consulting's health and welfare practice

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AON

On the Web

ONLINE EXECUTIVE FORUM™

Wellness, consumerism mix in CDHP webinar

Consumer-driven health care has emphasized encouraging employees to take greater responsibility for their health care needs through increased cost-sharing, but there is also a wellness component. Find out more during *Business Insurance's* Online Executive Forum™ "Wellness and Consumer-Driven Health Care: Contradictory or Complementary?" at 11 a.m. EDT Aug. 14. To sign up, go to www.BusinessInsurance.com/webinars.

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BI DIRECTORIES

Updated CDHP directory now available online

Business Insurance has updated its Consumer-Driven Health Care Plan Providers directory, available at www.BusinessInsurance.com/directories. All BI directories and rankings may be purchased online in either Excel spreadsheet or PDF file format.

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Ex-employee can sue after 401(k) cash out

More plans could face mismanagement charges

By JUDY GREENWALD

PHILADELPHIA—A former employee who has cashed out of his 401(k) plan can still sue the plan's administrator for mismanaging the plan's assets, says a federal appellate court, in a decision that observers says significantly increases the number of plan participants who can file suit against their plan sponsors.

The former employee is still considered a participant under the Employee Retirement Security Act, which governs the plan, says the 3rd U.S. Circuit Court of Appeals in its July 31 opinion in *Howard Graden vs. Conexant Systems Inc.* The unanimous three-judge panel's opinion reverses a lower court decision dismissing the case.

The lawsuit, which seeks class action status, has attracted significant attention, with the Washington-based National Manufacturers

Assn. submitting an amicus brief supporting Newport Beach, Calif.-based Conexant, while briefs supporting the plaintiff were filed by the Washington-based AARP and the U.S. Department of Labor.

According to the decision, Mr. Graden, who was a Conexant employee until 2002, and a participant in the company's 401(k) plan until 2004, had directed his money into a fund composed entirely of the stock of Conexant, which develops semiconductor devices for the telecommunications industry.

Between March 2004 and October 2004, when Mr. Graden cashed out, the company's stock dropped from \$7.42 to \$1.70 per share. Mr. Graden charged the drop "was the result of a risky and ultimately failed merger," says the opinion. He

See **ERISA** page 24

Arch fires back in battle for rival's former execs

Suit says Gen Re used courts to stifle competition

By DOUGLAS McLEOD

STAMFORD, Conn.—Arch Capital Group Ltd. has struck the latest blow in a noncompete dispute with General Re Corp., accusing Gen Re of misusing the courts to stop four former Gen Re executives from developing Arch's facultative reinsurance business.

In counterclaims filed in a Connecticut state court last week, Bermuda-based Arch charges that Gen Re tortiously interfered with Arch's business and committed libel in its efforts to deter competition from the four executives, who quit Gen Re in April and joined Arch.

Gen Re originally filed suit and won a temporary restraining order in May against Arch and the four facultative managers: Jennifer Agar, Philip Augur, Steven Franklin

and Kenneth Vivian. The court filings charged that the four plotted to move Gen Re's business to a new employer and orchestrated an "en masse departure" that included 26 other Gen Re employees (*BI*, May 28).

The temporary restraining order was later replaced with an agreed order that barred Arch from using any Gen Re proprietary information (*BI*, June 25).

In counterclaims filed Monday, though, Arch charges that Gen Re misled the court in winning the temporary restraining order and that it has wrongly pursued a plan to obstruct Arch's facultative business.

While Gen Re backed its temporary restraining order request partly

See **ARCH** page 6



GETTYIMAGES

Lindsay Lohan's latest run-in with the law won't endear her to insurers, who take into account an actor's actions away from the movie set when deciding whether to insure the production of a film.

Insurers keep close eye on stars behaving badly

Off-screen antics can increase costs for making movies

By BETH MURTAGH

Actress Lindsay Lohan's latest brush with the law has put a spotlight on the exposures movie producers and their insurers face when working with stars who have a penchant for headline-grabbing misbehavior.

Ms. Lohan, with more than a dozen films to her credit, is one young Hollywood star who has attracted as much attention for her offscreen performances as her for roles. The 21-year old reportedly is in drug rehabilitation for the third time this year following her July arrest on cocaine possession and other charges.

After Ms. Lohan's frequent absences and late arrivals to the set of "Georgia Rule" in 2006, she received a public scolding from a studio head who threatened to seek "full monetary damages" if the actress did not honor her obligations.

Industry insiders say contracts and risk management strategies that are crafted carefully can allow the show to go on for most Hollywood bad girls or boys.

"Self-indulgent behavior is not new to Hollywood," said Brian Kingman, the Los Angeles-based managing director of entertainment broker Aon/Albert G. Ruben Insurance Services Inc. "It's always been a festive community. Our industry has learned to deal with that to some extent."

An actor's off-screen antics aren't followed solely by tabloid readers. Insurance companies definitely take note, entertainment industry brokers say.

"When someone's face sprawls across the evening news, and (the) information isn't favorable, it doesn't do us any good in this business, placing insurance and keeping it fair," said Diane Yount, area senior vp in the Glendale, Calif.-based entertainment division of Arthur J. Gallagher & Co.

Entertainment insurance companies insure the production company, not individual actors, said Joe Finnegan, vp of Novato, Calif.-based Fireman's Fund Insurance Co.'s entertainment division in Universal City, Calif. Sickness, injury and death are the losses covered.

An actor with drug, legal or health issues is considered an "exposure" needing careful analysis

See **FILMS** page 20



ON OCT. 8, 2007, *Business Insurance* will celebrate its 40th anniversary of publication. Each week until then, *BI* will offer a peek at news we reported during the past four decades.

AUG. 30, 1993 Lloyd's of London moves ahead with its proposal to establish NewCo., a runoff reinsurance entity to which Lloyd's syndicates would transfer pre-1986 liabilities that remained open. Lloyd's estimated that NewCo. would be capitalized with £5 billion after syndicates paid the reinsurance-to-close premiums on the transferred liabilities.

SEPT. 6, 1993 CNA Financial Corp. and Chubb Corp. agree to pay more than \$3 billion to settle asbestos personal injury claims against Fibreboard Corp. CNA's \$2 billion share of the asbestos settlement stemmed from two liability policies written in the 1960s that generated less than \$20,000 in premium.

Court claims jurisdiction in out-of-state Internet libel case

California resident accused of defaming pair in New Jersey

By **JUDY GREENWALD**

TRENTON, N.J.—The case of a California resident accused of libeling two New Jersey residents and making direct references to the state in Internet newsgroup postings does come under New Jersey courts' jurisdiction, a state appellate court has ruled.

The Aug. 2 ruling by the Superior Court of New Jersey Appellate Division in *Danna Goldhaber vs. Charles Kohlenberg* reaches a different conclusion than other courts, which have ruled they have no jurisdic-

tion over out-of-state residents concerning material posted on the Internet, observers say. But the ruling also reflects the particular facts of the case rather than a conflicting legal analysis, they say.

According to the decision, Danna Goldhaber and her father, Richard Goldhaber, accused Charles Kohlenberg of making "extremely derogatory" comments about them on an Internet travel newsgroup in which all participated.

"These messages accused plaintiffs of base activities, including incest and bestiality. Some of the messages contained cruel references to the hearing limitations of plaintiff Danna Goldhaber," says the decision. "The record contains no explanation of what motivated defendant to act in such a manner

if, indeed, he did so," says the opinion.

The Goldhabers sued Mr. Kohlenberg for libel in New Jersey. Based on the advice of a California attorney, Mr. Kohlenberg did not respond to the suit, and a jury awarded the Goldhabers \$2,600 in compensatory damages and \$1 million in punitive damages.

Other courts have ruled that posting messages in a listserve or newsgroup "by a resident of one state that could be read in a second state was not sufficient to confer jurisdiction upon the latter," the appellate court ruled. Such rulings were made "either on the basis that there was insufficient evidence that the alleged tortfeasor had directed or focused the defamatory comments to the forum state or on the basis

that the site in question was passive, as opposed to active or interactive," the New Jersey court said.

In this case, "there is, in our judgment, evidence that the author of these messages did, indeed, target them to New Jersey," the three-judge panel ruled unanimously.

Mr. Kohlenberg "not only knew that plaintiffs resided in New Jersey, he knew the municipality in which they resided and made specific disparaging references to that municipality in many of his postings," the appellate court ruled. "He also made insulting comments about that municipality's police department."

While the appellate panel ruled New Jersey courts do have jurisdiction in this case, it set aside the jury verdict against Mr. Kohlenberg on

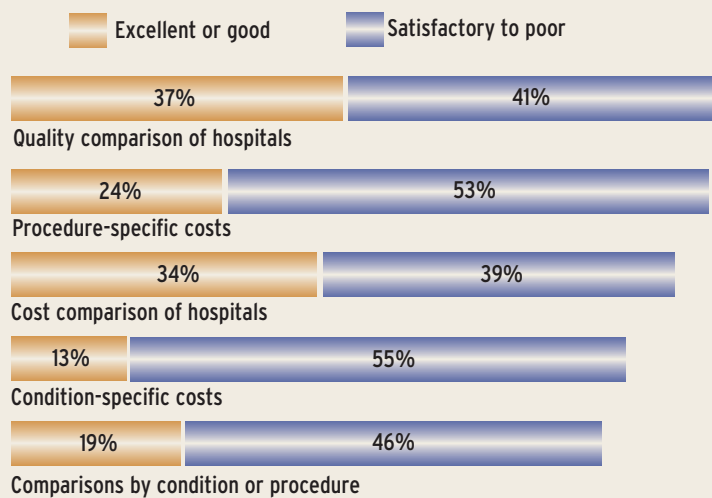
the grounds that the advice he received from his California attorney did establish "excusable neglect" in not responding to the libel claim. The case was remanded to the lower court for further proceedings.

Noel E. Schablik of Parsippany, N.J.-based Noel E. Schablik P.A., who represented Mr. Kohlenberg, said no decision had been made whether to appeal to the New Jersey Supreme Court. "It's a very ripe issue for further appeal," he said, however. "The appellate division focused its attention on what it concluded to be an intentional direction of language towards New Jersey residents, and that's debatable," said Mr. Schablik.

See **LIBEL** page 6

HOW EMPLOYERS RATED COST AND QUALITY INFORMATION TOOLS

Percentages reflect all survey respondents; not all respondents offer each tool



Source: Watson Wyatt Worldwide, RAND Corp.

Education efforts vital in move to CDHP: Study

But employers cite need for better tools to rate cost, quality

By **JOANNE WOJCIAK**

Employers that educate their employees early and often about why a consumer-driven health plan is being offered see greater enrollment than those that don't, concludes a study by Watson Wyatt Worldwide and RAND Corp.

Employers that began communicating six or more months prior to implementation averaged a CDHP penetration rate of 42%, while those that got a later start averaged only 25%, according to "The CDHP Implementation Experience with Large Employers," released last week.

The survey also found that employers that eliminated their most popular plan option saw a 52% penetration rate, compared

with 20% at those that just added a CDHP to their traditional health plan choices. Offering financial incentives also boosted CDHP penetration rates, the study found.

In addition, when a CDHP option had the lowest premium, employees chose the CDHP 36% of the time compared with 28% in companies in which it was not the lowest premium choice.

Despite the need for better consumer engagement to make CDHPs more effective in controlling health care costs, employers participating in the Wyatt/RAND study were generally disappointed in the current information tools to rate physician cost and quality. Only 11% of employers rated physician quality comparison tools as good or excellent, while 37% rated hospital quality comparison tools as good or excellent.

The findings are part of a four-year, ongoing project examining

See **STUDY** page 6

Devine tapped to head Aon Re Global

Joins CEO Case, other ex-McKinsey leaders holding top positions at Aon

By **JUDY GREENWALD**

CHICAGO—Aon Corp.'s promotion of Ted T. Devine to chief executive officer of Aon Re Global marks the ascension of another former McKinsey & Co. consultant to the brokerage's top ranks, and observers say the infusion of management consulting talent will likely benefit Aon.

Before joining Aon in 2005 as chief operating officer of Aon Risk Services Americas and head of global strategy, Mr. Devine led McKinsey & Co.'s North American insurance practice and North American insurance operations and technology efforts.

Other McKinsey alumni now at Aon include President and CEO Gregory C. Case, who was head of McKinsey's financial services practice when he joined Aon in 2005.

In addition, both Andrew M. Appel, who is CEO of Aon Consulting Worldwide, and Baljit Dail, Aon's global chief information officer, previously worked at McKinsey.

Mr. Devine replaces Michael D.

O'Halleran as Aon Re Global's CEO.

Mr. O'Halleran, formerly Aon Re Global's chairman and CEO, has been named executive chairman.

In his new position, Mr. O'Halleran will focus on working with clients.

"We have committed to be a client-centered firm, and we're committing me as the most senior executive to be 100% focused on clients," said Mr. O'Halleran.

Mr. Case said Mr. Devine's background as "kind of the ultimate insurance insider," along with his focus on organic growth since working at Aon, will be a "very powerful combination."

Ramani Ayer, chairman and CEO



Michael D. O'Halleran, left, executive chairman of Aon Re Global, and Ted T. Devine, CEO of Aon's reinsurance brokerage unit.

of Hartford Financial Services Group Inc., said Mr. Devine "is a very smart executive, and in his various roles in life he has actually gotten to know CEOs and company managements quite well, and will

See **AON** page 6

Assurant terminates two amid probe

By **ROBERTO CENICEROS**

NEW YORK—Assurant Inc. said it has terminated a senior vp and a risk manager who previously were placed on administrative leave amid a federal investigation into finite reinsurance arrangements.

Assurant's board of directors terminated Michael Steinman, who had been senior vp and chief actuary for Assurant Solutions/Assurant Specialty Property, the specialty insurer said last week. The board also fired Dan Folse, who had been vp-risk management for Assurant Solutions/Assurant Specialty Property.

Three other executives remain on administrative leave. They are: Robert B. Pollock, Assurant's president and chief executive officer; Philip Bruce Camacho, executive vp and chief financial officer; and Adam Lamnin, executive vp and CFO of Assurant Solutions/Assurant Specialty Property.

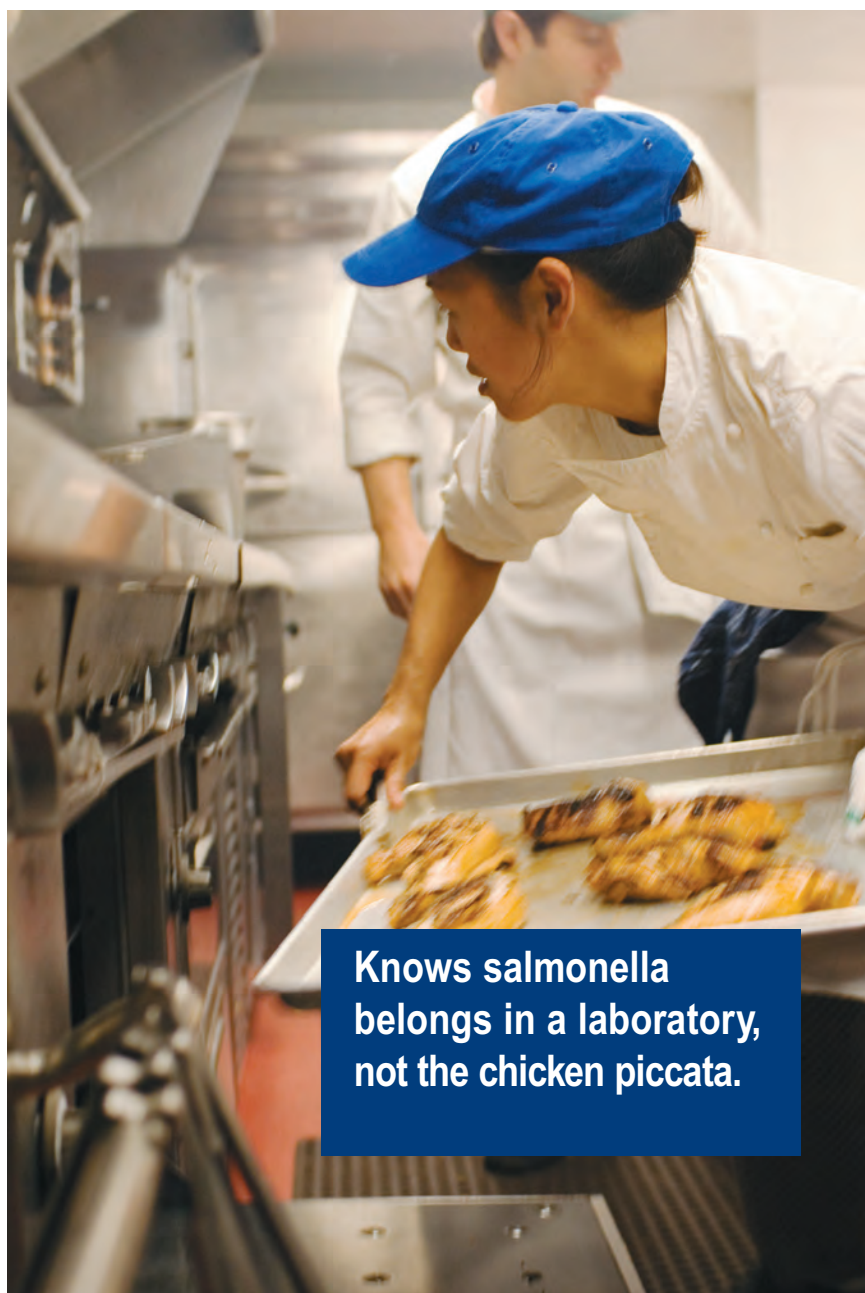
All five were placed on administrative leave last month after receiving so-called Wells notices, which are Securities and Exchange Commission notices that civil enforcement actions could follow (*BI*, July 23). An Assurant spokesman said he was not aware of SEC charges being

filed against any of the individuals.

The termination of Messrs. Steinman and Folse followed a review conducted by a special Assurant board committee formed to evaluate the matter, the company said.

Assurant also said it believes the SEC's investigation involves a catastrophe reinsurance contract the company had with one reinsurer commencing over a decade ago, which expired in 2004.

Federal officials have been investigating whether insurers used finite products to smooth earnings and conceal their true financial position.



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Arch: Reinsurer fires back in dispute over rival's former employees

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by arguing that the four former managers had attempted to destroy documents before leaving Gen Re and might destroy more, a Gen Re senior vp and an outside consultant later testified that Gen Re had no

factual basis for the charges, Arch alleges.

The four managers in fact had no employment contracts, noncompete agreements or other restrictive covenants with Gen Re, Arch's filing says.

Gen Re has also communicated

with clients and prospective clients about its dispute with Arch and has mischaracterized the agreed order as a continuation of the temporary restraining order, Arch alleges.

Gen Re has "exploited" its dispute with Arch "to create an opportunity to suppress (Arch's) ability to

compete and to misappropriate, for its own advantage and profit, Arch's business relationships with other members of the reinsurance industry," the filing charges.

Arch is seeking unspecified compensatory damages for lost business and punitive damages for libel.

Damon Vocke, Gen Re's general counsel, said Arch's counterclaims are "nothing more than an attempt to deflect attention from their own words and actions."

"We look forward to our day in court to resolve this matter on the merits," he said.

Aon: Devine to head reinsurance unit

CONTINUED FROM PAGE 4

be capable of really positioning Aon Re to continue to serve" its customers.

Observers say the executives' McKinsey background will benefit Aon.

John L. Ward, CEO of Cincinnati-based Cincinnati Partners L.L.C., an advisory firm specializing in insurance, said: "McKinsey is a world-class consulting firm, and they bring innovation to the table. They also bring deep experience at building relationships with (chief financial officers) and CEOs of major companies, and those relationships, and their experience in building those relationships, should benefit Aon in a big way going forward."

"There's definitely a correlation" between Aon and McKinsey's businesses, both of which deal with people, relationships and enhancing products' value, said Gretchen

Roetzer, an associate director at Fitch Ratings in Chicago.

Bruce Ballentine, vp and senior credit officer at Moody's Investors Service in New York, said the lack of direct experience working as an employee of an insurer or brokerage is not a problem for McKinsey alumni.

"I think they have gained ample experience with the insurance business and perhaps some helpful perspective from their role consulting to various insurance-related operations," Mr. Ballentine said.

Cliff Gallant, an analyst with Keefe, Bruyette & Woods Inc. in New York, said the McKinsey influence has proved valuable thus far. "If you remember where Aon was a couple of years ago, it was lagging its peers in terms of its margins, and the growth wasn't going anywhere," with Aon having many noncore businesses.

It might have taken outsiders "to sort of assess where the company

was missing the mark," he said. "They've done a pretty good job, I think, of identifying weak parts of the company and boosting the margins and financially putting the company in a pretty good position," said Mr. Gallant.

"The challenge might be, once the margins are up and things are going smoothly, do they know how to win clients and gain business. And when you get down to that, having people with real brokerage experience might be more useful."

Meanwhile, Aon last week named Geoffrey Bromley as head of Aon Re's U.K., European, Middle Eastern, African and Asia Pacific operations.

Mr. Bromley formerly was chairman of European and Asian operations for reinsurance intermediary Guy Carpenter & Co. L.L.C. in London. He assumes his new position, which has not been filled at Aon for several years, in February 2008.

Study: Early education vital to CDHP adoption

CONTINUED FROM PAGE 4

the experience of 42 large employers that offer at least one CDHP. The research, which also covers CDHPs' effect on the cost and quality of health care, was funded by the California HealthCare Foundation and the Robert Wood Johnson Foundation.

While the thinking of most employers offering CDHPs was that they would have to spend less time managing the health care benefit, "Clearly what this shows is that to have any success, they'll have to spend more time communicating with employees about why they're changing, and also after you've changed, so they can make use of (the CDHP) wisely," said Bill Custer, director of the center for health services research at Georgia State University in Atlanta, who was not involved in the study.

"Most employers don't understand the level of effort they're committing to" when they decide to introduce a CDHP, agreed Roland McDevitt, director of health care research at Watson Wyatt in Arlington, Va., and one of the consultants working on the study.

Indeed, Ray Brusca, vp of benefits at Black & Decker Corp. in Towson, Md., said his company began communicating in April about the CDHP it will introduce this fall, having learned from its bad experience in launching such a plan

in 2004.

"When we rolled out a plan back in 2004, only about 30 employees signed up, so the company decided to drop it," Mr. Brusca said.

This time, the company began communications earlier and published a booklet to educate employees about the need for the plan and its merits. Black & Decker also priced the CDHP more favorably, Mr. Brusca said.

"The sooner you start to communicate, the better your chances of success," he said.

Better tools needed

But like participants in the Wyatt/RAND study, Mr. Brusca said he, too, is disappointed in the quality of the consumerism tools available to plan members.

"Consumer-directed tools have come a long way, but they're still a long way from where they need to go," Mr. Brusca said. "It took me three hours to put my basic data in to try to do a calculation, and I'm the benefits manager. How viable is it for a factory worker who may have a high school education and their kid may have a PC, but they don't really get on it often?"

Copies of the research brief, "The CDHP Implementation Experience with Large Employers" are available free to registered users of My Watson Wyatt portal at www.watsonwyatt.com/cdhp.

Libel: Out-of-state resident can be sued for Web posting

CONTINUED FROM PAGE 4

"It's very clear that this person knew the Goldhabers were in New Jersey, he reached out to New Jersey and he leveled these personal attacks on people who were in New Jersey," said Paul W. Norris, a Lawrenceville, N.J.-based attorney with Star & Stark P.C., who represented the Goldhabers.

Charles S. Sims, an attorney with Proskauer Rose L.L.P. in New York, said: "I'm not certain (the New Jersey court is) relying on a different analytical approach" than other courts have used in ruling there is no jurisdiction.

"These court cases all have marginally different facts," Mr. Sims said. The New Jersey court seems to agree "that merely putting some-

thing up on a Web site is not enough to be sued in every state in the country."

The decision is a "fairly straightforward application of jurisdiction in a normal defamation case," said Bruce E.H. Johnson of Davis Wright Tremaine L.L.P. in Seattle. "This is another case where bad facts lead to a particular legal result."

Jeremy Feigelson, an attorney with Debevoise & Plimpton L.L.P. in New York, said, "It's not a decision I would expect to really move the law."

Danna Goldhaber and Richard Goldhaber, Plaintiffs-Respondents, vs. Charles Kohlenberg, Defendant-Appellant; Superior Court of New Jersey, Appellate Division; A-5114-05T2, Aug. 2, 2007



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EBN0607

Business Insurance OPINIONS

Buyers must be wary of broker payments

IT'S STILL TOO EARLY to tell whether the latest attempt by brokers to wring extra payments from insurers will result in conflicts of interest, but insurance buyers should be cautious before they OK the new fees.

As we report on page 1, Marsh last week announced that it has amended its settlement agreement with the New York attorney general's office to allow the brokerage to charge fees for services it provides to insurers, provided the fees are disclosed to the brokerage's clients.

It is unclear what services Marsh believes insurers should pay for and how those fees will be calculated.

At first glance it seems quite reasonable that one business should be able to charge another business for services rendered, but given the recent history of insurer payments to brokers and the expectation that brokers serve solely their clients, any insurer-paid fees should be carefully examined.

Before they give their approval for the set-up, clients should be comfortable that the fees are structured in such a way that they give no incentive to brokers to place business with one insurer over another—simply disclosing the amount of a fee and the service it is linked to does not necessarily mean conflicts of interest won't arise.

While it is understandable that Marsh and its rivals are looking for ways to recover the significant revenues that they gave up when they swore off contingent commissions, the brokerages' clients should not let those considerations color their judgment.

Natural catastrophe bill a step in right direction

WE CERTAINLY WELCOME the Senate Banking, Housing and Urban Affairs Committee's recent approval of the Commission on Natural Catastrophe Risk Management and Insurance Act of 2007.

The bill, which was introduced by the committee's chairman, Sen. Chris Dodd, D-Conn., calls for creation of a 16-member commission that would examine the best ways to deal with natural catastrophe risks. It would report its recommendations to the relevant congressional committees by Dec. 1, 2008. The body would examine such matters as the effectiveness of building codes, the private insurance market's ability to withstand natural catastrophes and the "benefits and costs of proposed federal natural catastrophe reinsurance programs." The commission also would examine "the impact demographic trends could have on the amount of insured losses inflicted by future hurricanes."

Such a broad mandate is more than justified. Natural disaster policy resembles a mosaic in which different tiles can be set in multiple ways. Having an independent body examine the myriad ways the tiles fit together, and suggest which patterns present the most effective design for dealing with natural catastrophe risk, makes perfect sense from a policy perspective. The commission can also provide a forum for dispassionate examination of a subject that's stirred sometimes overheated debate in the wake of Hurricane Katrina.

The Banking Committee was right to approve the bill, and we hope that the full Senate wastes no time in following suit when it returns from August recess.

Any insurer-paid fees should be carefully examined.



BI beats list

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

Agents/brokers:
Sally Roberts.

Benefits—health care and ancillary benefits:
Joanne Wojcik.

Benefits—retirement savings/pensions:
Jerry Geisel.

Bermuda market:
Rupal Parekh.

Canada—risk management and benefits:
Gloria Gonzalez.

Claims management:
Rupal Parekh.

Employment practices:
Judy Greenwald.

Environmental risk management: Sally Roberts.

Federal regulation/

legislation—benefits:
Jerry Geisel.

Federal regulation/legislation—risk management:
Mark A. Hofmann.

Health care industry operations: Gloria Gonzalez.

Industry Focus: Rodd Zolkos, Meg Fletcher.

Insurance coverage litigation: Douglas McLeod.

Insurance fraud:
Douglas McLeod.

Latin American markets:
Roberto Cenicerros.

Property/casualty industry operations: Judy Greenwald.

Professional liability:
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cat risks: Mark A. Hofmann.

Regulation of insurance:
Meg Fletcher.

Reinsurance:
Judy Greenwald.

Risk management profession: Dave Lenckus.

Runoffs/receiverships:
Douglas McLeod.

Safety/ergonomics: Meg Fletcher.

Surplus lines/wholesalers:
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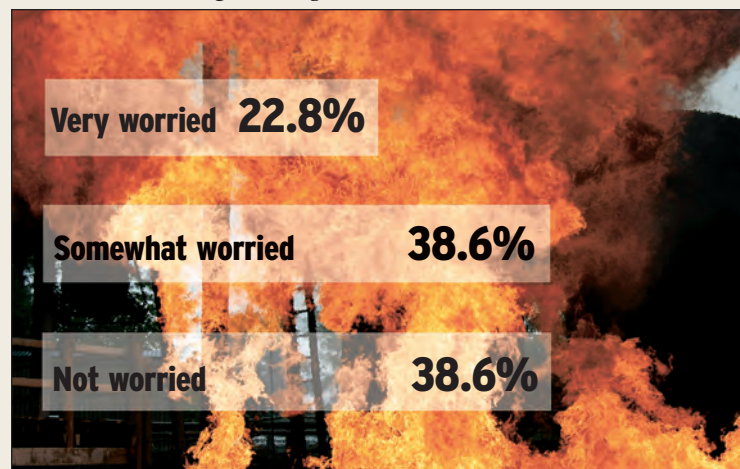
Tort reform: Mark A. Hofmann.

Work/life benefits and EAPs: Sally Roberts.

Workers compensation:
Roberto Cenicerros.

Online Poll at www.businessinsurance.com

How worried are you about a terrorist attack using nuclear, biological, chemical or radiological weapons?



NEXT WEEK'S POLL: Does full disclosure of insurer payments to brokers effectively guard against conflicts of interest?

BI Online Poll tool sponsored by Wausau Insurance Cos.

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CONSUMER-DRIVEN HEALTH PLANS

Employers proceed with caution when considering total replacement of other health plans / **Page 16**

Health care debit card providers unlikely to follow American Express out of the market / **Page 18**

BENEFITS MANAGEMENT

FINE-TUNING CONSUMER-DRIVEN PLANS

Companies revamp financing, improve communications

By **KAREN PALLARITO**

With a few years of experience under their belts, employers and health plans are adjusting their consumer-driven health plan offerings in an attempt to make them more attractive to plan sponsors and employees.

The changes include improved communication efforts, more user-friendly decision-support tools and revamped plan design and financing.

"The only constant in this kind of world is change, so there have continually been updates and tweaks," said Alexander Domaszewicz, a Newport Beach, Calif.-based principal and senior consultant with Mercer Health & Benefits.

Wendy's International Inc., for example, boosted employer contributions to workers' health savings accounts in 2006. Lynn A. Bauman, director of employee benefits for the Dublin, Ohio-based fast-food chain, said the CDHP did so well in the first year—leveling the annual double-digit cost trend to zero—that officials decided to put money back into the plan. To meet that goal and comply with new Internal Revenue Service "comparability rules," the company chose to increase its contribution to all plan options, even though the rules would have permitted the company to reduce its contribution to certain levels.

See **CHANGES** page 14

Do CDHPs increase use of wellness services?

Insurers, consultants differ over takeup rate estimates for preventive-care options

By **JOANNE WOJCIK**

Although most consumer-driven health plans are designed to emphasize wellness and prevention to reduce future health care costs, experts say it is too early to tell whether plan members are using those kinds of services more frequently than members of traditional health plans.

While insurers and vendors promoting CDHPs all claim to have statistics showing that members are more likely than their peers at health maintenance organizations or preferred provider organizations to access preventive health care services, such as cancer screenings, studies by benefit consultants and other organizations are finding just the opposite.

Most benefit experts chalk up the lower use of wellness and preventive care services by CDHP members to misunderstanding, and stress the need for stepped-up communications and incentives to ensure they use the benefits that the vast majority of CDHPs pay at 100% (see story, page 14).

Minnetonka, Minn.-based UnitedHealth Group Inc. reported in April that CDHP members were 16% more likely to receive cervical and prostate cancer screenings, 10% more likely to receive cholesterol screenings and 8% more likely to receive colon cancer screenings.

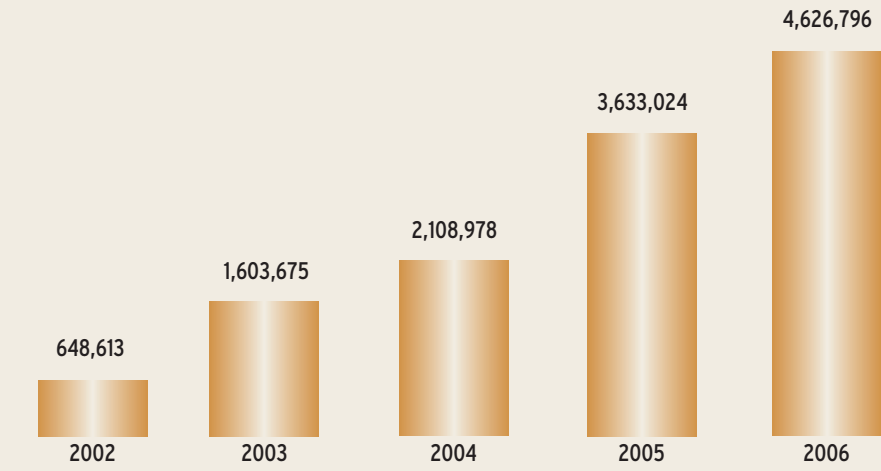
Likewise, Broomfield, Conn.-based CIGNA Healthcare reports that CDHP members are 12% to 13% more likely to access wellness and preventive services than their traditional health plan counterparts. The insurers say CDHP members seek out such services since they are generally paid at 100% and because their plans provide consumer engagement tools

See **WELLNESS** page 14

WEBINAR: *Business Insurance* Senior Editor Joanne Wojcik will host a webinar on wellness and consumer-driven health plans Aug. 14 at 11 a.m. EDT. Register online at www.businessinsurance.com/webinars.

CONSUMER-DRIVEN HEALTH PLAN UTILIZATION

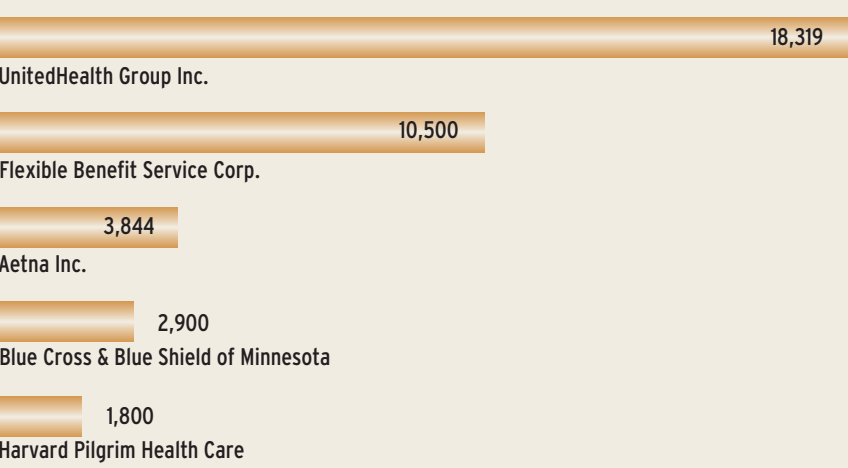
Total number of covered lives among the 10 largest providers listed in each year's ranking



Source: BI survey

LARGEST BY NUMBER OF CLIENTS

Plan providers by number of employer clients as of 12/31/06



Source: BI survey

Largest consumer-driven health care plan providers

Ranked by number of total covered lives at employer clients in 2006

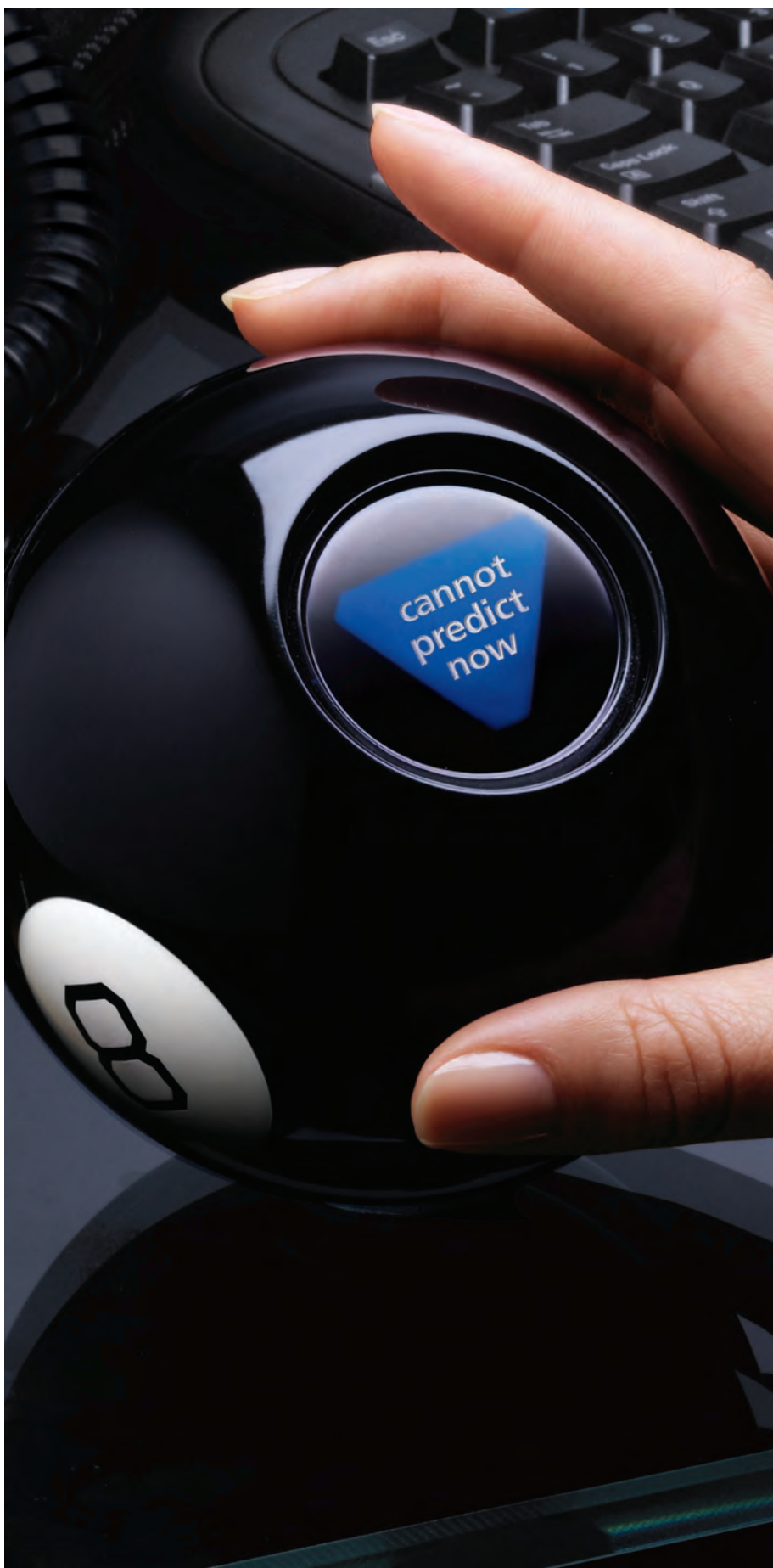
Rank	Company/Address	Phone/Fax/Web site	Health plan name(s)*	Total covered lives	Employer clients	Plan options	Principal officer
1	UnitedHealth Group 9900 Bren Road E., Minnetonka, Minn. 55343	866-799-1331 www.unitedhealthgroup.com	Definity	1,890,084	18,319	Dental, FSA, HRA, HSA, prescription drugs, vision	Michael Tarino, CEO-Definity Health, a UnitedHealth Group company
2	WellPoint Inc. 120 Monument Circle, Indianapolis, Ind. 46204	317-532-6000 www.wellpoint.com	Lumenos	821,000	N/A	FSA, HRA, HSA, PPO, prescription drugs, vision	Angela Braly, president/CEO
3	Aetna Inc. 151 Farmington Ave., Hartford, Conn. 06156	860-273-0123 www.aetna.com	Aetna HealthFund HRA, Aetna HealthFund HSA	611,225	3,844	Dental, FSA, HMO, HRA, HSA, indemnity, PPO, prescription drugs, vision	Ronald A. Williams, chairman/CEO
4	Humana Inc. 500 W. Main St., Louisville, Ky. 40202	502-580-1000 Fax: 502-580-3621 www.humana.com	SmartSuite, SmartExpress, SmartSelect, CoverageFirst	481,000	N/A	Dental, FSA, HMO, HRA, HSA, PPO, prescription drugs	Michael B. McCallister, president/CEO
5	CIGNA Healthcare 900 Cottage Grove Road, Hartford, Conn. 06152	860-226-6000 Fax: 860-226-7762 www.cigna.com	CIGNA Choice Fund	252,000	228	Dental, FSA, HRA, HSA, indemnity, PPO, prescription drugs, vision	Tom Richards, senior vp, product
6	Blue Cross & Blue Shield of Minnesota 3535 Blue Cross Road, Eagan, Minn. 55122-1154	888-878-0139 Fax: 651-662-6882 www.bluecrossmn.com	Options Blue	184,913	2,900	FSA, HRA, HSA, PPO, prescription drugs	Dr. Mark Banks, CEO
7	Great-West Healthcare 8505 E. Orchard Road, Greenwood Village, Colo. 80111	303-737-3000 Fax: 303-737-0008 www.greatwesthealthcare.com	Great-West Healthcare Consumer Advantage	119,755	889	Dental, FSA, HRA, HSA, indemnity, PPO, prescription drugs, vision	Richard F. Rivers, executive vp
8	Meritain Health 300 Corporate Parkway, Amherst, N.Y. 14226	800-828-6922 Fax: 716-319-5725 www.meritain.com	-	108,000	1,400	Dental, FSA, HMO, HRA, HSA, indemnity, PPO, prescription drugs, vision	Jacob L. Canova, chairman/CEO
9	Medica 401 Carlson Parkway, Minnetonka, Minn. 55305	952-992-2900 Fax: 952-992-3377 www.medica.com	Medica Direct	98,819	1,407	Dental, FSA, HMO, HRA, HSA, indemnity, PPO, prescription drugs, vision	David Tilford, president/CEO
10	Fiserv Health Plan Administration 5500 Wayzata Blvd., Suite 500, Golden Valley, Minn. 55416	866-881-0800 Fax: 715-841-6334 www.fiservhealth.com	Fiserv Health Consumer Connection	60,000	80	FSA, HRA, HSA, indemnity, PPO, prescription drugs, vision	Jay Anliker, president

*If different from company name. N/A=Not Available
Source: BI survey
Researched by Kevin Edison and Karen Tucker

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Changes: Plans fine-tuned by employers, insurers

CONTINUED FROM PAGE 11

Today, Wendy's share of HSA funding is about 60%, on average, across the various CDHP options it offers, up from 35% to 40% in the first year, Mr. Bauman noted.

The company also made changes to the frequency of HSA contributions. On Jan. 1, 2006, it switched from quarterly to semi-annual payments—funding six months worth of contributions on day one—to help employees pay for maintenance drugs for certain chronic conditions. Now, because many of those drugs are eligible for first-dollar coverage, and since most employees carried forward an HSA balance into 2007, the company began contributing monthly.

"So people are getting their money sooner than they used to," Mr.

and how the...design differs from a traditional PPO plan," said Janice Rahm, a Minneapolis-based senior vp of product and service innovation.

Many employers are enhancing "wellness" benefits, saying they want to make employees better health consumers and to bolster the value of CDHPs.

When Fujitsu America Inc. first introduced a CDHP in 2004, it capped preventive care at \$500 per employee per year. Now, it covers 100% of the cost of routine tests, screenings and other preventive services. "We were just nervous about the idea of an unlimited amount," said Kathy Bartow, director of benefit programs in the company's Sunnyvale, Calif., headquarters. "But as more studies have been done that show the value of preventive (care), we thought it made sense to totally lift that cap."

It appears to have been the right call: "We have several situations where employees have written Lumenos (the WellPoint Inc. subsidiary that administers the plan) and said, 'I'm so glad I did this (test or procedure) because the doctor found something,'" Ms. Bartow said.

This year, Fujitsu also expanded incentives for wellness, adding \$100 credits, respectively, for spouses who take a health risk assessment and for employees who complete Lumenos' smoking cessation program.

Dave Garratt, a Cleveland-based vp and market head for Aetna Inc.'s Ohio/Kentucky national accounts market, said that more employers are talking about implementing an incentive strategy that's tied to an individual's biometrics, such as body mass index, blood pressure and cholesterol levels. Aetna is piloting the concept with some of its customers. "It's sort of a new twist," he said, "and it's back to the notion of how do we reward people for doing the right things?"

Carl Mowery, managing director of compensation and benefits at SMART Business Advisory & Consulting L.L.C. in Chicago, said he is spending more time with clients on developing wellness strategies that underscore the value of staying healthy and accumulating a nest egg for when employees are older and require more medical services.

But there may be another way to move people into CDHPs. He has one client, a large school system, whose leadership is considering a "negative election" process, whereby all employees would be enrolled in the CDHP program unless they elect otherwise. "If we just say, you are now enrolled in this program unless you want to choose something else, they may just stay in the high-deductible program," he said.

Amid all the redesign activity, Mercer's Mr. Domaszewicz cautions plans sponsors to keep one thing in mind: "If you look at the plan and you wouldn't enroll yourself, why would you think anyone else would enroll?"

'If you look at the plan and you wouldn't enroll yourself, why would you think anyone else would enroll?'

Alexander Domaszewicz,
Mercer Health & Benefits

Bauman said. And the financial risk to the company of contributing to the account of a person who terminates employment is reduced, he added.

A recent Towers Perrin survey suggests that employers and health plans have a lot of heavy-lifting ahead of them if they want their CDHPs to succeed over the long haul. According to the survey, members of account-based health plans are significantly less satisfied with their plans than employees in traditional health plans. A major shortcoming: employer-employee communications.

Increasingly, though, employers are recognizing the "need for really clear and thoughtful and durable communications and marketing," said Jay Savan, a principal with Towers Perrin in St. Louis. As an example, they're using employee focus groups or advisory counsels to help design and tailor employee communications. One of Mr. Savan's clients, a national law firm, intends to solicit input on plan design and communication from the company's legal secretaries, who are regarded as opinion leaders and can "make or break an initiative," he said.

In early 2006, Meritain Health Inc., an Amherst, N.Y.-based CDHP administrator, rewrote and expanded member communication materials, including print and online tutorials that explain how the plan works. "Through our customer service reps and the type of questions that they were receiving from members, it was clear to us that members were still challenged with understanding the dynamics of the...plan

Wellness: Preventive care usage examined

CONTINUED FROM PAGE 11

encouraging usage.

At Destiny Health, there is a 20% to 60% increase in preventive care usage for people in its Vitality wellness program, said Stuart Slutzky, vp of product development at the Chicago-based CDHP vendor.

Hartford, Conn.-based Aetna Inc., which is still studying preventive care utilization in CDHPs vs. traditional health plans, said initial data shows that CDHP members made greater use of preventive care than other plan members, said Dr. Charles Cutler, chief medical director for national accounts.

However, non-CDHP vendors tell a different story.

A November 2006 study by the Menlo Park, Calif.-based Kaiser Family Foundation found that CDHP participants are less likely than their non-CDHP counterparts

(73% vs. 85%) to have received any health care services since enrolling in their current plan. They are also less likely to have had a medical checkup (63% vs. 74%). The KFF study also found that 25% of CDHP members skipped a recommended test or treatment, compared with just 15% of their non-CDHP peers.

The KFF study attributed the lower utilization to the cost of such services and CDHP participants who previously tapped health care benefits less often.

A study by Ann Arbor, Mich.-based Thomson Healthcare compared claims data from CDHP and PPO members from 11 large employers over a three-year period and found that PPO members used more preventive services than CDHP members (see chart).

For example, just 18.5% of CDHP members had prostate cancer screenings in 2004 vs. 31.7% of

their PPO counterparts, 16.9% of CDHP members received cholesterol screenings compared with 26.4% of their PPO peers, 36.6% of CDHP plan members received cervical cancer screenings vs. 42.6% of PPO members, and 40.6% of CDHP members received mammograms vs. 49.5% of PPO members.

Although the percentages accessing such services increased in the study's third year, usage among CDHP members still lagged that of the PPO group: 28% of CDHP members received prostate cancer screenings in 2006 vs. 36.6% of their PPO counterparts, 22.2% of CDHP members had cholesterol screenings vs. 31.5% of PPO members, 46.1% of CDHP members underwent cervical cancer screenings compared with 46.3% of PPO members, and 48% of CDHP members had mammograms

continued on next page

Employers beef up efforts to increase worker participation in wellness programs

By JOANNE WOJCIAK

Concerned that not enough employees would use wellness and preventive services when Bacou-Dalloz USA Inc. introduced its consumer-driven health plan last year, the Smithfield, R.I.-based manufacturer promoted the benefits as "free stuff," said Michael Vittoria, director of human resources.

"We used the language of consumerism and listed the wellness items that are covered at 100% and told them what things were 'free,'" Mr. Vittoria said. "Everyone likes free stuff. So we promoted wellness as being free stuff. That really got people's attention."

Well-child visits, routine checkups and gynecological visits, including related laboratory work, were promoted as "free" by the manufacturer of head, body and fall protection equipment.

Bacou-Dalloz also never used the term high-deductible health plan, Mr. Vittoria said. "Our employees don't know they have a high-deductible health plan. We call it an upfront deductible. We found people understand that a whole lot better. It also has a better connotation," he said.

Although the manufacturer does not yet have claims data for this year from its plan administrator to know if the promotion has been effective, "anecdotally, we've heard of lot of positive feedback from employees," Mr. Vittoria said.

To ensure that more CDHP members use wellness and preventive care services, a growing number of employers are turning to stepped-up communications

and financial incentives.

Aside from 100% coverage of preventive care, typical incentives include reductions in employees' monthly premiums, contributions to employees' health reimbursement arrangements or health savings

'We encourage incentives over the penalties. However, one person's incentive is another person's penalty.'

Steven Noeldner,
Mercer Health & Benefits

accounts, gift certificates and more. One health plan—Chicago-based Destiny Health—even offers discounted vacation packages to those who achieve a certain level of participation in its Vitality wellness program.

The incentives, which can be taxable income to employees if they are not directly tied to the health plan, are generally given to employees for enrolling in care management programs or for completing health risk assessments, although employers are increasingly making health risk assessments a required part of enrolling in health benefits, benefit experts say.

Stephanie Pronk, chief health officer at RedBrick Health, a CDHP education firm based in Minneapolis, said she is noticing a trend of using phased incentives, where payments are made

to plan members at the beginning, middle and end of a care management program to ensure they follow through.

Experts say it takes several years for an employer to realize a return on its investment in health and wellness programs. Vendors say that return can be as much as \$3 in health care savings for every \$1 spent on preventive services.

While many employers are using incentives with CDHPs, some are adopting a more punitive approach, such as imposing penalties on plan members based on poor health habits.

Indianapolis-based Clarian Health, for example, is charging employees \$5 per pay period more per factor if they smoke, are obese, have high cholesterol, uncontrolled hypertension or uncontrolled diabetes (*BI*, July 9). That maximum additional employee charge is \$25 per paycheck.

Minnetonka, Minn.-based UnitedHealth Group Inc. also recently unveiled a CDHP that provides deductible discounts for plan members who meet one of four biometrics that include not smoking (*BI*, July 16).

"I think we're seeing employers testing the waters now," said Steven Noeldner, principal and senior consultant in the health and productivity management specialty practice of Mercer Health & Benefits based in Newport Beach, Calif.

However, Mr. Noeldner and other consultants advise their employer clients to choose the carrot approach over the stick.

"We encourage incentives over the penalties. However, one person's incentive is another person's penalty," he said.

CONTINUED FROM PAGE 14

vs. 50.3% of PPO plan participants.

"One of the major issues is people think they shouldn't have tests because they think they'll have to pay for them," said Carl Mowrey, managing director of compensation and benefits at SMART Business Advisory & Consulting L.L.C. in Chicago.

"They don't understand that it's not going to come out of their accounts," said Elizabeth Dudek, Ann Arbor, Mich.-based vp-practice leadership at Thomson Healthcare.

There are other reasons CDHP members may shy away from preventive health care services, one consultant found.

In a survey Watson Wyatt Worldwide conducted in conjunction with Harris Interactive on all health plan members' attitudes about preventive care, the consultant found people often "save up" conditions until they have two or more before seeing a doctor, said Cathy Tripp, national leader for consumerism based in Minneapolis.

Not only does this defeat the purpose of many preventive care services, it also can cause confusion for claims administrators trying to separate services that should be 100% covered from those that are subject to the CDHP deductible, she said.

On a related front, Watson Wyatt is working with Santa Monica, Calif.-based RAND Corp. on a four-year study financed by the California Healthcare Foundation of CDHP

members' use of wellness and preventive health care services. Early results show CDHP members "are

'Whether it's a consumer-driven plan or not, we do a horrible job of telling people that health is an individual's responsibility.'

Jay Savan, Towers Perrin

more engaged in lots of other consumer areas, like quality and cost

information or taking the health risk assessment or using modeling tools," Ms. Tripp said. "But not all of them are getting preventive care."

Jay Savan, a principal at Towers Perrin in St. Louis, said the problem of employees not seeking preventive care is universal and not exclusive to CDHP members.

"Most employer-sponsored plans cover preventive care at 100%. But less than a majority of people get the amount and frequency of preventive care that they need in a given year. For example, only 30% generally get annual physicals," he said. "Ultimately, whether it's a consumer-driven plan or not, we do a horrible job of telling people that health is an individual's responsibility."

CDHPS VS. TRADITIONAL HEALTH PLANS

Utilization of preventive care services by plan members

	CDHP	Other		CDHP	Other
PROSTATE CANCER SCREENING			MAMMOGRAPHY		
2004	18.5%	31.7%	2004	40.6%	49.5%
2005	24.3%	35.0%	2005	47.3%	50.5%
2006	28.0%	36.6%	2006	48.0%	50.3%
CERVICAL CANCER SCREENING			CHOLESTEROL SCREENING		
2004	36.6%	42.6%	2004	16.9%	26.4%
2005	43.5%	45.8%	2005	21.7%	30.1%
2006	46.1%	46.3%	2006	22.2%	31.5%

Source: Thomson Healthcare

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More employers offering only consumer-driven health plans

Small but growing number of businesses abandon traditional managed care approach as consumerism gains traction

By RUPAL PAREKH

Plagued by high health costs, more employers are embracing the concept of replacing all existing medical insurance plans and implementing a full replacement consumer-driven health care program. But, they are proceeding with caution.

Among the top concerns for those pondering the move to a full replacement program is lack of choice for employees and protection under the plans for lower-paid

employees, experts say.

"Three or four years ago, we saw very few companies give serious consideration to full replacement," said Patrick Travis, senior manager, in Chicago for Deloitte Consulting L.L.P.'s Human Capital Practice. "In this last cycle, we are starting to see many, many more employers giving it a serious look."

One reason employers are starting to come around is simply that consumerism is no longer a foreign concept, Mr. Travis said. Most orga-

nizations now "at least have a toe in the water" when it comes to consumerism, and offer some type of CDHP alongside traditional plans, he said.

Additionally, continuing cost pressures are forcing companies to evaluate more aggressive strategies to contain costs, Mr. Travis said.

Overall, though, the number of companies taking the plunge remains small; about 10% of companies now offer CDHPs as the sole coverage option, said Helen Darling, president of the Washington-based National Business Group on Health.

"Relatively few employers are offering consumer-directed health plans only," Ms. Darling said. "But the ones who do full replacement are the ones who get significant savings."

When imposing a high-deductible health plan, both the employer and the employee tend to save money since utilization of health care goes down in frequency, Ms. Darling said.

"If all employees are in (a CDHP) plan, the savings would be higher than if only 10% to 20% of employees were in the less costly plan," she said.

Total replacement programs also tend to prevent adverse selection, which can occur when only the healthiest employees enroll in a CDHP while high-dollar claimants remain in traditional plan options, experts note.

"You don't have to worry about

the person who does five triathlons a year and are generally healthy electing a CDH plan while your smokers and cardiac patients are selecting traditional plans," said Mike Sturm, principal and consulting actuary at Milliman Inc. in Brookfield, Wis. "When you switch

'Most large employers are committed to the concept of choice for their employees, not saying one size fits all.'

Tom Billet, Watson Wyatt Worldwide

everyone over, you eliminate that selection bias."

Providence, R.I.-based Textron Inc.—which, in 2002, was one of the very first employers to introduce a full replacement plan—has seen an improvement in the overall health of its 28,000 employees, in part, because preventive care visits have spiked under its total replacement plan (*BI*, Aug. 14, 2006).

Over the past three years, lipid tests for cholesterol increased 27%, tests for coronary artery disease grew 24% and colonoscopies for those 50 and older are up 66%, George Metzger, Textron's vp of

human resources and benefits, said in an e-mail. In that same period, preventive visits have increased 20% among male employees, who traditionally have been less likely to seek preventative care, Mr. Metzger said.

According to Chris Calvert, vp and senior health consultant at the Sibson Consulting division of New York-based Segal Co., companies going to full replacement "really have bought into the theory of consumer-driven health care that employees should be more engaged in their health care."

"Companies that are doing full replacements are saying that 'we are in this together, company and employee'...they're getting everyone involved, which is one of the keys to success," Mr. Calvert said.

A common concern among employers is the burden of a full replacement program may fall disproportionately on lower-paid employees, consultants say.

"It's a legitimate concern, particularly in some industries where there is a very large disparity between individuals on a pay scale," said Deloitte's Mr. Travis.

Employers can, however, solve the problem by altering the plan's design. "There is nothing that says that you can't continue to do payroll contributions depending on level of pay. We often see that employers will do pay-banded contributions," to a health savings account, for example, Mr. Travis said.

Linking premium to salary

Another option, Milliman's Mr. Sturm said, is to charge employees premiums for their coverage based on their salary. "The less you make, the less you pay for health insurance."

Fairfield, Ohio-based Innomark Communications—which currently offers a mix of plans that include preferred provider organization offerings as well as CDHP options and is considering a full-replacement consumer-driven health program—is considering setting up a special account to help offset expenses for lower-wage employees or for catastrophic health events.

Under such a program, "the money stays with the company, so if (employees) don't use it or were to leave, the company can keep it," said David Vonderheide, Innomark's director of human resources.

Many employers also worry that implementing a total replacement CDHP would eliminate choice for employees and therefore not be well-accepted.

"Most large employers are committed to the concept of choice for their employees, not saying one size fits all," according to Tom Billet, senior benefits consultant at Watson Wyatt Worldwide in Stamford, Conn.

But according to Mr. Travis, "There is a misconception that elimination of non-CDH plans and

HEALTH PLAN REPLACEMENT STRATEGY

Successfully implementing a full replacement consumer-driven health program requires observing key points. Patrick Travis, senior manager in Chicago with Deloitte Consulting L.L.P.'s Human Capital Practice, suggests the following:

- Set employee contributions and plan cost-sharing elements to achieve an overall cost-sharing percentage consistent with past practices, the marketplace and your corporate financial goals.
- Create and communicate a compelling business case for why your organization is going full replacement.
- Consider varying employee contributions and/or plan cost-sharing levels by salary bands to provide consistent financial incentives that are not onerous for any group.
- Sell management, starting with the "C-suite," on a sustained, multiyear healthy workplace and consumerism communication campaign. Have the top executive endorse and launch the complete changeover and its underlying strategy.
- In unionized situations, get union leaders involved early and focus on the health status improvement that arises from members being more responsible consumers of medical services.
- Maintain some level of choice within the program design. Employees often are wary of a program with no options.

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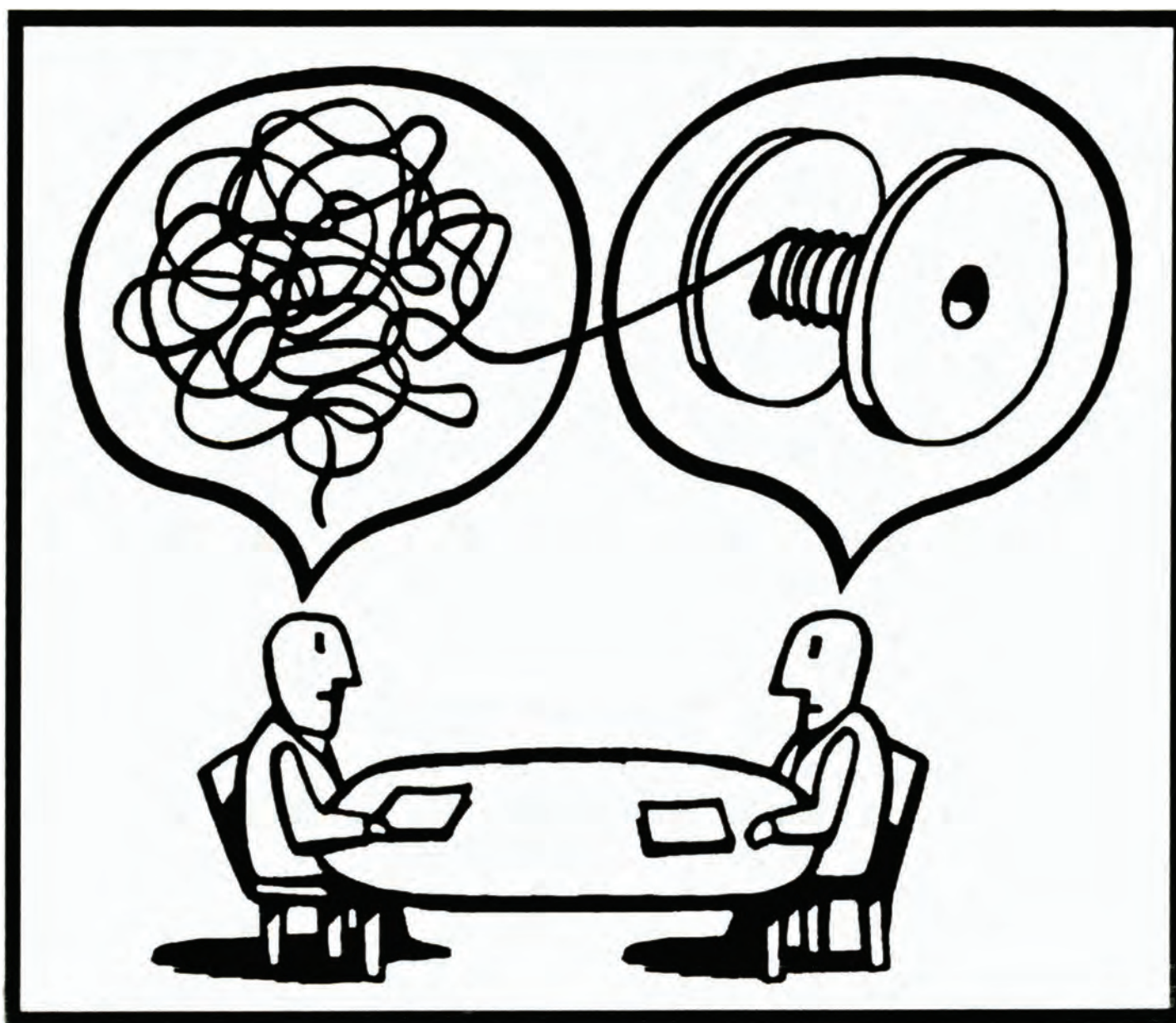
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Replacement: Employers limit options

CONTINUED FROM PAGE 16

going full replacement means elimination of choice." Choice could still be made available by changing plan design within the consumer-driven delivery model, he said.

A multitude of choices can also confuse employees, said Chiaw Eei NgGibson, head of benefits and HR economics for Hartford, Conn.-based Aetna Inc, which last year went to a full replacement plan for its 31,500 employees.

"In the years that we offered the PPOs, HMOs and CDHPs side-by-side, we got feedback from employees that those were too many choices," Ms. NgGibson said.

Currently Aetna offers two types of CDHPs, one linked to a health savings account and one to a health reimbursement arrangement, and typically has an 80% of employees covered by those plans.

Start early

When it comes to moving to a full replacement CDHP, there is no such thing as too much communication, experts say.

"The singular most important thing (employers) can do is communicate with the employees," and do so "months before they are going to implement" a full-replacement program, said Bill Tate, corporate vp, sales and market operations for Humana Inc.

Mr. Tate suggested appointing a team to develop an education campaign that involves insurers, consultants and the company's senior management.

In order to provide ample warning and support to employees as they make the transition, companies should ideally have a full year, said Ms. Darling.

"If you were planning to do it in January 2008, it's probably too late," Ms. Darling said, "but if you want to make that change for 2009," it can be done.

Health care debit cards remain convenient tool despite high-profile exit

Withdrawal by AmEx not expected to signal exodus of other issuers

By LOUISE ESOLA

Despite American Express Co.'s decision to stop offering its health

care-related debit cards at the end of the year, other major issuers will continue offering the credit cards to pay health care bills using employees' health savings accounts and health reimbursement arrangements.

American Express decided recently to pull its debit card because of slow consumer adoption of company-sponsored HSAs, a spokeswoman said. "Acceptance was moving more slowly than we anticipated," she said.

CIGNA Corp. and Empire Blue Cross Blue Shield, which both used American Express debit cards, are looking for new providers, spokesmen for the companies said.

Steve Raetzman, eastern division leader of group and health care consulting with Watson Wyatt Worldwide in Arlington, Va., said the lack of consumer education has much to do with the slow uptake of HSAs.

"This is going to take some education for sure," Mr. Raetzman said. "That's the responsibility of the employer."

It is estimated that 6 million U.S. residents are currently enrolled in HSAs, a number the Treasury Department estimates will reach 14 million by 2010.

Health benefit experts also expect the use of HSAs to grow exponentially over the next three years, which eventually would mean profits for companies providing debit cards as a means for employees to tap their HSAs and HRAs.

"I see this as continuing to grow," said Nancy Atkinson, a Pittsburgh-based senior analyst with Aite Group L.L.C., a financial institution research and consulting firm. "Health care remains a paper-intensive process that needs to be brought to the 20th century, and cards are the way to make that happen."

To date, most major credit card companies—Visa, MasterCard and American Express—offer health care

Continued on next page

Wellness & Consumer-Driven Health Plans: Contradictory or Complementary?

A Business Insurance Online Executive Forum™



Join Business Insurance Senior Editor Joanne Wojcik on August 14, 2007, along with our expert panel, for part two of our webinar devoted to wellness and consumer-driven health plans.

Much of the emphasis in consumer-driven health care has been on encouraging employees to take greater responsibility for their health care needs through increased cost-sharing, but there is also a wellness component to encourage employees to take better care of themselves. How can employers ensure that employees enrolled in high-deductible plans are not avoiding preventive treatment to keep their expenses low?

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- **Mark Snyder**, Director of Benefits, Owens Corning Corp., Toledo, OH

QUESTIONS TO BE ADDRESSED:

- Which is more effective – incentives or penalties – at raising use of wellness programs?
- How can health risk assessment data help employers and employees?
- What are IRS rules that impact wellness initiatives?
- What information technology infrastructure is needed for an optimum CDHP environment?

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CONTINUED FROM PREVIOUS PAGE

credit cards.

Lissa Thomson, a San Diego-based senior vp with the benefits practice for Lockton Cos. Inc., said the outlook is good despite American Express' decision.

"There is not a shortage of financial institutions that want to play a part in this business," Ms. Thomson said.

HSAs, created by federal law in 2003, allow consumers to save money in a tax-deferred employer-sponsored account to pay future health care costs. The accounts, often dubbed "medical IRAs," go hand-in-hand with high-deductible consumer-driven health plans, which are being offered more often

deductible CDHPs, meaning they are likely to sign up for HSAs to use pretax dollars to cover out-of-pocket health costs and deductibles.

In turn, credit card companies are looking at ways to increase usage by offering points and rewards for using their card, Mr. Sharon said.

In the future, Ms. Thomson said she expects credit card companies to link HSAs to personal checking accounts in case an employee exhausts funds in their HSA.

Credit card companies are also beginning to offer lines of credit attached to the HSAs, allowing employees to borrow in case of medical emergencies, Ms. Thomson said.

"There's opportunity here for financial institutions," she said.

'Health care remains a paper-intensive process that needs to be brought in to the 20th century, and cards are the way to make that happen.'

Nancy Atkinson, Aite Group L.L.C.

by employers seeking to lower their health care bills and place more financial responsibility on workers.

HSAs differ from flexible spending accounts, which require spending dollars put into the FSA within the same tax year or losing the funds. HSAs roll over each year and can be used for future health costs.

HSAs and FSAs both involve filling out forms and awaiting reimbursement—paper work and time that was eliminated when debit cards arrived as a means for employees to more conveniently access funds in the accounts. "This streamlined the process," said Aite's Ms. Atkinson.

Mr. Raetzman said many employees still confuse HSAs and FSAs and are reluctant to sign up for fear that they would lose their contributions at the end of the year.

"There is going to need to be a shift of thinking for those who had a use-it-or-lose-it account to this savings account," Mr. Raetzman said.

Ms. Thomson said as HSAs catch on, so will more tools—such as debit cards—to utilize them.

That's why most of the other credit card companies aren't about to follow American Express, according to spokespeople for the other major credit card companies.

"I think of this as a blip, limited to American Express," Mr. Raetzman said.

In fact, health care debit cards will become more convenient and user friendly, according to industry experts, and HSAs are slowly catching on.

Bill Sharon, a Tampa, Fla.-based senior vp with Aon Consulting's Health and Benefits Practice, said more than 400 financial institutions now offer HSAs, a figure that has doubled over the past year. Also, there are currently more than 9 million people enrolled in high-

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Films: Insurers work to find coverage solutions for at-risk actors

CONTINUED FROM PAGE 3

before covering as part of a movie.

That means higher premiums—or in rare cases, exclusions—for a hard-partying star than for a performer with no health or legal issues, Ms. Yount said. Exclusions can include not covering the actor if he or she becomes jailed during filming or declining to cover the individual altogether. “We’re not going to buy a loss,” she said.

With movie budgets inching higher and higher—the average production costs of a film are \$65 million, according to the Motion Picture Assn. of America—film producers want to be sure that an actor’s misbehavior doesn’t put the production in limbo.

“There’s more money at risk on these movies than ever before,” Mr. Kingman said. Cast and crew on a film can number in the hundreds, “so there’s a lot of people relying on these actors to get to work on time.”

But insurance companies will

work to provide coverage for films that include at-risk actors. “It’s a bold, glossy statement to say, ‘Yeah, there’s nobody who’s uninsurable,’” Mr. Finnegan of Fireman’s Fund said. “There may come a time when I’d say, ‘That’s too much. I’m not comfortable.’”

Mr. Finnegan said he and colleagues try to find solutions, although their answer might be “pretty tough to swallow” for movie producers, who may choose not to accept.

Insurance rates for at-risk actors can range from 1% to 3% of a film’s production budget, which can range from \$5 million to \$100 million, Mr. Kingman said.

A single DUI charge will not necessarily make an actor uninsurable, but a regular incidence of claims by a production company relating to a particular actor’s frequent absences “can be problematic from an insurability standpoint,” Mr. Kingman said.

To cover such an actor, brokers



Actor Robert Downey Jr., who has overcome substance abuse, was considered an “at-risk” actor.

take steps to craft risk management agreements with insurers.

“We leverage what we can,” said

Gallagher’s Ms. Yount. “There’s power in numbers.” When trying to obtain coverage for a film starring a tarnished actor, Ms. Yount said she tries to make the account “as attractive to a carrier as possible,” which at times includes keeping a close eye on the performer.

Risk management strategies include regular urine or blood samples, relinquishment of a driver’s license or even a “minder,” a sort of 24-hour babysitter to keep the actor on track and give executives updates on their charge’s conduct, according to entertainment brokers.

Financial incentives can serve as a carrot to keep a troubled actor in line, Aon/Albert G. Ruben Insurance’s Mr. Kingman said. Producers can withhold an actor’s salary or fees until the project is completed on schedule without a claim. “The stick is that they have to pay the loss up to their salary amount if there is a particular problem for that known risk,” he said.

And what of talk that Ms. Lohan

is an uninsurable risk?

“With Ms. Lohan, she’s very good. When she’s onscreen she delivers very well,” said Peter Marshall, senior vp at New York-based brokerage DeWitt Stern Group Inc. and a former senior vp of film production at Lions Gate Entertainment Corp.

Even so, “a lot of people in insurance and the bond world are scared to death to have her in a film right now” because of the uncertainty if she will delay a picture and cost producers more money, he said.

Insurers are willing, however, to give some actors a second chance. Robert Downey Jr., for example, is an actor who has overcome substance abuse, Mr. Marshall said.

“Robert has a really large body of extraordinary work that he created before he had problems,” Mr. Marshall said. “There was a great level of expectations and hope that he could return. With some people, they get into trouble really early in their career and it’s harder to rebound.”

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No 5330 of 2007
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and
**CITY GENERAL INSURANCE
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and IN THE MATTER OF THE
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Notice is hereby given that by application dated 25 July 2007, City General Insurance Company Limited (“City General”) applied to the High Court of Justice of England and Wales, for (inter alia) an order under section 111(1) of the Financial Services and Markets Act 2000 (the “Act”) sanctioning an insurance business transfer scheme (the “Scheme”) providing for the transfer of insurance business by Generali Assurances Générales (the “Transferor”) and for an order making provision under section 112 of the Act.

The business included in the Transfer is the insurance and reinsurance business written by the Transferor in the United Kingdom between 1 January 1956 and 17 March 1970, with the exception of certain policies details of which are included in the statement setting out the terms of the Scheme referred to below.

Copies of a report on the terms of the Scheme prepared by an independent expert in accordance with section 109 of the Act (the “Scheme Report”) and copies of a statement setting out the terms of the Scheme and containing a summary of the Scheme Report may be obtained, free of charge, from City General c/o Ruxley Ventures Limited, 150 Minories, London, EC3N 1LS, United Kingdom, during normal office hours (ref: Scot Ramsay); fax: +44 (0) 20 7347 5011; e-mail: scot.ramsay@ruxleyventures.com or may be downloaded from the website www.citygeneral.co.uk.

The application will be heard on 11 October 2007, before the Applications Judge at the Royal Courts of Justice, Strand, London WC2A 2LL, United Kingdom. Any person (including an employee of City General or the Transferor) who alleges that he or she would be adversely affected by the carrying out of the Scheme may appear at the time of the hearing in person or by Counsel. Any person who intends so to appear and any policyholder who dissents from the Scheme but does not intend to appear is requested to give written notice not less than 2 clear business days’ prior to the hearing of such intention or dissent and of the reasons for it to the Solicitors named below.

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ARRANGEMENT

SCHEME EFFECTIVE DATE AND CLAIMS SUBMISSION DATE

NOTICE IS HEREBY GIVEN that, by Order of the Supreme Court of Bermuda (the “Court”) dated July 20, 2007, the Court sanctioned the Scheme of Arrangement between Walton Insurance Limited (“Walton”) or the “Company”) and its Scheme Creditors pursuant to section 99 of the Bermuda Companies Act 1981 and as approved by the meeting of Scheme Creditors held on June 21, 2007. An office copy of the Order was lodged with the Registrar of Companies in Bermuda on July 27, 2007 and the Scheme became effective on that date. Capitalised terms not defined in this notice are defined in the Scheme Document.

In accordance with section 3.3 of the Scheme, Walton’s Scheme Creditors are now required to file a Claim Form, along with supporting documents, on or before the Claims Submission Date which is 5 pm (Bermuda time) on October 26, 2007 (being the first Business Day falling 90 days after (and not including) the Effective Date). CLAIM FORMS MUST BE RECEIVED BY THE COMPANY, INCLUDING SUPPORTING DOCUMENTATION, ON OR BEFORE THE CLAIMS SUBMISSION DATE unless Scheme Creditors have already filed a Scheme Voting Form and marked that form as their Claim Form. Failure to file a Claim Form by the Claims Submission Date will result in Scheme Creditors receiving distributions under the Scheme equal to their Agreed Claims.

Claim Forms have been forwarded to all Non-SVF Scheme Creditors (i.e. those Scheme Creditors who did not mark their Scheme Voting Form as their Claim Form) by post. Copies of the full text of the Scheme Document, including the Explanatory Statement and Claim Forms are also available free of charge from the Scheme Website at www.waltonscheme.com or by writing to the Company at, 26 Cornet Street, St. Peter Port, Guernsey, GY1 1LF, Channel Islands, attention Walton Scheme Administration.

Scheme Creditors who have marked their Scheme Voting Form as their Claim Form are able to amend or supplement their Scheme Claim by submitting a new Claim Form, together with revised supporting documentation.

Completed Claim Forms can also be faxed to the Company on the fax number: +44 1481 259 883 (attention: Walton Scheme Administration) or emailed to enquiries@waltonscheme.com; provided however that the Company receives an original signed copy of the documents within three Business Days of the electronic copies being received (and in any event no later than October 31, 2007).

Timothy Spafford, Director, Walton Insurance Limited
10 August 2007

BUSINESS RESOURCES

EDUCATION & TRAINING

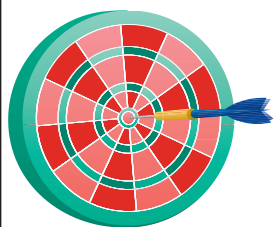
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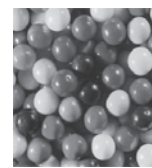
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International NEWS

Updated U.K. rehab code seen as aid to employers' return-to-work policies

By SARAH VEYSEY
and BEN NORRIS

LONDON—The U.K. risk management association has welcomed updates to a code of practice designed to improve access to rehabilitation for personal injury insurance claimants.

REVISED CODE

Revisions include:

- Rehabilitation now has a timetable for key stages of care.
- Rehabilitation can now start even when liability has not been admitted by the compensator
- Rehabilitation paid for by insurers during the litigation period will be nonrefundable

The voluntary rehabilitation code, first developed in 1999 for lawyers and insurers, aims to promote rehabilitation to ensure injured employees can return to work sooner.

Last week, a working party made up of representatives from the International Underwriting Assn., Assn. of British Insurers and the Nottingham, England-based Assn. of Personal Injury Lawyers, among others, published a revised version.

The revamped code introduces a timetable for key stages within the process of care, the working party said.

Under the new version of the code, an assessor's response is expected within 14 days of an initial meeting with the claimant, and compensators must reply within 21 days where rehabilitation is recommended. Previously, there was no response timetable.

In another major change to

the code, rehabilitation can now start even when liability has not been admitted by the compensator.

And rehabilitation paid for by insurers during the litigation period will be nonrefundable, should the claim prove to be unsuccessful in whole or part, according to the revised code. In some rare cases of serious injury, insurers or other compensators may decide to fund rehabilitation—because it can make a big difference to the injured party—and then later deny liability, said Ian Walker, the London-based former president of APIL.

Typically, insurers and other compensators know early on whether they are likely to deny a claim, he said.

The code is predominantly aimed at personal injury lawyers and insurers, but progress also must be made in other areas such as employers liability, noted Justin Jacobs, assistant director of liability and motor at the London-based ABI.

In addition to insurers, the compensators to which the code applies can also include employers with self-insured retentions, public authorities and the government-based National Health Service, noted Mr. Walker.

The Assn. of Insurance & Risk Managers supports the changes to the code, said David Ireland, chairman of the London-based risk management group's rehabilitation and absence management group.

The code has already made a significant difference to the way injured employees are treated and has been of benefit to them, their families, employers and insurers, he said.

The new code is more flexible and accessible “and will enable even more progress to be made in this important area,” he said.

Buyers debate insurer competition

European Commission may halt exemption allowing cooperation

By RICHARD MILLER

Risk managers are divided on whether the insurance industry's block exemption from certain European rules hinders competition in the sector.

The European Commission is set to release conclusions of its inquiry into the business insurance sector next month. That inquiry examined, among other issues, whether the exemption stifles competition and restricts choice for buyers.

Since 1992, the exemption has effectively allowed insurers to cooperate in certain areas of business. For example, it allows the use of standard policy wordings. It is set to expire in 2010 and may not be renewed.

While the insurance industry vigorously argues the merits of keeping its exemption, some corporate risk managers favor eliminating it on grounds that they would benefit from a more competitive insurance environment.

Others, however, contend that the exemption does not hinder competition and in some cases enables insurers to come up with wordings and policies that otherwise they would not.

In Finland, for example, large corporate buyers generally feel competition in business insurance is “inadequate,” said Lassi Väisänen, chairman of the Finnish Risk Management Assn., and chief risk officer at TeliaSonera Corp., a Helsinki-based telecommunications company.

“By abolishing the block exemption, competition might be increased in a positive way, and therefore it would be helpful to insurance buyers,” said Mr. Väisänen, recounting views from a mem-

ber's meeting earlier this year. “It might result in more variety on terms and conditions and ultimately help buyers to get better terms and premiums.”

From another standpoint, Ralf Oelssner, chairman of the Deutscher Versicherungs-Schutzverband e.V. in Bonn, Germany, and director of corporate insurance at Cologne-based airline Lufthansa A.G., said he is skeptical that removing the block exemption will increase competition.

“It was no jeopardy to us so far, so what do we gain by them getting rid of it?” Mr. Oelssner asked. “Unfortunately, insurers will just have to make sure that they supply some decent reasoning to Brussels why they should keep it is,” he said.

Such diversity of views is the reason that the Federation of European Risk Management Assns. in Brussels, Belgium, has decided not to take an official stance on the topic, according to Thierry Van Santen, FERMA's manager for European affairs.

“Indeed, we had different opinions between our members, and both points of view are valid,” said Mr. Van Santen, group risk manager of Paris-based Group Danone.

“Some may consider that this elimination would make life quite difficult for small and medium-sized insurance companies, reducing again the number of players. It may also bring confusion with every

company having very specific conditions making coinsurance and reinsurance difficult,” he said.

“Others consider that this would eliminate market consensus on

terms and tariff and would bring new innovations and competitive products,” Mr. Van Santen said. “In any case, this termination would be a major market change for all the insurance buyers with new rules and new practices.”

The Commission, which began its inquiry into competition in the business insurance sector in June 2005, is still on target to publish its final conclusions in September, according to a spokeswoman. If it finds instances of anti-competitive behavior, the Commission may take steps to

change European insurance law.

Speaking at a conference in July hosted by the Brussels, Belgium-based arm of Washington-based law firm Steptoe & Johnson L.L.P., Irmfried Schwimann, head of the Commission's Directorate-General for Competition's financial services unit, said the block exemption may soon be history.

In her remarks, Ms. Schwimann noted that “mainstream thinking is clearly heading in the direction that the exemption will be reduced or

See **EXEMPTION** page 24



‘Indeed, we had different opinions between our members, and both points of view are valid.’

Thierry Van Santen, Federation of European Risk Management Assns.

Flexible work rules vary across E.U.

By MICHAEL BRADFORD

Workers in Finland and Sweden are more likely to be employed at companies with highly flexible working arrangements, while those in Greece, Hungary and other southern European nations are apt to be working in the least-flexible environments, a study says.

The European Union's European Foundation for the Improvement of Living and Working Conditions analyzed the results of questionnaires

sent to more than 21,000 establishments in 21 European countries to determine how countries differ in their application of flexible work-time systems and the impact of those arrangements on company performance and employment.

The 83-page study concluded that the country where a company is located is the strongest determinant of flexibility, reflecting legal and cultural influences. The second strongest determinant was company size as measured by the number of employ-

ees, while the sector to which the company belonged was the third-strongest determiner of flexibility.

Across Europe, organizations with 50 or more employees in commercial services and public administration were more often found to be highly flexible in working arrangements aimed at meeting workers' needs, while small construction firms and other industry businesses were the least flexible.

The survey is available at www.eurofound.europa.eu.

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Commentary

Airline passengers face the summertime blues

If it's summer, no doubt someone is waiting out a flight delay.

Over the past few years, as much as a time for sharing such seasonal experiences as baseball and barbecues, summer has become a time for groaning along with others as the word "canceled" appears next to your flight number on an airport monitor.

Whether vacationing or on business, this time of year you run a constant risk that thunderstorms in Dallas or air traffic control issues on the East Coast will play havoc with your travel plans.

I saw an interesting piece about the current state of commercial air travel recently on the Knowledge@Wharton site of the University of Pennsylvania's Wharton School of Business (knowledge.wharton.upenn.edu). Its perspective likely won't surprise anyone who travels regularly.

According to the article, not only is the air travel experience these days frequently bad to miserable, but, as bad experiences have become the norm, airlines have largely stopped caring about customer service.

The piece, "Feel Free to Move About the Airport: Turbulence Continues to Roil the Airline Industry," quoted Wharton Professor Serguei Netessine reflecting on the new reality of airline customer service: "Previously airlines worried about dissatisfied customers. Now, I don't think they worry about it because the customer service at all airlines is so horrible."

Interesting approach to business: Everybody's service stinks so don't sweat the customer service.

For this year's first six months, major airlines' on-time arrival rate was just over 72.6%, according to the federal Bureau of Transportation Statistics, the lowest for the same period in seven years. In June, the on-time arrival rate was just 68.1%.

Meanwhile, DOT reported that complaints about airline service were up 47.2% in the first half of 2007 vs. the same period last year.

Not surprisingly, like other experts, the Knowledge@Wharton article cites airlines' reduced capacity as a factor behind much of the decline in service.

In an effort to operate profitably, airlines have cut capacity, leading to increased demand for available seats. Coupled with their tendency to overbook flights in an effort to avoid flying with empty seats, and the American airline industry's reliance on a hub-and-spoke model, problems tend to escalate quickly when bad weather or other factors force delays or cancellations.

While I've had my share of air



RODD ZOLKOS

Senior Editor Rodd Zolkos can be reached at: rzolkos@businessinsurance.com

travel nightmares in the past, I've been generally pretty lucky on my travels so far this summer. Of course by saying so, I've likely cursed my next trip. And it's probably worth noting that my home airport is Chicago's O'Hare International, a notorious flight delay culprit, according to the federal statistics. So my perspective on air travel misery might unconsciously reflect lowered expectations.

I was talking with a neighbor the other night, though, who

As bad experiences have become the norm, airlines have largely stopped caring about customer service.

related a litany of delays and cancellations she's experienced on her travels this summer. For her, the topper was getting stuck overnight in New York recently due to flight cancellations. Inconvenient, of course, and not getting home that evening to her husband and children was certainly disappointing.

Making things worse, though, was that she was on what was supposed to be a day trip—fly to New York in the morning, fly home to Chicago that night—so, naturally enough, she hadn't packed for an overnight stay.

My neighbor vows she won't fly again in the summer, but whether the law firm that employs her helps her uphold her vow remains to be seen.

Meanwhile, many experts say the situation is only likely to worsen in the months ahead. Congress can debate "Airline Passenger Bill of Rights" proposals, but perhaps the best approach we travelers can take is to try to manage the risks inherent in our travel plans. Assume that what can go wrong will and, whenever possible, plan accordingly.

Comings & Goings

BROKERS:

Jeff Cox has been named president and chief executive of Haake Cos., an Overland Park, Kan.-based insurance brokerage.

Charlie Haake, who previously held those titles, becomes chairman. Mr. Cox most recently was president and chief operating officer of the Lockton Cos. Inc.'s affinity group.

Atlanta-based Beecher Carlson has appointed **Gerald Levine** managing director, responsible for client development for Beecher Carlson's risk management practice in Old Lyme, Conn. Previously, he was executive vp of Webster Insurance.



Mr. Levine

Kerry R.

Martin has joined the Buffalo Grove, Ill.-based Plexus Groupe Inc. as COO. He most recently was senior vp for Aon Corp. in its financial services group.

Redwood City, Calif.-based ABD Insurance & Financial Services Inc. has named **Brian Hetherington** executive vp and managing director of property/casualty services for ABD's Redwood City headquarters. Previously, he was senior vp, managing director, technology and global specialties.

INSURERS:

New York-based Assurant Inc. has named **Gene Mergelmeyer** president of Assurant Specialty Property. Before his promotion, he was executive vp.

Springfield, Mass.-based MassMutual Retirement Income has appointed **Douglas G. Russell** senior vp, COO and chief financial officer. He most recently was senior vp and head of client services for Prudential Retirement.

REINSURANCE:

New York-based Guy Carpenter & Co. L.L.C. has named **Simon Welton** senior vp of the firm's U.K. retrocessional practice in London. Most recently, he served as underwriting officer of Pentelia Capital Management.

ASSOCIATIONS:

James A. Rodda, a certified public accountant with extensive background in accounting and controller issues as well as Sarbanes-Oxley Act compliance, has joined the Washington-based Council of Insurance Agents & Brokers as CFO. He joins the CIAB from Resources Global Professionals. In addition to his CPA designation, Mr. Rodda is a certified fraud examiner.

MANAGED CARE:

San Francisco-based United Behavioral Health has named **Dr. William Bonfield** senior medical director for its public sector business segment. Previously, he was chief medical officer at ValueOptions Inc.

OTHER PROVIDERS:

Rebecca McLaughlan has been appointed managing director for McGraw Wentworth, an employee group benefits company in Troy, Mich. She previously was practice

UP CLOSE Mark Montgomery

NEW JOB TITLE: Director of the Palm Beach, Fla., office of Frank Crystal & Co.

PREVIOUS POSITION: Vp of Marsh's private client services division. I ran the new-business development practice for the Palm Beach, Fla., market.

REASON FOR THE SWITCH: Frank Crystal's business model offers me the resources to more effectively meet the entire risk management needs of my clients. Furthermore, because (the company is) privately held and family owned, they can react more nimbly and decisively to our clients' complex and unpredictable concerns and interests. Frank Crystal offers a highly integrated approach that involves the expertise of all of their divisions and senior management. Lastly, the company is strongly committed to the private client services practice, which they have developed into an integral component of the company's overall success and growth plans.

VITAL STATISTICS: I have a B.A. in marketing and an MBA from Stetson University in Deland, Fla. Before Marsh, I was a new business producer for a State Farm insurance agent.

GOALS FOR NEW POSITION: To market the resources and expertise of the company to further its mission of delivering industry-leading services to our clients. I want to take the success that I have achieved in



Palm Beach County to other strategic locations around the state to help Frank Crystal be recognized as a leading resource in risk management services. I was recognized as the single top producing sales professional for Marsh's Private Client Services practice in the country for the past two years, and I plan on utilizing my strengths that helped me achieve that position to further Frank Crystal's mission.

FIRST TIME IN THE JOB MARKET:

See above. I'm kind of an old-school company guy and have only worked for two companies since college.

TOP ADVICE: Care. Sincerely care about others' needs. Listen, be genuine and transparent, and strive to meet others' needs. Be resolute in your pursuit to uncover and meet your clients' needs.

OUTSIDE THE INDUSTRY, A DREAM JOB:

To operate an outdoor adventure company in western North Carolina leading small groups on team-building cycling and hiking excursions.



Ms. McLaughlan

Inc. have named **David Huntington** president and COO of PAI. Previously, he was vp of large-group marketing of the third-party administrator.

Gloria Lesmeister has joined Buck Consultants L.L.C. as principal and Houston retirement practice leader. Previously, she was a senior actuary with Wyatt Worldwide.

Atlanta-based Crawford & Co. has appointed **Kevin Frawley** as executive vp for global business development. He will continue to lead Crawford Strategic Warranty Services and oversee Garden City Group Inc.

Phoenix-based Schaller Anderson Inc., which administers physical and behavioral health care for Medicaid, Medicare, commercial and employer self-funded plans, has named **Dr. Laura Nelson** medical director of behavioral health/physical health integration. Previously, she was medical

leader and principal, and will continue as an account director.

Columbia, S.C.-based BlueCross BlueShield of South Carolina and Planned Administrators

director of the Arizona Department of Health Services' behavioral health division.

Also at Schaller, **Dr. Jack Weiss**, formerly COO



Dr. Nelson

for Ameri-group Community Care, has been named medical director of clinical operations in Schaller Anderson's medical management department.



Dr. Weiss

TO SUBMIT ITEMS

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

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AMENDMENT TERMS

Pursuant to its January 2005 settlement with New York authorities, Marsh & McLennan Cos. Inc. has the right to request modifications to the terms and conditions of the settlement if compliance proves impracticable. MMC has amended its agreement four times.

AMENDMENT NO. 1: Reached April 27, 2005; clarifies limitations in the settlement for U.S. and non-U.S. domiciled Marsh entities.

AMENDMENT NO. 2: Reached Sept. 27, 2005; clarifies that if Schinnerer Group Inc. or Price Forbes Ltd. are no longer directly owned by Marsh as of Oct. 31, 2005, they will not be subject to the settlement agreement requirements. After that date, the settlement provisions continue to apply even if the units are sold at a later date.

Schinnerer, a Chevy Chase, Md.-based underwriting manager, remains part of Marsh, while management of London-based Price Forbes bought out the wholesaler from Marsh in September 2006.

AMENDMENT NO. 3: Reached Aug. 17, 2006; recognizes that part of Marsh's business is to act as a managing general agent or underwriting manager for insurers. When acting in that capacity, Marsh is not barred from receiving additional compensation from insurers.

AMENDMENT NO. 4: Reached Aug. 3, 2007; broadens the form of compensation Marsh can receive in connection with brokerage transactions to include specific fees for services paid by insurers. Such fees must be disclosed to clients.

Settlement: Marsh gets OK to charge insurers new fees

CONTINUED FROM PAGE 1

Willis, said in an e-mailed statement. "It is important that we reiterate our absolute commitment to our principles—namely we will always be compensated in a manner that promotes the best interests of our clients."

Marsh Inc.'s latest amendment was revealed last week by Brian M. Storms, chairman and chief executive officer, during the company's second-quarter analyst call. He declined to discuss details, noting that Marsh will be making a public statement soon.

He did note, though, that Marsh is in "active discussions" with insurers about the new fees. Mr. Storms also stressed that the fees are a "completely different form of revenue from supplemental compensation," which he also specifically addressed in the analyst call (see related story).

In a later interview, a Marsh spokesman gave an example of how the brokerage might negotiate a fee from an insurer under the new arrangement.

"If we consistently take more time to review insurance policies issued by Carrier A than we do for Carrier B, we think it's reasonable that we should be allowed to charge Carrier A a fee for the additional labor and other costs required to process its policies," the spokesman said.

"It's too early to tell" how much additional revenue these insurer fees will add to Marsh's top and bottom lines, the spokesman said. "Over the next few weeks and months, we'll be ironing out the details of this new stream."

The agreement mandates that Marsh disclose to clients the

amount of the insurer fees it will receive as well as the nature of the service for which it is compensated.

In the wake of a 2004 lawsuit leveled by then-Attorney General Eliot Spitzer, Marsh gave up about \$850 million a year in high-margin market services revenues, including contingent commissions and a small amount of fees from insurers. It has since struggled to make that up.

News of the amended agreement came as Marsh posted a 1% rise in revenue to \$2.3 billion for the first half of the year. For MMC, overall revenues increased 6.1% to \$5.63 billion.

First-half operating income for MMC's risk and insurance services unit, which includes Marsh Inc., was down 5.7% to \$384 million, while its margin dropped one percentage point from the year-earlier period to 13.4%. MMC attributed the unit's second-quarter profitability decline to the absence of market services revenue and greater-than-expected expenses supporting Marsh's long-term growth initiatives.

It's too early to say what impact the agreement will have on Marsh financially, analysts say.

"I think I'm going to wait before I declare it's a big deal," said Cliff Gallant, an analyst with Keefe, Bruyette & Woods Inc. in New York. "I don't think they're in a position right now to raise their prices on anybody," he said, noting Marsh's loss of business over the past few years. But "at this point, at least in the near future, I'm not expecting it to cause much of a boost to their earnings power."

"On the surface, it would seem that Marsh is just looking to collect some fees for certain services rendered to insurers," said Greg Dicker-

son, associate director of Fitch Ratings in New York. So while it doesn't appear that there is any impropriety, "it's really up to their clients" to decide, he said.

Terry Fleming, RIMS' director of external affairs, said the New York-based association "has no issue" with the agreement, which "specifies that contingent commissions

are not included in the list of...fees paid by insurers."

"RIMS supports the economic growth of the broker community to the extent that the services provided are transparent with respect to fees and do not present a conflict of interest," said Mr. Fleming, who is director of the risk management division for Montgomery County, Md.

Brokers refuse some revenues

Although the world's two largest brokerages have not fully denounced supplemental commission programs, neither has accepted them, according to the firms' chief executive officers.

"We've been offered (supplemental commissions) by multiple carriers and we have currently said 'no,'" Greg Case, CEO of Chicago-based Aon Corp., said when asked about the commissions during an analyst conference call last week. "We're never going to do anything to jeopardize trust. In the current form, supplements, as we think about them and as defined...don't meet our standard...of client service and client leadership," he said.

While Marsh has not accepted any supplemental commissions, it continues to study them, a spokesman said. The brokerage, however, will not accept any supplements that are based on volume, profitability or growth, he said.

"Supplemental commissions that are specifically related to volume concerns are not in the best

interest to clients or to Marsh," CEO Brian M. Storms of New York-based Marsh Inc. said in an analyst call last week.

In May, Joe Plumeri, chairman and CEO of London-based Willis Group Holdings Ltd., likened supplementals to contingent commissions, which Willis, Marsh and Aon ceased collecting in 2004, and said the brokerage will not be accepting the new form of compensation.

Chubb Corp. and Travelers Cos. Inc. introduced supplemental payments to replace contingent commissions earlier this year following state investigations of broker compensation practices. Hartford Financial Services Group Inc. said it will launch a new supplement commission program in 2008.

Unlike contingents, which are paid after brokers hit volume or profit thresholds with insurers, supplementals are retrospective and provide brokers fixed compensation based on their prior performance with insurers.

—By Sally Roberts

Exemption: Opinions differ

CONTINUED FROM PAGE 21

abolished."

Most likely, the block exemption will not be scrapped altogether but will be modified, said Martin Bechtold, a partner in the International Antitrust Group at law firm Allen & Overy L.L.P. in Brussels, Belgium.

Meanwhile, asked to respond to Ms. Schwimann's recent remarks, insurance associations reiterated that the forms of cooperation between insurers allowed under the block exemption regulation do not impede competition, but rather have fostered greater competition.

"The block exemption regulation...has proven beneficial to competition, led to the opening up of markets to new players and small- and medium-sized insurance undertakings, enhancing thus the variety of products to the advantage of the consumer," said William Vidonja, head of single market for the Brussels-based CEA, which represents European insurers and reinsurers.

Berlin-based Gesamtverband der Deutschen Versicherungswirtschaft, Germany's insurance association, expanded on the necessity for the exemption in a position paper in April. In that paper, the GDV cited

its development of a nonbinding standard wording for liabilities created under the European Union's Environmental Liability Directive (2004/35/EC).

"The significant effort that was required for the drafting of these sample terms shows that probably only a small number of companies would have been able to develop corresponding insurance cover," the GDV said at the time.

Opinions among risk managers from some of the newer European Union members are also divided.

Rafal Rudnicki, board president of PolRisk, the Polish risk management association in Warsaw, Poland, said forcing insurers to always come up with their own wordings "will naturally produce plenty of confusion and misunderstanding, as well as result in a much worse quality wordings."

Stoian Lilov, head of risk management for the Bulgarian Telecommunications Co. and chief executive officer of the Bulgarian Risk Management Assn., both in Sofia, said he supports eliminating the exemption.

He believes it would allow more flexibility in designing customized wordings, among other benefits.

ERISA: Employee can sue after cash out

CONTINUED FROM PAGE 3

said Conexant had breached its fiduciary duty by offering the stock fund as an investment option and making false and misleading statements about the merger.

The question presented "is one of statutory standing," says the opinion. "ERISA defines a participant as 'any employee or former employee...who is or may become eligible to receive a benefit of any type from an employee benefit plan.'"

ERISA "entitles individual account plan participants not only to what is in their accounts, but also to what should be there given the terms of the plan and ERISA's fiduciary obligations," says the decision. "From this, it is not difficult to conclude that Graden has standing as a plan participant. As an account holder in the Conexant plan, he was entitled to the net value of his account as it should have been in the absence of any fiduciary mismanagement."

The decision notes that NAM's amicus brief said finding Mr. Graden to be a participant would require employers to make costly disclosures to people who have cashed out. But the appellate decision said "inclusion of ostensibly cashed-out

employees derives from the text of the definition" and a 1989 U.S. Supreme Court decision in *Firestone Tire & Rubber Co. vs. Bruch*.

"We cannot imagine holding a plan fiduciary liable for failing to provide information to someone who, as far as the fiduciary knows, is cashed out," the ruling stated.

Defense attorney Robyn F. Tarnofsky, of New York-based Paul, Weiss, Rifkind, Wharton & Garrison L.L.P., which represented Conexant, said, "We're still studying the decision."

"It's obviously a huge decision because many district courts have been going the other way on this particular issue," said plaintiff attorney Jeffrey M. Norton, of Harwood Feffer L.L.P. in New York.

Stephen D. Rosenberg, an attorney with McCormack Firm L.L.C. of Boston, said, however, the decision "is consistent with a trend we're seeing in deciding how to interpret this language. Many courts are...giving plaintiffs in these cases standing."

Attorneys say the decision means more plaintiffs will file suit against plan administrators. "It means untold numbers of retirees and employees and former employees" who had lacked standing to pursue

losses because of fiduciary breaches "now have a cause of action where they didn't before, where that right was more or less in limbo for the last couple of years," Mr. Norton said. Even so, he said he does not think there will be an significant increase in ERISA litigation.

Mr. Rosenberg said if there are layoffs, "people are going to cash out," and these will be people "who aren't too happy with their former employer and may be more willing to file suit than someone still with the company."

"And at the same time, you have what's clearly a developing wave of litigation" over the issue of fiduciary breaches in managing 401(k) assets, Mr. Rosenberg said.

Mr. Rosenberg said the case is also significant because the "first wave of defense in all fiduciary cases is always procedural," and a court may not have been allowed to proceed to a lawsuit's merits. A decision like *Graden* "is saying the court can get to the merits," said Mr. Rosenberg.

Howard Graden, appellant, vs. Conexant Systems Inc., et al., 3rd U.S. Circuit Court of Appeals No. 06-2337, July 31, 2007.

China: Product recalls renew risk management focus

CONTINUED FROM PAGE 1

Plaintiffs attorney Bruce T. Clark, who has represented claimants nationwide in several major food-borne illness cases since the early 1990s, said defendants typically have not adequately sorted out beforehand the financial responsibilities of the various parties in the supply chain.

For example, parties that had contracted with business partners to be named as additional insureds on their partners' insurance policies often find out during product liability litigation that they were not included in the coverage, said Mr. Clark, a partner at Marler Clark, Attorneys at Law L.L.P. P.S. in Seattle. Mr. Clark currently represents dozens of claimants who are suing Robert's American Gourmet Food Inc. of Sea Cliff, N.Y., over a salmonella-contaminated snack food that the company recalled in June. Roberts has traced the salmonella to a spice originating with a supplier in China.

The selection of defense counsel also creates tension among co-

defendants, Mr. Clark said.

He attributed the problem to "sloppy" agreements among business partners. The agreements likely are crafted by in-house counsel who write them "in a pro-forma fashion" that does not anticipate a claim actually arising or how the contract would "really work if the company got into a jam."

Those contracts also should be vetted by outside counsel, Mr. Clark advised.

Policyholder attorney Stephen Weisbrod, a partner with Gilbert Randolph L.L.P. in Washington, agreed that one key mistake is failing to ensure that the organization or its personnel are adequately insured. Mr. Weisbrod expressed concern about companies' common assumption that another party most likely would be faulted for a defective product.

But foreign suppliers often cannot obtain insurance that covers claims filed in the United States, and they sometimes shut down abruptly and with no notice after product quality problems emerge, experts noted.

Producers, therefore, should require their foreign suppliers to maintain some U.S. assets that could be attached if a product liability claim is filed, advised Joe Underwood, a senior consultant with Albert Risk Management Consultants in Needham, Mass.

In addition, coverage beyond a company's own product liability insurance might be available under various policies, including directors and officers liability and errors and omissions insurance, noted policyholder attorney Jonathan M. Cohen, also a partner with Gilbert Randolph.

Other experts stressed the importance of imposing tougher loss prevention and mitigation measures but cautioned that not all of those measures are foolproof.

For example, risk management consultant MaryAnn Sackman bemoaned the lack of quality controls over foreign suppliers that have joint venture agreements with U.S. producers.

"Typically, the biggest problem is there are no controls when these products are made overseas and

sold in the U.S.," said Ms. Sackman, president of RMI Consulting Inc. of Port Washington, N.Y.

But outside of joint venture relationships, simply identifying all sources of components used in a finished product can be challenging, said defense attorney John McDonough, a partner at Cozen O'Connor P.C. in New York. While that is critically important information to producers, intermediaries often fear they will be eliminated from future transactions and refuse to identify those suppliers, Mr. McDonough said.

Mr. McDonough, who represents Robert's American, noted that the company believed it was obtaining the spice that turned out to be tainted from a U.S. supplier.

While companies often have established protocols on how to respond when a product defect is identified, too few have it codified in print, Mr. Underwood said.

"By having a written protocol, it allows you to respond more quickly" both in deciding when to issue a recall and how to conduct it, he said.

Product liability coverage remains competitive

By DAVE LENCKUS

U.S. food and consumer goods makers can expect the product liability insurance market to remain competitive despite a spate of product recalls and import bans linked to Chinese suppliers, market experts say.

The profitability of the liability insurance market should ensure that insurers will remain eager to write coverage, they say.

Meanwhile, companies increasingly are looking at trade disruption coverage, which can help defray the cost of replacing foreign suppliers that fold unexpectedly after product quality problems emerge, brokers say.

Lawsuits by individuals as well as suits seeking class action status have been filed against many food processors and consumer products manufacturers that in recent months have sold products that have been contaminated or rendered defective by suppliers in China, attorneys say.

Still, market experts say, companies with suppliers in China should not face problems when buying product liability coverage.

The liability market in general remains highly competitive due to property/casualty insurers' record profits in 2006 (*BI*, March 26).

Product liability losses stemming from suppliers in China "are not enough to turn the casualty market around," said Carol Murphy, managing director for the casualty central region at Aon Corp. in Chicago.

Risk managers, however, should expect greater scrutiny of product liability risks. Underwriters likely will ask more questions about operations and outsourcing, in an effort to remain comfortable with their aggressive pricing, Ms. Murphy said.

Underwriters, especially excess insurers, likely will pay special attention to pharmaceutical companies and tire manufacturers—companies with "batch exposures"—that have had recent product defect problems, she said.

For food companies, underwriters likely will not impose more requirements on top of the Food and Drug Administration's, she said. And most other producers have had few product defect problems that would concern insurers, she said.

Insurer attorney Joseph F. Bermudez agrees an insurance market pullback on product liability coverage, especially for food processors, is unlikely. "At this time, I don't see that," said Mr. Bermudez, a partner with Cozen O'Connor P.C. in Denver and chairman of its food contamination coverage practice area.

Risk managers' greater concern should be ensuring that their companies have adequate coverage, suitable quality controls and a crisis

management plan in place to respond if a product defect is discovered, Mr. Bermudez said.

Aon's Ms. Murphy and Joe Underwood, a senior consultant with Albert Risk Management Consultants in Needham, Mass., also cautioned risk managers to fully understand their coverage in light of the common policy exclusions that bar coverage for losses resulting from contaminants and lead.

But plaintiffs' attorney Bruce T. Clark, who has represented claimants in major food-borne illness cases since the early 1990s, said he has never seen an insurer invoke a contamination exclusion to deny product liability coverage to a food company defendant.

Mr. Clark, a partner at Marler Clark L.L.P. P.S. in Seattle, represents claimants who are suing Robert's American Gourmet Food Inc. of Sea Cliff, N.Y., over a salmonella-contaminated snack food that the company recalled in June. Roberts has traced the salmonella to a spice originating with a supplier in China.

Recall cover is pricey

Unlike product liability insurance, product recall coverage is expensive, and food companies are the major buyers, experts say.

London market insurers comprise the major part of the recall market, providing \$70 million of capacity for accidental defects and \$150 million of limits for malicious product tampering, according to Julie Ross, a vp with Marsh Ltd. in London. The coverage sometimes can be augmented with an additional \$15 million/\$50 million of capacity from the U.S. market, she said.

But another type of coverage that U.S. companies increasingly are demanding is trade disruption insurance, brokers say. The cover-

age is a derivative of political risk insurance, which is designed to cover the loss of a policyholder's subsidiary overseas due to nationalization, appropriation or terrorism.

A trade disruption policy responds when foreign suppliers fold or are barred by political actions abroad or domestically from honoring their contracts. It covers the policyholder's lost revenues and the cost of arranging a replacement supplier, including retooling the new supplier, brokers say.

The policy, however, does not respond when a policyholder wants to drop a supplier because of its shoddy work, said Bryan Squibb, the Chicago-based managing director of Aon Risk Services Inc.'s trade credit practice.

Attorneys note that many U.S. companies recalling products have found that their suppliers in China have folded.

But buyers are interested in the insurance because it covers them if suppliers become unavailable due to political acts by the U.S. or foreign governments, Mr. Squibb said. That is important because a trade dispute over a narrow issue between two governments could grow and affect unrelated products because of their value as leverage in the dispute, he said.

Only a couple of Lloyd's of London syndicates and a U.S. insurer, which brokers refused identify, write the coverage.

As a result, market capacity is about \$50 million, which satisfies midsize companies but is inadequate for large companies, said Ken Horne, managing director and political risk practice leader for Marsh Inc. of New York.

Marsh is trying to arrange more capacity for larger companies "sometime this year," Mr. Horne said.

RECALLED PRODUCTS

Numerous defective or tainted food products originating in China have been recalled in recent months. Among the recalls have been:

MARCH 16: Menu Foods Inc. of Streetsville, Ontario, recalls 60 million



cans and packages of pet food over concerns that the product poses a serious health threat to animals. Eventually, several U.S. pet food makers recall thousands of

products contaminated in China with melamine, an organic compound used in plastics and flame-resistant materials.

MAY 23: Hong Chang Corp. of Santa Fe Springs, Calif., recalls 282 22-lb. boxes of monkfish, which originated in China and were distributed in California, Hawaii and Illinois, because the product may contain a deadly toxin.

JUNE 1: The U.S. Food and Drug Administration issues an import alert and warns consumers not to use any toothpaste manufactured in China, because it may contain a poisonous chemical used in antifreeze and as a solvent. Companies later issue voluntary recalls.



JUNE 13: RC2 Corp. of Oak Brook, Ill., voluntarily recalls 1.5 million Thomas & Friends wooden toy trains because a factory in China coated them with lead paint.

JUNE 25: The National Highway Traffic Safety Administration orders tiny importer Foreign Tire Sales Inc. of Union, N.J., to recall up to 450,000 light truck tires made in China since 2002, because a defect could cause dangerous tread separation.

JUNE 28: After an outbreak of 60 salmonella cases, mostly toddlers in 19 states, Robert's American Gourmet Food Inc. of Sea Cliff, N.Y., recalled its Veggie Booty snack food. Later, the salmonella was traced to a spice supplier in China, and the recall was expanded to the company's Super Veggie Tings Crunchy Corn Sticks.



AUG. 2: Mattel Inc. of El Segundo, Calif., recalls 83 Fisher-Price toy products, a total of 967,000 items made in China, because they are finished with lead paint.

Source: U.S. government agencies and affected companies

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options. Heath Lambert last year was in preliminary discussions to be acquired by Jardine Lloyd Thompson Group P.L.C. but pulled out of those talks, saying only that a merger would not have been in the best interest of its staff or clients.

Work fatalities hit new low: BLS

The rate of fatal workplace injuries in 2006 dropped to its lowest level since the U.S. Bureau of Labor Statistics conducted its first fatality census in 1992. According to BLS, there were 5,703 fatal work injuries in the United States last year, down from the revised total of 5,734 a year earlier. That resulted in a fatal work injury rate of 3.9 per 100,000 workers in 2006, down from 4.0 per 100,000 workers a year earlier. Highway accidents remained the most frequent source of work-related fatalities, accounting for about 23% of all such fatalities. But the number of highway-related deaths dropped 8% in 2006 from a year earlier. Homicides dropped 9% in 2006.

AIG unit to buy German insurer

American International Group Inc. subsidiary American International Underwriters has agreed to acquire German property/casualty insurer Württembergische und Badische Versicherungs-A.G. from private equity firm J.C. Flowers & Co. L.L.C. for an undisclosed amount. The Heilbronn, Germany-based insurer offers property/casualty, marine, personal lines and accident and health insurance through 2,500 broker relationships across the country.

Miss. regulator Dale loses primary bid

Mississippi Insurance Commissioner George Dale, who has been in office for 32 years, narrowly lost his re-election bid for a ninth term in the Democratic primary election. Major factors in his defeat were "(Hurricane) Katrina and Dickie Scruggs," Mr. Dale said. Richard "Dickie" Scruggs, whose law firm represents hundreds of homeowners in lawsuits against insurers, was a

major donor to a political action committee that ran advertisements attacking Mr. Dale for failing to make insurers pay more hurricane-related claims and for allowing them to raise rates. Gary Anderson, the Democratic primary winner, is a former state fiscal officer.

Calif. to publish PPO report cards

California will have the first statewide health insurance report card for preferred provider organizations under an initiative announced by Insurance Commissioner Steve Poizner. Several large PPOs have agreed to collect and report data on various quality-of-care measures and patient satisfaction surveys using Healthcare Effectiveness Data and Information Set measures developed by the National Committee for Quality Assurance. The measures include information on clinical factors and consumer satisfaction survey data. The California Department of Insurance plans to publish its first statewide PPO report card by 2009.

Most Segal judgments upheld on appeal

A federal appeals court in Chicago has upheld all but one of the judgments against Michael Segal, the former Near North National Group Inc. owner convicted of 19 counts of racketeering, fraud, embezzlement and other charges in 2004. Prosecutors alleged Mr. Segal looted Near North Insurance Brokerage Inc.'s premium fund trust account of \$35 million for his own and his company's use. He was sentenced to more than 10 years in prison and ordered to pay \$841.5 million in restitution and forfeit \$30 million in ill-gotten gains and his entire ownership in NNNG, of which he was the sole owner. The 7th U.S. Circuit Court of Appeals rejected appeal arguments but did ask a lower court to review whether Mr. Segal must personally repay \$30 million.

Noted

Andrew Carrier will become president of Argo Group International Holding Ltd.'s **Peleus Reinsurance Ltd.** unit in December. Argo Group announced last week. Mr. Carrier has been the active underwriter for the Kiln Group's Catastrophe Syndicate 557 at Lloyd's of London....**Commercial property/casualty insurance rates** fell an average 14% in July compared with a year earlier, MarketScout reported. The drop matched a 14% reduction in June, according to the Dallas-based electronic insurance exchange.

Flex: IRS issues guidance

CONTINUED FROM PAGE 1

been going and it doesn't require major course correction."

The regulations tell employers practices that should be spelled out in their plan documents, consultants said.

The regulations retain, as expected, an earlier IRS rule that requires employees to forfeit unused FSA balances at the end of the plan year or 2½ months after the close of the plan year if a so-called grace period feature is adopted. However, the rules make clear that employers can use remaining balances to pay for administrative expenses they incur in offering FSAs.

Employers forged existing administration and operations practices by attempting to follow IRS proposed regulations in 1984 and 1989. But those pronouncements lacked specif-

of nondiscrimination rules to follow, Ms. Cohen said.

Several consultants agree.

"Section 125 has been in the Internal Revenue Service code since 1978, and this is really the first time the Service has provided substantive, interpretive guidance on these nondiscrimination rules," said Mike Langan, a principal at Towers Perrin in Valhalla, N.Y.

The regulations do not create new tests for areas such as plan eligibility or election of contributions and benefits. But the IRS does clarify how to conduct the tests.

To test for nondiscriminatory eligibility, the IRS confirms that it is appropriate to rely on rules already established for qualified retirement plans under its code section 410(b). Additional guidance on objective testing to determine whether contribution and benefit election practices are discriminatory includes a specific formula or ratio to measure use among employees, Ms. Cohen said.

The IRS proposes that its rules apply for plan years beginning Jan. 1, 2009. But it wants public comment before finalization, and it said it will hold hearings on Nov. 15. Taxpayers, however, may rely on the new regulations pending the final rules, the IRS said. When the IRS finalizes its regulations, it will use them to audit employers' flexible benefit plans, it added.

Because the IRS has not provided substantive interpretation or guidance on nondiscrimination tests before, enforcement has been lax, Mr. Langan said.

Other consultants say some employers either haven't tested or their tests have been perfunctory.

"The sea change here is that the Internal Revenue Service has not only issued this interpretive guidance, but that they seem to have signaled that they are going to move forward over the next several years and perhaps enforce these rules," Mr. Langan said.

While the new regulations are more specific than what employers have had to work with in the past, some ambiguities remain and are likely to draw public comment and future changes, the consultants said.

In addition to nondiscrimination testing, the proposed regulations address a host of issues including debit cards, paid time off, 401(k) plan contributions and what constitutes a flexible benefit plan year.

For instance, they definitively require that a flexible benefit plan year must be 12 months—a practice employers generally but not always have adopted, consultants said.

FLEXIBLE BENEFIT PLAN RULES

The Internal Revenue Service's proposed regulations clarify that Section 125 flexible benefit plans "are generally the sole method of preserving the nontaxable nature of employer-provided benefits where employees are allowed to elect between taxable compensation and nontaxable benefits."

The proposed regulations contain:

- **New rules for objective testing to determine whether a flexible benefit plan improperly discriminates in favor of highly compensated employees.**
- **Added payment flexibility, such as allowing orthodontia expenses to be paid in advance.**
- **Requiring Section 125 plan years to be 12 consecutive months.**
- **Other previously incorporated regulations, such as those providing guidance on using debit cards, grace periods for using health flexible spending account money and the FSA "use it or lose it" rule.**

Source: www.ustreas.gov/press/releases/reports/section125.pdf.

ic direction and tax law changes have occurred since, observers added.

A significant area of guidance focuses on testing flexible benefit plans to assure they do not discriminate in favor of highly compensated employees and against employees that are not highly compensated, said Sharon Cohen, group and health benefits council for Watson Wyatt Worldwide in Arlington, Va.

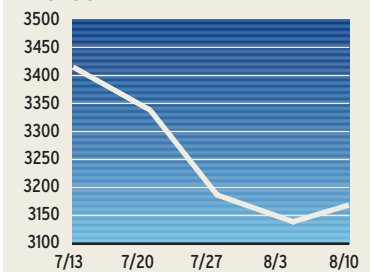
Employers that have already implemented measures they hoped would eliminate that possibility relied on a "very general discussion"

Stock Index

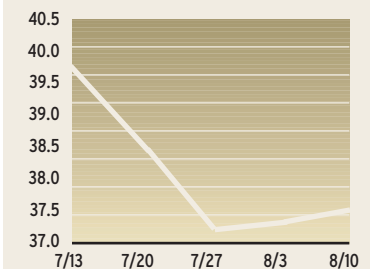
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Up-to-the-minute data for all 82 companies that comprise the BI Stock Index can be found at www.BusinessInsurance.com.

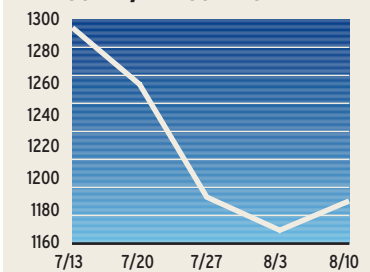
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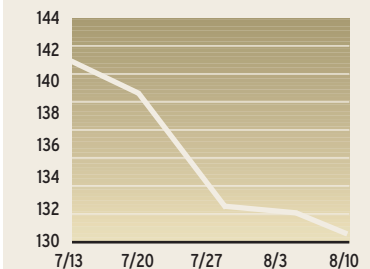
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Percentage change of BI Stock Index vs. key indicators

BI STOCK INDEX	3159.47	0.88%
DOW JONES	13239.54	0.44%
S&P 500	1453.64	1.44%

LARGEST GAINS

United Fire & Casualty	20.80%
MBIA Inc.	13.92%
Selective Insurance	12.75%
CNA Surety Corp.	12.17%
Zenith National Insurance	9.65%

LARGEST LOSSES

NYMAGIC Inc.	-16.79%
American Safety Insurance	-11.45%
Transatlantic Holdings	-9.26%
Allmerica Financial Corp.	-7.73%
Humana Inc.	-4.85%

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Judge may lose more than pants

The strange and terrible saga of the District of Columbia administrative court judge who initially sought \$65 million from a mom-and-pop dry cleaner for temporarily misplacing a pair of suit pants may be coming to a long-overdue end.

In a first step to removing Judge Roy L. Pearson from the bench, the Commission on Selection and Tenure of Administrative Law Judges sent the jurist a letter on Aug. 7 formally notifying him that he may not be reappointed to the bench. While the letter is not the last word on the matter—Judge Pearson has 15 days to issue a rebuttal and can make an appearance before the commission next month to argue his case—the missive sounds like a pretty strong vote of no confidence.



Judge Pearson achieved national notoriety when he sued the Chung family, who own a dry cleaning establishment in Washington, for \$65 million for allegedly failing to meet their promise of “satisfaction guaranteed” when they allegedly lost his suit pants. The amount sought in the suit was later reduced to \$54 million, but D.C. Superior Court Judge Judith Bartnoff recently rejected Judge Pearson’s arguments and said that the Chungs owed him nothing.

Meanwhile, sympathy for the Chungs mounted to such a point that even the American Assn. for Justice—the national organization for trial lawyers—set up a fund to help their defense. The American Tort Reform Assn. and the U.S. Chamber of Commerce held a fundraiser last month that netted more than \$62,000 for the Chungs.

Mr. Pearson may still have another day in court—he can still appeal Judge Bartnoff’s ruling against him. But if he chooses to do so, it’s looking increasingly like he’ll do so as just another plaintiff rather than one entitled to wear a judge’s robe.

Unbeatable coach loses insurance suit

College basketball coach Bobby Knight hates to lose, and he just lost a big case against his insurer.

The Indiana Court of Appeals upheld a lower court decision to grant summary judgment in a lawsuit Mr. Knight filed against Indiana Insurance Co. for denying coverage and failing to defend him in a claim filed by his former assistant coach at Indiana University in Bloomington.

Mr. Knight, famous for his angry outbursts against players and referees, got into a verbal and physical confrontation in 1999 with Ronald Felling, who then sued him. The Indianapolis-based insurer denied coverage because of exclusions in Mr. Knight’s homeowner’s policy, namely for acts connected with the policyholder’s business.

Mr. Knight—the all-time wins leader among National Collegiate Athletic Assn. men’s basketball coaches—settled with Mr. Felling in 2002 by paying him \$25,000 and admitting he shoved Mr. Felling.

Mr. Knight, now the head coach at Texas Tech, sued the insurer for breach of contract, bad faith, negligence and punitive damages, but the court of appeals said the encounter with Mr. Felling was a workplace incident and a reasonable claims manager could determine it was outside the policy’s coverage.

Contributing: Mark A. Hofmann, Gloria Gonzalez, Beth Murtagh



NI SYNDICATION

Donkey derby risky for kids

A risk management tactic in Wales left children watching from the sidelines as inflatable sheep and a toy orangutan took on jockey duties in an annual donkey derby.

Insurers refused to cover the 39th running of the Llandudno Rugby Club’s donkey derby in North Wales last month, forcing organizers to make the jockey swap.

Parents of the participating children had signed disclaimer forms, the British Broadcasting Corp. reported. But lawyers for the club warned that parents could not sign away their child’s rights with a waiver, leaving the club open to a lawsuit if an injured child decide to sue on his or her own.

Both the club’s insurer and the donkey owner’s insurer refused to cover the event if children raced atop the animals, despite “hardly any accidents” other than minor bumps in the derby’s history, the BBC reported the club chairman as saying.

A broker was unsuccessful in finding an insurer willing to take on the risk.

“We came up with the notion of putting some sort of inflatable objects on the donkeys,” the club’s chairman told the BBC. “We chatted to the donkey owner, who said the donkeys will run with whatever on their backs.”

Despite the children’s disappointment, the stand-ins’ performance was flawless—almost.

“One sheep deflated spontaneously, so he had to be substituted by an orangutan,” the event’s organizer told the BBC. “He was a last-minute replacement jockey but performed admirably.”

Insurer rains on parade

During small-town parades, many people have childhood memories of waving to the crowd while riding atop a fire truck. In Bloomsburg, Pa., residents must remain at the curb.

Two years ago, the town’s insurer threatened to increase rates by at least \$8,000 should the all-volunteer fire department allow anyone but firefighters on the trucks, said Carol Mas, town administrator.

The town’s fire chief, Bob Rupp, recently suggested new guidelines in hopes of allowing guests back on to the vehicles during events. He suggested they be seated and wear seat belts, Ms. Mas said. Before, riders would stand in the truck bed.

Mr. Rupp said that allowing children on board can ignite an interest in the career and by not allowing them and their families on board, the department may be deterring people from joining, the area’s newspaper, the Press Enterprise, reported.





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