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PASSES STATE ASSEMBLY,
HURDLES REMAIN / PAGE 3**



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OF JOB APPLICANTS / PAGE 4**

In Brief

**Mental parity law
extended one year**

Congress has given final approval to legislation that extends through 2008 the federal law that bans group health care plans from imposing lower annual and lifetime dollar limits for coverage of mental disorders than for other medical conditions. The one-year extension of the law, which was set to expire on Dec. 31, buys time so federal lawmakers can decide whether to expand the parity law to make other plan designs discriminatory.

**P/C profits expected
in 2008: Ill forecast**

The U.S. property/casualty insurance industry should remain profitable in 2008, according to financial analysts and insurance industry professionals polled by the New York-based Insurance

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SPOTLIGHT

YEAR IN REVIEW: EMPLOYEE BENEFITS

A look back at the major issues and stories in the



employee benefits sector in 2007: VEBAs for retiree health cover, physician ranking

controversies, 401(k) auto enrollment and more; plus profiles of the people who 'made headlines. **Page 10**

Congress extends TRIA for 7 years

Scaled-down bill's passage a relief to many

By **MARK A. HOFMANN**

WASHINGTON—Risk managers, insurers and brokers all expressed relief last week following the House of Representatives' final approval of a bill that would extend the federal terrorism insurance backstop for seven years beyond its scheduled Dec. 31 expiration.

The 360-to-53 vote, which came Dec. 18, cleared the way for the measure to go to President Bush, who is expected to sign the bill. In addition to extending the program, the bill calls for allowing the backstop to respond to catastrophic acts of domestic terrorism as well as foreign terrorism.

The measure, initially passed by the Senate last month, is far less expansive than a measure passed earlier this year by the House. Among other things, the earlier bill would have added group life insurance to the lines of insurance covered by the backstop. The White House reiterated its threat to veto any measure more expansive than the Senate bill.

Before the vote, House Democratic members made no effort to disguise their dissatisfaction with the

Senate's approach. Rep. Gary Ackerman, D-N.Y., said House members were "faced with a very difficult challenge," which was to accept what he called "a shell of a bill" or risk having the program expire. "We must do the responsible thing," he said.

He said the Senate measure should be passed "with the understanding that the fight is not over." In fact, Rep. Ackerman introduced a bill last week that would add the "reset mechanism" to the terrorism insurance program. That provision, which was contained in the House bill and opposed by the White House, would lower deductibles and trigger levels for those insured sites already hit by a terrorist attack.

The program was initially created by the Terrorism Risk Insurance Act of 2002, and renewed for two years in late 2005. Risk managers and other supporters hoped that Congress would extend the backstop for a longer period in this year's renewal legislation.

The House action came as a relief for risk managers, who feared they would have to contend with condi-

See **TRIA** page 22



LANDOV

After three years as CEO of Marsh & McLennan Cos. Inc. and several quarters of disappointing results, MMC's board said it is seeking to replace Michael G. Cherkasky.

MMC seeks new CEO to halt firm's slide

Cherkasky staying on until successor is found

By **MARK A. HOFMANN**

NEW YORK—The ouster of Michael G. Cherkasky as chief executive officer of Marsh & McLennan Cos. Inc., while no surprise, opens the way for the company to get a better grip on its core businesses, analysts say.

But they also warn that the fix won't happen overnight as MMC struggles to get its financial house in order.

The Dec. 21 announcement that Mr. Cherkasky would resign after MMC finds a new CEO is the sec-

ond major management change in less than four months. The board fired Brian Storms in September as chairman and CEO of brokerage unit Marsh Inc. for what MMC viewed as poor execution of Marsh's long-term strategy (*BI*, Sept. 24). Earlier this month, Marsh tapped Daniel S. Glaser, managing director of AIG Europe (U.K.) Ltd. and regional president of American International Underwriters' U.K./Ireland division as well as a

See **MARSH** page 22

Aon exits underwriting in \$2.75 billion deals

Split sale of Combined sends accident and health business to ACE, life insurance unit to Munich Re

By **SALLY ROBERTS**

CHICAGO—More than six years after it first announced its intention to exit the underwriting business, Aon Corp. last week agreed to sell its remaining insurance operations for

more than \$2.75 billion.

The Chicago-based brokerage said it had signed separate definitive agreements to sell Combined Insurance Co. of America to ACE Ltd. for \$2.4 billion and Combined unit Sterling Life Insurance Co. to

Munich Re Group for \$352 million.

The all-cash deals will give Aon \$2.6 billion after tax, which it will use to buy back company stock. The Sterling deal is expected to close in the first quarter of 2008 and the Combined deal is expected to close in the second quarter, Aon said.

The move culminates Aon's effort to focus solely on its core brokerage and consulting business—a process that began in 2001 when it put all of its underwriting operations under one holding company and attempted to spin it off to shareholders.

Aon scrapped the spinoff in 2002 due to unfavorable market conditions and had been selling its underwriting units piecemeal ever

since (see chart, page 21).

Combined, which underwrites accident and health, and life insurance and generated \$2 billion in 2006 revenues, was Aon's last remaining underwriting unit.

As a result of the deals, Aon's core assets will be more strategically aligned as it continues to expand its capabilities to better serve its brokerage and consulting clients, said President and Chief Executive Officer Greg Case.

"To me this is a tour de force in the growth of Aon and the commitment Aon has to brokerage and consulting," Mr. Case said in an interview. "There cannot be a

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On the Web

LOOKING BACK ON 2007

Major events affecting risk managers this year

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Business Insurance

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Calif. health reform effort faces uphill battle

State senate must vote on the measure and voters must approve funding mechanism

By JOANNE WOJCIK

SACRAMENTO—While California Gov. Arnold Schwarzenegger has already begun a statewide campaign to drum up voter support for a sweeping health reform plan, the proposal still faces big—and perhaps insurmountable—hurdles.

The measure, which passed the state Assembly last week by a 46-to-31 vote, is a compromise reached by a handful of Democratic lawmakers led by Assembly Speaker Fabian Núñez, D-Los Angeles, working overtime in a special session with the Republican governor.

The measure shares some common elements with Massachusetts' landmark 2006 health care reform law.

Like the Massachusetts law, which already has reduced the number of uninsured in the Bay

State by nearly 75%, the California measure would require most state residents to obtain health insurance while the state would subsidize premiums for lower-income residents.

Unlike the Massachusetts law, the California initiative would require employers to spend a specific percentage of payroll—ranging from 1% to smaller firms—to 6.5% for the largest employers—for health insurance coverage. Those employers not spending those amounts would have to pay into a pool that would be created to provide coverage to the uninsured.

By contrast, the Massachusetts law imposes a modest penalty—only \$295 per employee—for employers that do not provide coverage to employees.

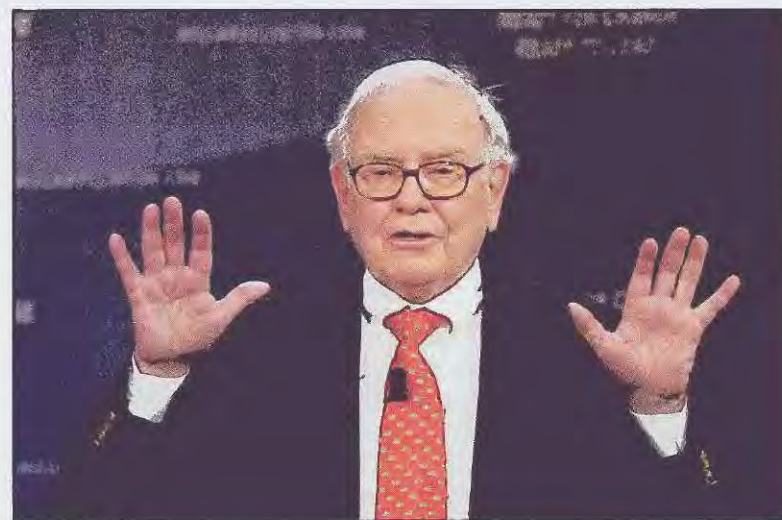
And the most significant differ-

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ZUMA PRESS

California Gov. Arnold Schwarzenegger said that the proposed health care reform measure would not adversely affect the state's general fund.



LANDOV

Lawyers for Ronald E. Ferguson are seeking communications between Berkshire Hathaway Chairman Warren E. Buffett and other Gen Re executives in connection with a finite reinsurance deal with AIG.

Ferguson seeks to tie Buffett to finite deal

Ex-Gen Re chief tries to establish paper trail to bolster defense

By DOUGLAS McLEOD

HARTFORD, Conn.—Lawyers for former General Re Corp. Chief Executive Officer Ronald E. Ferguson are seeking copies of Warren E. Buffett's communications with two other Gen Re executives at the time the reinsurer entered into an allegedly sham reinsurance deal with American International Group Inc.

Mr. Ferguson subpoenaed Gen Re earlier this month in seeking copies of all letters, memos and other written communications during 2000 between Mr. Buffett, chairman of Gen Re parent company Berkshire Hathaway Inc.; Joseph Brandon, Gen Re's current CEO; and Franklin

Montross IV, the reinsurer's president.

The documents are necessary to counter federal prosecutors' contention that Mr. Ferguson lied to other Gen Re officials about having Mr. Buffett's approval for the AIG deal, Mr. Ferguson's lawyers argue.

Mr. Ferguson, three other former Gen Re officers and a former AIG official are facing conspiracy and securities fraud charges for allegedly engineering a fraudulent loss portfolio reinsurance deal intended to inflate AIG's loss reserves. A trial is scheduled to start Jan. 7.

In a Monday filing supporting the subpoena, Mr. Ferguson cited a Nov. 6, 2000, e-mail that he sent to Messrs. Brandon and Montross reporting "a good discussion with our WEBmaster," a reference to Mr. Buffett. Mr. Ferguson said he want-

See **TRIAL** page 6

Former Ren Re chief sets up new venture

By JUDY GREENWALD

GREENWICH, Conn.—Insurance industry veterans James N. Stanard and Rod Fox are launching a new underwriting management firm with the help of venture capital.

The firm, Greenwich, Conn.-based New Asset Class Management, will be owned by F&S Ventures, a privately held investment company.

Mr. Stanard, who is chairman of the firm, served as chairman and chief executive officer of Pembroke, Bermuda-based RenaissanceRe Holdings Ltd. before



Mr. Fox



Mr. Stanard

resigning in 2005 following regulatory investigations of the reinsurer. Mr. Fox, New Asset's CEO, previously was CEO of New York-based Praxian Financial Group Ltd. and prior to that was a reinsurance brokerage executive.

Representatives of New Asset Class were not available for comment on the venture's operations. The amount of the company's start-up capital and projected first-year earnings were not disclosed.

According to a statement, the firm will generate income from three sources: managing and acquiring large portfolios of insurance risk; managing risk portfolios for insurers; and providing advice and risk analysis to insurers, hedge

funds, private equity firms and other investors interested in insurance risks. It will specialize in "rigorous underwriting using resident expertise and the latest technology," according to the statement.

"Our goal is to help insurance operators and risk investors make the most efficient use of their capital," Mr. Fox said in the statement.

The firm is expected to have offices in New York and Bermuda in addition to its Greenwich headquarters.

Mr. Stanard and two other RenRe officials face civil fraud charges in connection with a finite reinsurance deal completed in 2001.

While the other two officials have reached settlements with the Securities and Exchange Commission, the SEC's case against Mr. Stanard remained pending as of Nov. 7, according to an SEC statement. An SEC spokesman could not immediately be reached for comment.

John L. Ward, CEO of Cincinnati-based Cincinnati Partners L.L.C., an insurance industry consulting firm, said, "The timing seems to be great for any new venture like this."

"The industry is always more open to new ideas for risk management and underwriting management" in a soft market, Mr. Ward said.

EEOC move may signal more scrutiny of employment tests

Agency outlines issues employers must weigh to avoid bias charges

By JUDY GREENWALD

WASHINGTON—Claims of discrimination arising from employment tests and selection procedures may increase following the publication earlier this month of a "fact sheet" on the issue by the Equal Employment Opportunity Commission, some attorneys say.

Employment tests can violate federal antidiscrimination laws if employers intentionally use them to discriminate based on factors including race, age and sex, according to the EEOC.

These tests can also violate the

law if they disproportionately affect people in a particular group, unless employers can justify the tests or procedures under the law.

According to the EEOC, employment testing accounts for a small but growing number of charges filed by the EEOC, with the number of charges filed in fiscal 2006 standing at 141 compared with 26 in fiscal year 2003.

The types of tests and selection procedures covered by the EEOC's five-page fact sheet include cognitive tests, personality tests, medical examinations, credit checks and criminal background checks.

The fact sheet discusses the relevant laws involved, which include Title VII of the Civil Rights Act of 1964, the Americans with Disabilities Act and the Age Discrimination in Employment Act. It also discuss-

es recent EEOC litigation and settlements and employer best practices for testing and selection.

Employment testing has increased in recent years in large part due to security concerns since the Sept. 11, 2001, terrorist attacks and issues related to workplace violence, safety and liability, according to an EEOC statement. "In addition, the large-scale adoption of online job applications has motivated employers to seek efficient ways to screen big applicant pools in a non-subjective way," the EEOC said.

"Employers usually think in terms of intentional discrimination," said Francis P. Alvarez, an employer attorney with Jackson Lewis L.L.P. in White Plains, N.Y. "They're pretty comfortable understanding they can't adopt policies or practices that intentionally dis-



TESTING: The widespread adoption of online job applications is a factor in the increased use of employment tests by employers.

criminate against applicants or employees on the basis of race, religion, disability, age and gender.

"But these rules implicate practices that may be very well-intentioned, and therefore employers are often caught off guard by them" when they are found to have a disparate impact on particular groups, said Mr. Alvarez (see story, page 20).

EEOC legal counsel Reed Russell said "The EEOC has been looking at this issue for some time" and wanted to get out a document that points out "the right direction on some best practices and...maybe help clarify the thinking of some employers and employees."

The fact sheet, which follows a May 16 public hearing on the issue, clarifies existing law rather than

See **EEOC** page 20

Medicare pay bill passes

Plan tackles health care bills for elderly workers

By JERRY GEISEL

WASHINGTON—Legislation on its way to President Bush would give federal regulators the authority to demand health care coverage information from employers and plan administrators to ensure that employers, not Medicare, are paying older workers' health care bills.

The provision, tucked into a broader Medicare measure that received final approval last week, is the latest congressional initiative to attempt to ensure that the government reaps the full savings legislators intended by passing a series of bills in the 1980s that shifted some health costs previously paid by Medicare to employer plans.

Under those laws, employer plans became the primary payer of health care bills for employees over 65—the normal eligibility age for Medicare entitlement—and Medicare became the secondary payer. The laws also made employer plans the primary payer for some workers with kidney failure and certain other disabilities rather than Medicare.

Congress passed those measures to save the financially ailing Medicare program billions of dollars. But those savings have not been fully realized because Medicare, in some cases, continued to pay claims for beneficiaries not eligible for primary coverage from Medicare—generally employees and their spouses age 65 and older. That problem can occur when, for example, a hospital bills Medicare, not realizing that an older patient is still working and covered by an employment-based health plan.

Under an initiative called Data Match, federal regulators scour payroll records to determine if Medicare paid claims of older employees that hospitals and other providers should have sent to employers.

While Data Match has had some success in uncovering claims that employer plans—not Medicare—

should have paid, complying with Data Match requests can be burdensome, requiring employers to dig up old health care coverage and employment information.

In an acquisition, for example, obtaining that information can be difficult because the buyer may not have access to coverage and claims information for prior years, said Fran Bruno, an attorney with Mercer L.L.C. in Washington.

The newest legislation, which President Bush is expected to sign, takes a different approach. Its intent is to stop improper billing of Medicare rather than recover funds after claims were paid.

It would require health plan administrators to obtain information from employers to enable Department of Health and Human Services regulators to determine if a group health plan is the primary payer. The legislation, which would take effect in January 2009, would give HHS the authority to decide how and how often the information would have to be provided.

"It is pretty much of a blank check" for regulators, said Frank McArdle, a consultant with Hewitt Associates Inc. in Washington.

"We don't know what information will be required or the frequency in which it would have to be provided. It could be quite burdensome," said Mercer's Ms. Bruno.

On the other hand, if the new program is effective in preventing Medicare from paying claims that should be paid by health plans, it could reduce the frequency of Data Match requests about past claims.

Typically, few employees stay on the job past age 65. But those numbers are expected to increase as a result of a 1983 law that is gradually increasing the age to 67 from 65 at which an employee can retire and collect full Social Security benefits, said Karen Frost, Hewitt's health and welfare outsourcing practice leader in Lincolnshire, Ill.

Tort reform group slams venues it deems unfair to defendants

ATRA names South Florida as worst 'Judicial Hellhole' during 2007

By MARK A. HOFMANN

WASHINGTON—South Florida tops the American Tort Reform Assn.'s "Judicial Hellholes 2007" report released last week.

According to Washington-based ATRA, "their collective reputation for high awards and plaintiff-friendly rulings make Miami-Dade, Palm Beach and Broward counties a launching pad for class actions, dubious claims and novel legal theories of recovery."

Groups representing consumers and trial lawyers condemned the report, which ATRA has published annually since 2002.

Five other jurisdictions that made this year's list of judicial hellholes,



which ATRA defines as "places where judges systematically apply laws and court procedures in an unfair and unbalanced manner, generally against defendants in civil lawsuits," included the Rio Grande Valley and Gulf Coast, Texas; Cook County, Ill.; West Virginia; Clark County, Nev.; and Atlantic County, N.J. All except the last two appeared on last year's list as well.

But perennial "hellhole" Madison County, Ill., is no longer on ATRA's list of the worst jurisdictions, falling instead to its watch list, as did neighboring St. Clair County, Ill.

ATRA credits Madison County

See **HELLHOLES** page 6

Nova Scotia changes pension law

Employers must fund deficits before winding up defined benefit plans

By GLORIA GONZALEZ

HALIFAX, Nova Scotia—Pension plan sponsors in Nova Scotia now must fully fund deficits when they terminate their pension plans, a change seen as another disincentive for employers to offer defined benefit plans.

The province, meanwhile, will follow Ontario, Alberta and British Columbia in reviewing its pension statute, which has not been substantially revised since 1988.

Earlier this month, Nova Scotia's Legislature amended the Pensions Benefits Act to require most employers that wind up their pension plans to make payments into the pension fund if funds are insufficient to pay for benefits. Multiem-

ployer pension plans are exempt from the amended law.

Before the amendment, employers making partial or complete plan terminations were required to make contributions due only until the wind-up was implemented, meaning that employers with plan deficits were not required to fully fund them, sometimes resulting in plan members receiving reduced benefits.

The amendment does not affect funding of ongoing pension plans. Plan sponsors "are only affected if they decide to wind up the pension plan," said Nancy MacNeill Smith, superintendent of pensions for Nova Scotia.

The impetus for the change was a decision by Lake Oswego, Ore.-

based Greenbrier Co. to close its Nova Scotia plant and wind up its plan, which was about 91% funded. The company stated that it had no obligation to fund the deficit under Nova Scotia's pension law.

The United Steelworkers union lobbied to amend the law to require full funding of plan deficits upon partial or full plan wind-ups. The amendment is retroactive to May 1 to capture the closure of the Greenbrier plant with the owner required to contribute roughly \$2 million Canadian (\$1.96 million) to fully fund the plan, Ms. MacNeill Smith said.

Greenbrier officials could not be reached for comment.

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Gen Re: Subpoena focuses on e-mails

CONTINUED FROM PAGE 3

ed to confirm with Mr. Buffett that the AIG deal "passed the NYT test," meaning that it would not embarrass Gen Re if a story about it appeared in the New York Times; Mr. Buffett replied, "Yes, but not by a huge margin," according to Mr. Ferguson's e-mail.

Federal prosecutors contend that Mr. Ferguson fabricated Mr. Buffett's approval of the deal in order to cover himself and blunt objections from other Gen Re executives.

Prosecutors allege, for example, that Messrs. Brandon and Montross "were wary of Ferguson's penchant for accommodating AIG on questionable deals and might have frustrated" the loss portfolio transaction, court filings say.

It would make no sense for Mr. Ferguson to lie to Messrs. Brandon and Montross about Mr. Buffett's approval, though, if they communicated directly with Mr. Buffett themselves, Mr. Ferguson's lawyers argue. Evidence already shows that Mr. Brandon discussed the AIG

deal and other topics with Mr. Buffett, the lawyers said in last week's filing.

The subpoenaed documents are needed to "shed light" on Mr. Buffett's exchanges with Messrs. Brandon and Montross and to undercut the prosecution's argument that Mr. Ferguson misled them, the filing says.

Gen Re has filed a motion to void or limit the subpoena. That motion is pending before U.S. District Judge Christopher F. Droney in Hartford, Conn.

Hellholes: South Florida tops ATRA list

CONTINUED FROM PAGE 4

Chief Judge Ann Callis with pursuing a reform agenda that included placing Judge Daniel Stack in charge of the county's asbestos docket, where "he immediately began dismissing cases with no connection to the jurisdiction," according to ATRA.

While the number of asbestos cases filed in the county in 2007 rose after three years of decline, Judge Stack attributed it to a rise in secondary asbestos exposure claims, "in which lawyers widen the asbestos litigation by suing on behalf of family members claiming to have been exposed to asbestos at home through contact with a family member who worked with the substance" according to report, which added that Judge Stack is "not worried about the increase."

ATRA President Sherman Joyce said during a news conference announcing the report's findings

that the reforms have not made Madison County "a pro-defendant jurisdiction" but rather have made

'This report demonstrates there is an ongoing need to...level the playing field in these jackpot jurisdictions.'

Lisa Rickard,
Chamber Institute for Legal Reform

it a place where defendants can "get a fair shake."

The New York-based Center for Justice & Democracy blasted the report as "dishonest and unfair with apparently no other point other than to undermine the independence of our judges and juries."

The report also drew fire from the American Assn. for Justice, a Washington-based trial lawyer's group. In a statement, AAJ Chief Executive Office Jon Haber dismissed the study as "propaganda."

"The civil justice system is the last resort for those who are injured and the only place every person can get justice when up against the most powerful corporations," Mr. Haber said.

Lisa Rickard, president of the U.S. Chamber Institute for Legal Reform, praised the report, saying in a statement that "although legal reform efforts have resulted in progress in some places, this report demonstrates there is an ongoing need to make judicial and legislative changes that will help level the playing field in these jackpot jurisdictions."

The PDF of the full report "Judicial Hellholes 2007" can be found at www.atra.org/reports/hellholes.

Why runoff disputes often linger

By REGIS COCCIA

EAST RUTHERFORD, N.J.—Unrealistic expectations, misunderstandings and other issues tend to prolong disputes involving runoff insurance companies, according to legal experts.

In a panel discussion at the Assn. of Insurance & Reinsurance Run-off Cos./Cavell 2007 Commutations & Networking Event held in the fall in East Rutherford, N.J., attorneys remarked on some of the challenges they're seeing in arbitrations with runoff entities.

"Normally, there is a cause for a company to go into runoff," such as inability to handle a difficult risk, said Clive O'Connell, a partner at Barlow Lyde & Gilbert L.L.P. in London. "There is almost always a desire to achieve a swift resolution."

But the loss of a commercial relationship between a ceding insurer and a reinsurer in runoff can lead to problems, said Marvin Mohn, general counsel at runoff services company Tawa P.L.C. in London. "There can be a hardening of positions, with the runoff person taking a tougher position" than might

have been the case if the business relationship were ongoing, he said.

Mr. Mohn said he has observed lengthy runoff cases in which "the lack of corporate memory liberated parties to advance ridiculous positions."

"One change I've seen in arbitra-

MORE AIRROC

COVERAGE: Berkshire Hathaway's Brian Snover is named Runoff Person of the Year and other conference news can be found at www.businessinsurance.com/conferenceextra.



tion is there isn't the same stigma there was even five years ago," in runoff said Kevin Walsh, a partner at Locke Lord Bissell & Liddell L.L.P. in New York. As a result, disputes may last longer as each side clings to its respective position.

Janet Kloenhamer, president and chief executive officer of discontinued business operations at Fireman's Fund Insurance Co. in Novato, Calif., suggested that mediation might be an alternative.

"If arbitration is not so attractive,

what about mediation? Mediation has long been regarded as an effective tool by litigators, particularly on the direct side of the (insurance) business. Mediation takes less time and is less formal than adversarial proceedings, whether that's litigation or arbitration," she said. "Arbitration has become neither quick nor efficient."

Another point raised by the panel was that the industry would be better served by quicker resolution of disputes, particularly in cases that establish precedents.

"The cases that don't go away quickly are the hard cases, those that arise from egregious behavior," said Mr. O'Connell.

"These are the cases that make up precedent and set the law for the future. There is an old legal maxim in England: Hard cases make bad law. The problem is multiplied in the runoff market as people seek short-term solutions," Mr. O'Connell said.

"Look carefully at bad arguments that you raise and the bad cases" cedents bring, he advised. "Judges that look at those cases only see the bad cases. We don't need that as an industry."

Commentary

Wishing for the best, planning for the worst

December is a season of giving for people of all faiths—even for some who do not profess a faith. Whatever one's beliefs, I think peace, health and prosperity are universally welcome wishes.

On the subject of wishes, here is my own wish list for the new year, in no particular order:

- More tolerance for differences in religious beliefs, ethnicity and economic background.

Many of the world's conflicts are based on religion, race or class. If we are able to focus less on our differences and more on our common ground, the world will be a far better place.

- Greater value of human life. Violence will not end until people recognize the intrinsic value of every man, woman and child—born and unborn—and do their utmost to protect it.

- Financial literacy. Automatic enrollment in retirement savings and pension plans is a fine start, but workers and their dependents need to know how to make smart choices in all areas of their financial lives.

Would the subprime loan crisis have been as severe and widespread if people understood the contracts they signed? Predatory lending is abhorrent and should be banned, and all people should know what they're committing themselves to when they sign a contract. Anyone can have bad luck, but without a financial plan to absorb life's inevitable bumps, a job loss or disability can become catastrophic.

- More participation in wellness programs that put individuals on the path to long-term good health.

Chronic diseases will always be with us, though they can be better managed and their costs reduced. With increased utilization and development of new technologies and therapies, it's debatable whether health care costs can ever decrease. Wellness at least holds the promise of keeping cost increases in check.

- Breakthroughs in treating autism and other behavioral disorders, and more coverage of them in benefit plans.

One in every 150 children in the United States has an autism spectrum disorder, and the economic cost of these developmental delays has been estimated at \$90 billion a year and growing. Yet few benefit plans provide much coverage for the therapies that help, forcing many families to fund treatment with other means, or forgo it.

- Fewer product recalls, through greater attention to quality and safety.



REGIS
COCCIA

Editor Regis Coccia's commentary appears periodically. He can be reached at: rcoccia@businessinsurance.com

Disturbing news of lead and other toxins in goods made in China, for example, led many people during 2007 to avoid buying items produced there. Safety should never take a back seat to production cost savings, no matter where the goods originate.

- More transparency in the underwriting and placement of risks, without regulatory pres-

Safety should never take a back seat to production cost savings.

sure.

Insurance buyers deserve—and should demand—to know how their risks are underwritten and priced and how their brokers are compensated. Past abuses such as bid rigging and conflicts of interest are far less likely to occur where there is complete transparency, full disclosure and regular discussion of every party's interest in the transaction.

- Less volatility in the global insurance marketplace, with stability in rates and capacity.

It's hard for a risk manager to explain why rates fluctuate as wildly as they do, and that volatility plays havoc with risk financing budgets. Buyers, brokers and underwriters should all cooperate to remove pricing volatility as much as they can. While I'm not wishing for the soft market to turn, it would be beneficial to all sides to have stable, fair rates that reflect the risks assumed.

Whether any of these wishes will come true in 2008 is anybody's guess. Because I'm an optimist, I like to plan for the worst and hope for the best. Happy holidays and best wishes for a safe, healthy and prosperous new year.

Health plan cost hikes stay at 6.1%

November 19, 2007 – Business Insurance

'Value-based' health plan designs focus on health, not merely dollars

October 29, 2007 – Business Insurance

More burdens seen for benefits plans

October 8, 2007 – Business Insurance

Health insurance premiums continue to outpace inflation

September 17, 2007 – Business Insurance

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Business Insurance OPINIONS

MMC needs CEO to get it back on track

AS MARSH & McLENNAN Cos. Inc. seeks a new chief executive to replace Michael Cherkasky, we think the world's largest broker should return to its roots.

In our view, that means a candidate from the brokerage field. Earlier this month, MMC tapped Daniel Glaser, a former employee, to head flagship unit Marsh Inc. It did so after a disappointing performance under Brian Storms, a capable executive and former head of MMC unit Mercer L.L.C. whose background was in investment banking.

To his credit, Mr. Cherkasky steered MMC through extremely turbulent times. He was named CEO in October 2004, shortly after then-New York Attorney General

Eliot Spitzer forced MMC's board to remove Jeffrey Greenberg. For a brief time, it was not clear if MMC would survive. Mr. Cherkasky, a former prosecutor who had worked with Mr. Spitzer earlier in his career, seemed a logical choice. That clearly was the right move at that time.

With its legal troubles now behind it, MMC wants to rebuild the value its shares have lost since 2004. How will it do that? Its troubles largely stemmed from failing to put its clients first. MMC has a long and distinguished history, and it has shown a remarkable resilience though the shocks of the last few years.

We think in large part that's due to its employee talent and depth of resources. Those strengths remain, and that's why we believe—if the company recognizes, as it once failed to do, that clients come first—the odds are high that MMC will get back on track.

*The world's largest broker
should return to its roots.
That means a candidate
from the brokerage field.*

California health plan needs some rethinking

DRAFTING AND ENACTING state health care reform measures to achieve universal coverage—or something close to it—is a tough business.

If such measures are too weak, they won't accomplish much. If they're too tough, they might do more harm than good, such as driving out businesses to neighboring states that don't have such burdensome laws.

That said, we think the way California Gov. Arnold Schwarzenegger and Assembly Speaker Fabian Núñez, D-Los Angeles, want to enact universal health care reform legislation in the Golden State is the wrong approach. As we report on page 3, a key aspect of the proposal—a mandate that employers spend a certain percentage of payroll on providing health insurance coverage to employees and their dependents—could not be implemented unless approved by California voters next year.

To us, that approach defeats what our system of government is all about: Voters choose representatives whom they believe will make the right policy decisions.

Of course, the real reason for this ballot approach is that Gov. Schwarzenegger and Speaker Núñez don't believe they have the necessary support to enact the employer mandate and other parts of their proposal. Under California law, any change that raises taxes requires approval by at least 65% of state legislators.

That should tell those two political leaders that perhaps they need to take another approach. Successful reform is possible only when it has overwhelming bipartisan support in the state legislature.

Perhaps, the governor and his allies have reached too far on this one and may want to scale back their bill so that its elements are those on which there is a broad consensus.

That bill then could be a building block for more ambitious efforts.

I had just settled in on a cold winter's night
when my 10 year old son sat himself on my right.
"I've known it for ages, there's no Santa," he said,
"Though you once tried to fool me by dressing in red."

I looked up in surprise and I smiled to myself
for I knew I'd never tried to play the old elf.

But one Christmas Eve, my son's dreams became real
and Santa appeared for his milk and cookie meal.

Now, wouldn't it be fine if wishing were the cure
and believing solved the problems we must endure?

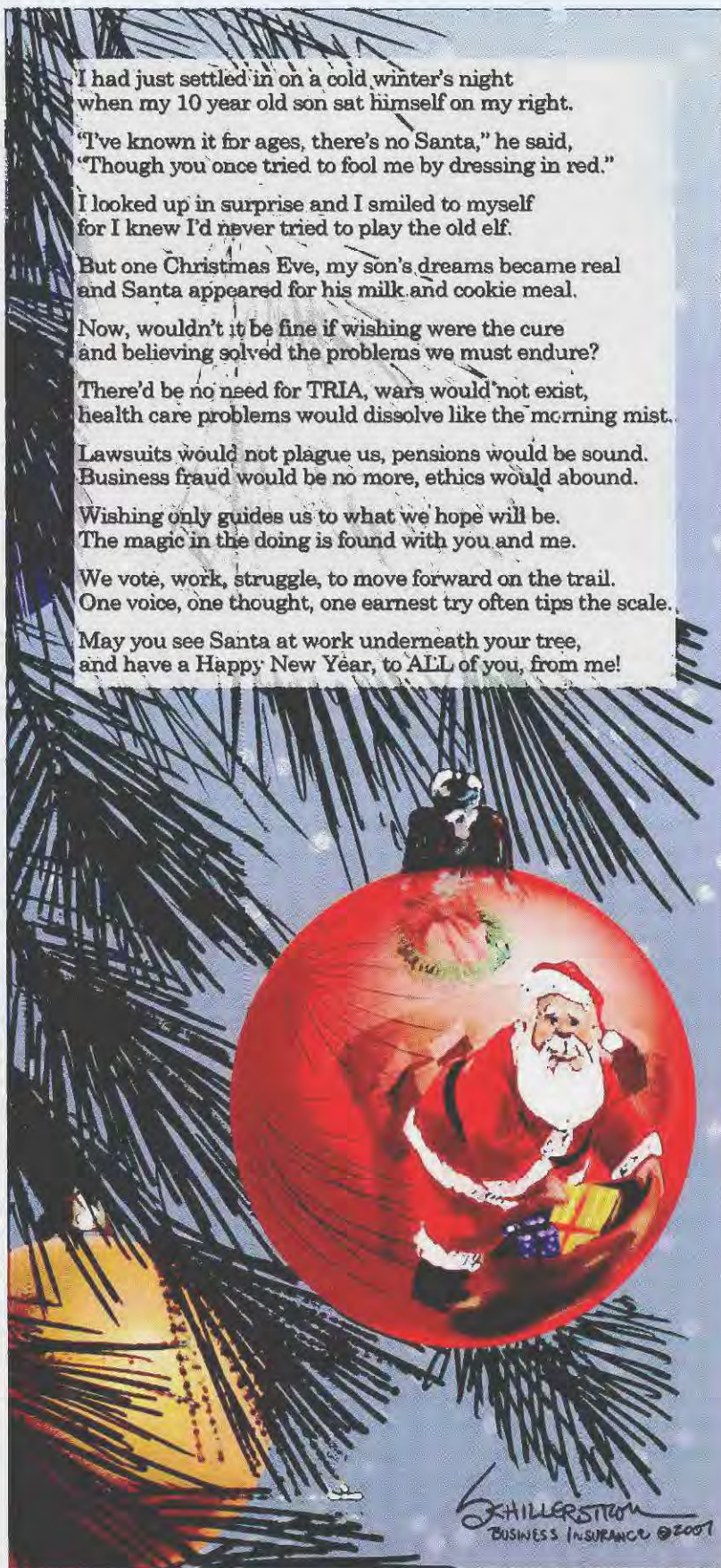
There'd be no need for TRIA, wars would not exist,
health care problems would dissolve like the morning mist.

Lawsuits would not plague us, pensions would be sound.
Business fraud would be no more, ethics would abound.

Wishing only guides us to what we hope will be.
The magic in the doing is found with you and me.

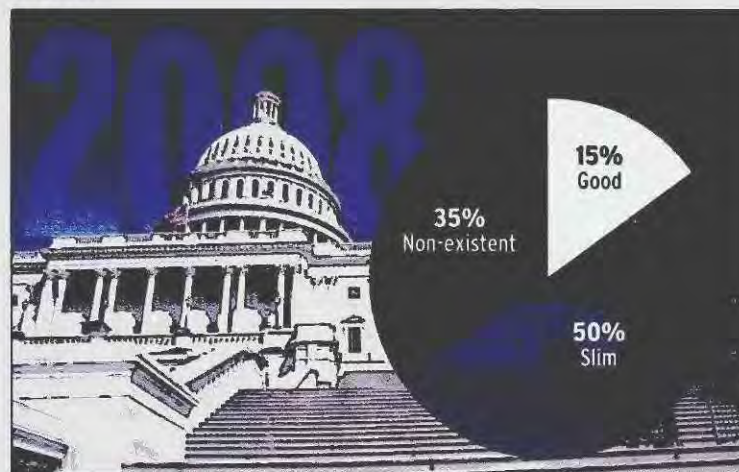
We vote, work, struggle, to move forward on the trail.
One voice, one thought, one earnest try often tips the scale.

May you see Santa at work underneath your tree,
and have a Happy New Year, to ALL of you, from me!



Online Poll at www.businessinsurance.com

What are the chances of insurance regulatory reform at the federal level in 2008?



NEXT WEEK'S POLL: How long will it take Marsh & McLennan Cos. Inc. to find a new CEO?

BI Online Poll tool sponsored by Wausau Insurance Cos.

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Top 10 employee benefits stories of 2007

1. Major automakers, others shift retiree health care liabilities to union-run voluntary employees' beneficiary associations.
2. Increases in health care costs remain steady.
3. Other states try to follow the health care trail that Massachusetts blazed, but the efforts falter.
4. Insurer efforts to rank doctors run into state resistance.
5. Employers embrace automatic enrollment in 401(k) plans, with a boost from final Labor Department and IRS rules.
6. The Pension Benefit Guaranty Corp.'s deficit falls to its lowest level in four years, generating cautious optimism.
7. Congress moves to expand employee benefits parity law to encompass mental health treatment.
8. Courts dismiss age discrimination charges against cash balance pension plans.
9. Scrutiny increases of fees charged for 401(k) accounts.
10. IRS issues tougher rules for 403(b) pension plans.

Employers eyeing strategies to boost health care value

Wellness programs and retiree benefit options in sync with business goals draw greater attention

By KRISTIN GUNDERSON HUNT

Steadily rising health care costs remain a leading concern for employee benefit managers in 2007, causing them to become more interested in the concept of value-based benefit design, benefit managers say.

A value-based plan design uses employee data to strategically focus resources so the result will be healthier employees and better returns on the company's health care investment, said Chris McSwain, who recently joined Ben-

ton Harbor, Mich.-based Whirlpool Corp. as global benefits manager.

"Value doesn't necessarily have to mean changing your pharmacy design or your medical design," Mr. McSwain said. "It can mean more effectively using your resources to optimize your employees' experiences."

Value-driven health care also aims to improve employee behavior and health, often through offering wellness programs and incentives, other experts say.

"If you want employees to change behavior and manage their

GET THE BOOK:
"BenefIT Design," published by Pitney Bowes and GlaxoSmithKline, is available by calling 1-888-825-5249.

own health, you have to offer incentives," said Larry Boress, president and chief executive officer for the Midwest Business Group on Health in Chicago. "You can't just raise premiums and think that (alone) will be effective."

He said business and health strategies have to be synchronized for companies to maximize the value of their health plans and produc-

tivity of their employees.

"At the end of the day, it's productivity that employers are most concerned about," Mr. Boress said. "Wellness is no longer a lunch-and-learn activity. It's not just a fringe benefit. It's a strategy."

While value-based benefit design has existed for some time, Mr. McSwain said it has gotten more attention since publication of the new book "BenefIT Design: Seven Steps to Value-Based Health Benefit Decisions" by Pitney Bowes executives David Hom and Dr. Jack Mahoney.

"It very simply lays out what I believe to be a road map that's easy for others to follow," Mr. McSwain said. "It makes following a value-based benefits design achievable."

Paul Hackleman, benefits manager for San Mateo County, Calif., has seen little public sector interest in value-based benefit design. Instead, he said he's seen more businesses focusing on core areas such as retirement and health as opposed to work/life balance programs, which have been the focus in recent years.

See **REVIEW** next page

GM-UAW accord removes billions in liabilities for retirees

While not the first of its kind, a 2007 agreement between General Motors Corp. and the United Auto Workers union was unprecedented in size.

It allows GM to walk away from retiree health care liabilities valued in the tens of billions of dollars in exchange for a huge contribution to a special trust fund.

As part of a contract that UAW members ratified in October, GM agreed to contribute about \$30 billion to a voluntary employees' ben-

eficiary association to be set up by the UAW.

In return, the automaker will be able to move roughly \$50 billion in accumulated retiree health care obligations off its books and to the VEBA.

After GM completes its VEBA contributions—made in the form of cash and a note that VEBA trustees can convert to GM stock and sell—its responsibility to provide health care benefits to cur-

rent and future UAW-represented retirees will end, and retiree health care benefits no longer will be subject to collective bargaining with the union.

For GM, the appeal of the deal is obvious. It is able to rid itself—and at a discount—of a huge liability, the future size of which is almost impossible to predict.

For the UAW, the approach also is appealing in that a clear-cut amount will pay for what was large-

ly an unfunded promise of benefits in the future. And VEBA assets can't be touched by creditors if GM, which has lost more than \$12 billion in the past two years, were ever to file for bankruptcy reorganization.

The GM retiree health care VEBA agreement became a model for similar agreements that the UAW subsequently reached with Ford Motor Co. and Chrysler L.L.C.

More such deals between organized labor and financially dis-

tressed employers battling lower-cost competitors are expected in 2008.

While more agreements are likely, it will be some time before it is known whether unions and the investment advisers they retain will succeed in generating sufficient investment income from the huge VEBA contributions to provide retired union employees and their dependents health care coverage for decades to come.

—By Jerry Geisel

Review: Stage set for fewer to offer retiree benefits

CONTINUED FROM PREVIOUS PAGE

This focus on health care and retirement options comes at a time when employers are becoming more concerned with the long-term costs of providing retiree benefits, experts say.

Experts say deals by three major automakers in 2007 highlight those concerns. Detroit-based General Motors Corp., Dearborn, Mich.-based Ford Motor Co. and Highland Park, Mich.-based Chrysler L.L.C. reached collective bargaining agreements this year with the United Auto Workers union to shift their retiree health care liabilities to voluntary employees' beneficiary associations that will be set by the UAW.

"The dramatic nature of what happened with that watershed event will make benefit managers pay attention to their retiree benefits even more so," Mr. McSwain said. "The stage is set for fewer and fewer companies over time to offer retiree benefits."

With employees' retirement savings in mind, experts say more employers embraced automatic enrollment for 401(k) plans during 2007, particularly after new laws and regulations made the programs easier to implement.

"The new regulations have opened up opportunities for individuals who may have taken a passive or delayed approach to saving in a 401(k)," said Delia Vetter, senior director of benefits and programs for EMC Corp., a technology company in Hopkinton, Mass. "Auto-enroll may have a significant impact on long-term wealth accumulation and financial security."

Experts say benefits management ultimately comes down to value for employers and employees, with most of the major events during 2007 pointing in such a direction.

"The health care marketplace, with employers paving the way, is focused on value of service—pay for performance," Ms. Vetter said. "It's about driving engagement based on quality, not cost."

Health care costs still rising amid debate on reasons for flatter trend

Health care cost increases continued to hold steady in 2007, marking the third consecutive year that employers' group health plan costs have grown in the neighborhood of approximately 6%.

A survey released in November by Mercer L.L.C. found that group health plan costs increased by an average of 6.1% in 2007, the same percentage cited by the Washington-based Kaiser Family Foundation's "2007 Employer Health Benefits Survey", which was unveiled in September.

In July, Ann Arbor, Mich.-based health benefit consultant Thomson Healthcare also reported a 6% growth rate in group health care costs for 2007.

Some industry experts attributed the leveling off of cost increases to a growing number of employers

that have been implementing wellness and disease management programs.

"We're seeing the fruits of the changes employers have made," said Blaine Bos, a worldwide partner at Mercer Health & Benefits in Minneapolis.

"So trends that were in the very low double-digits are going to be closer to 7% to 9%," Mr. Bos said.

However, researchers at the Kaiser Family Foundation suggested that the slowdown is a temporary reprieve that is attributable to the natural swings of the underwriting cycle.

"We have seen these peaks and valleys in rates of increase before," said Drew Altman, president and chief executive officer of KFF. "But we've done little as a nation to deal with the underlying cost drivers,"

he said.

Though some benefit consultant surveys found that preliminary rate hike requests were significantly higher—usually in the low double-digit range—from health maintenance organizations, those projections dropped considerably after employers made plan design changes to focus on health management.

Consumer-driven health plans featuring large deductibles also had a mitigating effect on overall health plan trend rates, according to consultants.

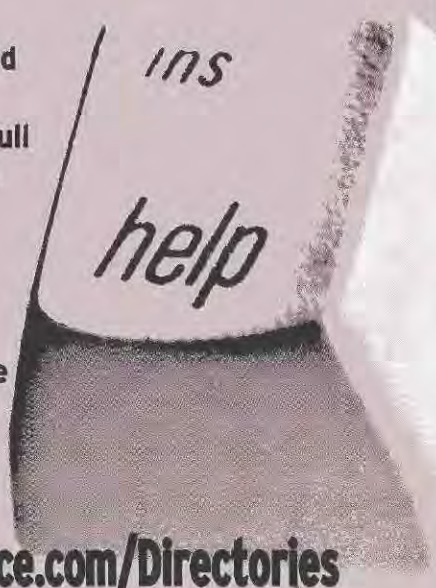
"The net effect of increased cost-sharing and transparency of information is causing people to be more thoughtful in how they use the system," regardless of their health plan type, according to Mike Thompson, a principal at Pricewaterhouse Coopers L.L.P. in New York.

—By Joanne Wojcik

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Why trail blazed by Massachusetts has yet to be trod by other states

When Massachusetts passed landmark legislation in 2006 aimed at moving the state very close to universal health care coverage within a few years, many experts said it would be just a matter of time before other states followed Massachusetts' trailblazing approach.

And shortly after Massachusetts completed action, Vermont enacted a somewhat similar reform measure.

But the health care reform drive became much tougher in 2007. Universal or near-universal coverage measures advanced by Illinois Gov. Rod Blagojevich and Pennsylvania Gov. Ed Rendell failed to gain much traction.

In California, a universal coverage bill was approved this month by the state Assembly, but its prospects

in the Senate are uncertain.

There are several reasons why a reform drive that went so smoothly in Massachusetts has stalled elsewhere. One major reason is the scope of the problem—the number of uninsured—was much smaller in Massachusetts than in other states where reform drives stalled.

While estimates have varied somewhat, less than 10% of Massachusetts residents lacked coverage before the enactment of the reform legislation. By contrast, 6.5 million residents in California—nearly one-fifth of the population—are uninsured.

A high uninsured rate means much higher costs for a state that wants to achieve universal coverage, since a key way to expand coverage is for the state to subsidize

premiums for the low-income uninsured.

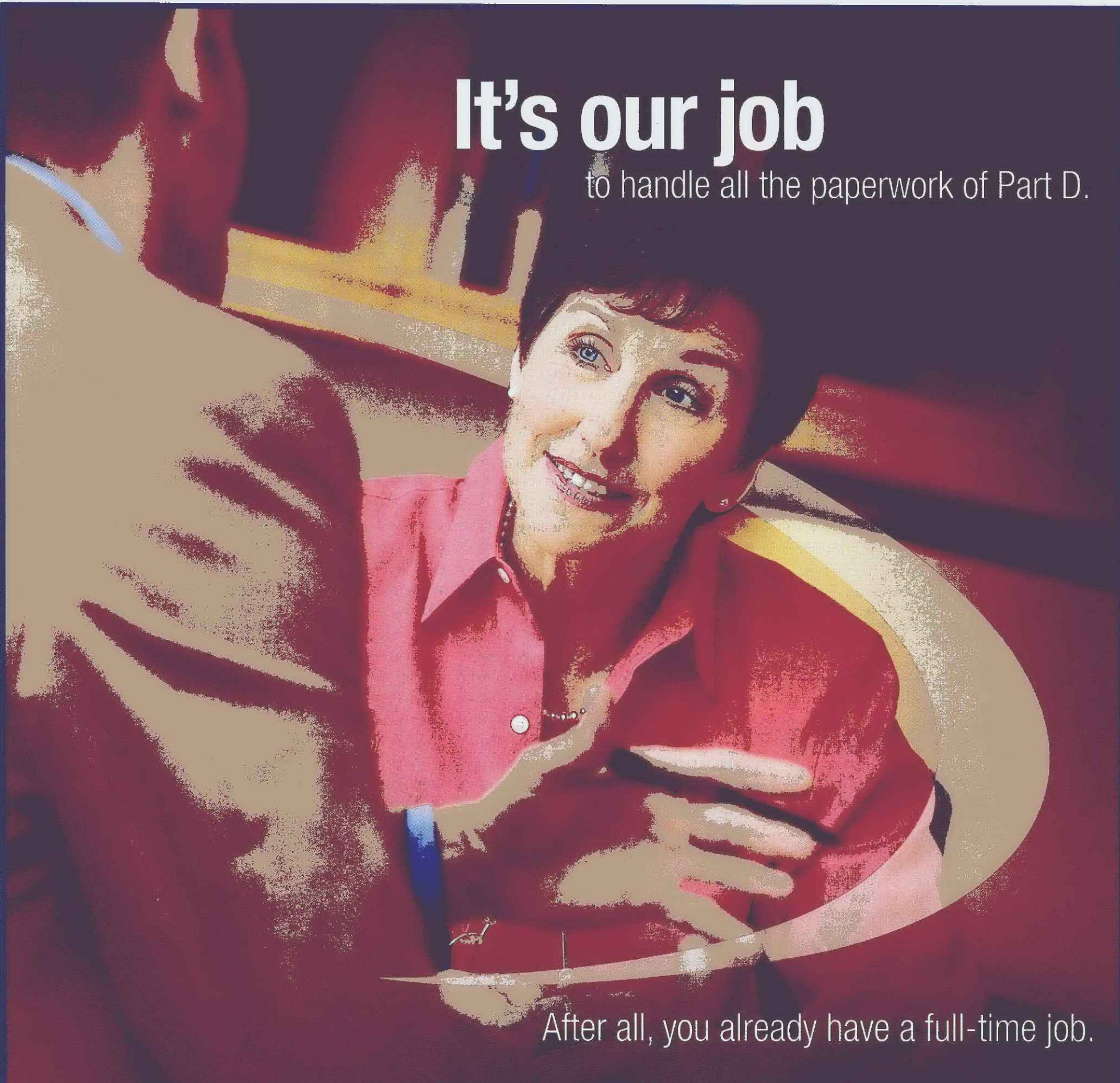
Additionally and unlike other states, Massachusetts already had a major source of revenue, a surcharge imposed on hospital bills that had been used to reimburse hospitals for uncompensated care, that it could partially divert to fund coverage for the uninsured.

While major reform efforts stalled in other states, that isn't to say that reform efforts petered out completely.

In Indiana, legislation approved earlier this year will provide access to state-subsidized, lower-cost consumer-driven health care plans to low-income, uninsured state residents.

That program could reduce Indiana's uninsured population by 50,000 a year.

—By Jerry Geisel



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Physician ranking plans meet New York roadblock

Health insurers implementing programs to rank the performance of physicians encountered strong opposition during 2007 from an unexpected source: New York Attorney General Andrew Cuomo.

In July, Mr. Cuomo's office asked a UnitedHealth Group Inc. unit to cease implementation of a program to rank New York doctors according to quality and cost and threatened to seek a court order barring the Minnetonka, Minn.-based insurer from implementing the program.

Mr. Cuomo launched an industrywide investigation of physician ranking programs and sent letters to other insurers operating in the state, requesting information on the metrics used in their programs.

He later devised a model for physician ranking programs that requires an insurer to disclose to consumers how much of its physician evaluation process is based on

cost efficiency and how much on quality measures, a blueprint developed with input from physician and consumer stakeholders. The model also mandates retaining an oversight monitor to assure compliance with all aspects of the agreement and reporting to the attorney general every six months.

A CIGNA Corp. unit was the first insurer to agree to implement Mr. Cuomo's model, with other national and local health care insurers quickly following suit.

Instead of adopting the model solely to rank New York doctors, several national insurers also agreed to adopt its principles for their programs across the United States.

Employers and consumers are the beneficiaries of the adoption of Mr. Cuomo's model because they will receive necessary and reliable information on physician performance, observers say.

—By Gloria Gonzalez

4

Automatic enrollment surges for 401(k) plans

The hottest trend in the defined contribution savings plan universe during 2007 was rapid adoption of automatic enrollment programs.

In just two years, the percentage of large employers with such programs nearly doubled, Hewitt Associates Inc. found, with the expectation that the programs will continue growing at a rapid clip during the next year.

Several factors are fueling growth of the programs, perhaps the biggest of which is the demise of defined benefit plans. As employers phase out those plans, defined contribution plans, especially 401(k) plans, have become the sole employer-provided retirement savings plan.

If employees don't contribute to those plans, the odds increase that they will lack enough savings to retire at the normal age and force them to work longer than either they or their employers would like.

Automatic enrollment makes that less likely to happen. Once employees are enrolled, they rarely opt out of such programs, meaning their contributions and the matching contributions by employers

continue to flow into their 401(k) accounts.

Congress and regulatory agencies also have boosted automatic enrollment programs.

Legislators did their part by including a provision in the 2006 pension funding reform law that pre-empts any state laws that could interfere with the programs.

On the regulatory side, the Department of Labor issued final rules in 2007 that protect employers adopting automatic enrollment programs—if they, among other things, funnel contributions to certain types of investment funds—from fiduciary liability if the investments do poorly.

Not every employer will adopt an automatic enrollment program. Such programs increase costs since employers typically match employees' salary deferrals. But with a growing concern that employees still decades away from retirement won't have enough savings, automatic enrollment seems certain to become a widely used feature of 401(k) plans.

—By Jerry Geisel

5

Top benefits newsmakers of 2007

In taking the reins of WellPoint Inc. in June, **Angela Braly** joined a select group of women who lead



Ms. Braly

Fortune 500 companies. As the president and chief executive officer of the nation's largest health insurance company in membership, Ms. Braly will be responsible for guiding the Indianapolis-based insurer during a time of significant evolution in the health care industry. That evolution has been accelerated by a growing consensus on the need for health care reform and the presidential elections in 2008.

It has long been a given that health insurance premiums paid by employers should not be added to the taxable income of employees, regardless of how much is spent.

President Bush challenged that assumption this year when he proposed, as part of his State of the Union address, a radical new tax plan. Under that plan, everyone with health insurance—whether purchased on their own or obtained through an employer—would be entitled to a \$7,500 tax deduction for single coverage and a \$15,000 tax deduction for family coverage.

In turn, though, the cost of a health insurance plan in which employees were enrolled would be added to their taxable incomes. In short, employees enrolled in plans with costs exceeding the deduction amounts would be taxed on the difference.

In backing the tax rule change, President Bush said tens of millions of employees would have lower tax bills, with a

new level playing field—taxwise—for those who buy insurance on their own and those who receive it through their employers.

This change in the tax code, President Bush said, would help to make health insurance more affordable. Federal lawmakers, though, were not convinced and the Bush proposal has yet to receive serious congressional consideration.

Heeding protests from health care provider and consumer groups, New York Attorney General **Andrew Cuomo** demanded that health insurers justify the cost and quality metrics used in physician ranking programs. Mr. Cuomo expressed concern during 2007 that consumers might be steered toward doctors based on "faulty data and

criteria," and might be encouraged to choose doctors based on price rather than quality. He secured a pledge by national and local health insurers to adopt his model for an ideal physician ranking program. Mr. Cuomo said his job is not yet done, promising to work with state legislators to codify the core principles of his physician ranking program into New York state law.

To borrow an expression from poker, Maryland Attorney General **Douglas Gansler** knows when to fold.

In 2007, after two consecutive losses in court defending a Maryland law aimed at requiring Wal-Mart Stores Inc. to spend more money on employees' health care benefits, Mr. Gansler threw in the towel. Mr. Gansler said he believed the law, which required any employer with at least 10,000 employees in Maryland to spend at least 8% of payroll to provide health



Mr. Gansler

insurance benefits or pay the difference to a state fund, was constitutional. But he acknowledged that seeking a Supreme Court review of the law, which would have applied to only Wal-Mart due to the way it was written, was unlikely to be successful. He noted that courts earlier ruled that the statute ran afoul of the federal Employee Retirement Income Security Act, which pre-empts state and local rules and laws that relate to employee benefit plans. Legal experts predicted as much when the Maryland Legislature passed the measure—at the urging of the AFL-CIO—overcoming a veto by then-Gov. Bob Ehrlich.

Union leaders aren't in the business of negotiating agreements that may result in smaller benefits for members. That's especially true for the United Auto Workers, where top officials enjoyed extraordinary success for decades in winning gold-plated benefits for members.



Mr. Gettelfinger

Given that histo-

ry, the willingness of UAW President **Ron Gettelfinger** to negotiate agreements with General Motors Corp., Ford Motor Co. and Chrysler Group that allow the automakers to walk away from tens of billions of dollars in retiree health care liabilities in exchange for much smaller contributions to special UAW-controlled trusts is extraordinary.

But if anything, Mr. Gettelfinger is a pragmatist.

Knowing full well that the automakers, all of which are in varying degrees of financial difficulty, could legally walk away from providing retiree health care benefits if they declared bankruptcy, Mr. Gettelfinger reasoned that iron-clad security for those benefits was an acceptable price to pay for what almost certainly will be a future reduction in benefits.

After Nevada's insurance commissioner granted approval for UnitedHealth Group Inc.'s planned acquisition of Las Vegas-based Sierra Health Services Inc. during 2007, Nevada Gov. **Jim Gibbons** immediately expressed concern about the

"potential monopolistic tendencies" and the commissioner's limited statutory ability to address such issues."

Mr. Gibbons asked Nevada's attorney general and the U.S. Department of Justice to examine the merger and take all steps to ensure consumers are protected from the potentially negative impact of reduced competition that could occur if the deal were consummated.

While Massachusetts Democrat **Edward Kennedy** is known well for his soaring rhetoric during 45 years in the U.S. Senate, he also has been a political pragmatist.

While no fan of medical savings accounts—the predecessor to health savings accounts—Sen. Kennedy in 1996 brokered a deal with congressional Republicans in which he supported tax breaks for MSAs in exchange for GOP support for legislation that curbed the use of exclusions of pre-existing medical conditions in group health care plans.

In 2007, Sen. Kennedy, who chairs the Health, Education, Labor and Pensions Committee, also



Mr. Gibbons



Sen. Kennedy

Continued on next page

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EMPLOYEE BENEFIT TIMELINE OF NOTEWORTHY

EVENTS DURING 2007

YEAR IN REVIEW - EMPLOYEE BENEFITS

CONTINUED FROM PREVIOUS PAGE

showed his willingness to negotiate on another benefit issue: mental health care benefits parity legislation.

Eager to defuse employer opposition and after lengthy negotiations with business groups, Sen. Kennedy backed a slimmed-down parity bill in which employers would retain the ability to decide which mental disorders they would cover in their health plans, though such conditions would have to be covered the same way as other medical conditions.

While not wild about the new bill, several business groups said they would not oppose it, and the Senate approved the measure unanimously.

Sen. Kennedy's negotiating skills will almost certainly be tested in 2008 if the House passes, as is expected, a more expansive mental parity bill and legislators then have to try to work out a compromise measure.

If 2006 was the year of health reform in Massachusetts, then 2007 was the year state regulators took steps to implement the law.

Leading the implementation effort was **Jon Kingsdale**, executive director of the Massachusetts Health Connector.

Indeed, a slew of rules were proposed and adopted under Mr. Kingsdale's direction.

For example, requirements that were laid down on standards that group health insurance plans must meet for plan enrollees



Mr. Kingsdale

to have so-called creditable coverage, while schedules were laid down detailing how much income state residents could earn and still be eligible for state subsidies for premiums charged by health insurance plans in which they enroll.

The implementation effort clearly is bearing fruit. Nearly 75% of the state's uninsured are expected to have coverage by Jan. 1, 2008.

House Education and Labor Committee Chairman **George Miller**, D-Calif., has complained that despite the tens of billions of dollars that 401(k) plan participants have plowed into the plans, they are in no position to know how much they are paying in fees because of weak disclosure rules.

But he is trying to do something about it.

In July, Rep. Miller introduced the 401(k) Fair Disclosure for Retirement Security Act of 2007, which would require plan administrators to disclose to plan partici-



Rep. Miller

pants all fees that are charged to 401(k)-type retirement savings plans. The proposal would require such disclosures be in clear and simple language. It also would require more detailed information on investment strategies, risks and returns, and other requirements.

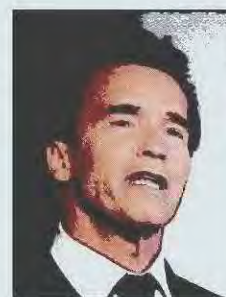
In recent weeks, Rep. Miller said he hopes the House will act on the measure during the first quarter of 2008.

After being at odds with California's Democrat-controlled Legislature

over health reform for most of 2007, Republican **Gov. Arnold Schwarzenegger** was finally able to turn things around in September when he called a special session for the two opposing forces to duke it out.

Observers say the move, which was welcomed by the governor's Democratic rivals, showed the he was willing to compromise to enact health reform before he leaves office. But the bill he presented to the committee appointed by Assembly Speaker Fabian Nunez, D-Los Angeles, largely resembled a

measure the governor had proposed earlier in the year. It still included an individual mandate, an anathema to both Democrats and the labor groups that support them.



Gov. Schwarzenegger

But because the new bill also included an employer mandate—a provision Democrats had sought—lawmakers said it was something they would consider.

As the year came to a close, a \$14 billion compromise plan won state Assembly approval but faced skepticism in the state Senate.



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Business Insurance PERSPECTIVE

Sharpen focus on health care risks

Wise, flexible investments can achieve a healthier workforce and bolster the corporate bottom line

By Michael Turpin



Michael Turpin is chief executive officer of UnitedHealthcare's Northeast operations in Trumbull, Conn.

As health care costs continue to rise, business leaders are searching for someone who can halt the national health care cost trajectory, which now has reached nearly 16% of our gross domestic product. However, some businesses already have achieved annual medical cost trends that are flat or negative.

In those organizations that have not, there is often a fatal disconnect between the people who manage risk and those who manage benefits, which can inhibit an organization's holistic approach to health care. More effective management of health care risk is needed.

Certainly, barriers exist that may hinder an employer's health care-based interventions. Some federal legislation poses challenges for employers designing health programs that could be construed as discriminatory.

A patchwork of state-mandated benefits, which often benefit a few at a cost to many, makes it more difficult to maintain consistent programs to improve workforce health and well-being.

However, those who have been successful in managing their health care costs have begun to take a more active role in their employees' treatment and personal health choices, testing the boundaries imposed by various rules and regulations.

Employers need to be less focused on individual disruption and more focused on improving the health of our workforce.

So what would risk managers do?

Assess the risk. Data is king in any initial view of health care utilization. Is a small percentage of your workforce driving the largest part of your claims? How many of these claims are potentially lifestyle-driven and influenced by smoking, cholesterol, blood sugar and blood pressure? Do you know which health care providers deliver the highest quality, most efficient outcomes over entire episodes of care? By reviewing all available data, employers can get a clearer picture of where their health care dollar is being spent most efficiently and where it is being wasted. Risk managers know that information is the foundation to taking action.

Eliminate the risk. Is your pharmaceutical formulary out of date, not allowing you to take advantage of lower-cost generics? Is your provider network utilizing hospitals that provide care at higher unit costs to maintain broad access in an effort to minimize employee disruption? By making informed changes, employers can begin reducing risks where changes make sense and begin mitigating losses they cannot eliminate through loss-control programs.

Mitigate the risk. Wellness and health risk control programs are a

continuous challenge to employers as the return on investment for keeping employees healthy is often elusive. But in addition to mitigating rising health care costs, partnering with employees to help them lead fuller and more productive lives may reduce such quantifiable costs associated with absenteeism and staff turnover. Not ready for aggressive loss-control programs? Adopt a plan design that rewards workers and their families for compliance with lower deductibles and out-of-pocket expenses. Fewer claims mean lower costs.

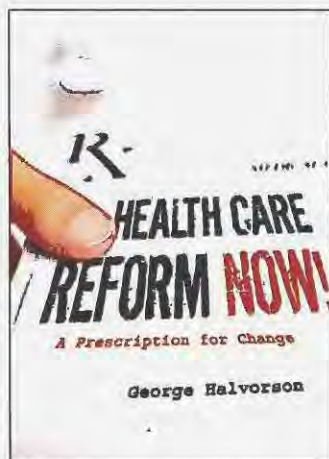
Assume the risk. While some companies assume all the claims risk by self-insuring, others look to share the risk by partnering with a third party, such as health insurers. No matter the arrangement, without a better understanding of your employees and their health, and your overall claims history, you cannot predict your potential claims liability and enact internal programs to further mitigate your exposure—thus flattening your health care cost trend. Performance guarantees with brokers and insurers can ensure that they are delivering on their role in mitigating losses through their loss-control programs.

Transfer the risk. In health care today, this is where most employers start—shop for insurance, find the lowest risk transfer cost and hope that in 12 months the costs will

miraculously moderate. Risk managers consider risk transfer the last step in this process, but offering health benefits is complicated. For some, they are an untouchable entitlement. For others, they are a tool to attract and retain talent. Today, disruption is the enemy, and today's health care consumers are still grappling with the march toward creating a more informed group of health care consumers. The increasing adoption of consumer-driven health plans suggests that employers are not yet willing to limit coverage but are willing to have consumers share more in their health care decisions and costs.

Risk management is the cornerstone of workers compensation programs, focusing on work processes that drive higher losses and fixing them. Can the same be applied to health care benefits? While health care expenditures cannot be simplified to the level of workers compensation, they can be controlled. An active commitment to a healthier workforce from the C-suite down, coupled with wise—and flexible—investments in health programs and care, can bring health care cost trends in line.

At a time when business risk has never been more challenging, is it not appropriate to start viewing health costs through a different lens? The future of health care may depend on it.



"HEALTH CARE REFORM NOW! A PRESCRIPTION FOR CHANGE"
By George Halvorson

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Book tackles 'hard but useful truths' in health care

Industry veteran backs electronic medical record system and universal coverage to save money

By LOUISE ESOLA

As chairman and chief executive officer of Oakland, Calif.-based Kaiser Foundation Health Plan Inc. and Kaiser Foundation Hospitals, well-known health care leader and author George Halvorson uses his knowledge and experience to identify key problems and craft a plan to fix U.S. health care.

His assessment, strategy and roadmap for change are outlined in his latest book, "Health Care Reform Now! A Prescription for Change." The 322-page manifesto takes readers on a journey through the maze of some of the most challenging health care problems.

To start, Mr. Halvorson points out that the United States does not have an actual health care system in place. Instead, it has a "plethora of uncoordinated, unlinked, economically segregated, operationally lim-

ited microsystems...a nonsystem of care."

With facts and figures to back his statements, Mr. Halvorson spends a hefty portion of the book zeroing in on what he refers to as the "hard but useful truths" about health care in the United States. For example, costs are distributed unevenly: Just 1% of the U.S. population spends more than 35% of the health care dollars; 5% of the population spends 60%; and 10% spends nearly 70%, according to Kaiser Permanente data.

Another poignant truth extensively discussed in Mr. Halvorson's book: Five chronic diseases—and cases of co-morbidities, or the combination of two or more of the ailments—are responsible for a lion's share of health care costs at upwards of 70%. The diseases include asthma, diabetes, congestive

heart failure, coronary artery disease, and depression.

Problems arise when different doctors treating patients for different diseases fail to communicate with one another; instead, each

George Halvorson's approach is conversational and, at times, even funny.

caregiver tracks patients with illegible files and "silos" of paperwork and tests. The real risk in failing to link care? Increased problems with drug interactions and costly hospitalizations, according to Mr. Halvorson.

With each discussion of the problems facing U.S. health care Mr.

Halvorson offers a solution.

Mr. Halvorson's approach is conversational and, at times, even funny. For example, "It's called a computer," is his one-liner solution to the lack of health care best-practices data and provider performance records, which he sees as key to adopting a market approach to making health care more affordable and better for patients, especially those with costly co-morbidities.

One of Mr. Halvorson's key reform proposals is already being used at Kaiser: centralized electronic medical records. Under the current system, he says, patients' medical records are often handwritten and poorly organized.

While a completely computerized system, mandated at hospitals and among providers, could take more than a decade to implement, Mr.

See **BOOK REVIEW** page 16

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Business Insurance PERSPECTIVE

Ask a Risk Manager

Limit reputational risks with solid plan



This month's column on reputational risk is written by Christopher E. Mandel, assistant vp, enterprise risk management at USAA Group in San Antonio. He is the 2004 Risk Manager of the Year and is a past president of the Risk & Insurance Management Society Inc.

Q: How can risk managers effectively address the identification, assessment and measurement of reputational risk?

Like many other business or strategic risks to enterprises of all types, risk to reputation is one of the more amorphous and difficult to define, let alone address effectively.

Brand image, another way to label this risk, is critical to most companies, whether public or private. It is how your customers identify with you and what you offer them in the marketplace. It carries with it the whole weight of your market presence, and when adversely affected, it can significantly impact your revenues, profitability and/or net worth.

This issue has received heightened attention from boards and senior management as a result of significant losses occurring across a broad spectrum of industries in recent years. Brand image is considered by many to be a key source of competitive advantage and an asset of often incalculable worth. In extreme cases, reputational events can and have threatened companies' existence. In a few cases, companies have disappeared from the impacts of their crises, with Enron Corp. being a prime example.

Enron also exemplifies the reality that reputational risk is not a risk per se. It is, in fact, an endless list of risk events leading to reputational impacts that run the gamut from minor to company-ending. Therein is the challenge: You can only begin to manage reputational damage by understanding and mitigating the reputational risks.

Some of the more common examples of risk events that can impact a firm's reputation include:

information security failures; significant employee fraud events; malicious employee manipulation of customer information, especially that protected by privacy regulations; loss of key employees; major damage to physical infrastructure; exposure of unethical practices; failure to deliver products or services according to promised standards; failure to comply with regulatory standards; workforce issues; and environmental catastrophes, among others. Managing the reputational risk area requires effective identification, assessment and management of the underlying risks to reputation, all of which have financial consequences.

Another element of reputational risk management is to understand your company's key stakeholders, which are, of course, your customers. Indirectly, however, you must be concerned that what you do and how you do it impacts regulators, rating agencies, stock analysts, legislators, government agencies and the media.

Depending on the event, how each stakeholder is affected will be different. Nevertheless, a good reputational risk program includes responses customized to each of these stakeholders based on the type of events most likely to occur. For that assessment, your best source of information is looking at the events/losses that have occurred within the past few years in your industry.

In short, what has happened to your competition is part of your exposure profile. Effective mitigation requires new or more effective controls that your competitors may have lacked. The best single tool for managing the reputational risk area is a good comprehensive crisis man-

agement plan that is regularly tested for effectiveness. The common core components of this plan include: identifying the threats most likely to impact your firm; in the case of a product-related problem, developing criteria for determining whether a recall is in order and how to manage it; a plan for how suppliers will respond if they are the source of the event; a communications plan for messaging to both employees and external parties; and a training plan that enables executives and other key employees to respond effectively and quickly in the event of a crisis. More than any other two things,

Your best source of information is looking at the events/losses that have occurred within the past few years in your industry.

the speed and honesty with which you respond to an event will determine its ultimate impact on your brand and financial position.

To get ahead of the curve of brand-impacting events, the following capabilities are of utmost importance: a plan for quickly and accurately communicating with your customers and employees based on a philosophy of full disclosure as the facts are known, the ability to execute your crisis management plan effectively; effective coordination among and between key response functions, having the tools and well-practiced techniques at hand and in place should an event occur, and a strong leader assigned to lead the response,

which most often will be the chief executive officer.

Some preventive and/or mitigating elements of a good reputational risk management plan include: systematic tracking of reputational threats, established relationships with pressure groups and other likely critics, a thorough process for dealing with crisis events, standards set and promoted in human rights areas, standard publicity practices; enforced environmental policies; regular measurement and timely tracking (for trend shifts) of external perceptions of your firm, trained employees to identify and manage reputation threats, driving and reinforcing ethical behaviors throughout your firm, ensuring you have effective controls in governance, and compliance areas, monitoring both internal and external environments for threats to your brand.

There are plenty of obstacles to effectively managing this exposure, not least of which is the difficulty in quantifying and convincing others that it can be managed. However, many companies have learned the hard way that not trying is sure to lead to disastrous results. Having a plan will get you 90% of the way to containing this risk area.

Ask A Risk Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.

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

Book review: Health care problems, solutions examined

CONTINUED FROM PAGE 14

Halvorson provides a short-term solution: access to insurance records. Health insurance companies, Mr. Halvorson says, already have the details of every health procedure performed, medication prescribed, provider visited and why. Access to those records could help jump-start a drive to a system of electronic medical records.

Another solution proposed by Mr. Halvorson is the use of computerized medical records to track performance and mistakes by providers, who will as a result see an incentive for improving care.

Mr. Halvorson mentions Six Sigma, a trademarked, data-driven system designed to measure the error rates of any process, as a way to improve health care, and thus drives costs down by eliminating costly errors. He argues that system, used by General Electric and other manufacturers, could be used in the medical field to gradually track and improve treatments and care management for patients.

The five diseases at the heart of rising health care costs are also targeted heavily in Mr. Halvorson's book. He proposes ways to better track and provide interventions for patients, and he argues that follow-

ups to care and procedures is lacking and is key in improving the state of many sufferers of chronic illnesses.

On the issue of wider health care funding, Mr. Halvorson says that costs could be greatly reduced through a universal health care program that would greatly reduce the need for unpaid emergency room visits for the uninsured, particularly those suffering from chronic illnesses. The need for hospitals to provide uncompensated emergency services for the uninsured is often cited as a cause for increased health care costs generally. The costs of providing universal health care would be off-

set by the reduction or elimination of uncompensated care for the uninsured, he writes.

In addition, improving health care for those who suffer from costly chronic diseases would provide billions of dollars in savings, and would be "more than enough to fund total and universal health care coverage for the uninsured," he writes.

No simple feat, the book provides a wealth of information to help support proposed changes.

It sells itself as a primer for anyone wishing to better understand the nation's health care crisis and how to fix it.

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International NEWS

MOST COSTLY INSURED CATASTROPHES OF 2007

Losses in millions of dollars.

Date	Events	Country	INSURED LOSSES
1-18-07	Windstorm Kyrill	Europe	\$5,859
6-25-07	Rainfall, flooding (wave 1)	U.K.	\$2,597
7-20-07	Rainfall, flooding (wave 2)	U.K.	\$2,077
4-13-07	Storm, rainfall, flooding	U.S.	\$1,562
10-21-07	Witch urban forest fires in Calif.	U.S.	\$1,100
6-07-07	Storm flooding NSW	Australia	\$1,000

Source: Swiss Reinsurance Co.

Insured property losses hit \$25 billion in 2007

By JEFF CASALE

ZURICH, Switzerland—Catastrophes during 2007 led to an estimated \$61 billion in losses worldwide, with insured property losses totaling \$25 billion, according to a forthcoming Swiss Reinsurance Co.'s Sigma report.

While the second half of the year has been relatively quiet, Swiss Re's report shows that insured losses this year are \$9 billion higher than in 2006. Despite this, Zurich-based Swiss Re said this year's insured losses are below the long-term loss trend.

Earlier this year, Europe was "unusually" hard-hit by windstorms, most notably Kyrill, which caused flooding in the United Kingdom and large losses in Belgium, Germany and the Netherlands. The United Kingdom also was hit hard by heavy rains and flooding during the summer, Swiss Re said.

In North America, things weren't much different. A winter storm struck the East Coast in April, bringing heavy rainfall that resulted in flooding. In October, wildfires ravaged acre after acre in Southern California.

Property insurers paid out around \$22 billion for these events, Swiss Re said, adding that an additional \$2 billion was paid out as a result of "man-made" catastrophes. Those incidents include major industrial fires, explosions and aviation and spacecraft losses.

The report, "Natural and man-made catastrophes in 2007," is to be published next spring, Swiss Re said.



REUTERS

Workers cleaned up damage at a warehouse after windstorm Kyrill crossed Austria.

The preliminary numbers are the result of natural catastrophes in Europe and North America, with a bulk of the large insured losses in Europe taking place in the first half of the year.

U.K. shores up pension safety net

Infusion to Financial Assistance Scheme raises maximum payout

By JONATHAN GARDNER

LONDON—The U.K. government's plan to settle the claims of 140,000 retirees whose employer-sponsored pension plans became insolvent before 2005 won't significantly affect employers and may restore the public's trust in the country's pension system, experts say.

The plan, announced last week by the Department for Work and Pensions, would help fund the defined benefit pensions of those retirees by making a contribution of general taxpayer funds of £935 million (\$1.88 billion). That comes on top of £2 billion (\$4.03 billion) the government has already committed to the Financial Assistance Scheme, a safety-net program. In addition, the proposal calls for taking over £1.7 billion (\$3.42 billion) of plans' residual assets, which had been slated to be tapped for annuities.

The cash injection to the FAS will allow it to increase to £26,000 (\$52,447) per year the maximum a retiree can receive, the department said in statement. That sum represents up to 90% of retiree's accrued pension benefits.

Unions and worker advocates hailed the proposal, and pension consultants said the plan gives relief to the retirees without penalizing plans with secure funding.

"It closes the door on an unpleasant chapter," said Deborah Cooper, principal in London for New York-based Mercer L.L.C. Employers

"should feel quite comfortable as it stands at moment," she said.

The department's plan brings to a total of £2.9 billion (\$5.85 billion) in net present value the government's funding of the Financial Assistance Scheme, a program to aid retirees of companies that went bankrupt or began shutting down their pension funds because of underfunding before April 2005. At that time, the government set up the Pension Protection Fund, which is financed by a levy on defined

PENSION PROTECTION

Thanks to the U.K. government's infusion into the Financial Assistance Scheme, retirees whose pension plans became insolvent will be able to receive up to £26,000 (\$52,447) per year, or up to 90% of their accrued benefits.

benefit plans that is based on their levels of underfunding and risk of insolvency.

Benefits offered by the Financial Assistance Scheme have been smaller than those available under the Pension Protection Fund. As a result, Financial Assistance Scheme retirees sued the British government and won a judgment in January from the European Court of Justice, which said their compensation levels did not comply with European directives. While the court said the U.K. government was not obligated

to provide 100% compensation, it did put pressure on the government to improve benefits under the Financial Assistance Scheme, pension experts said.

A key part of the proposal is the takeover of plans' residual assets.

The 20 largest pension funds covered by the Financial Assistance Scheme held about half of the £1.7 billion in assets, most of that in government bonds and other fixed-interest instruments.

Had the funds been paid to employees in annuities, there would be little left for employees of smaller firms, the government concluded previously, leading it to suspend payment in April. In addition, the government determined that it could boost the value of those assets by managing them.

For current employer plans, the key impact of the proposal may be elimination of the "background noise" about retirees losing their pensions at the same time the United Kingdom moves toward a system of personal retirement accounts in 2012 (BI, May 29, 2006).

The bad news discourages workers from saving, even if nearly all retirees in pension plans received all they were promised, said Paul McGlone, principal in London with Chicago-based Aon Consulting. "Those half-percent (who didn't) make an awful lot of noise," he said. "Unless you have confidence, the whole personal accounts scheme is going to collapse."

Catlin securitizes quake, wind risks

By JUDY GREENWALD

HAMILTON, Bermuda—Catlin Insurance Co. Ltd. has obtained \$225 million of catastrophe coverage for three years under a swap agreement.

Under the terms of the transaction, Hamilton, Bermuda-based Catlin Insurance will receive fully collateralized protection totaling \$87.5 million to respond to a severe U.S. earthquake, as well as \$137.5 million that would be triggered by a severe U.S. hurricane, Catlin Group Ltd. said in a statement.

Newton Re, a Cayman Islands-based special-purpose reinsurer, has issued \$225 million in three-year principal at-risk variable rate notes in two classes—one for the quake risk and one for the hurricane risk—

to provide it with collateral under the risk transfer agreement, according to Catlin.

Catlin will recover under the swap agreement if earthquake or hurricane losses exceed a certain threshold. That will be determined by the application of a pre-determined formula based on insurance industry losses reported by the Jersey City, N.J.-based Property Claims Services division of the Insurance Services Office Inc., according to the statement.

Catlin Chief Executive Stephen Catlin said in a statement the transaction "provides Catlin with fixed-price protection for a three-year period, whilst mitigating the credit and dispute risks that are inherent in conventional reinsurance transactions."

Newark, Calif.-based Risk Management Solutions performed the risk analysis for the transaction. Aon Capital Markets, the investment banking group of Chicago-based Aon Corp., and New York-based J.P. Morgan Securities Inc. were joint lead placement agents.

The deal is not Catlin's first catastrophe swap agreement. In late 2006, Catlin Insurance entered into a catastrophe swap agreement with Bay Haven Ltd., another Cayman Islands-based special-purpose vehicle, that provided it with coverage of up to \$200.3 million during a three-year period (BI, Oct. 9, 2006).

It subsequently entered into additional catastrophe swap agreements to provide it with another \$56.5 million in coverage, said the company.

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Lexington enhances EPL offerings

NEW YORK—Lexington Insurance Co. has enhanced its employment practices liability insurance offerings to include E-Discovery Response, an endorsement designed to cover a policyholder's payroll expenses incurred while retrieving electronically stored information requested during discovery in a covered EPL claim.

Coverage with the E-Discovery Response endorsement will reimburse policyholders, subject to a sublimit, for payroll expenses, including payroll taxes and fringe benefits, that are incurred when information technology employees locate, extract, translate and/or restore electronically stored data to comply with a written discovery request in a covered claim.

Pursuant to underwriting approval, E-Discovery Response is available to qualified Lexington EPL policyholders, who can receive this coverage for no additional premium by endorsement to their existing EPL policy with Boston-based Lex-

ington, a unit of American International Group Inc.

For more information on E-Discovery Response or EPL insurance, contact Mark Ogilvie, product line manager, at 617-443-4644 or at mark.ogilvie@aig.com.

Liberty Mutual expands real estate line

BOSTON—Liberty Mutual Property, a unit of Boston-based Liberty Mutual Group, has expanded its industry-specific offerings with RM Custom Select Commercial Real Estate. The product features coverage enhancements designed to complement all-risk property coverage and meet the coverage requirements of midsize commercial real estate accounts.

The enhancement offers protections for tenant's improvements and betterments; canceled leases; soft costs and delays in opening; tenant emergency evacuation, relocation and move-back expenses; and real estate brokers' commissions.

The service component of RM Custom Select Commercial Real Estate includes a preloss claims consultation to review policy language and explain how the policy would respond in certain loss scenarios. It



also provides access to real estate-specific risk management guides and case studies written by Liberty Mutual Property's loss prevention consultants and claims adjusters.

For more information, e-mail property_info@libertymutual.com.

Watson Wyatt offers financial services tool

WASHINGTON—Watson Wyatt Worldwide is offering VIPtech, a financial and actuarial modeling tool, to financial services companies in the United States.

The tool allows users to model any aspect of their business, including complex reporting requirements, within the framework of a single, scalable and auditable model.

VIPtech's interface enables users to handle a wide range of financial analyses, including statutory valuations, product pricing, financial reporting, stochastic projections, business planning, asset liability management and evaluation of alternative risk management strategies.

For more information, visit www.watsonwyatt.com.

Chubb introduces excess D&O policy

WARREN, N.J.—Chubb Corp. has introduced Executive Elite, an excess directors and officers liability

policy that provides a dedicated limit of liability for directors and officers that is not shared with the corporation.

Executive Elite offers an endorsement called Director Protector, which can help protect independent directors and officers who serve on board committees, Chubb said.

The Director Protector endorsement allows companies to designate a portion of the policy limits to specific board committees. The policy does not exclude bodily injury and property damage, and offers expanded definitions of loss and claim, full severability for each insured person and fully non-repudiable coverage.

For more information, contact Tony Galban, senior vp and underwriting manager for directors and officers liability insurance, Chubb Specialty Insurance, at 908-903-4590 or at galbant@chubb.com.

Lexington increases bio-chem capacity

NEW YORK—Lexington Insurance Co. has increased the capacity of its BioChem Shield coverage from \$10 million to \$25 million. BioChem Shield is Lexington's coverage for property damage losses arising from terrorist attacks using biological or chemical weapons.

BioChemShield is an endorsement to Lexington's property insurance that is offered on most policies that provide cover for terrorism.

For more information, contact Rob Cruz, homeland security practice leader at 646-857-1436 or robert.cruz@aig.com, or Michael Fogarty, product line manager, at 646-857-1357 or michael.fogarty@aig.com.

Sedgwick introduces absence system

MEMPHIS, Tenn.—Sedgwick Claims Management Services Inc. has introduced the next generation of its total absence management system for the administration of incidental and casual absences, family medical leaves, and state-mandated and customized employee leave programs.

As part of Sedgwick's proprietary JURIS claims management information system, the enhanced TAMS module offers streamlined administration of absence programs and options for integrating the delivery of Family and Medical Leave Act, disability and workers compensation claims management services.

The enhanced TAMS module incorporates advances in workflow automation and document imaging capabilities intended to improve the accuracy and efficiency of absence management services. The system also reinforces regulatory compliance and supports claims professionals in dealing with complex and high-value cases.

Additionally, Sedgwick CMS says the flexible programming tools make it easy for it to offer customized features.

Sedgwick CMS has begun the phased migration of current absence management clients to its next-generation TAMS solution and will implement the facility for new clients beginning in January 2008.

For more information, go to www.sedgwickcms.com.



AIG updates U.S. Web site

NEW YORK—American International Group Inc. has launched its enhanced aig.com Web site. The revamped site has been designed to allow AIG's U.S.-based commercial clients and insurance brokers to quickly find information and enable simpler business transactions with AIG companies.

The site is now arranged so users can search 13 vertical market segments to access 169 products from AIG's U.S. commercial insurance operations. Additionally, aig.com enables insurance brokers to log onto the site to access several online tools, including click-and-bind technologies.

The enhanced version of the Web site is available to the company's U.S.-based commercial customers and brokers. AIG plans to redesign sites for other countries to add new features in the next few months.

Schinnerer launches environmental cover

CHEVY CHASE, Md.—Victor O. Schinnerer & Co. Inc. has launched an environmental coverage for businesses that may have environmental risks that are not obvious.

The program, which is offered on an admitted basis, is designed to protect commercial or industrial facilities with the potential of pollution-related issues. Under the terms of an agreement with Schinnerer, ACE USA will provide coverage through ACE American Insurance Co.

The program features pollution liability protection for gradual as well as sudden and accidental release of pollutants, which include claims for onsite remediation, and coverage for third-party bodily injury, property damage or remediation costs arising from pollution conditions that also emanate from the insured location. This also includes pollution that may be released during transportation and disposal of wastes or products.

Premiums start at \$5,000.

For more information on Premises Pollution Liability, go to: www.schinnerer.com/ezppl.html.

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Taking Stock

Celebrating the 12 Days of Bedlam

In past years, I have summarized my thoughts about the property/casualty industry via rhymes and letters. It was time again this year and I opted to work with a rhyme and the "12 Days of Christmas" fit the bill—except it popped out

as the "12 Days of Bedlam!" Why the title? Well, among the definitions in Webster's Dictionary for the word bedlam is "any insane asylum" or "any place of noise and confusion."

By Myron M. Picoult

On the first day of Bedlam,
this would be great news:
A state attorney general with intelligent
risk transfer reviews.

On the second day of Bedlam,
this would be great news:
Two proactive rating agencies,
And a state attorney general with intelligent
risk transfer reviews.

On the third day of Bedlam,
this would be great news:
Three industry spokesmen with
cautionary diatribes,
Two proactive rating agencies,
And a state attorney general with intelligent
risk transfer reviews.

On the fourth day of Bedlam,
this would be great news:
Four brokers with innovative profit sharing ideas,
Three industry spokesmen with cautionary diatribes,
Two proactive rating agencies,
And a state attorney general with intelligent
risk transfer reviews.

On the fifth day of Bedlam,
this would be great news:
Five incisive catastrophe modelers,
Four brokers with innovative profit sharing ideas,
Three industry spokesmen with cautionary diatribes,
Two proactive rating agencies,
And a state attorney general with intelligent
risk transfer reviews.

On the sixth day of Bedlam,
this would be great news:
Six fiscally responsible boards of directors,
Five incisive catastrophe modelers,
Four brokers with innovative profit sharing ideas,
Three industry spokesmen with cautionary diatribes,
Two proactive rating agencies,
And a state attorney general with intelligent
risk transfer reviews.

On the seventh day of Bedlam,
this would be great news:
Seven insurance regulators who conceive simpler rules,
Six fiscally responsible boards of directors,
Five incisive catastrophe modelers,
Four brokers with innovative profit sharing ideas,
Three industry spokesmen with cautionary diatribes,
Two proactive rating agencies,
And a state attorney general with intelligent
risk transfer reviews.

On the eighth day of Bedlam,
this would be great news:
Eight self-reflective senior insurance risk managers,
Seven insurance regulators who conceive simpler rules,

Six fiscally responsible boards of directors,
Five incisive catastrophe modelers,
Four brokers with innovative profit sharing ideas,
Three industry spokesmen with cautionary diatribes,
Two proactive rating agencies,
And a state attorney general with intelligent
risk transfer reviews.

On the ninth day of Bedlam,
this would be great news:
Nine customer service-oriented CEOs,
Eight self-reflective senior insurance risk managers,
Seven insurance regulators who conceive simpler rules,
Six fiscally responsible boards of directors,
Five incisive catastrophe modelers,
Four brokers with innovative profit sharing ideas,
Three industry spokesmen with cautionary diatribes,
Two proactive rating agencies,
And a state attorney general with intelligent
risk transfer reviews.

On the 10th day of Bedlam,
this would be great news:
Ten forward-thinking risk managers in their fields,
Nine customer service-oriented CEOs,
Eight self-reflective senior insurance risk managers,
Seven insurance regulators who conceive simpler rules,
Six fiscally responsible boards of directors,
Five incisive catastrophe modelers,
Four brokers with innovative profit sharing ideas,
Three industry spokesmen with cautionary diatribes,
Two proactive rating agencies,
And a state attorney general with intelligent
risk transfer reviews.

On the 11th day of Bedlam,
this would be great news:
Eleven actuaries setting realistic pricing,
Ten forward-thinking risk managers in their fields,
Nine customer service-oriented CEOs,
Eight self-reflective senior insurance risk managers,
Seven insurance regulators who conceive simpler rules,
Six fiscally responsible boards of directors,
Five incisive catastrophe modelers,
Four brokers with innovative profit sharing ideas,
Three industry spokesmen with cautionary diatribes,
Two proactive rating agencies,
And a state attorney general with intelligent
risk transfer reviews.

On the 12th day of Bedlam,
this would be great news:
Twelve bottom line-oriented marketing gurus,
Eleven actuaries setting realistic pricing,
Ten forward-thinking risk managers in their fields,
Nine customer service-oriented CEOs,
Eight self-reflective senior insurance risk managers,
Seven insurance regulators who conceive simpler rules,
Six fiscally responsible boards of directors,
Five incisive catastrophe modelers,
Four brokers with innovative profit sharing ideas,
Three industry spokesmen with cautionary diatribes,
Two proactive rating agencies,
And a state attorney general with intelligent
risk transfer reviews.



Myron M. Picoult is an independent insurance consultant. An archive of Mr. Picoult's columns is available online at www.businessinsurance.com. He can be reached at mpicoult@aol.com.

EEOC: May boost scrutiny of employment screening

CONTINUED FROM PAGE 4

expands it, say observers.

"It is useful in the sense that they have summarized and laid out existing, basic legal principles associated with testing, but I don't see they've broken any new ground or given any additional guidance," said Fred W. Alvarez, an employer attorney with Wilson Sonsini Goodrich & Rosati P.C. in Palo Alto, Calif.

Some attorneys say the publication of the fact sheet signals intensified EEOC interest in the area, and that it is likely to lead to increased litigation.

Adam T. Klein, a plaintiff attorney with Outten & Golden L.L.P. in New York, said the fact sheet offers "a road map to employers on what the EEOC is looking at, and I would be sure that this will be the focus of additional litigation by the EEOC and by private counsel."

John F. Lomax Jr., an employer

attorney with Greenberg Traurig L.L.P. in Phoenix, said it is a fair assessment that because the EEOC has noticed a trend in this area "and devoted some time to promulgating this, they're going to look more closely for charges that involve employment testing or selection procedures, and it may signal a willingness or desire on the agency's part to initiate more enforcement actions in this area."

"But it's also a signal to employers that you may need to be reminded of what the standards have been for employment testing and selection procedures for a number of years," Mr. Lomax said.

However, Cyrus Mehri, an attorney with Mehri & Skalet P.L.L.C. in Washington, said, "I can't really say there would be more litigation because if anything, it's a somewhat dormant area, and there's not a lot of evidence to say there's been a big change in that."

Pensions: Nova Scotia revises wind-up funding

CONTINUED FROM PAGE 4

The amendment aligns Nova Scotia's pension statute with provinces such as Ontario, Alberta and British Columbia that already require employers to fully fund plan deficits upon termination.

Complying with the amendment, though, could be costly for Nova Scotia employers with generous early retirement provisions because of the "grow-in" provisions of the province's pension law, observers say. Grow-in rights entitle certain employees of wound-up plans to any early retirement benefits for which they would have been eligible had the plan and their employment continued.

Ontario and Nova Scotia currently are the only Canadian jurisdictions with grow-in rights.

"That's the first thing that's problematic for Nova Scotia employers," said Doug Brake, principal and actuary for Mercer L.L.C. in Halifax. "They're held to a higher standard than anyone else."

In 2004, Nova Scotia removed a requirement to prefund grow-in benefits to relieve financial stress on employers, but the recent amendment essentially reverses that change for employers winding up plans. "The employer would be required to fund the grow-in benefits as well," Ms. MacNeill Smith said.

Employers and consultants are concerned that the changes could accelerate the deterioration of defined benefit plan coverage in the province. The number of defined benefit plans with Nova Scotia members declined 20% from 1996 to 2005 while the number of defined contribution plans increased by 6.7%, according to the

superintendent's annual report.

"For any company looking to set up shop in Nova Scotia that has a defined benefit plan, (the amended law) would certainly send a chill down a company's spine," said Leanne Hachey, vp, Atlantic Canada in Halifax, Nova Scotia, for the Canadian Federation of Independent Business, which represents more than 100,000 small to midsize employers across Canada.

Employers are unlikely to wind up pension plans in light of the amendment, although some may consider the option out of concern that their deficits will continue to grow and future wind-ups will be unaffordable, Mr. Brake said. "For private-sector employers, this will be one more burden that will cause them to rethink having a defined benefit plan," he said.

The amendment, meanwhile, was "premature" given that Nova Scotia recently announced a review of its pension legislation, Mr. Brake said. "I welcome the Nova Scotia review. I think it's well-timed," he said.

Model-law efforts continue

In addition, Toronto-based Canadian Assn. of Pension Supervisory Authorities, the coalition of federal and provincial pension regulators, continues to develop a model pension law to streamline pension regulation across Canada. "The potential is there and the timing is quite good in getting a lot of movement toward that commonality," Ms. MacNeill Smith said.

The process should be completed next year, although widespread disagreement still exists on pension issues such as grow-in rights that will be addressed during the provincial review, she said.

Pitfalls abound in testing prospects' job qualifications and suitability

By JUDY GREENWALD

WASHINGTON—Testing current or prospective employees presents employers with a daunting challenge, say observers.

The tests must strive to objectively evaluate whether the applicant has the required skills to do the job, yet must avoid testing for factors that could inadvertently favor one group over another, and thus violate the law.

For example, a test can appear neutral and non-discriminatory "in any way shape or form," but still be one in which men score substantially higher than women and therefore have a disparate impact, said Eric Donleavy, a psychologist and senior consultant with DCI Consulting Group Inc. in Washington.

Strength tests, for example, tend to exclude female applicants disproportionately, said Francis P. Alvarez, an employment attorney with Jackson Lewis L.L.P. in White Plains, N.Y. "You have to establish validity" under the Equal Employment Opportunity Commission's Uniform Guidelines on Employment Selection Procedures, he said.

Employers are "sort of caught between the rock and the hard place," said Fred W. Alvarez, an employer attorney with Wilson Sonsini Goodrich & Rosati P.C. in Palo Alto, Calif. They "want to select the best-qualified people for

their jobs, and they often think about doing testing as an objective way to find people," but the guidelines in this area "are very difficult to meet," he said.

Observers warn that employers may put themselves in dangerous territory by testing intangible qualities.

In court, it is a "lot easier to defend" tests of tangible skills, such as typing, than tests that try to measure imagination and initiative, Mr. Alvarez said.

Credit history-based hiring

Adam T. Klein, a plaintiff attorney with Outten & Golden L.L.P. in New York, said one "substantial issue" in this area is the "significant number" of employers that use credit history or scores to determine employment, when there is "little, if any, evidence that supports the idea" that such scores relate to "job performance or a propensity to steal or any other characteristic an employer would want to look at when considering whether to hire somebody." Mr. Klein said he is representing several clients who were denied employment on this basis.

He said other problematic areas include English proficiency tests, criminal background checks, personality tests and medical inquiries, "many of which have a substantial impact on protected groups, and because of that, employers need to

be very concerned or very cautious if they use it and for what purpose."

Companies doing medical testing "tend to get tripped up" by the Americans with Disabilities Act, said Jonathan T. Hyman, an employer attorney with Kohrman Jackson & Krantz P.L.L. in Cleveland. Standards differ depending upon whether someone is an applicant, has been offered the job or has already started working, he said. For instance, employers cannot ask job applicants to undergo medical exams; once an employee has started working, only exams that are "job related and consistent with medical necessity" can be required, he said.

John F. Lomax Jr., an employer attorney with Greenberg Traurig L.L.P. in Phoenix, said another pitfall is that if employers "adopt a screening mechanism or some type of cognitive test, they tend to use it for long periods of time," sometimes decades, without giving it any additional thought. "They probably should occasionally visit whether that test...is still related to the jobs that it's being used for" and whether its use may create a discriminatory impact.

"Also, you want to have some idea that the test has been validated at some level by testing professionals, that it truly uncovers or yields the result that you're hoping for," said Mr. Lomax.

Court OKs chronic pain evaluations

By GLORIA GONZALEZ

HALIFAX, Nova Scotia—Nova Scotia employers will not pay higher rates for workers compensation coverage even though chronic pain claims are expected to increase given a recent court ruling, a workers comp spokeswoman says.

And the cost of complying with the ruling will expand an already substantial deficit in the province's workers comp system.

In *Philip Cohen vs. Nova Scotia (Workers' Compensation Board)*, the Nova Scotia Court of Appeal ruled that a worker who developed chronic pain before April 17, 1985, is entitled to have his case reviewed to determine if he is eligible for workers comp benefits.

The ruling revolved around interpretation of legislation and policy developed in response to a 2003 Supreme Court of Canada ruling in *Nova Scotia (Workers' Compensation Board) vs. Donald Martin* that struck down limitations on comp benefits for chronic-pain claims (*BI*, May 24, 2004).

The Supreme Court case was based on equality provisions, which went into effect on April 17, 1985, of the Canadian Charter of Rights and Freedoms. In response, Nova Scotia's workers comp statute was amended to specify that a worker is entitled to an assessment to deter-

mine benefit eligibility if medical evidence established that the employee had chronic pain on or after that date.

The WCB's policy, though, specified that a worker had to develop the chronic pain after that date. A case manager denied Mr. Cohen's claim since his chronic pain developed before April 17, 1985. He appealed and the Nova Scotia Court of Appeal ruled earlier this month that workers injured before that date are eligible to be assessed for chronic pain benefits.

About 1,400 people have contacted the WCB saying they were injured before that date and asked to be assessed for chronic pain benefits, a WCB spokeswoman said. The court ruling "doesn't mean they're going to receive benefits," she said. "It just means they're eligible to be assessed."

Canadian workers comp coverage is provided largely by provincial workers comp boards and financed by employer-paid premiums. Nova Scotia employers pay the second-highest premiums among the provinces, with an average rate of \$2.65 Canadian (\$2.60) per \$100 Canadian (\$98.32) of insurable earnings.

Nova Scotia's workers comp system has a deficit of \$390 million Canadian (\$383.4 million), partly due to the \$197 million Canadian

(\$193.7 million) in claim costs arising from the Supreme Court decision that led the board to raise rates by 8 cents per \$100 Canadian in 2005.

The recent decision likely will result in an additional \$12 million Canadian (\$11.8 million) for chronic pain claims before 1985, but the board decided it will not raise rates to pay for those claims, the spokeswoman said.

While employers had hoped for a reduction in rates before the ruling, "It looks like (the rates) are not going down anytime soon because we have a huge unfunded liability and we keep adding to it," said Leanne Hachey, vp, Atlantic Canada in Halifax for the Canadian Federation of Independent Business, which represents more than 100,000 employers.

The more the WCB pays for the additional claims, though, the less that will be available for increased benefits for employees or rate reductions for employers, the WCB spokeswoman said.

These court decisions place the sustainability of the workers comp system in jeopardy because they drive the system deeper into debt, observers say.

Philip Cohen vs. Nova Scotia (Workers' Compensation Board), 2007 NSCA 118; Dec. 12, 2007

Reform: Affordability an issue for California health care proposal

CONTINUED FROM PAGE 3

ence is that key components of the California bill—the employer health care coverage spending requirements, the increase in the cigarette tax and fees paid by hospitals to support increases in provider reimbursement from the state's Medicaid program—would also have to be approved by voters before becoming law.

The financing mechanism for the plan was omitted from the bill because it lacks the two-thirds majority vote that is necessary for tax increases under the state's constitution, a spokesman for Speaker Núñez said.

Even though a Senate vote has been postponed until mid-January, lawmakers have already begun draft-

ing the ballot initiative. To get on the Nov. 4, 2008, ballot, an initiative has to qualify by June 26, 2008. The time it takes to gather enough signatures to qualify averages roughly three and a half months.

Senate President Pro Tem Don Perata, D-San Francisco, delayed the vote until after lawmakers can review an analysis of the bill's fiscal impact. He requested the analysis out of concern that the financially strapped state could not afford it. The reforms are projected to cost \$14.4 billion, roughly the size of the deficit the state is facing going into 2008. The governor says that the health care overhaul is "self-financing" and will not adversely affect the state's general fund.

While several members of the employer, labor and hospital com-

munities, as well as several health insurers, stood beside the governor and Speaker Núñez to show their support when the passage of the reforms was announced, the measure's future is uncertain.

In fact, several of the organizations that had opposed either the individual and employer mandates, or both, either are maintaining those positions or reserving judgment until after they read the ballot initiative, which is expected to be released this week.

"There are a lot of questions," said Kevin Westlye, executive director of the Golden Gate Restaurant Assn., which is challenging a San Francisco ordinance that would require businesses operating in the city to provide health care coverage to their workers.

"It flies in the face of the intent of ERISA," he said, referring to the federal Employee Retirement Income Security Act, which preempts state laws that relate to employee benefit plans.

The National Federation of Independent Business's California chapter "is gravely disappointed that the Assembly irresponsibly passed a bill creating a state health care bureaucracy, with no funding, during a major budget crisis," said John Kabateck, executive director of the Sacramento-based organization.

"The individual mandate still may be a sticking point," said a spokeswoman for the California Labor Federation. Three of the organization's more than 20 members have come out in direct support of the measure and among those often represented at the governor's press conferences are the Service Employees International Union, the American Federation of State, County and Municipal Employees and the California Conference of Carpenters.

"Affordability is still an issue," the labor spokeswoman said. "We haven't seen a cap on what insurers can charge."

The Los Angeles Chamber of Commerce, which previously broke ranks with the California Chamber of Commerce by supporting an employer mandate, "is still looking it over," a spokeswoman said. "We have no position yet."

"We're still waiting for the initiative language," said a spokeswoman for the state Chamber. "We're reserving judgment until then. Basically, it's half a proposal at this stage."

The Sacramento-based California Manufacturers Assn. also has taken no official positions on the bill, but is generally opposed to employer mandates, a spokesman said.

Although the plan is being touted as bipartisan because it has the support of both the Republican governor and most of the Legislature's Democrats, Assembly Republican Leader Mike Villines of Fresno called

it "a back-room deal that will make health care more expensive for everyone."

"This is a flawed plan that will impose billions in higher taxes and spending, and I am disappointed that Democrats would rush this through rather than work with Republicans to craft fiscally responsible reforms," he said in a statement.

Even though the bill has a long way to go even before it reaches voters, employers should keep an eye on the measure's progress, benefits experts warn.

"This doesn't look like an initiative that would cause a multistate employer to start to panic," said Kirby Bosley, a consultant at Watson Wyatt Worldwide in Los Angeles. "But I would say most employers nationally are on reasonably high alert now, whereas six months ago that was less so."

Ms. Bosley added that because the measure that passed the Assembly does not contain an employer mandate "there is no ERISA challenge opportunity."

And even if the reforms become law, the bill contains a provision repealing the entire measure should any part of it be deemed invalid by a court.

Moreover, "employers have reason to be skeptical that this will go forward regardless of ERISA. The cost of the program matches the projected budget deficit, and other proposed budget cuts could even affect existing health care programs in the state," Ms. Bosley said.

The tobacco industry also is likely to challenge the source of funding that pertains to it, as it did the in 2006 when the state attempted to raise tobacco excise taxes via ballot initiative.

"We don't think funding an expanding program with a declining revenue source makes sense," said a spokesman for Philip Morris USA. He said that cigarette sales have been declining by 2% each year for the past 10 years.

Aon: To exit underwriting business

CONTINUED FROM PAGE 1

stronger statement to the commitment we have to continuing to take what we believe is a very unique platform and making it stronger."

Over the past 30 months, Mr. Case said, Aon has invested roughly half a billion dollars in building the brokerage with acquisitions, recruiting people and adding capabilities and it has no plans of stopping.

"The buyback signals (our board's) faith in the firm and what we're trying to accomplish," Mr. Case said. "It also signals we are going to continue to be in growth mode." He said that Aon has little debt and had a strong cash position even before the sale.

For ACE and Munich Re, the underwriting operations will further diversify the organizations, executives there said.

"The acquisition (of Combined) essentially doubles our already significant personal accident and health insurance franchise, which has been and remains an area of focus for our company," said Evan G. Greenberg, chairman and CEO of Bermuda-based ACE.

ACE plans to export Glenview, Ill.-based Combined's franchise to developing markets in Latin America, Asia-Pacific and other promising regions where ACE has an established presence and where a growing middle class presents favorable conditions, the company said.

For Munich Re, the addition of

Bellingham, Wash.-based Sterling Life, which provides health insurance products to the Medicare market, furthers growth of its health insurance business, executives said.

"Sterling gives us an important platform with an excellent reputation to gain access to the fast-growing senior markets in the U.S., and to leverage our existing business," Peter Choueiri, a member of Munich Re's International Health Board, said in a statement.

Analysts say the deals make sense for all parties involved.

"While the dilution of earnings is greater than we initially anticipated, we continue to believe this was the right move for Aon," David Small, an analyst with Bear, Stearns & Co. Inc., said in a note to investors. "Management can now spend more time focusing on its core business, where it is showing increasing momentum. Additionally, this gives Aon greater capital flexibility as they no longer need to be as focused on maintaining an investment-grade rating, something that was critical while they had an insurance underwriting subsidiary."

"For a long time, Combined was great for this company," said Cliff Gallant, an analyst with Keefe, Bruyette & Woods Inc. in New York. "It was a cash cow and a stable source of earnings. But I don't think they need that anymore. They've sort of outgrown their need for the company."

Mr. Gallant, who described the divestiture as "a good deal," noted that Aon "clearly beat expectations" on Combined's purchase price. "We were expecting a sale price of \$2.3 billion on the piece sold to ACE and they got \$2.4 billion."

Mr. Small also said the \$2.75 billion purchase price for the units surpassed his estimate of between \$2.0 and \$2.5 billion.

He also said that Combined is a "good strategic fit" for ACE. Not only will it double the size of ACE's successful accident and health franchise and provide a "solid platform" for further international expansion, it also "should lower ACE's earnings volatility through the P/C cycle," he wrote.

DIVESTITURE COMPLETE

It took more than six years, but Chicago-based Aon Corp. has achieved its goal of fully divesting itself from insurance underwriting.

APRIL 2001: Aon announces it plans to spin off to its shareholders Combined Specialty Corp., a new holding company under which it organized all of its underwriting operations that include Combined Insurance Co. of America, Aon Warranty Group Inc., Virginia Surety Co. Inc. and London General Insurance Co. Ltd.

OCTOBER 2002: Citing difficult market conditions, Aon scraps the spinoff and instead opts to sell all or part of its underwriting operations.

NOVEMBER 2002: Aon sells Sheffield Insurance Corp., a small excess and surplus lines insurer, to AXIS Specialty Ltd.

NOVEMBER 2005: Aon announces it is exploring strategic alternatives for its warranty, credit insurance and property/casualty underwriting businesses. Combined Insurance Co. of America is excluded from consideration.

JUNE 2006: Aon sells Aon Warranty, including Virginia Surety and London General, to an affiliate of Toronto-based investment firm Onex Corp. for \$800 million Canadian (\$710 million).

OCTOBER 2006: Aon sells managing general underwriting unit Construction Program Group to Old Republic Insurance Co. for \$85 million.

FOURTH QUARTER 2006: Aon places all of its remaining P/C underwriting business into runoff.

JULY 2007: Aon announces it is exploring strategic alternatives for CICA and its subsidiaries, including Sterling Life Insurance Co.

DECEMBER 2007: Aon signs a definitive agreement to sell CICA to ACE Ltd. for \$2.4 billion and Sterling Life to Munich Re Group for \$352 million.

ACE said it will finance the \$2.4 billion deal with cash and a "modest amount of new debt."

Funding to go before voters

SACRAMENTO, Calif.—Similar to reforms passed last year in Massachusetts, the California health care coverage proposal would require residents to enroll in a health plan by July 1, 2010, with the cost for lower-income individuals offset through state subsidies and tax credits.

To ensure access to coverage, the California plan also would bar insurers from denying coverage to anyone regardless of age or medical history, and mandate that health plans spend at least 85 cents of every premium dollar on patient care.

In addition to employer contributions, which would be assessed on a sliding scale ranging from 1% for the smallest businesses to 6.5% for the

largest employers, other funding issues that would go before voters in November 2008 include: a 4% tax on hospital revenues; an increase in the state excise cigarette tax, from 87 cents per pack currently to as much as \$2.87; and other potential sources of revenue to provide the premium subsidies for qualifying individuals.

An additional \$4.6 billion in funding is expected to come from federal government matching funds for the state's Medicaid program, which is known as Medi-Cal. The measure also seeks a Medicaid waiver to allow the state to provide coverage to childless adults, said a spokesman for Assembly Speaker Fabian Núñez, D-Los Angeles.

—By Joanne Wojcik

ADVERTISER

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News
In Brief

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Information Institute. Analysts in the annual "Earlybird Forecast" projected on average that premiums would decline 0.3% in 2008. The analysts projected a deterioration in the industry's 2008 combined ratio, rising to 97.3% from an estimated 93.8% this year.

SCHIP extension bill
won't hit employers

Congress has passed a bill to reauthorize the government health insurance program for uninsured children. The House and Senate last week agreed to extend funding through March 31, 2009, for the State Children's Health Insurance Program—a joint federal-state program that provides health care for children in families with income above Medicaid-eligibility thresholds. Provisions from earlier bills seeking to expand the program, which would have affected employers, were not included in the extension measure.

William Gallagher
settles fees probe

William Gallagher Associates Insurance Brokers Inc. has agreed to pay \$4 million to settle charges leveled by Massachusetts Attorney General Martha Coakley over its compensation and other business practices. The suit alleges that the Boston-based broker billed clients undisclosed and unauthorized fees that exceeded customers' insurance premiums by 20% to 100%, and that it double-billed certain customers by charging brokerage fees while simultaneously charging undisclosed standard commissions. The judgment also requires WGA to send statements to more than 700 clients to correct prior allegedly false representations the broker made regarding its employees' knowledge of contingent commissions and its participation in reinsurance. Going forward, WGA also has agreed to provide enhanced compensation disclosures to customers. WGA noted that all the energy group employees implicated in the matter left the firm in early 2005.

Noted

Lloyd's of London said last week that Wendy Baker, president of Lloyd's America Inc., will leave the organization at the end of the year, after serving nine years as president....Allied World Assurance Co. Holdings Ltd. is paying \$563.4 million to buy back the 19.4% of its outstanding stock held by founding shareholder American International Group Inc. Founders of publicly held AWAC that remain large shareholders include Chubb Corp. and affiliates of Goldman Sachs & Co....The Risk & Insurance Management Society Inc. has made a \$300,000 contribution to the Spencer Educational Foundation Inc.

Cherkasky: Out as leader of MMC

CONTINUED FROM PAGE 1

former Marsh employee, to head the brokerage. (BI, Dec. 10).

In a statement announcing its search for a new chief for the parent company, the MMC board said it had "determined that a change in leadership will best enable MMC to move forward and enhance shareholder value. Mr. Cherkasky will continue to serve as MMC's CEO while the search is conducted."

The move followed disappointing financial results. "MMC's financial performance in 2007 has fallen far short of our expectations," said Stephen R. Hardis, nonexecutive chairman of the MMC Board, in the same statement. "The board has taken this performance into account, and listened to concerns raised by some of the company's largest shareholders in recent quarters, in making this change."

In addition, Mr. Hardis said, the board will "evaluate strategies to enhance shareholder value, including optimizing the company's capital structure, reviewing its mix of businesses and improving operating performance, particularly at Marsh."

Mr. Cherkasky, a former prosecutor, was named CEO of MMC in 2004 after then-New York Attorney General Eliot Spitzer pushed MMC's board to remove Jeffrey Greenberg. At the time, Marsh's survival appeared less than certain.

In the announcement, Mr. Hardis praised Mr. Cherkasky for leading the brokerage through a difficult time, going so far as to say that "MMC is a venerable institution that might not be here today were it not for Mike Cherkasky."

Analysts welcomed the move. "I don't think it's a surprise," said Keith F. Walsh, an analyst with Citigroup Research in New York. MMC's

performance has been "significantly below expectations," from what the company seemed to indicate a year ago. While there were signs of improvement then, "the level of deterioration we saw in 2007 was very surprising to many people," he said.

Mr. Walsh said last week's move "brings everything full circle."

"To be fair, Mike Cherkasky did an outstanding job in October 2004," said Mr. Walsh. "He came in to a company that was in significant regulatory distress," and he "did a great job brokering an agreement" with Mr. Spitzer but "after that part of the job was done, I don't know he was the right person to lead that company. It's not a knock on him—it just that his expertise lies in other areas. I think what they needed was a brokerage person."

"The key hire was bringing Glaser in," said Mr. Walsh. MMC is a collection of three companies—Marsh Inc., Mercer L.L.C. and Kroll Inc.—but "Marsh is the real leverage point to the story. If you fix Marsh, you fix the stock," he said.

But "this is not an overnight fix; it takes a while to lay the groundwork here," Mr. Walsh said. Marsh needs to get more money for the services it provides while keeping a tight lid on expenses, he said.

The wording of the announcement may indicate a breakup of the company, said another analyst.

"I think the market seems to have focused on the range of strategic alternatives language in the (Marsh statement) as something that might signal a potential breakup of the company as something of value for shareholders," said Bill Bergman, an equity analyst with Morningstar in Chicago.

But "the company is more valuable in its current structure and the mix of businesses that exist; particu-

larly if they work better together down the road," Mr. Bergman said.

Citigroup's Mr. Walsh said that while immediate spin-offs may not occur, if they do, Kroll could be a likely candidate. Kroll, a security consulting business, never really fit with the rest of MMC, but had been headed by Mr. Cherkasky before he assumed MMC's top job. Absent Mr. Cherkasky, "maybe they'll take a second look at that now," he said.

"In addition to replacing Mr. Cherkasky, it appears the board will also review MMC's conglomerate strategy," David Small, an analyst with Bear Stearns, said in a note to investors. "Many investors have hoped that MMC would sell pieces of its consulting division that have few synergies with its core brokerage business in order to maximize shareholder value. We believe this review will also be viewed positively by the street."

Mr. Small raised a question about the timing of the move, though.

"In our view, Mr. Cherkasky should have been let go when Mr. Storms was let go, as it was clear then that his plan was not working," he wrote. "To allow Mr. Cherkasky to choose a new CEO of Marsh was a mistake, in our view, as it should have been one of the most important decisions of a new MMC CEO." And a new CEO of MMC may have other ideas about who should lead Marsh, he said.

"We wonder if, in order to find the high caliber CEO that is necessary to fix this organization, that MMC's board will have to allow the CEO to hand select a new leader for the overall Marsh business. This situation should lead to continued uncertainty within the organization and we don't expect operating results to improve over the next two quarters," Mr. Small said.

TRIA: Backstop extended for seven years

CONTINUED FROM PAGE 1

tional terrorism exclusions popping up in policies on Jan. 1, 2008, had the backstop expired. For many risk managers, extending the program was their greatest concern of 2007.

"This was my biggest issue and I'm very pleased that it passed," said Terry Fleming, director-division of risk management for Montgomery County, Md. in Rockville.

"This is an ideal holiday gift for policyholders. With a seven-year term, we have come a long way from what many legislators had envisioned in 2002 to be short term and temporary fix to an insurance market failure," said Bradley R. Wood, senior vp-risk management for Marriott International Inc. in Bethesda, Md. "We have always respectfully disagreed with the idea that private insurance markets can ever fully manage this risk based on the indiscriminate and catastrophic nature of terrorism."

Laurie Findley, vp-risk management for commercial real estate investment firm Transwestern Investment Co. in Chicago, also hailed the extension. "It's critical

it's there; it's critical for people in the real estate industry; it's critical from our lenders' perspective," she said.

The New York-based Risk & Insurance Management Society Inc. hailed the move.

"RIMS views the willingness of the House and Senate to work together to extend the TRIA program as one of the highlights of this legislative year," said RIMS President Janice Ochenkowski, who is also managing director of Jones Lang LaSalle in Chicago.

Risk managers were not the only ones pleased with last week's vote. Every major insurer group had pushed for extension. Brokers were particularly pleased with the results.

"It's absolutely a wonderful development. And the fact that the feds finally removed that ludicrous distinction between domestic and foreign-inspired acts will effectively allow the real estate business to move forward and have lenders and insureds be satisfied until a permanent solution can be developed," said Alexandra Glickman, area vice chairman for Arthur J. Gallagher Risk Management Services in Glen-

dale, Calif.

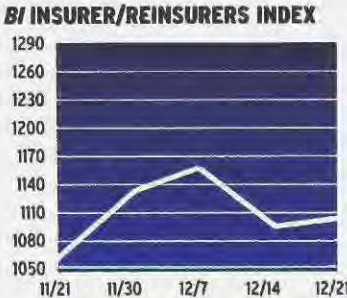
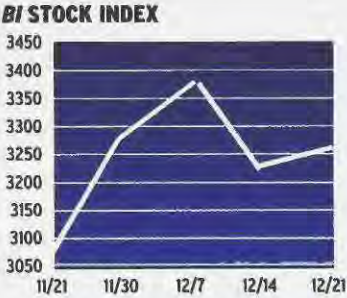
She said it would have been great to have a requirement that insurers offer coverage of nuclear, chemical, biological and radiological terrorist acts, "but realistically, lenders thus far have not required it and I'm always concerned when the proverbial Christmas tree gets over-decorated. For now, this is a solution that meets everyone's expectations, particularly with our clients in the real estate and hospitality sectors."

"We're thrilled with the outcome," said Joel Wood, senior vp with the Washington-based Council of Insurance Agents & Brokers. "The most important feature is its longevity—not only because of the political relief that it provides for an extended period time, but development projects are almost always long-term. From a policyholder standpoint, this will assure that financing is going to be available for many major developments, and that's not just commercial real estate."

He said a variety of other industries—entertainment, travel and utilities among them—depended on the backstop's continuation.

Stock
Index

[12/17 - 12/21]



Percentage change of BI Stock Index vs. key indicators

BI STOCK INDEX	3254.95	1.68%
DOW JONES	13454.65	0.83%
S&P 500	1484.46	1.67%

LARGEST GAINS

Ambac Financial Group Inc.	16.88%
PMA Capital Corp.	11.52%
Unitrin Inc.	11.23%
EMC Insurance Group Inc.	10.51%
Zenith National	9.55%

LARGEST LOSSES

MBIA Inc.	-27.43%
Berkshire Hathaway Inc.	-6.29%
Allmerica Financial Corp.	-4.69%
XL Capital Ltd.	-4.38%
Gainsco Inc.	-4.10%

Source: Financial Content Inc.
http://financialcontent.com

Business Insurance END PAGE

NEW YEAR'S RESOLUTIONS

1. lose weight
2. exercise
3. drink more water
4. quit smoking
5. earlier to bed

drink less CC credit card

Resolutions made to be broken?

The three most common New Year's resolutions among U.S. residents during 2007 were closely tied to health and wellness, according to a survey sponsored by Philadelphia-based CIGNA Corp.

Fifty-one percent of the nation's residents vowed to lose weight, exercise more or stop smoking this year.

Seven in 10 said they made New Year's resolutions in 2007, according to the survey of 1,000 people. Of the 28% who resolved to lose weight, the 12% who vowed to exercise more and the 11% who pledged to stop smoking, the joggers and the quitters had more success than the dieters.

More than half of the survey participants said they stuck to their New Year's resolution. Still, nearly one-third stuck to their resolution less for than three months.

Those who told others about their pledge or checked their progress regularly had greater success.

The survey also found regional differences. Some 55% of Southerners were at least somewhat successful in making and sticking to their resolutions, while 41% of Westerners "didn't bother" to make a New Year's pledge.

Contributing: Jeff Casale, Roberto Cenicerio, Judy Greenwald, Kristin Gunderson Hunt



Teen pop sensation Miley Cyrus performed at the first event held at the Hartford Civic Center after it was renamed the XL Center.

LANDOV

The Hartford Civic Center is NOW



Hannah Montana debuts XL venue

XL Insurance last week shared the spotlight at a soldout concert with "Hannah Montana" star Miley Cyrus.

The Bermuda-based global insurance unit of XL Capital Ltd. purchased the naming rights of the Hartford Civic Center, signing a six-year agreement with Northland AEG L.L.C., the management group overseeing the Connecticut venue.

Northland described the accord as a "seven-figure agreement."

The Best of Both Worlds Tour by Ms. Cyrus, the pop singer-entertainer who stars in the popular TV show, was the first event held at the renamed XL Center.

The insurer has put its moniker on the 32-year-old venue that includes the 16,500 seat Veterans Memorial Coliseum and an exhibition hall. It is home to the American Hockey League's Hartford Wolf Pack and the men's and women's basketball teams at the University of Connecticut. The venue also hosts concerts, trade conferences and even the circus.

XL already had a presence in Connecticut, with an office in Hartford and its reinsurance unit based in Stamford. While XL may not be as well-known as other Hartford-based insurers such as Aetna, The Hartford or CIGNA, putting the XL Insurance brand on the venue is intended to provide greater exposure for the insurer.

"Hartford is considered the city where the U.S. insurance industry began and remains a very influential business center in our industry today," John Glancy, chief underwriting officer of XL Insurance's Hartford-based global professional unit, said in a statement. "The city offers us a strategically central location in the Northeast to conduct our worldwide business and gives us access to a talented, educated workforce."

Elvis has left the Ohio BWC

It's an unusual day when a bourbon-filled figurine of Elvis, a lock of Marilyn Monroe's hair and a Dr. Seuss book intersect with the workers compensation world.

But it happened last week when the Ohio Bureau of Workers' Compensation disclosed that the items were among thousands of memorabilia pieces sold to Illinois-based Mastro Auctions Inc. to help recoup funds lost in the so-called "Coingate" scandal.

The case involved Republican fundraiser Tom Noe, who managed an unorthodox \$50 million rare-coin investment for the bureau and now is serving a 27-month federal sentence for illegally funneling money to President Bush's campaign in 2003.

He was also sentenced to state prison for charges related to the disappearance of money from the coin fund, although he reportedly plans to appeal.

Former Ohio Gov. Bob Taft, who pleaded no contest in 2005 to misdemeanor ethics charges, was among politicians and money managers ensnared by the Coingate investigation.

The memorabilia collection managed by Mr. Noe included political pins, photographs and hand-written letters related to President William Howard Taft, the former governor's great-grandfather.

Items sold to the auction house also included a cracked Reggie Jackson bat, an autographed Hillary Clinton book, a 1972 Richard Nixon Frisbee, and bats and basketballs autographed by sports teams.

The sale of the memorabilia brought more than \$2.5 million, according to a bureau spokesman. In total, liquidators for the bureau's fund have recouped \$45 million, the spokesman added.

S.F. mayor sour on soda sweetener

San Francisco Mayor Gavin Newsom wants to help his city's citizens lose some weight.

The lean mayor said last week that he is considering proposing that a "small" unspecified fee be imposed on big-box retailers that sell drinks sweetened with high-fructose corn syrup.

Mr. Newsom said the money collected from the fee would be used to

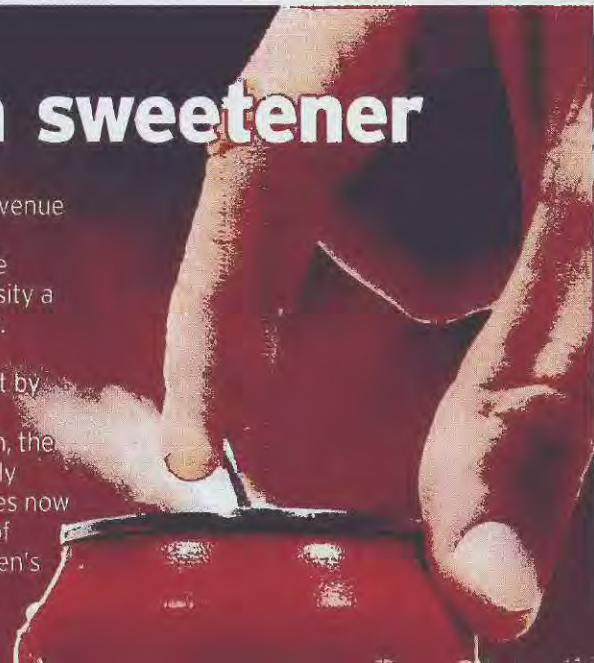
expand his Shape Up San Francisco anti-obesity initiative.

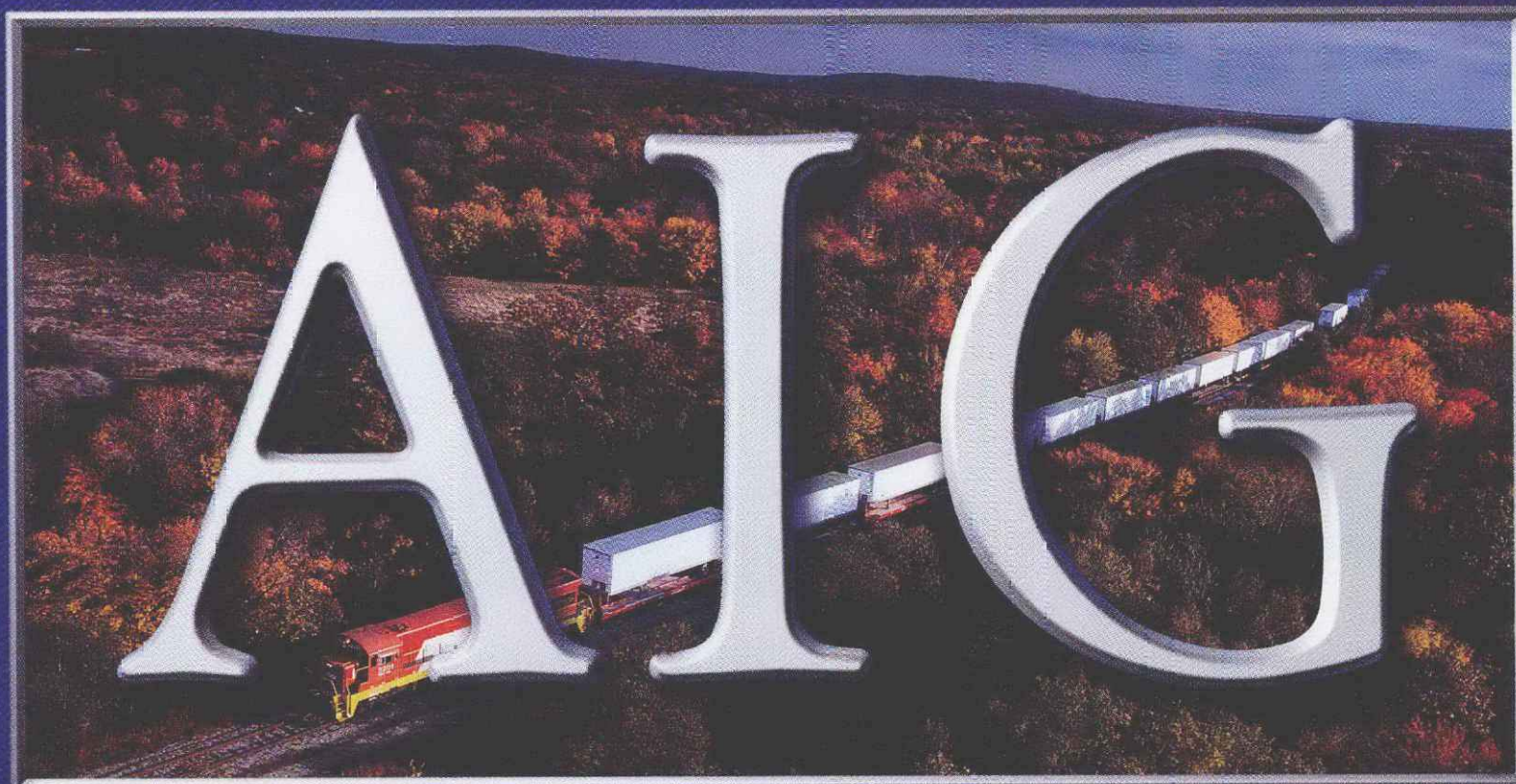
"Beverages sweetened by high-fructose corn syrup are standing in the way of our efforts to combat obesity," Mr. Newsom said in a statement.

"With all the mounting evidence showing that children are increasingly at risk for poor health because of these drinks, it's time for

us to explore every avenue and examine every innovative idea, in the hopes of making obesity a thing of the past," Mr. Newsom said.

Citing a draft report by the San Francisco Department of Health, the mayor said "calorically sweetened" beverages now are the No. 1 source of added sugar in children's diets.





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A GOOD BUSINESS PARTNER YEAR AFTER YEAR."**

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— Daniel R. Madock, General Counsel, Rescar, Inc.

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