

Business Insurance

\$5

December 25, 2006

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OHIO SUPREME COURT ALLOWS LIABILITY COVERAGE TRANSFER FOR POLLUTION CLAIMS / PAGE 3

INSURERS FOLLOW EMPLOYERS IN EFFORT TO PROMOTE ELECTRONIC RECORDS / PAGE 4

In Brief

Bush signs tax bill with HSA changes

President Bush last week signed into law tax legislation that will significantly boost the appeal of health savings accounts. The HSA provisions, incorporated in the broader tax bill H.R. 6111 that received congressional approval earlier this month during the brief post-election session, will allow significantly larger contributions to HSAs and will ease interaction problems related to flexible spending account grace periods and HSAs.

Cat losses total \$15B in 2006

Natural and man-made catastrophes in 2006 caused insured losses of \$15 billion and total economic losses of \$40 billion, according to preliminary estimates from Swiss Reinsurance Co. To date, only

See **IN BRIEF** page 26

Compensation shake-up continues

Chubb pays \$17M, ends all contingents

By **SALLY ROBERTS**

WARREN, N.J.—Chubb Corp. last week became the first property/casualty insurer to agree to eliminate all contingent commissions on U.S. business as part of an agreement to settle state officials' probes into its compensation practices.

The Warren, N.J.-based insurer said that, starting Jan. 1, 2007, it would cease paying contingent commissions on all such lines and in their place institute a "supplemental compensation program" for its producers, a move that some observers say could serve as a model for other

insurers' future pay programs.

Chubb also agreed to pay \$15 million in policyholder restitution to resolve the investigations by attorneys general in New York, Illinois and Connecticut. Chubb, which was not assessed any fines or penalties or required to apologize to its customers, also will pay \$2 million to the states for the cost of the investigations, which were led by New York Attorney General Eliot Spitzer.

Mr. Spitzer's office said in a statement that the settlement resolves an investigation of "cus-

See **CHUBB** page 25

Acordia vows fight over steering charge

By **SALLY ROBERTS**

CHICAGO—Acordia Inc. has become the latest insurance brokerage to face charges over its compensation practices, but, unlike its competitors, the Chicago-based brokerage intends to fight the lawsuits.

Attorneys general in Connecticut, Illinois and New York filed separate but simultaneous lawsuits last week against Acordia—and also against its parent, Wells Fargo Bank N.A., in the New York case—charging that the world's fifth-largest brokerage accepted nearly \$200 million in undisclosed commissions

from insurers between 2000 and 2005 for steering business their way.

The suits are the latest chapter in the more than two-year-old investigations of broker compensation practices first launched in 2004 by New York Attorney General Eliot Spitzer.

Since January 2005, several of the world's largest brokerages, including Marsh & McLennan Cos. Inc., Aon Corp., Willis Group Holdings Ltd., Arthur J. Gallagher & Co., Hilb Rogal & Hobbs Co. and most recently Brown & Brown Inc., have

See **ACORDIA** page 25

SPOTLIGHT

YEAR IN REVIEW: EMPLOYEE BENEFITS

Management of health care costs remains the top priority for benefit managers; a look back at the issues that made news in 2006 and the top 10 newsmakers of the year; a timeline of major benefits-related events.

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PBM offer raises concerns about market control

Express Scripts bid trumps CVS offer for Caremark Rx

By **GLORIA GONZALEZ**

While the possible merger of two of the nation's largest pharmacy benefit managers has potential advantages for employers, some express concern that ongoing consolidation of the PBM industry will lead to decreased competition and, ultimately, higher prescription drug benefit costs.

St. Louis-based Express Scripts Inc. has proposed a \$26 billion

acquisition of its larger rival Caremark Rx Inc. in a deal that would create the largest PBM in lives covered and revenues (see box). The Express Scripts offer, if accepted, would derail Nashville, Tenn.-based Caremark's planned \$21 billion merger with Woonsocket, R.I.-based CVS Corp. (*BI*, Nov. 6).

The PBM industry has already seen significant consolidation in recent years, with Caremark purchasing rival AdvancePCS in 2003 (*BI*, Sept. 22, 2003) and Express Scripts completing five acquisitions since 1998. The three largest PBMs—Franklin Lakes, N.J.-based Medco Health Solutions Inc., Caremark and Express Scripts—control

MAJOR PBM COMPANIES AT A GLANCE

	2005 revenues	Covered lives
Medco Health Solutions Inc.	\$38.0 billion	60 million
Caremark Rx Inc.	\$32.9 billion	90 million
CVS Corp.	\$26.7 billion*	30 million**
Express Scripts Inc.	\$16.2 billion	50 million

*Reflects all pharmacy revenues **Covered by CVS' PBM unit PharmaCare
Source: Company reports

70% to 75% of the U.S. PBM market.

While the merger of CVS and Caremark was generally seen as creating significant benefits for employers through more effective cost management and innovative new programs, an Express Scripts/Caremark merger would have positive and negative implications for plan sponsors, observers say.

A combined entity would be a positive development for employers as it would have greater leverage to negotiate better pricing arrangements for prescription drugs and rebates from drug manufacturers, benefit managers say.

"Those rebates or discounts being passed on to an employer may lower the employer's drug costs," said Jim Crockett, manager of risk and benefits at Denver Water, a municipal utility company.

A combined entity could achieve substantial operational synergies, observers say. The transaction is expected to generate annual cost synergies of about \$500 million, according to Express Scripts.

A merger of Express Scripts and Caremark would make the combined PBM more competitive with pharmacy services provided by

See **PBMs** page 24

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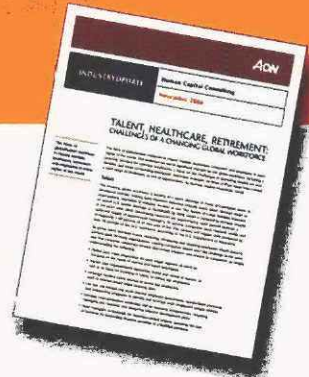


As globalization reshapes the workforce, your company is facing a growing demand for talented employees, a heightened focus on healthcare and benefits, and issues surrounding employee retirement strategies. Leading companies are answering these

— Andrew Appel, chief executive officer, Aon Consulting Worldwide

challenges with innovative strategies and solutions in health, talent management and rewards. To learn how to design and implement programs for attracting, developing and enriching the lives of your employees, visit www.aon.com/ask.

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WHITE PAPERS

Kaiser white paper views health care

"The State of Health Care," a Kaiser Permanente-sponsored white paper, outlines where the U.S. health care system is today, how it got there and what's being done to address the growing crisis. Based on a survey of benefits and HR professionals and employer executives, the white paper can be accessed in the White Papers area of www.BusinessInsurance.com.

BENEFIT MANAGER OF THE YEAR®

Nominate your favorite benefit manager in 2007

Business Insurance launched the Benefit Manager of the Year® award in 2005 to salute outstanding performance in the field of benefits management. Nominations are now being accepted for the 2007 award. The deadline for completed nominations is June 1, 2007. For rules and a nomination form, go to www.BusinessInsurance.com/BMOY.

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Northwest storm losses could top \$500M: AIR

Wind, floods wreak havoc over wide area

By MARK A. HOFMANN

BOSTON—Insured losses from the winter storm that raked the Pacific Northwest could surpass \$500 million, according to an estimate released last week by risk modeler AIR Worldwide Corp.

The storm, which occurred Dec. 14-15, packed wind gusts of more than 90 mph and heavy precipitation triggered some flash flooding. It was the worst storm to strike the region in nearly 13 years,

when severe weather hit the Northwest on Inauguration Day, 1993, said Peter Dailey, Boston-based AIR's director of atmospheric science for research and modeling, in a statement announcing the loss estimate.

"The wind speeds observed from (the) storm were similar or a bit higher than those of the 1993 storm but were more widespread, extending south to Oregon and east to Montana, so total damage is likely to be higher," Mr. Dailey added in his statement.

Most of the damage was caused by wind, according to AIR, which is a unit of Jersey City, N.J.-based Insurance Services Office Inc.



AP WIDE WORLD

Debris fills a street in Montesano, Wash. following an overnight windstorm that occurred earlier this month. Risk modeling agency AIR Worldwide Corp. estimates that the storms were the worst to hit the region in 13 years.

Coverage transfer OK for past losses: Court

Ohio liability ruling favors policyholder in pollution case

By ROBERTO CENICEROS

COLUMBUS, Ohio—Insurers must indemnify the current owner of a glass manufacturer facing environmental liability claims even though the insurers sold their policies to the manufacturer's former owner, Ohio's Supreme Court ruled last week.

Each commercial general liability insurance policy at issue in *Pilkington North America Inc. vs. Travelers Casualty & Surety Co. et al.* contained a provision prohibiting the assignment of interests without the insurers' consent, court records state. But despite those provisions, the court found that under occurrence-based policies, a right to bring action for recovery is transferable when a covered loss has already occurred.

The court said it was unable to answer definitively, though, whether such an action is transferable for a duty to defend.

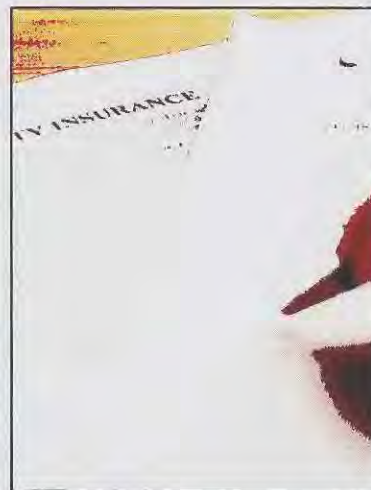
The case was closely watched because only California's Supreme Court has addressed whether a corporate successor can obtain coverage under its predecessor's policies, according to attorneys at Covington & Burlington L.L.P. in Washington.

California's high court, however, ruled for insurers on the issue, said the Covington & Burlington attorneys who argued the Ohio case on behalf of Toledo, Ohio-based Pilkington.

The issue of coverage for successor entities under most liability policies remains largely unresolved nationwide, and a handful of appellate courts are now weighing the matter, said Laura Foggan, a partner at Wiley Rein & Fielding L.L.P. The

law firm filed an amicus brief on behalf of the Complex Insurance Claims Litigation Assn. in Washington.

The Ohio court's decision does contain some good news for insurers, Ms. Foggan pointed out. She noted that the court rejected the idea that insurance rights transfer automatically, finding instead that coverage transfers only when a predecessor and successor agree to transfer liability and indemnity coverage.



The court decision notes that the insurance policies at issue were not transferred to Pilkington. But the predecessor company in its agreements with Pilkington essentially agreed to "carve out" indemnity rights under the policies to the predecessor, Ms. Foggan explained.

The ruling would not apply to cases where such an agreement is absent, Ms. Foggan said. Additionally, the court found that when a predecessor company transfers its right to insurance coverage to a successor, it loses the right to also obtain coverage under the same policy, Ms. Foggan said.

Pilkington North America Inc. vs. Travelers Casualty & Surety Co. et al.; Ohio St.3d, 2006-Ohio-6551.

PRAETORIAN FINANCIAL GROUP INC.

Annual gross premium: **\$1.4 BILLION**

SUBSIDIARIES: Praetorian Insurance Co., Redland Insurance Co., and Praetorian Specialty Insurance Co.

FOCUS: Primary insurance coverage to small and mid-sized accounts with emphasis on specialty business. Underwrites 37 specialty insurance programs covering:

Commercial auto	22%	Fronted business	13%
Commercial casualty	22%	Commercial property	12%
Workers compensation	22%	Specialty auto	10%

Source: QBE Insurance Group Ltd.

Deal to buy Praetorian will more than double QBE's U.S. business

Australian insurer pays \$800 million for specialty unit

By LOUISE ESOLA

NEW YORK—QBE Insurance Group Ltd.'s agreement to buy New York-based Praetorian Financial Group Inc. for \$800 million will significantly boost the Australian insurer's presence in the United States, QBE says.

QBE, which reached the agreement with Germany-based reinsurer Hannover Re Group to buy its recently created Praetorian, said it expects to finalize the acquisition in the second quarter of 2007 pending regulatory approvals.

Hannover Re launched Praetorian early this year to take over the specialty business of New York-based Clarendon Insurance Group

Ltd., which Hannover purchased in 1998.

The acquisition of Praetorian includes Praetorian Insurance Co., Praetorian Specialty Insurance Co. and Redland Insurance Co.

Praetorian will add about \$1.4 billion in gross premium income annually, QBE said. The figure includes about \$200 million in fee-based "fronted" primary insurance, which QBE said it expects to cancel. The acquisition of Praetorian will more than double QBE's business in the United States. According to QBE's financial statements for 2005, the gross premium income for the Americas division was just over \$1 billion.

Praetorian writes 37 specialist property/casualty insurance programs, 78% of which is written by managing agents and 22% through brokers, QBE said.

See **PRAETORIAN** page 6

Business Insurance®

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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MODEL PHR ELEMENTS

Potential information in electronic patient records:

- Doctor encounters
- Medications
- Allergy alerts
- Lab results
- Family history
- Providers
- Facilities

Insurers join employers in health records push

Electronic profiles viewed as key tool to optimize care

By JOANNE WOJCIK

A project to develop personal health records, announced by America's Health Insurance Plans in concert with the Blue Cross & Blue Shield Assn., demonstrates the growing interest in creating electronic medical records, health benefit experts say.

Both AHIP and BCBSA have committed to having all member health plans offer a PHR to participants by the end of 2008.

Although its timing closely follows another PHR initiative launched earlier this month by an employer group, industry experts say it will put pressure on all PHR developers to build more competitive products more quickly.

"What this shows is that stakeholders across the board agree that consumers need PHRs, that there's consensus about that," said a spokeswoman at the Washington-based AHIP. "I think that we'll see a variety of projects and, as we go forward, there will be standards so that things will work together. But basically what it shows is that everybody's in agreement that if you're

going to optimize your health, you're going to need some basic information about your health and health care" in an electronic format, the spokeswoman said.

AHIP and the Chicago-based BCBSA on Dec. 13 announced a partnership to create a standardized PHR model that can be accessed by consumers, medical providers and health plans. It would be portable so that plan members could take it with them from plan to plan or to administrators of self-funded health benefit plans.

The industry model PHR would contain, at a minimum, patient information, encounters, medications, lab results, providers, facilities, subscriber information, benefit information, family history, physiological information, immunizations, health risk factors, advance directives, alerts such as allergies, plans of care—all of which would be derived from claims and administrative information.

Both AHIP and BCBSA have committed to having all member health plans offer a PHR to participants by the end of 2008.

Because AHIP and BCBSA member companies collectively control claims data on nearly two-thirds of the nation's insured population, it made sense for them to lead the effort, said Alissa Fox, vp-legislative and regulatory policy at the BCBSA in Washington.

"We have a panoramic view that already exists about a consumer," Ms. Fox said. "We know if you went to four doctors, if you went to a rehab clinic or a hospital, if you have five prescriptions. We have that information already, so we are perfectly positioned to put that in a user-friendly way so the consumer

See PHRs page 6

AIA deems terrorism backstop 'most urgent' concern for 2007

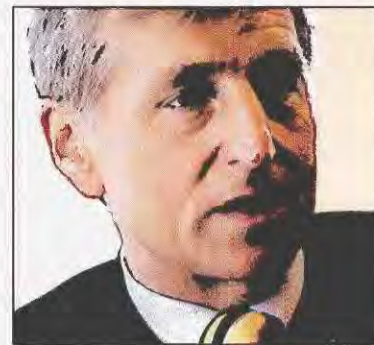
But federal support not needed to tackle natural cat risks

By MARK A. HOFMANN

WASHINGTON—Finding a long-term solution to the issue of terrorism insurance is the "most urgent" matter on the American Insurance Assn.'s legislative agenda for the new Congress that convenes next month, AIA President Marc Racicot said during a news conference last week.

Mr. Racicot noted that the current federal backstop is slated to expire on Dec. 31, 2007. He added that the new Democratic chairmen of the committees that exercise jurisdiction "have placed that at the top of their agenda as well."

Mr. Racicot repeated the property/casualty insurance industry's belief that terrorism risk—unlike



Mr. Racicot

ROLL CALL PHOTOS

other risks—cannot be quantified. In addition, private insurance markets don't have access to "top-secret information" regarding the threat, he said.

Mr. Racicot also played down concerns that some business interests have become so sure that the program will be extended that they've become complacent.

"I can tell you that the concern amongst property owners is abso-

lutely intense," he said. "It's as keen and focused as ours is."

The Washington-based insurer group's other major federal legislative concerns are dealing with natural catastrophe exposure and reforming insurance regulation by allowing insurers to be chartered by the federal government.

"We believe the market can respond and there is no need for a federal system" to insure against natural catastrophes, he said.

The U.S. government's foray into guaranteeing insurance—the National Flood Insurance Program—"has not been entirely successful," he said.

"Federally chartered companies would allow a greater spread of risk throughout" regions or the country as a whole, Mr. Racicot said.

Insurers would be able to spread risk more broadly and create new private-sector responses to providing insurance to areas prone to natural disaster losses, he said.

FMLA work time rule does not require continuous service: Appeals court

Right to leave holds despite five year gap in employment record

By JUDY GREENWALD

BOSTON—The 12 months of service an employee is required to work before becoming eligible for leave under the federal Family and Medical Leave Act does not necessarily have to be continuous, says a federal appellate court in overturning a lower court's decision.

Last week's unanimous decision in *Kenneth Rucker vs. Lee Holding Co., dba Lee Auto Malls* by a three-judge panel of the 1st U.S. Circuit Court of Appeals in Boston involved car

salesman Kenneth Rucker, who had worked at Auburn, Maine-based Lee Auto Malls for five years.

He left the firm, then rejoined five years later. Seven months after rejoining, he took medical leave. About two months later, Mr. Rucker's employment was terminated.

Mr. Rucker then filed suit, claiming that his termination violated the FMLA, according to court records.

A district court granted Lee's motion to dismiss, holding that Mr. Rucker could not combine his previous period of employment with the more recent period and that, therefore, he had not satisfied the FMLA's 12-month employment requirement.

The appellate court disagreed.

"We hold that the FMLA is ambiguous as to whether previous periods of employment count toward the 12-month requirement, but regulations promulgated by the United States Department of Labor (DOL), as interpreted by the DOL, establish that previous periods of employment do count," said the decision, which noted also that the DOL reiterates this position in an amicus brief submitted in the case at the court's request.

The DOL's "interpretation of its regulation is reasonable, and that regulation, so interpreted, is a reasonable exercise of the DOL's exercise of the DOL's statutory authority," said the decision, which remanded the case back to the lower court for further proceedings.

Experts debate drug costs online

BI webinar highlights successful strategies to fight rising prices

Some factors in the rising cost of prescription drugs are outside employers' control, but benefit plan sponsors can implement strategies to reduce costs and enhance the value of drug benefits, experts said during a recent *Business Insurance* Online Executive Forum.

BI's free Dec. 12 webinar, "Hard to Swallow: Why the Costs of Drugs are so High," has been archived online at www.BusinessInsurance.com/webinars.

Among the strategies that plan sponsors can use are active management of drug utilization and cost-sharing programs, such as tiering copayments and providing incentives to use less expensive alternatives. Plan designs may include deductibles for prescriptions and exclusions or limits for certain lifestyle drugs. Communication with plan members and working with prescription benefit management firms to align incentives are other important tools available to employers, the speakers said.

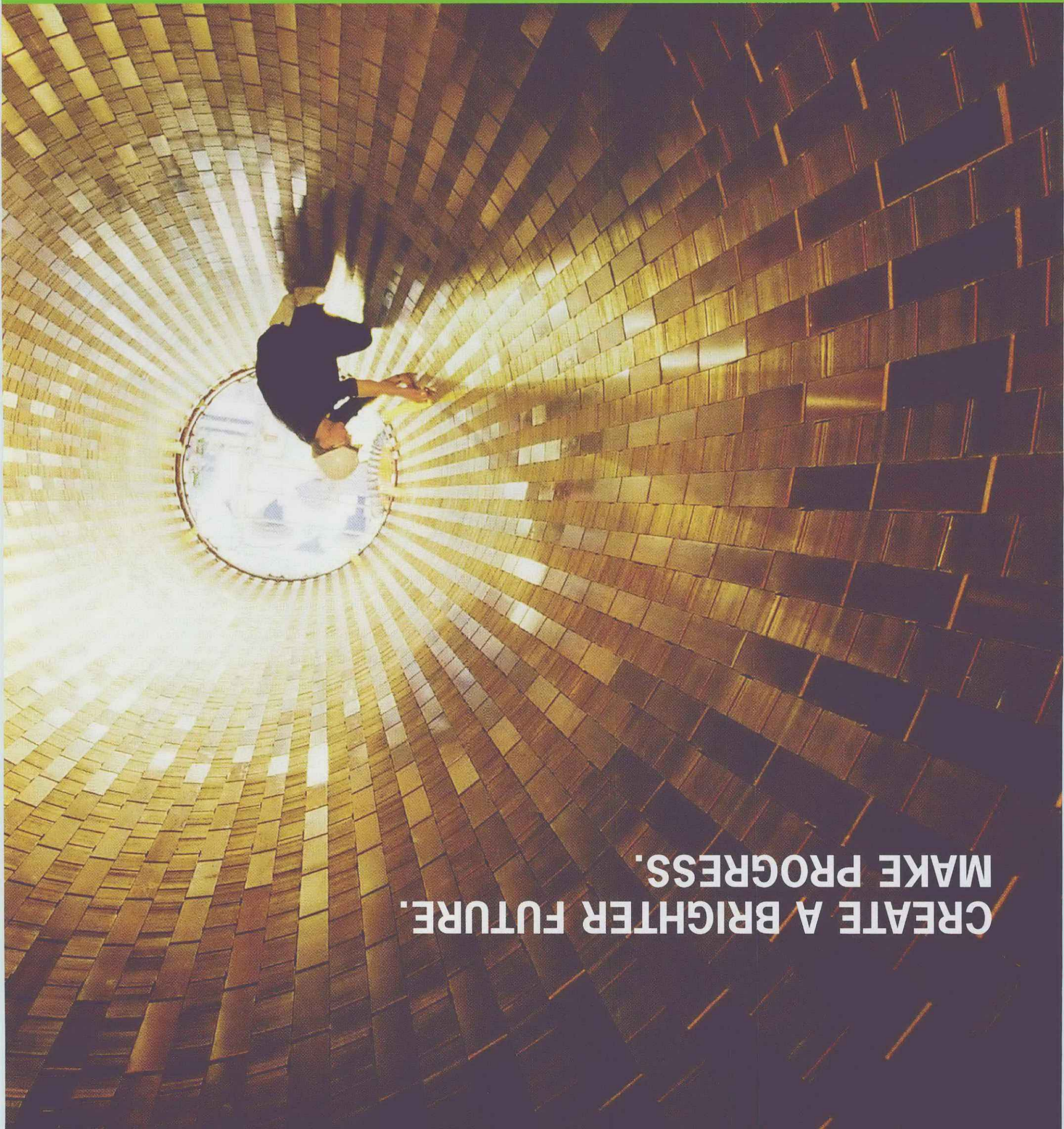
Experts on the panel were: Rhonda Grabow, vp of strategic planning at Innoviant Inc.; Michael Jacobs, a principal and national practice lead-

er at Buck Consultants L.L.C.; and Lisa Zeitel, a principal and health & benefits consulting practice leader at Mercer Health & Benefits. BI Editor Regis Coccia moderated the panel.

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PHRs: Move by insurers follows effort by employers to create records

CONTINUED FROM PAGE 4

has access to those records in a way they can use it."

The AHP/BCBSA project was announced shortly after five major employers unveiled their jointly financed project. Dubbed Dossia, the employer effort will provide a common technological framework to facilitate sharing PHRs over the Internet, according to its developer, J.K. Kleinke, chairman and chief executive officer of Omnimedix Institute, a not-for-profit based in Portland, Ore. Its participants are Applied Materials, BP America Inc., Intel Corp., Pitney Bowes Inc. and Wal-Mart Stores Inc. (31, Dec. 11).

Having various development projects in the works could encourage greater acceptance of PHRs among employees and their dependents, many of whom have been reluctant because of security concerns to use the first generation of electronic health records their employers and health plans have made available, said Della Vetter, director of benefits at EMC Corp., a technology company based in

Hopkinton, Mass.

EMC has provided PHRs through WebMD to its employees since 2004 and will offer them to dependents in early 2007, Ms. Vetter said.

"The deal would be for everyone to operate collectively and collaboratively," she said. "But we're still in the innovation period. You're creating demand from consumers and you're also creating a sense of security that this is the way the world is going. If it becomes the norm, it will facilitate consumer acceptance of PHRs."

Ray Brusca, vp of benefits at Black & Decker Corp. in Towson, Md., expressed concern that the separate efforts would create only partial PHRs and that additional work is needed to create a truly comprehensive PHR.

Though it may seem like many groups are inventing the same wheel, "they're inventing half a wheel as far as I'm concerned," Mr. Brusca said. "Insurers may have more information than just traditional claims data, and it's better than nothing, but it is not a true electronic medical record."

'Doctors are still going to be as much in the dark as they are today. They may not order duplicate tests if they can find out if they've already been done. But they won't know a person's complete health history from an insurance company claims database.'

Ray Brusca, Black & Decker Corp.

Mr. Brusca said insurance companies don't have all the data needed to create a PHR that provides a complete picture of a person's health history.

"Doctors are still going to be as

much in the dark as they are today. They may not order duplicate tests if they can find out if they've already been done. But they won't know a person's complete health history from an insurance company claims database. Unless something has all your health history—not just claims history—I don't think it's a real health record," he said.

Omnimedix's Mr. Kleinke agreed. "What (insurers) have in their database is paid claims. Paid claims is not the entirety of a person's health record. They actually have mangled clinical detail, specifically because of adjudication," he said.

Mr. Kleinke said distrust and incomplete or inaccurate claims data are among the reasons that the five employers are financing the Dossia project.

"Health plans have been offering PHRs for several years now and nobody uses them, Mr. Kleinke said. He went on to say that the inability to transfer records from insurer to insurer is not the reason that people are not using them.

"All the market research we have either conducted or seen is that people don't trust their health plan. Health plans have to threaten them with perjury to volunteer information about their own medical conditions," Mr. Kleinke said.

But an industry-led PHR development project will provide the upfront investment and resources that are necessary to make PHRs a reality, according to Black & Deck-

er's Mr. Brusca.

"A true electronic health record that really is all-encompassing is not free. It may pay for itself over time by eliminating medical errors and redundancies, but there is still an upfront development cost," he said. Insurer involvement in transferring information also may be necessary because most employees have been reluctant to share their personal health information, he said.

"If you rely on the employees pulling the data along with them, I don't think that's going to happen. Insurers will have to do the pushing," Mr. Brusca said.

Good first steps

Taken together, both the employer-supported and industry PHR development projects "are good first steps," Mr. Brusca said. "It's in its infancy. And we need it. We're never going to get rid of some of the waste, some of the defensive medicine, some of the excess of things that go on unless we have" PHRs.

"We're not going to have better health care. Most doctors are operating blindly. At least when my car breaks down, I can go from Mechanic A to Mechanic B and he can hook it up to a computer and tell what has happened to it" based on information from embedded computer chips in the vehicles, Mr. Brusca said. "Nothing similar exists in the medical world."

Praetorian: Acquisition to boost specialty business

CONTINUED FROM PAGE 3

Rod Fox, chief executive officer of Praetorian, said in a statement that Praetorian will continue to focus on specialty markets.

"Over the past year, Praetorian has made significant strides in strengthening and refining the com-

'If you look at the commitment of the (new) parent company, their commitment to the specialty market will be beneficial for Praetorian.'

David Blades, A.M. Best Co. Inc.

pany's operational capabilities," Mr. Fox said. "The combination with QBE...will build on those successes while allowing us to offer a broader range of products and maintain continuity in client relationships."

Tim Kenny, president and CEO of QBE's New York-based Americas division, said the acquisition is in line with QBE's U.S. goals.

"The acquisition is consistent with our strategy of building our business in the specialist insurance program and small to medium regional markets of the U.S.," Mr. Kenny said in a statement. "It fol-

lows the successful acquisitions of National Farmers Union Property & Casualty Co. in 2005 and the One Beacon Agriculture division earlier this year."

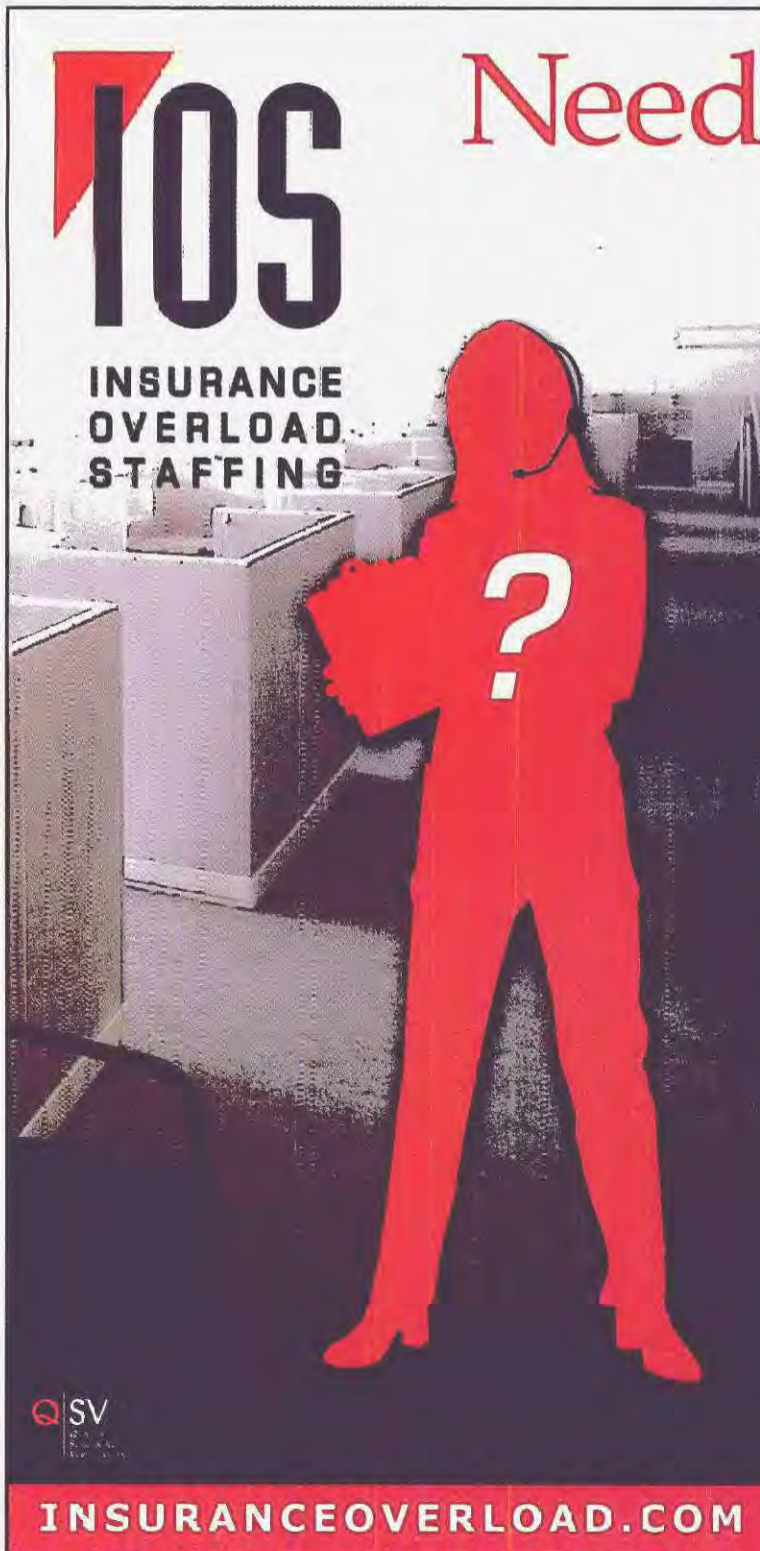
Following the announcement, Oldwick, N.J.-based A.M. Best Co. Inc. issued a statement that QBE would maintain its financial

strength rating of A pending a review of the acquisition "with negative implications." Praetorian Financial Group and its members also maintained an A- rating pending a review "with developing implications."

David Blades, an Oldwick, N.J.-based analyst with Best said, Praetorian stands to benefit from the acquisition. "If you look at the commitment of the (new) parent company, their commitment to the specialty market will be beneficial for Praetorian."

Hannover Re is a strong company, Mr. Blades said, but is one that wants to focus on its mainstream businesses.

In its statement, Hannover said it intends to use capital freed by the sale of Praetorian to beef up its core property/casualty and life/health reinsurance businesses.



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Business Insurance OPINIONS

Collateral rule change a modernizing move

THE DECISION of the National Assn. of Insurance Commissioners to move ahead with a rating-based approach for the regulation of reinsurers should, on balance, be welcomed by risk managers.

When U.S. regulators earlier this month agreed to move toward a system that would change the requirements that make non-U.S. reinsurers post 100% collateral to back the risks they assume in the United States, they took a step in a direction that more fully reflects the nature of the global insurance market.

While we understand, and have some sympathy with, the argument that policyholders that use insurers that buy reinsurance from non-U.S. reinsurers would be best protected if that coverage is fully collateralized, we think the issue is wider than that.

Those collateral rules are not as onerous as they might appear at face value. Non-U.S. companies can use letters of credit as tools to post collateral, but the rules still put up a barrier to many well-capitalized and well-regulated reinsurers seeking to do business in the United States.

And, although the attraction of tapping the largest insurance market in the world is likely sufficient to make many reinsurers jump through regulatory hoops, making them perform those financial acrobatics should no longer be necessary when sophisticated rating tools are readily available to regulators and policyholders.

Sophisticated rating tools are readily available to regulators and policyholders.

Terrorism backstop top priority in 2007

FIRST THINGS FIRST. When it comes to the federal legislative agenda concerning risk management, the first thing has to be reauthorization of the federal terrorism insurance backstop.

And we're not alone in that contention, either. As we report on page 4, dealing with the terrorism insurance issue is the American Insurance Assn.'s priority for the new Congress as well. It's easy to see why.

The federal terrorism insurance program will expire next Dec. 31 unless Congress extends it, or—preferably—replaces it with a permanent public/private mechanism to help guarantee that losses from future catastrophic terrorist attacks don't go uncovered. The new leaders of both committees with jurisdiction over the issue have promised to move quickly on the issue, but even the best intended congressional schedules can be thrown out of kilter by outside forces.

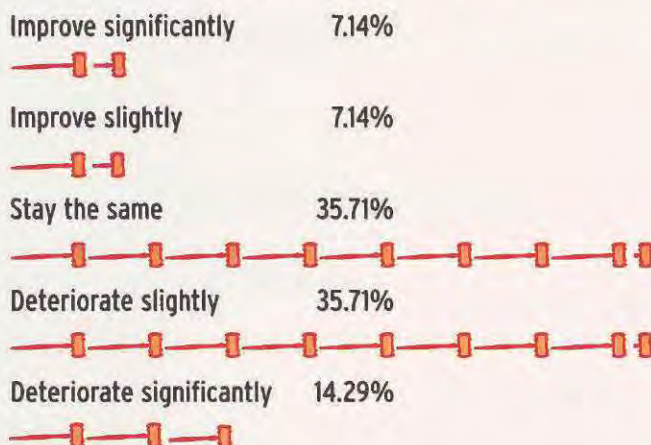
Only continued emphasis on the importance of maintaining the backstop by risk managers, insurers, producers and the business community as a whole can keep the issue in the priority position it deserves. Even then, finding a real solution to this very real problem won't be easy, at least as long as the administration—once one of its most fervent supporter—continues to question the need for the backstop.

As the AIA says, this should be the first order of risk management and insurance-related business considered by Congress next year. And swift passage and enactment will mean that supporters of the backstop will be looking toward a Happy New Year, indeed, this time next year.



Online Poll at www.businessinsurance.com

During the next year, do you expect the civil justice environment to:



NEXT WEEK'S POLL: Will the proposed easing of collateral requirements for non-U.S. reinsurers be beneficial for U.S. risk managers?

BI Online Poll tool sponsored by Wausau

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In Brief

**ING unit settles
kickback charge**

A unit of Dutch financial services firm ING Group last week agreed to pay \$33 million to settle litigation in New York and New Hampshire for allegedly accepting kickbacks to promote certain funds as part of retirement plans. Under the settlement, New York teachers and former teachers are eligible for \$30 million in restitution, while New Hampshire state employees are eligible to receive a total of \$3 million. ING did not admit or deny any wrongdoing.

**UnitedHealth loses
bid to block probe**

Minnesota Attorney General Mike Hatch has the right to investigate UnitedHealth Group Inc.'s executive compensation.

See **IN BRIEF** page 30

Benefits Management Technology & Online Solutions

Benefits managers turn to the Internet to speed up processes; personal health

IRS rules create problems for firms launching HSAs

By **JEFREY GEISEL**

WASHINGTON—Employees who start health savings accounts next year could be shortchanged if their employers offer flexible spending accounts with grace periods. In such situations, the maximum tax-free contribution made to an employee's HSA could be cut by as much as 25% during the first year of HSA enrollment, reducing funds available to pay for current year's health care expenses.

"If you have adopted a grace-period FSA, it can be very damaging for those who want to make maximum contributions to their HSAs," said Jay Savan, health and group welfare leader in the St. Louis office of consultant Towers Perrin.

The problem arises from Internal Revenue Service rules governing HSAs and grace-period FSAs. Those FSAs are so named because, unlike traditional FSAs in which employees forfeit unused account balances at the end of year, employees in

grace-period FSAs can tap balance that remain at the end of a year to pay for uncovered health care expenses incurred during the first 10 weeks of the next year.

The IRS, under pressure from Congress, in 2005 authorized grace periods for FSAs to reduce the impact of the end-of-year FSA forfeiture requirement, which has come to be known as "use it or lose it."

IRS rules, though, say that, w

See **HSAs** page 6

Drug pricing system nixed by pact

**Class settlement may
lead to reduced
prescription costs**

By **JOANNE WOJCIK**

A proposed settlement of a class action lawsuit against the nation's No. 1 provider of average wholesale prices for pharmaceuticals likely will result in pharmacy benefit managers attempting to renegotiate their contracts to preserve their profit margins, experts say. Employers, organizations and other PBM users should not pin their hopes on lowering their drug



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Year in Review
Employee
Benefits

SPOTLIGHT

Top employee benefit stories of 2006

1. Congress passes comprehensive pension funding reform legislation
2. Federal appeals court reverses IBM cash balance plan ruling
3. Corporations accelerate move away from defined benefit plans
4. States, municipalities try new ways to expand health care coverage
5. Competition and consolidation increase in the Rx field
6. Congress passes legislation to boost the appeal of HSAs
7. Insurers and employers step up medical cost transparency efforts
8. Employers take Medicare Part D Rx subsidy
9. UnitedHealthcare chief resigns amid backdated stock options scandal
10. States give children more time in parents' health care plans

Health care cost management still top priority

Despite lower hikes, employers struggle to contain increases

By GLORIA GONZALEZ

Despite moderation in medical price increases, managing the still-rising cost of health care benefits has been the biggest challenge for benefit managers in 2006.

While shifting costs via plan design changes has become standard practice for many employers, increased employee contributions alone can not stem the rising cost of providing health care benefits, benefit managers say. In response, employers have considered or incorporated other initiatives, including the implementation of consumer-driven health plans and an enhanced focus on disease man-

agement and wellness programs.

Meanwhile, examining the impact of pension legislation passed this year was another important task for benefit managers.

In 2006, benefit managers spent much time and effort exploring ways to cope with a constant problem: the continued escalation of medical costs.

"We continued in 2006, as we will in 2007, to cope with the rising cost of employees' health insurance," said Jim Crockett, manager of risk and benefits at Denver Water, a municipal utility company.

Plan design changes such as increases in deductibles, coinsurance and copayment levels have become the norm for benefit managers trying to control health care cost increases. Denver Water spent a substantial amount of time this year educating its employees on

several benefit changes taking effect in 2007, including increases in employee premiums of about 20% for one health plan and 100% for the other. The increased employee contributions were aimed at addressing medical cost increases in the range of 13% to 17% that the organization has faced during the past few years, he said.

"They were large changes," Mr. Crockett said. "Our workforce was not accustomed to paying much higher premiums, having higher out-of-pocket costs in the form of coinsurance and deductibles."

Search for root causes

Standard plan design changes alone, though, have not slowed medical cost trends for some organizations and they are exploring or planning to implement other options that include CDHPs.

JohnsonDiversey Inc., for exam-

ple, plans to replace its traditional plans with CDHPs beginning Jan. 1, 2008. That is because it continues to see annual health care cost increases of 10% to 15% and raising employee contribution levels has not helped slow trends, said Todd Blazei, vp, total rewards group, for the Sturtevant, Wis.-based marketer and manufacturer of cleaning product and building maintenance supplies. Shifting costs to employees is "just not something we think we can continue indefinitely," he said.

Companies also are more closely examining the root causes of medical claims. Reed Elsevier, a global publishing company, formed a mental health task force to discover the key causes of behavioral health issues and develop solutions, said Anne Silverman, vp-compensation and benefits for Reed Elsevier P.L.C.,

See **HEALTH CARE** next page

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BENEFIT ISSUES
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**PEOPLE BEHIND
THE HEADLINES
LAST YEAR**
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**BENEFITS
TIMELINE: A
LOOK AT THE
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PAGE 18

Health care: Offerings change as costs rise

CONTINUED FROM PREVIOUS PAGE

The Americas in New York. "We're starting to focus on productivity, keeping people healthy, trying to work with our disability vendors to get people back to work," she said.

Health care companies continued their focus on saving money by managing claims through disease management programs, said Scott Clark, risk and benefits officer for Miami-Dade County Public Schools in Miami.

Investments in disease management and wellness programs, particularly those that aim to improve medication compliance, have become increasingly popular, he said. The school system, for example, worked with its health care insurer, UnitedHealthcare of Florida, to offer a 50% reduction in copayments for medications treating chronic conditions such as asthma and diabetes, Mr. Clark said. "Our hope was that if we lower the cost of our copays, people will be more able to afford refills and keep on medications so they wouldn't have serious health effects down the road," he said.

Benefit managers also spent a great deal of time this year monitoring political developments with respect to pension issues and were encouraged by the passage of legislation that protects cash balance plans from age discrimination, even though the law was not retroactive.

The Pension Protection Act of 2006 clearly laid out the rules for cash balance plans, said Mr. Blazei, whose company has a cash balance plan. "We feel our plan fits those

rules," he said.

Employers also favorably viewed a ruling this year by the 7th U.S. Circuit Court of Appeals in Chicago that said IBM Corp.'s cash balance plans do not violate age discrimination law.

Ms. Silverman said she and her colleagues carefully monitored the development of the IBM pension dispute because Reed Elsevier also has a cash balance plan. "I see our pension plan as a good retention tool and a competitive advantage, she said. "But (the IBM case) was certainly on our minds."

Pension law revised

Employees also praised passage of a provision in the Pension Protection Act that makes it easier to implement automatic enrollment, in which an employer enrolls an employee and contributes part of an employee's salary into the company's 401(k) plan unless the employee specifically objects.

Congressional approval of automatic enrollment, something Reed Elsevier has had for five years, "makes me feel like we were making the right decisions all along," Ms. Silverman said.

Despite the new law clearing the way for automatic enrollment, Denver Water will continue to offer its 401(k) plan on a voluntary basis alongside its defined benefit plan because it has successfully encouraged employees to sign up due to a generous match, Mr. Crockett said. The organization offers a 100% match up to 3% of salary, and 90% of eligible employees have taken

advantage of the retirement savings opportunity, he said. "As long as enrollment remains high, we probably wouldn't make any changes," Mr. Crockett said.

JohnsonDiversey, meanwhile, is examining its new contribution levels under the new law and will review its pension plans next year, but Mr. Blazei said he does not expect major pension plan changes. "I think every year you look at it to see if it's the right vehicle," he said.

On another front, several benefit managers said educating employees about the need to properly plan for retirement was a key focus this year.

Reed Elsevier launched a Financial Fitness campaign this year aimed at helping employees better understand their finances and encouraging them to increase their participation in voluntary retirement plans. The campaign underscored one of Ms. Silverman's key concerns—employees' tendency to remain at the default 2% savings rate in their 401(k) plans despite a maximum contribution level of 6% of salary. "It's very difficult to get people over the inertia and increasing their contribution," she said.

While several major companies this year announced that they are phasing out their defined benefit plans, Ms. Silverman said the plans still offer certain advantages for both employers and employees and should be offered alongside defined contribution plans rather than being replaced by them.

"Defined contribution-only is not going to give people enough money for retirement," she said.

Lawmakers compromise to pass major reforms of pension funding rules

Massive plan failures spur years-long drive to overhaul system

A multiyear drive to tighten pension plan funding rules came to an end in 2006 with Congress passing the biggest changes in pension funding rules since the enactment of the original pension reform law more than three decades ago.



fell by the wayside as legislators rejected it as being so harsh as to drive employers out of the defined benefit plan system.

But both the Senate and House passed their own reform packages in 2005 and the challenge for legislators in 2006 was to hammer out the differences in the two bills and agree on a compromise uniform reform bill.

It was a big challenge. To be sure, both the House and Senate reform packages included many similar, if not identical, provisions. Both measures, for example, accelerated funding schedules, barred employers with underfunded plans from boosting benefits and created a new methodology to value liabilities.

But there were plenty of differences, including the amount of time over which changes in interest rates—used to value plan liabilities—would be averaged, whether companies with below-par credit ratings would be required to make extra contributions to their plans, whether commercial airlines would be given extra time to fund their pension plans and what requirements employers setting up new cash balance plans would have to meet for the plans to be protected from age discrimination suits.

Resolving these differences took time—a lot of time. From March to late July, House and Senate conferees met to try to reach an agreement. Finally, with time running out as the month-long August recess neared, a final agreement was reached.

Give and take

In true congressional style, many differences were split. For example, while the House bill called for three-year smoothing of interest rate changes and the Senate bill set one-year, the final bill laid down a two-year smoothing rule.

Similarly, the final bill's concession to commercial airlines giving them 17 years to fund plan liabilities was a compromise from the 27-year amortization period in the Senate bill and no special funding relief in the House bill.

The impact of the legislation on pension plans will be huge. "It is the most significant change to pension laws in a generation," declared Lynn Dudley, vp and senior counsel with the American Benefits Council in Washington.

Rep. John Boehner, R-Ohio, said the new law, and its tougher funding rules, will help to avert what could have been a multibillion-dollar taxpayer-funded PBGC bailout.

Others, though, were less optimistic. They worried that the tougher funding rules and the increased volatility due to the shortening of interest rate smoothing will ultimately drive out more employers from the defined benefit plan system.

—By Jerry Geisel

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IBM pension ruling favors employers with cash balance plans

Other courts still hold popular plan option is age discriminatory

A key chapter in the cash balance pension plan litigation saga has been completed this year, but the final chapter has yet to be written.

The saga began years ago when the trial bar launched a litigation offensive against cash balance plans, which have both defined benefit and defined contribution features but legally are defined benefit plans.

The central feature of those suits was that the plans discriminate against older employees. At its most basic level, the plaintiffs' bar argument was this: The account balance of a younger employee would be worth more, when expressed as a retirement age annuity, than that of an older employee. That is the result of the younger employee's account balance having more time to earn interest than the balance of the older employee.

A federal judge in Southern Illinois accepted that argument in a widely publicized 2003 ruling against IBM Corp. and its then 4-year-old cash balance plan.

Judge G. Patrick Murphy rocked employers with his decision that, if upheld, would have meant all cash



balance plans were age discriminatory, exposing plan sponsors to billions of dollars in damages.

This year, some of that fear instilled in roughly 1,000 U.S. employers that sponsor cash balance plans lifted. In August, the 7th U.S. Circuit Court of Appeals in Chicago reversed Judge Murphy's ruling.

In the decision—the first on the age discrimination issue by an appeals court—Judge Frank Easter-

brook, writing for a three-judge panel, said the terms of IBM's plan were "age-neutral" and noted that the size of the benefit credits provided to plan participants did not vary by age.

While account balances—when expressed as a retirement age annuity—would be greater for younger employees than similarly situated older employees, that was the result of the "time value" of the money which is not age discrimination Judge Easterbrook wrote.

The appeals court ruling was a huge relief not just to IBM, but to all employers with cash balance plans. Many believed that the appeals

court decision would serve as precedent, with other courts following it and bringing an end to the age discrimination litigation.

That optimism, at first, seemed justified. Shortly after the appeals court handed down its decision, two district court judges cited that ruling in dismissing age discrimination charges in two other cash balance suits.

But the optimism was short-lived. Two decisions made more recently—one involving JPMorgan Chase & Co. and the other targeting Citigroup Inc.—have gone the other way with the judges in those suits ruling that cash balance plans are

age discriminatory.

Many now believe the age discrimination issue will not be resolved until several more appeals courts hand down their rulings in cases before them.

For employers starting new cash balance plans, though, there is legal certainty. As part of a broad pension funding reform measure it passed this summer, Congress made clear that plans started on or after June 29, 2005, are protected from age discrimination so long as they provide at least the same benefit and interest credits to older employees as they do to younger employees.

—By Jerry Geisel

Big names join defined benefit exodus

Changes, phaseouts attempt to reduce volatility in costs

The phasing out of defined benefit pension plans is not a new story.

Indeed, over the past 25 years employers have been moving away from the plans—with their contribution and cost volatility—in favor of defined contribution plans, especially 401(k) plans, whose contributions and costs are more predictable.

But what made 2006 so extraordinary in terms of defined benefit

plans was the sheer number of big-name companies that announced they were phasing out some or all of their defined benefit plans. Those corporations included Alcoa Inc., General Motors Corp., IBM Corp., NCR Corp., Unisys Corp. and WellPoint Inc.

Corporations freezing their pension plans did so in several different ways. For example, aluminum giant Alcoa is retaining its defined benefit plan for existing employees, with new employees receiving retirement savings benefits exclusively through a 401(k) plan.

Others, such as health insurer WellPoint, allowed existing employees whose combined years of service are at least equal to a certain number to remain in the existing plan, with younger, shorter-tenured employees, as well as new employees, receiving future benefits through souped-up 401(k) plans.

And some, such as Unisys, implemented so-called hard freezes in which all future retirement benefits will be earned through defined contribution plans.

For some companies, the pension plan freezes they announced in 2006 were the second and final step away from defined benefit plans. For example, in 2004, IBM announced that employees hired as of Jan. 1, 2005, would be covered only by an enhanced 401(k) plan; existing defined benefit plan participants, though, continued to earn benefits under the defined benefit plans—either a cash balance or a pension equity plan—in which they were enrolled.

Then earlier this year, IBM said that beginning in 2008 all defined benefit plan participants would earn future benefits through an enriched 401(k) plan.

Competitive considerations

For some companies, a key motivator behind their moves away from defined benefit plans was cutting costs to a level more in line with competitors that don't offer defined benefit plans. For example, Randy MacDonald, IBM's senior vice-human resources, said an all-defined contribution plan approach would allow IBM to provide benefits that "remain ahead of, but more in line with our competitors." IBM



pegged the cost savings of its pension revamp—along with several other contemplated pension plan changes outside the United States—at between \$2.5 billion and \$3 billion between 2006 and 2010.

The volatility associated with defined benefit plans also was a big driver away from the plans. For example, Lincoln Electric, a Cleveland-based designer and manufacturer of welding products, said "eliminating potential volatility in the cost elements" of its pension plan was a key reason behind the phaseout of its plan.

The long-term implications of the move away from defined benefit plans could be good for some employees, but disastrous for others. Shorter-service employees, for example, might do better in enriched defined contribution plans compared with being in traditional plans where it can take decades to earn meaningful benefits.

Similarly, employees who are savvy investors could reap a huge pot of savings through an all-defined contribution plan design. On the other hand, employees who don't contribute in a big way to defined contribution plans or those whose investments go south may find themselves working a lot longer than either they or their employers anticipated.

—By Jerry Geisel

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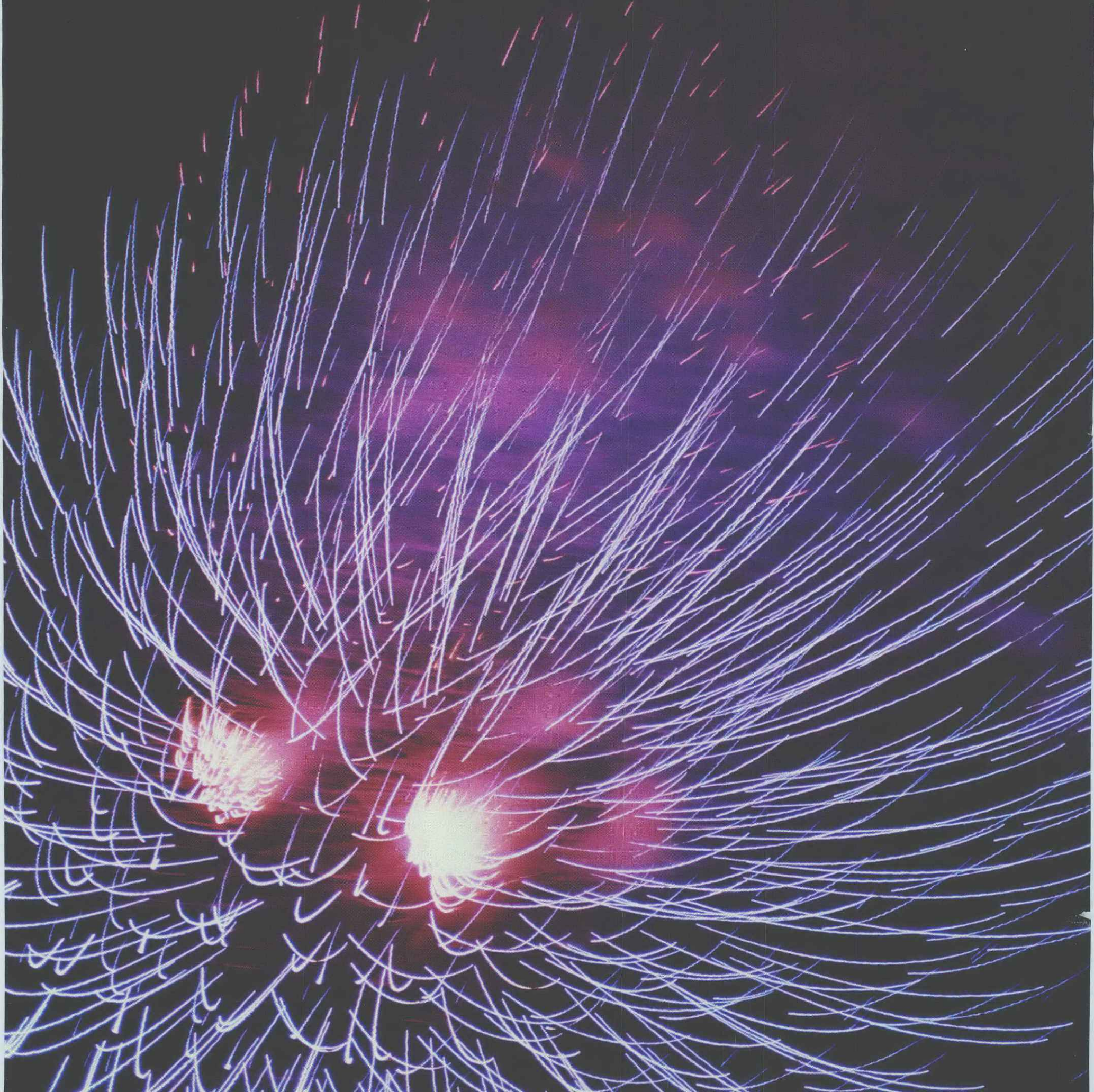
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States, municipalities take on growing uninsured issue

Few health care measures enacted, others fall short

Throughout 2006, numerous states and municipalities continued to grapple with the growing uninsured problem by considering and, in some cases, approving legislation aimed at expanding access to health care coverage.

Though some measures made it out of their respective legislative bodies, only few actually became law, while the more controversial proposals succumbed to either gubernatorial or mayoral vetoes or court challenges.

In April, Massachusetts enacted what is widely considered landmark health care legislation. The law will provide state health insurance premium subsidies for lower-income

individuals, establish a program to make it easier for employers and individuals to obtain insurance, and require residents to obtain insurance or face significant financial penalties—making Massachusetts the first state to impose an individual mandate.

Other surviving laws took a limited approach to health reform, such as those approved in Vermont and Tennessee.

Vermont's law expands coverage through a new insurance program sold by commercial insurers in which the state subsidizes premiums for low-income individuals. The subsidies come from increases in the cigarette tax as well as a \$365 per employee annual fee on employers that do not offer health insurance and have nine or more employees.

Tennessee's law creates a program in which the state pays one-third of



the total health insurance premium—estimated at about \$150 a

month for single coverage—for low-income employees working for small employers, initially those with 25 or fewer workers.

Meanwhile, Maryland's Fair Share for Health Care Act, which made headlines at the end of 2005 when Gov. Robert Ehrlich vetoed it and again in early 2006 when the state's legislature overrode the veto, once again is in limbo at year-end.

The fate of the measure, which would require employers with 10,000 or more employees to spend at least 8% of payroll on health benefits beginning in January 2007, hinges on the outcome of an appeal filed by Maryland's attorney general in response to a federal court ruling in July that the measure violates the Employee Retirement Income Security Act.

In the municipal realm, a mandate passed last summer by San Francisco also faces an ERISA

challenge filed by the Golden Gate Restaurant Assn. The city ordinance, slated to take effect July 1, 2007, would require employers with 50 or more employees to pay a fee for each hour that an employee works into a fund to be used to cover the cost of their health care.

Meanwhile, Chicago Mayor Richard M. Daley struck down the city's so-called "big box" ordinance, which would have required retailers with at least 90,000 square feet of space in a single location to pay their employees at least \$10 an hour and provide another \$3 an hour in benefits by 2010.

And in California, Gov. Arnold Schwarzenegger vetoed two pieces of legislation: a bill similar to Maryland's and a more radical measure that would have created a single-payer system.

—By Joanne Wojcik

Mergers, drug price competition may cut employers' costs

Potential termination of average pricing tool adds more pressure

Three significant events in 2006 involving prescription drug pricing could be the combination punch employers have been seeking in the long-running boxing match against runaway pharmacy benefit costs.

The merger of Nashville, Tenn.-based Caremark Rx Inc.—which buys drugs directly from manufacturers and distributes them through a network of 60,000 pharmacies as well as mail order—with Woonsocket, R.I.-based CVS Corp. will benefit employers and health plans by creating an integrated and cost-effective pharmacy services provider, both companies' executives said in making the announcement in November.

But an even better offer made last week for Caremark by St. Louis, Mo.-based PBM Express Scripts Inc. would create an even larger company that could have even greater leverage to demand lower prices from drug manufacturers, enabling both of these PBMs to pass on those discounts to employers.

Employers also should benefit from Wal-Mart Stores Inc.'s announcement in September that it was rolling back prices on nearly 300 prescription generic drugs. The effort, rolled out in the Tampa, Fla., market and later expanded to nearly the rest of the nation, ignited a national price battle. Minneapolis-based Target Corp. said it would match the Bentonville, Ark.-based retailer's new pricing strategy.

In addition to saving money for employers with prescription drug plans, the retail competition should



stimulate greater use of generics, which are seen as vital in efforts to

reduce employers' drug costs, benefit experts say. Many benefit consultants also expect lower generic pricing at retail pharmacies to put pressure on PBMs to reduce the wholesale prices they charge employers for many of the same drugs.

The impact of the third major drug pricing event of 2006 is less certain.

Employers, organizations and other PBM users are unlikely to feel an immediate impact of the proposed resolution of class action litigation against First DataBank Inc., the nation's leading provider of average wholesale pricing for pharmaceuticals, industry experts said. However, if the settlement is finalized, PBM users could see more competitive drug prices going forward.

The settlement also could lead to the end of the AWP system, which some PBM experts suggested arti-

cially inflated some prescription drug prices. The AWP often is the starting point in negotiations for employers seeking discounts from their PBMs.

The lawsuit, which was filed by two union plans, alleged that First DataBank, a San Bruno, Calif.-based division of publisher Hearst Corp., conspired with San Francisco-based drug wholesaler McKesson Corp. to arbitrarily increase AWP markups to 25% from 20% between 2002 and 2005, resulting in overpayment to PBMs and pharmacies of as much as \$4 billion.

Under the proposed settlement, First DataBank would reduce average wholesale prices by 5% and eventually cease publishing the drug price benchmark that insurers, employers, pharmacies and PBMs use in setting prescription drug prices.

—By Joanne Wojcik

Looking back at 2006's top employee benefits newsmakers

Rep. John Boehner

If there were just one person considered to be the father of the Pension Protection Act, most Washington pension observers agree that it would be Rep. John Boehner, R-Ohio.

As chairman of the U.S. House Education and the Workforce Committee, the Ohio Republican launched the reform drive in 2003 with a series of hearings on pension plan underfunding and the threat it posed to the Pension Benefit Guaranty Corp., the federal pension insurance agency.

Rep. Boehner unveiled a reform bill last year to strengthen pension plan funding and spearheaded its passage in his committee and later in the House of Representatives,

where his bill picked up significant bipartisan support.

While a loyal Republican, he was not blindly loyal. The funding rules in his bill, for example, were less stringent than those proposed by the Bush administration—a difference that was deliberate.

"Make the rules too harsh and you drive employers out," Rep. Boehner warned.

After his elevation to House majority leader this year, he continued to play a pivotal role in the reform drive. He sought and won membership on the conference committee assembled to craft a compromise from the House bill and a somewhat different measure approved by the Senate.

Rep. Boehner was very much in

the thick of things, helping, among other issues, to iron out differences in the two bills concerning how cash balance plans should be protected from age discrimination suits.

His long crusade was successful when conferees agreed on a final bill in late July, with House and Senate approval coming soon after.

The final result, said Rep. Boehner, who in January becomes the House minority leader given Democrats' taking control of Congress, will protect the interests of taxpayers who could have been on the hook for a multibillion dollar bailout of the PBGC had Congress not acted.

Mayor Richard M. Daley

When Chicago Mayor Richard M. Daley vetoed legislation mandating

that major retailers provide a minimum level of wages and benefits, supporters of the so-called "big box" ordinance were confident that the mayoral veto would be overridden.

In July, the city council had approved the measure—on a 35-14 vote—to require retailers with at least 90,000 square feet of space in a single location to pay their employees at least \$10 an hour and provide another \$3 an hour in benefits.

Supporters had to hold on to 34 votes of the 50-member city council to override the mid-September veto.

But Mayor Daley applied the pressure and supporting votes slipped away.

He warned—at a site of a store proposed by Target Corp., one of the big retailers that would have been affected by the measure—that the bill would harm city neighborhoods most in need of additional economic activity.

Joined by community, business, civic and religious leaders who supported the veto, Mayor Daley said the bill would not generate better wages and benefits for Chicago workers, but instead drive businesses and jobs out of the city to the surrounding suburbs.

As it turned out, Mayor Daley's lobbying campaign proved to be a success. Several council members who had voted for the measure originally switched



Rep. Boehner



Mayor Daley

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sides, and the veto override failed on a 31-18 vote.

Judge Frank Easterbrook

In analyzing whether cash balance pension plans discriminate against older workers, Frank Easterbrook, a judge on the 7th U.S. Circuit Court of Appeals in Chicago, wrote that it all comes down to "inputs"—how much an employer allocates to the accounts of plan participants.

Since cash balance plan benefit formulas are age-neutral—a 50-year-old employee earning \$50,000 a year will receive the identical benefit credit as a 30-year-old employee earning the same salary—the plans are not age-discriminatory, Judge Easterbrook wrote.

While a younger employee's account balance will be worth more—expressed as an annuity payable at retirement age—than the balance of an older employee, that difference is solely the result of the younger employee's account balance having more time to earn interest.

In short, treating the time value of money as age discrimination is "not sensible," Judge Easterbrook wrote in overturning a 2003 ruling by a federal judge that had come to the opposite conclusion.

That earlier ruling involving IBM Corp.'s cash balance plan stunned employers and raised the possibility, had the decision been upheld, that all cash balance plans might be considered



Judge Easterbrook

age-discriminatory, exposing employers to billions in damages.

The ruling by Judge Easterbrook, a former University of Chicago Law School professor and a federal judge since 1985, makes that possibility much less likely. His ruling, handed down in August, already has been cited by two federal judges in their rejections of age discrimination charges.

How much influence the ruling, which Judge Easterbrook wrote for a unanimous three-judge appeals court panel, has on other appeals courts could be known soon. At least one and possibly two other appeals courts are expected to rule on the cash balance age discrimination next year.

William W. McGuire

After helping to build UnitedHealth Group Inc. into the nation's second-largest health insurer, Dr. William W. McGuire in October was forced to step down as chairman and chief executive officer of the company—making him one of several high-profile executives to be claimed by wide-ranging regulatory investigations of corporate stock option practices.

His ouster coincided with the release of an outside review of the Minnetonka, Minn.-based insurer's stock option grant



Dr. McGuire

program, which found that several option grants awarded to executives over an eight-year period "likely" were backdated, and occurred during Dr. McGuire's watch.

Dr. McGuire was credited with boosting the insurer's revenues to \$70 billion from \$600 million and guiding the company through numerous and highly successful acquisitions, including its December 2005 purchase of PacificCare Health Systems Inc.

But the executive, who led UnitedHealth from 1991 until his departure this year, now faces possi-

ble civil and criminal charges by regulators.

Judge J. Frederick Motz

Maryland's Fair Share Health Care Fund Act would have become law on Jan. 1, 2007, had it not been for U.S. District Judge J. Frederick Motz.

The act, which would have required employers with 10,000 or more employees in the state to spend at least 8% of their payroll on health benefits, was resurrected early in 2006 when Maryland's General Assembly overrode the veto that Gov. Robert Ehrlich had issued at year-end 2005.

Responding to a legal challenge

filed in February 2006 by the Retail Industry Leaders Assn., Judge Motz ruled that the measure violates the Employee Retirement Income Security Act.

"The act violates ERISA's fundamental purpose of permitting multistate employers to maintain nationwide health and welfare plans, uniform benefits and permitting uniform national administration," wrote Judge Motz, who was named to the federal court in 1985 by President Ronald Reagan.

Now, the fate of the act remains uncertain as Judge Motz's ruling awaits the outcome of an appeal filed by Maryland Attorney General J. Joseph Curran Jr.

Continued on next page

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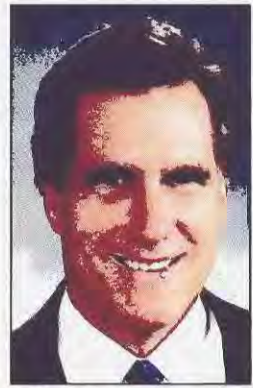
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Gov. Mitt Romney

In 2006, Massachusetts Gov. Mitt Romney accomplished what few thought was possible: working with a state Legislature controlled by the opposite party to enact first of its kind legislation to help the Bay State achieve near-universal health insurance coverage.



Gov. Romney

The key to success, said Gov. Romney, a Republican, was bipartisan cooperation. "An achievement like this comes around once in a generation, and it proves that government can work when people of both parties reach across the aisle for the common good," Gov. Romney said at the time he signed the legislation.

The foundation of the law is requiring all individuals to have health insurance and redirecting funds used to offset hospitals' costs of treating the uninsured to subsidizing premiums for the low-income uninsured.

With the new law in place, Gov. Romney, widely thought to have presidential ambitions, now is directing the next stage in the health care reform effort: producing regulations to implement the landmark law.

Gov. Arnold Schwarzenegger

One of the top newsmakers of 2006—California Gov. Arnold Schwarzenegger—almost surely will earn that status in 2007 as well.

This year, Gov. Schwarzenegger made headlines when he vetoed two health care initiatives. One, aimed at retailer Wal-Mart Stores Inc., would have required companies with at least 10,000 employees in the state to spend at least 8% of payroll on health care benefits or pay the difference into a state fund providing coverage to the low-income uninsured.



Gov. Schwarzenegger

The other measure would have created a state-run single-payer health insurance system.

Gov. Schwarzenegger was especially critical of the latter approach. A single-payer system, he said, would reduce state residents' ability to choose their own physicians, make them wait longer for treatment and raise the cost of the treatment.

But Gov. Schwarzenegger pledged to work toward a new approach to make coverage more available and affordable in 2007. He pledged, while working with state legislators, to develop a legislative package that will support cost con-

tainment and recognize the shared responsibility of individuals, employers and the government.

He said last month that the stage is set for comprehensive health care reform, making coverage more affordable and covering more of the uninsured.

H. Lee Scott Jr.

H. Lee Scott Jr., Wal-Mart Stores Inc.'s president and chief executive officer, announced in September that the Bentonville, Ark.-based retail giant intended to roll back prices on nearly 300 generic drugs to \$4.

Though the pricing strategy initially was limited to the Tampa Bay, Fla., area, it quickly spread throughout the country. It also prompted rival retailers, such as Minneapolis-based Target Corp., to lower their prices for generic drugs.



Mr. Scott

The initiative marked the fourth time since October 2005 that Wal-Mart has moved to improve health benefits. Aside from the generic drug effort, the company relaxed eligibility requirements for part-time workers desiring health insurance and extended coverage to employees' children, introduced a low-cost health plan to make coverage more affordable for its lower-paid workers, and opened

in-store clinics to provide low-cost nonemergency care to employees and the public.

"Each day in our pharmacies we see customers struggle with the cost of prescription drugs," said Mr. Scott. "By cutting the cost of many generics to \$4, we are helping to ensure that our customers and associates get the medicines they need at a price they can afford."

Rep. Bill Thomas

When U.S. Rep. Bill Thomas, R-Calif., the outgoing chairman of the House Ways and Means Committee, won committee approval in September for legislation to boost the appeal of health savings accounts, the action seemed more symbolic of his longtime support of HSAs than a serious effort to win congressional approval of the proposal.

That was because the regular session was coming to an end and few thought the proposal could attract



Rep. Thomas

enough attention and support to be considered—much less passed—during the brief congressional session that would follow the November elections.

But Rep. Thomas, aided by a big lobbying campaign by employer groups, fought to have the HSA measure included in a so-called tax "extender" bill to be considered during the lame-duck session.

His efforts, which involved some political horse-trading with congressional Democrats who got some of their pet proposals added to the tax bill, were successful when the HSA legislation was included in the broader bill. That bill passed this month.

It was the last political triumph for Rep. Thomas, long known for his intellect and biting wit. Rep.

Thomas, who has served as chairman of the Ways and Means Committee since 2001 and played a key role in the drafting and passing of the 2003 law that expanded Medicare to cover prescription drugs, as well as creating HSAs, did not seek re-election and is retiring from Congress.

Rick Wagoner

A large and growing number of retirees coupled with a generous package of retirement benefits can spell trouble for any company.

But it is especially troubling if that company is in an extremely competitive industry in which many competitors' retirement benefit programs are not as extensive.

That is the situation in which General Motors Corp. finds itself and, as a result, the company has less cash available for product development and capital projects, the big automaker says.

GM Chief Executive Officer Rick Wagoner approved several steps this year to cut the company's retirement costs. Salaried employees hired before Jan. 1, 2001, and covered under a traditional final average pay plan will earn future benefits under a less generous career

average pay plan; salaried employees hired on or after Jan. 1, 2001, and covered under a cash balance plan will, effective Jan. 1, 2007, earn retirement benefits

through an enhanced 401(k) plan. The changes, intended to reduce GM's pension obligations by \$1.6 billion this year, were needed to save money and reduce risk, Mr. Wagoner said.

GM clearly needs to do that: In 2005 alone it lost a whopping \$10.6 billion.

GM clearly needs to do that: In 2005 alone it lost a whopping \$10.6 billion.

GM clearly needs to do that: In 2005 alone it lost a whopping \$10.6 billion.

worker with single coverage; the maximum deductible was \$2,700. Congress, though, does not act on the proposal.

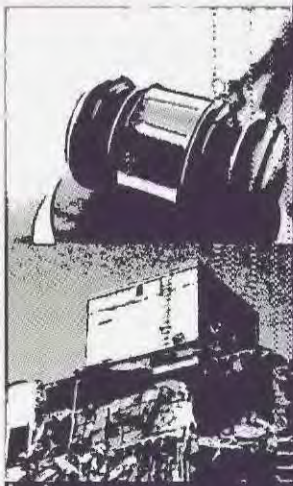
President Bush signs legislation boosting the base annual premium employers with pension plans must pay to the Pension Benefit Guaranty Corp. to \$30 per participant from \$19. The legislation, intended to ease the PBGC's nearly \$23 billion deficit, also imposes a new annual fee of \$1,250 per participant for three years on employers that terminate underfunded pension plans as part of a bankruptcy filing.

MARCH

Chrysler Group announces it will base salaried employees' health insurance premium contributions on their rank and salary level. For example, midlevel man-

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SPOTLIGHT

agers will pay an additional \$450 in premiums while top executives will pay an extra \$1,500. On average in 2006, salaried employees paid \$950 a year in health insurance premiums. The change came as Chrysler struggled to bring health care costs, which had doubled in five years, under control.

APRIL

Massachusetts Gov. Mitt Romney signs landmark legislation to enable the state to achieve near-universal health care coverage within a few years. Under the law, all state residents are required to obtain health insurance. To achieve that goal, the state will heavily subsidize premiums for low-income individuals. The expansion of coverage is financed in part by a new surcharge on all but very small employers that do not offer or pay for at least part of employees' health insurance premiums.

MAY

Vermont lawmakers approve legislation intended to boost the percentage of state residents with health care coverage to 96% from 90%. The measure, like the one passed in Massachusetts, subsidizes premiums for low-income individuals with the amount of the subsidy linked to the individual's income.

Health care plans can seek reimbursement of medical expenses from beneficiaries who receive third-party settlements, the U.S. Supreme Court rules in a unanimous decision. Chief Justice John Roberts writes that the Employee Retirement Income Security Act considers such reimbursement equitable relief. The case before the court involved a health insurer seeking reimbursement for about \$75,000 in medical expenses from a California couple injured in an automobile accident and who sued several parties and ultimately received a tort settlement of \$750,000.

JUNE

Tennessee becomes the third state in as many months to pass comprehensive legislation to reduce the number of people without health insurance. Tennessee's approach, though, is markedly different than Massachusetts and Vermont, which requires employers not offering health insurance to pay an assessment to the state. Under the Tennessee law, the state will pay one-third of the health insurance premium for low-income employees working at small companies. Insurers are to be selected by the state through a bidding process.

Delta Air Lines Inc. says it will terminate its massively underfunded pilots' pension plan because it can no longer afford it. The plan, which covered about 13,000 current and retired pilots, had promised participants \$4.7 billion in benefits, but had just \$1.7 billion in assets. The Pension Benefit Guaranty Corp., which would take over the plan, says it would guarantee about \$913 million in benefits.

JULY

A Maryland law requiring very large employers to spend at least 8% of payroll on health care for employees or pay the difference to a state fund that provides coverage to low-income uninsured residents is illegal, a federal judge says. U.S. District Court Judge J. Frederick Motz says the statute violates an ERISA provision that pre-empts state rules and



BLOOMBERG NEWS /LANDOV
Rep. John Boehner, R-Ohio, looks on as President Bush signs the Pension Protection Act.

laws that relate to employee benefit plans. The way the statute was written, it would have applied only to Wal-Mart Stores Inc.

AUGUST

President Bush signs comprehensive pension reform legislation. The Pension Protection Act requires employers to fund pension obligations within seven years, creates a new methodology to value plan liabilities and prevents employers with underfunded plans from boosting benefits. The bill also makes clear that new cash balance plans do not violate age discrimination law. A rash of huge pension plan failures raised congressional concerns that the federal pension insurance program could go broke unless funding rules

were tightened to avert yet more plan collapses.

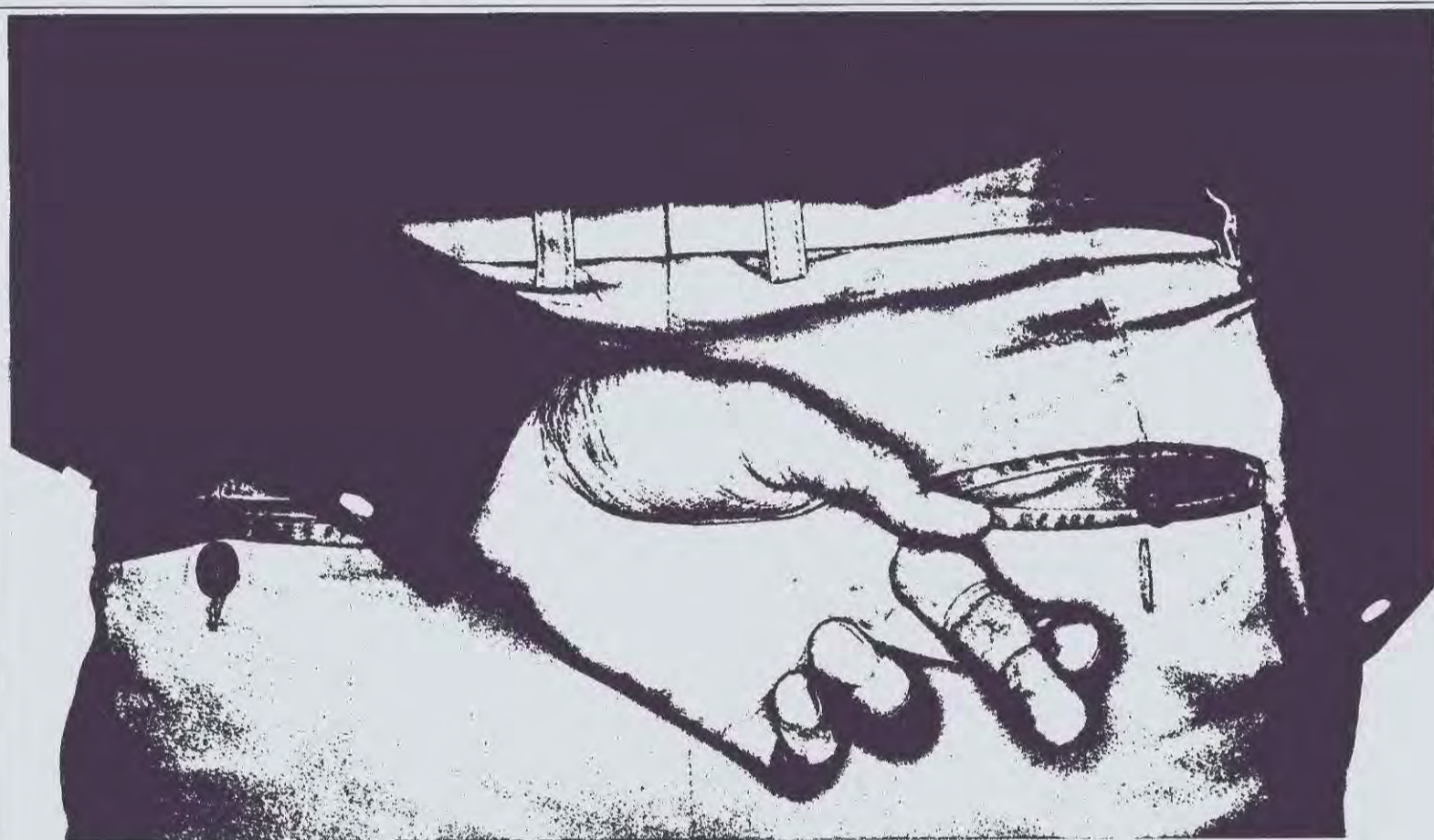
Cash balance plans are not age discriminatory, a federal appeals court says. In the first ruling on the issue at the federal appeals court level, the 7th U.S. Circuit Court of Appeals reverses a judge's 2003 decision that all cash balance plans in general, and IBM Corp.'s plan in particular, are age discriminatory because younger employees have more time to earn interest on their benefits than older employees. But the appeals court rejects the argument, saying the difference in value of the accrued benefit—expressed as a retirement age annuity—between older and younger employees reflects the time value of money, which is not age discrimination.

SEPTEMBER

Two top elected officials veto bills mandating that large employers spend a certain amount of money on health care benefits. California Gov. Arnold Schwarzenegger vetoes a bill, which would have applied only to retailer Wal-Mart, to require employers with at least 10,000 employees in the state to spend an amount equal to 8% of payroll on health care benefits or pay the difference to a state fund. Gov. Schwarzenegger says the law would do nothing to guarantee coverage or lower costs.

In Chicago, Mayor Richard M. Daley vetoes a bill that would have mandated

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so-called "big box" retailers to pay workers at least \$10 an hour in wages plus \$3 in benefits. Mayor Daley says the plan would drive jobs from neighborhoods most in need of economic recovery.

Wal-Mart cuts prices on nearly 300 generic prescription drugs to \$4 for a 30-day supply. The price cut triggers competitors, such as Target Corp., also to discount generic drugs. The moves are expected to boost generic drug use and reduce employers' drug costs.

OCTOBER

Dr. William McGuire, who helped grow

UnitedHealth Group Inc. from a small health maintenance organization to the nation's second-largest health insurer with more than \$70 billion in revenues, says he will step down as chief executive officer following an outside review that found numerous stock option grants were "likely backdated." Dr. McGuire and UnitedHealth reach agreement to reprice his stock options to the highest point each year between 1994 and 2002, reducing their value by about \$200 million.

NOVEMBER

Drug giant CVS Corp. and pharmacy benefit manager Caremark Rx Inc. say they have agreed to merge. Experts say the

\$21 billion deal should result in lower prescription drug prices because the combined entity should have greater leverage in price negotiations with drug manufacturers. Caremark buys directly from manufacturers and distributes drugs through 60,000 pharmacies and mail-order. CVS operates nearly 5,400 retail stores with pharmacies. In December, however, Express Scripts Inc. submits a "superior" \$26 billion offer for Caremark, saying a union would create an "industry-leading PBM." Caremark says it is bound by its agreement with CVS.

Paper packaging and office products giant MeadWestvaco Corp. says it is converting its traditional final-average pay pension plan to a cash balance plan, the

first company to do so since Congress passed legislation protecting cash balance plans from age discrimination suits. MeadWestvaco says cash balance plans are appealing because the benefit formula is visible, easy to understand and shields employees from investment risk.

Health care cost increases, while still outpacing overall inflation, are holding steady, according to a survey of nearly 3,000 employers by Mercer Health & Benefits L.L.C. Group health care plan costs increased by an average of 6.1% in 2006, the same increase as in 2005. After torrid increases just a few years earlier, Mercer says the easing of health care inflation reflects greater corporate emphasis on con-

sumerism and case management.

DECEMBER

Congress gives final approval to legislation that will allow many employees to boost contributions to HSAs. Among other things, employees could make the maximum contribution to their HSAs regardless of when they were hired in a plan year. Current rules require contributions to be prorated to reflect when an employee was hired. Other changes would make it easier to transfer balances from health reimbursement arrangements to HSAs and no longer link the maximum HSA contribution to the deductible in the health plan connected to the HSA.

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The specific proposal information is set forth in the document entitled "Request for Proposal for Performance of Expert Professional Brokerage Firm Services for The World Trade Center Insurance Program". A copy of this RFP is available via download at www.panynj.gov. A copy can also be requested, via e-mail, at askforbids@panynj.gov. Upon requesting the RFP, please reference **RFP Number 11854** in the subject line. Your e-mail should include the following information: full legal firm name, email address, contact person, mailing address, and telephone number. Joint Ventures/teams are acceptable.

Proposals in response to this RFP are **due by 2:00 P.M. on January 16, 2007** and must have the RFP Number and full legal firm name clearly indicated on the outside package.

REQUEST FOR PROPOSALS**LEGAL NOTICE**

IN THE SUPREME COURT OF BERMUDA
CIVIL JURISDICTION
NRC REINSURANCE COMPANY LTD
and IN THE MATTER OF THE
COMPANIES ACT 1981, SECTION 99
NOTICE OF TERMINATION OF
SOLVENT SCHEME OF ARRANGEMENT
NOTICE IS HEREBY GIVEN that the scheme of arrangement between NRC Reinsurance Company Ltd (the "Company") and its Scheme Creditors, which became effective on 31 March 2006 (the "Scheme"), has been fully implemented in accordance with its terms. In accordance with the provisions of Clause 8 of the Scheme, the Scheme is terminated upon all Scheme Liabilities having been paid in full. The date of Scheme termination is 24 November 2006. No further payments shall be made to Scheme Creditors by the Company in respect of Scheme Claims. Should you have any questions regarding this notice, please address them to:
Rene Lapiere & Associates, 700 de la Gauchetière Street West, Suite 1810, Montreal, QC H3B 0A6, Canada (telephone: +1 514 982 4852, facsimile: +1 514 284 1914)
Dated this 24th November 2006

To place your legal notice
Contact Tina at 312-649-5340.

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UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

RELiance NATIONAL INSURANCE COMPANY (EUROPE) LIMITED

Case No.: 05-46232 (ALG)

PLEASE TAKE NOTICE that on December 12, 2006, the Bankruptcy Court for the Southern District of New York entered an order (the "Order") pursuant to 11 U.S.C. § 541 and 304(b) granting the Petition heard before the Honorable Allan L. Gropper in the Alexander Hamilton Custom House, One Bowling Green, New York, New York on December 12, 2006 for injunctive relief that, among other things, gives full force and effect in the United States to the Scheme of Arrangement, dated November 1, 2006, between Reliance National Insurance Company (Europe) Limited and its Scheme Creditors (the "Scheme") and enjoins all persons and entities from taking any action inconsistent with the Scheme.

Any person wishing to obtain a copy of the Order should contact Tania Ingman at (212) 610-6300 or at tania.ingman@allenoverly.com. The Order, the Scheme and the related Explanatory Statement are also available to review and download at www.omniwhittington.com.

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IN THE HIGH COURT OF JUSTICE (IN ENGLAND AND WALES) CHANCERY DIVISION COMPANIES COURT NO 4433 OF 2005

IN THE MATTER OF

THE SCOTTISH EAGLE INSURANCE COMPANY LIMITED
(formerly known as M.U. Cambridge Insurance Company Limited)

IN THE MATTER OF THE COMPANIES ACT 1985, SECTION 425

NOTICE OF CRYSTALLISATION OF ASCERTAINED CLAIMS

NOTICE IS HEREBY GIVEN in the matter of The Scottish Eagle Insurance Company Limited that, following the sanction of the scheme of arrangement (the "Scheme") which became effective on 31 October 2005 and in accordance with clause 17.3 of the Scheme all Ascertained Claims have been designated as Crystallised Claims.

A copy of the Scheme and details relating to it may be obtained from the website (<http://www.scottisheaglesolventscheme.co.uk/>)

Should you have any questions regarding this Notice, please address them to Steve Crawley at: The Scottish Eagle Insurance Company Limited, 5th Floor, Cutlers Exchange, 123 Houndsditch, London EC3A 7PQ, United Kingdom (Tel: +44 (0)20 7626 4266, Email: solventscheme@scottishilon.co.uk)

International NEWS

E.C. pushes back report on competition probe

Findings of inquiry into insurance firms now out in early 2007

By MICHAEL BRADFORD
and ADRIAN LADBURY

BRUSSELS, Belgium—The European Commission has confirmed that its interim report into competition in the commercial insurance sector—launched in the summer of last year—will not be ready until January and could even slip into February.

The Commission sent detailed questionnaires to leading insurance trade bodies at the end of 2005 and to individual insurance companies and brokers in early 2006.

It intended to use this information as the basis for an interim report planned for the end of this year.

But a spokeswoman for the Commission said that the interim report being prepared by the Competition Directorate had been delayed because of “administrative reasons” and “various planning purposes.”

The Commission spokeswoman declined to give any more details,

but added that the publication of the report could even “slip to early February.”

The Commission will hold a public hearing on Feb. 12 to debate its report.

The meeting will form part of a 10-week consultation period that is intended to enable third parties to respond to the interim report and help the Commission prepare the final report, which is expected in June next year.

The purpose of the inquiry is to determine whether the structure of the commercial insurance market in Europe is distorting or restricting competition.

One Brussels-based lobbyist said that the core issue will be whether or not the Commission will allow the insurance sector to continue to benefit from what is known as a “block exemption” that enables it to share data unlike most other industries.

This exemption was granted by the Commission because it was decided that the insurers need to share data and information in order to come up with the relatively accurate risk measurement needed to devise adequate pricing that enables them to offer their products and services in the first place.

Regulator says more work needed on U.K. contract certainty effort

FSA, industry welcome progress in meeting goals

By ADRIAN LADBURY
and SARAH VEYSEY

LONDON—The United Kingdom’s insurance regulator says it is satisfied that the market has done enough to meet contract certainty targets to avoid regulatory intervention for the time being.

But in a letter to the chief executives of all brokers and insurers conducting nonlife insurance business in the United Kingdom, the regulator warned that “there are areas where more work is needed to ensure the market-led solution is successful and continues to be beyond 2007.”

Before the FSA’s “Dear CEO letter” was sent out late last month, executives from the London and wider U.K. insurance market expressed confidence that the industry would meet its contract certainty targets and stave off intervention by the Financial Services Authority.

In December 2004, John Tiner, CEO of the FSA, challenged the U.K. insurance industry to find a solution to the issue of contract certainty by the end of this year.

The FSA has made clear that it always has favored a market-led solution to meeting this requirement.

The Market Reform Group, set up by members of the Lloyd’s of Lon-



ISTOCKPHOTO

don and London insurance markets to find a way to address the issue, defines contract certainty as “the complete and final agreement of all terms (including signed lines) between the insured and insurers before inception.”

In its letter to CEOs, the London-based FSA said it recognized that “many firms have made significant progress towards achieving contract certainty since the start of our challenge.”

But Sarah Wilson, the FSA’s insurance sector leader and author of the letter, said that there were some failings among certain sectors of the market.

In the letter, Ms. Wilson said that “some parts of the market are less engaged than others, believing that contract certainty does not apply to them. In particular, some smaller firms and, notably, brokers outside the London market appear to be less

engaged in this initiative than they should be at this late stage.”

The FSA said it had found “good evidence of data verification among firms of all sizes.”

But the regulator did cite some examples of poor practice and failure of firms to accurately measure contract certainty.

Leading figures in the London insurance market, however, were confident that the market had succeeded in its effort to tackle contract certainty.

However, they note that the process should not stop and that policyholders, intermediaries and insurers need to keep up the pressure on each other to make sure that the concept of contract certainty is embedded in the market.

Dane Douetil, chief executive of Brit Insurance Holdings P.L.C.,

See FSA next page

HRH buys brokerage Glencairn in bid to boost U.K. operations

Deal will improve U.S. broker’s access to London market

By MARK A. HOFMANN

LONDON—Hilb Rogal & Hobbs Co. last week agreed to acquire Glencairn Group Ltd., a London-based independent insurance and reinsurance brokerage group for an undisclosed sum.

Glencairn, founded in 1991, has offices in Australia, Russia and South Africa, as well as in London.

It provides products and services primarily in the property, casualty, reinsurance, financial, professional, accident and health, and specialty areas, including political risks and cargo, through both wholesale and retail operations. Glencairn’s annualized 2006 revenues are expected to reach about \$39 million, making it Glen Allen, Va.-based HRH’s largest international acquisition.

“By uniting Glencairn with our existing London operations, HRH will triple its size in the United Kingdom, combining the forces of some of the most talented insur-

ance professionals in London,” Martin L. Vaughan III, HRH’s chairman and chief executive officer, said in a statement announcing the acquisition. “Our expanded presence in this marketplace will allow HRH increased access to the Lloyd’s of London market and other critical international underwriting markets, including Bermuda.”

Steve Hearn, Glencairn’s current chairman and CEO, will be appointed CEO of HRH’s existing London operations—HRH Reinsurance Brokers Ltd. and Lloyd’s broker NIB (UK) Ltd.—and continue to lead his current staff. The transaction is

scheduled to be completed on Jan. 2, 2007.

HRH ranked 10th on *Business Insurance’s* 2006 ranking of the world’s largest insurance brokerages, based on 2005 brokerage revenues of around \$658 million.

Two stock analysts who follow HRH said the acquisition made a lot of sense.

“It’s a pretty positive deal for them,” said Mark Dwelle, an analyst with Ferris, Baker Watts Inc. in Richmond, Va. “It greatly expands their presence in the Lloyd’s of London markets. It gives them a cross-sell opportunity, in that if they have

U.S. clients that want access to the Lloyd’s markets, they can get them there directly rather than having to go through somebody else.”

“We were calling for \$40 million of acquired revenue next year, and this \$39 million acquisition therefore almost meets the goal, and anything else they acquire is accretive earnings,” said Nik Fiskens, managing director with Stephens Inc. in Little Rock, Ark.

“This definitely boosts the overseas wholesaling operations that they’ve been trying to add to, so it seems like a great deal all told,” Mr. Fiskens said.

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Commentary

Congressional fighting good for the system

'Tis the season of peace on earth and good will toward men.

That's true even in Washington, at least officially.

The change in control of both houses of Congress has led to promises of change in congressional conduct as well. These promises go far beyond ending inappropriate e-mails to congressional pages and getting caught with your hands in a lobbyist-stocked cookie jar.

These promises go to the heart of human nature, at least that of the political species. Acrimony will be banished, and human kindness shall reign. We are about to enter a glorious era of productive bipartisanship.

While I don't want to play the Grinch or Scrooge, I can't help but be a bit skeptical of these claims. The emphasis on a return to civility is more than welcome, but an era of pure bipartisanship might not be in the best interests of the nation.

That isn't to say that bipartisanship doesn't have a place in Washington. Consider the question of the federal terrorism insurance backstop. Extending the backstop beyond its scheduled Dec. 31, 2007, expiration date—or making some form of it permanent—enjoys the support of a wide majority of lawmakers from both parties. Doing so is opposed by the Consumer Federation of America on the left, and the administration aided by a handful of Republican lawmakers and The Wall Street Journal editorial board on the right.

Relatively few major issues cross party lines so readily as terrorism insurance. That kind of broad support, other than in times of national emergency, is often reserved for the naming of post offices and the recognition of hitherto unsung patriots whose neighborhood virtue made the country a better place.

The truth is, we need partisanship. Without it, it would be a lot harder to keep the other side honest. Of course, partisanship in and of itself isn't enough to keep people honest. Even with the sharp-edged partisanship of the past couple of Congresses—not to mention what erupted time and again during the Democrats' 40-year unbroken hold on the House—malefactors still got away with quite spectacular misdeeds.

There has to be a watchdog; in the political arena, the guys who want your job perform that function very well. One-party government, which is the



MARK A. HOFMANN

Senior Editor Mark A. Hofmann can be reached at: mhofmann@businessinsurance.com

case when there's truly only one party involved or when two or more parties basically scratch each others' backs and look the other way when something foul's afoot, can't do that.

Partisanship has gotten a deservedly bad rap of late because it has been played out in a particularly nasty way. Partisanship doesn't mean that you have to paint the guy from the other party as some sort of spawn of Satan for disagreeing

The truth is, we need partisanship. Without it, it would be a lot harder to keep the other side honest.

with you on the question of, say, whether federal subsidies should be provided to kumquat growers who just happen to be major contributors to your re-election campaign.

After all, one enduring bit of Washington folklore concerns how the late House Speaker Tip O'Neill and President Ronald Reagan could fight political battles during the day and then socialize quite pleasantly during the evening. They remained partisans, but they did not go out of their way to demonize each another.

Such civility can't—and shouldn't—paper over real political differences. That's why we have political parties. There has to be a vehicle for presenting policy proposals to the public and then to fight for those proposals.

But the fights can and should be conducted in a civil manner. There's nothing Pollyannaish about that, either. Partisanship we need—extended rancor we don't. It's a bit of the Christmas spirit this town could use all year long.

FSA: Regulator pushes contract certainty

CONTINUED FROM PREVIOUS PAGE

chairman of the Market Reform Group and constituency representative of insurers on the London market's Contract Certainty Steering Group, said that Mr. Tiner and the FSA should be pleased with achievements to date.

"We will exceed the self-imposed targets," he said. But he did warn those brokers and insurers that may have not taken the project seriously enough and have hidden behind the majority that the FSA will not let them get away with it, even if the market as a whole meets the

regulator's criteria.

Mr. Douetil said that the steering group will continue to operate until the end of next year to ensure that the concept is truly embedded in all companies' processes.

During this year, the FSA strongly urged risk managers to play a central role in the pursuit of market reform.

David Gamble, executive director of the Assn. of Insurance & Risk Managers, said that he believes that the risk management profession has played its part in the reform effort.

AIRMIC, which has two represen-

tatives on the Market Reform Group board, produced a contract certainty guide in the summer and carried out a road-show across the country, he said.

"The challenge is to keep it going. The large brokers have gone through a very significant behavior change, and our members are certainly very positive about the way they have reacted.

There is still a concern about what is happening outside of our membership, but overall we have seen that the market has learned how to make changes which are beneficial," said Mr. Gamble.

Comings & Goings

INSURERS:

Richmond, Va.-based **Markel Corp.** has promoted **John Latham** to senior vp in operations. Replacing Mr. Latham as chief information officer will be David Egbert, currently Markel's chief technical officer.

BROKERS:

Willis Group Holdings Ltd. has appointed **Richard Donahue** as senior vp, director of claims and loss control in its New Hampshire operations for the MountainGuard Program in Portsmouth. Before his promotion, he was a claims specialist.

Also at **Willis**, **Joe Beesack** has been named senior vp in the alternative risk solutions practice in Toronto. Before joining Willis, he was a senior vp and chief analytical officer at Aon Reed Stenhouse Inc.

Kenneth W. Felton has been named senior vp and national clinical risk management consultant for Glen Allen, Va.-based **Hilb Rogal & Hobbs Co.** Previously, he was health care practice leader for Webster Insurance Inc.

Cherry Hill, N.J.-based Commerce Banc

Insurance Services has appointed **Thomas Nolan** as senior vp. Previously, he was vp and account manager for The Graham Co.

REINSURANCE:

New York-based **Guy Carpenter & Co. Inc.** has named **Nick Gralton** as head of U.S. wholesale casualty in London. Previously, he was head of R.K. Carvill & Co.'s casualty specialty division.

Also at **Guy Carpenter**, **Eric Johnson** has been named senior vp in the Minneapolis office. He most recently was a senior vp at Willis Re Inc.

Transamerica Reinsurance has made two senior-level appointments in its Paris office.

- **Christian Mounis** has been named president, Transamerica Reinsurance Europe. Previously, he was an executive vp for SCOR Vie.

- **René Lemaire** has been appointed senior director, northern Europe. Before joining Transamerica Re, he was senior vp, global marketing department, for SCOR Vie.

OTHER PROVIDERS:

Milwaukee-based **Zywave Inc.** has named **Charles Bacciocco** as senior vp, product strategy. Before joining the technology products and services provider, he was vp of technology and chief software architect for Arthur J. Gallagher & Co.'s corporate e-business practice group.

Seattle-based **Zynchros Inc.**, a developer of formulary management strategies, has promoted **Robert Pinkerton** to president and chief operating officer. Previously, he was chief marketing officer.

Portland, Ore.-based **StanCorp Equities Inc.** has appointed **Sheri Fitts** as director of retirement plans communications and large plan sales. Previously, she was vp of business development in U.S. Bank's institutional trust and custody division.

Mesirow Financial Services Inc. in Chicago has named **Richard S. Price** as the firm's president and chief operating officer, a newly created position. Previously, he was vice chairman of the firm and president of the insurance services division.

TO SUBMIT ITEMS

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

How to submit a Perspective article for publication in *Business Insurance*

Business Insurance accepts articles from experts in commercial insurance, risk management and employee benefits management for publication in its Perspective section.

The section is intended to be a forum for readers' opinions and a forum for the discussion of technical topics that do not lend themselves to a news story. Therefore, Perspectives articles should take a point of view, offer advice and/or explain a technical subject. They should not present case studies or promotional information.

All articles for the Perspective page should address the concerns of the corporate buyer of insurance; that is, the risk management or

employee benefits manager. Material written for only the concerns of brokers or underwriters is not appropriate.

To submit an article for the Perspective section:

- Send us a letter describing the topic you would like to address. You might want to suggest alternative topics. For each topic, briefly describe what you want to say and accomplish in the article.

- You will receive from us an acceptance or declination of your article idea.

- If accepted, we will respond with comments and request the full article, which generally should be 800-900 words in length.

- All articles are to be accompanied by color photograph of the author and a brief biography.

- We will notify you of any questions we have about your article or any substantial editing we think is necessary.

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THE BENEFITS OF BETTER COVERAGE.

The '12 days of Chaos'

By Myron M. Picoult

In past years, I have summarized my thoughts about the property/casualty industry via rhymes and letters. This year, it was again time for a rhyme, and the "12 Days of Christmas" popped out—except it emerged as the "12 Days of Chaos!"



On the first day of Chaos,
this would be great news:
An industry spokesperson
to fill Hank's shoes.

On the second day of Chaos,
this would be great news:
Two customer service reps with a clue,
And an industry spokesperson
to fill Hank's shoes.

On the third day of Chaos,
this would be great news:
Three analysts building earnings
models from scratch,
Two customer service reps with a clue,
And an industry spokesperson
to fill Hank's shoes.

On the fourth day of Chaos,
this would be great news:
Four technology gurus
who will advocate change,
Three analysts building earnings
models from scratch,
Two customer service reps with a clue,
And an industry spokesperson
to fill Hank's shoes.

On the fifth day of Chaos,
this would be great news:
Five savvy CEOs,
Four technology gurus
who will advocate change,
Three analysts building earnings
models from scratch,
Two customer service reps with a clue,
And an industry spokesperson
to fill Hank's shoes.

On the sixth day of Chaos,
this would be great news:
Six actuaries who'll defend finite con-
tracts,
Five savvy CEOs,
Four technology gurus who
will advocate change,
Three analysts building earnings
models from scratch,
Two customer service reps with a clue,
And an industry spokesperson to fill
Hank's shoes.

On the seventh day of Chaos,
this would be great news:
Seven risk managers
who'll stand up to brokers,
Six actuaries who'll defend
finite contracts,
Five savvy CEOs,
Four technology gurus
who will advocate change,
Three analysts building earnings
models from scratch,
Two customer service reps with a clue,
And an industry spokesperson
to fill Hank's shoes.

On the eighth day of Chaos,
this would be great news:
Eight progressive underwriters,
Seven risk managers
who'll stand up to brokers,
Six actuaries who'll defend
finite contracts,
Five savvy CEOs,
Four technology gurus
who will advocate change,
Three analysts building earnings

models from scratch,
Two customer service reps with a clue,
And an industry spokesperson
to fill Hank's shoes.

On the ninth day of Chaos,
this would be great news:
Nine regulators to discuss regulation,
Eight progressive underwriters,
Seven risk managers
who'll stand up to brokers,
Six actuaries who'll defend
finite contracts,
Five savvy CEOs,
Four technology gurus
who will advocate change,
Three analysts building earnings
models from scratch,
Two customer service reps with a clue,
And an industry spokesperson
to fill Hank's shoes.

On the 10th day of Chaos,
this would be great news:
Ten consultants worth their services,
Nine regulators to discuss regulation,
Eight progressive underwriters,
Seven risk managers
who'll stand up to brokers,
Six actuaries who'll defend
finite contracts,
Five savvy CEOs,
Four technology gurus
who will advocate change,
Three analysts building earnings
models from scratch,
Two customer service reps with a clue,
And an industry spokesperson
to fill Hank's shoes.

On the 11th day of Chaos,
this would be great news:
Eleven directors discussing term limits,
Ten consultants worth their services,
Nine regulators to discuss regulation,
Eight progressive underwriters,
Seven risk managers
who'll stand up to brokers,
Six actuaries who'll defend
finite contracts,
Five savvy CEOs,
Four technology gurus
who will advocate change,
Three analysts building earnings
models from scratch,
Two customer service reps with a clue,
And an industry spokesperson
to fill Hank's shoes.

On the 12th day of Chaos,
it would be great news:
A dozen CFOs reviewing
risk transfer rules,
Eleven directors discussing term limits,
Ten consultants worth their services,
Nine regulators to discuss regulation,
Eight progressive underwriters,
Seven risk managers
who'll stand up to brokers,
Six actuaries who'll defend
finite contracts,
Five savvy CEOs,
Four technology gurus
who will advocate change,
Three analysts building earnings
models from scratch,
Two customer service reps with a clue,
And an industry spokesperson
to fill Hank's shoes.



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.

PBMs: Express Scripts ups the ante for Caremark

CONTINUED FROM PAGE 1

insurance companies, Mr. Crockett said. This might be a good option for self-insured employers because insurers "have less negotiating leverage for lower priced drugs in comparison to a large, merged PBM" with its far greater number of covered lives, Mr. Crockett said.

Express Scripts, meanwhile, has distinguished itself in moving its members to generic drugs and may be able to implement some tools it uses to promote generic utilization at Caremark, which would effectively lower drug costs for employers, said David Dross, national practice leader for Mercer Health & Benefit's managed pharmacy practice based in Houston. Express Scripts had a generic dispensing rate of 58.3% in the third quarter of 2006 vs. Caremark's retail generic dispensing rate of 57.6% and mail service generic dispensing rate of about 44.1%.

The key employer and consultant concern is whether the combined PBM would have too much market power as it would control about 45% to 50% of the PBM market.

"I personally think there might be some antitrust issues now," Mr. Crockett said. In a less competitive environment, the PBMs would have "the power to control the price of drugs and raise the price of drugs."

"You just have to be careful you don't end up with some lack of competition that will drive prices up," said Scott Clark, risk and benefits officer for Miami-Dade County Public Schools.

While there is significant price competition currently, "With fewer entrants involved, I would be concerned that we would see less and less price competition in the future and that would be a concern for employers," Mr. Dross said.

Factoring in pharmacy services offered by health plans, retailers and independent PBMs, there is "significant competition" in the market that should overcome any regulatory questions related to an Express Scripts/Caremark merger, said George Paz, president, chief executive officer and chairman of Express Scripts. "We feel confident we can pass those hurdles."

Employer concerns

Many employers are concerned about the potential for erosion in service delivery that arises from having a contract with a large PBM, and better pricing from a combined entity will not matter if the PBM fails to do a good job of delivering pharmacy services, Mr. Dross said.

An increasing number of employers may be open to a different business model than the one employed by the major PBMs, observers say.

"It's just safe to say there is some concern that employers feel PBMs may not be operating 100% in their best interests," Mr. Dross said.

Smaller PBMs are more willing to be transparent than the three big PBMs, observers say.

Innoviant Inc., a Wausau, Wis.-based PBM with nearly 1 million lives, provides employers with

access to its drug manufacturer and pharmacy network contracts; explains how it makes decisions on which drugs to promote; and discloses savings from rebates, discounts or cost management programs. "Our model makes it easier for them to make those informed decisions," said Mark Campbell, president and CEO of Innoviant. "Transparency to us is a business philosophy, an open access policy."

Whether CVS will counter the Express Scripts offer remains uncertain. In a statement last week, CVS said it had not yet reviewed Express Scripts' proposal, but the organization believed the prospects for completing the merger were excellent.

Also last week, in separate statements by CVS and Caremark, the companies said a primary regulatory hurdle to their potential merger was removed when the initial waiting period required by the Hart-Scott-Rodino Act expired without the U.S. Federal Trade Commission seeking more information. Even so, shareholders still would have to give their approval.

Long-term impact

If Caremark were to accept the Express Scripts offer, the next question will be whether the cost would have any long-term impact on cash flow or return on investment for the merged PBM, Mr. Dross said.

The Caremark board also has to consider which offer has the potential to bring the most value to the marketplace and deliver more innovation or service delivery improvements. A possible disadvantage of an Express Scripts/Caremark union is that it may not feature the same innovation potential as a CVS/Caremark merger because of substantial overlap of products and services that Express Scripts and Caremark offer, benefit consultants say.

"I think the CVS/Caremark merger is a little bit more intriguing in that employers wouldn't really know what to expect because it would be a new type of arrangement, whereas Express Scripts/Caremark would just be more PBM consolidation," said Sean Brandle, a vp at The Segal Co. in New York.

The Caremark board, though, may be pressured to take Express Scripts' offer because the financial value offered is in the best interests of shareholders, Mr. Dross said.

The Express Scripts offer of \$58.50 per share in cash and stock is a 15% premium over the all-stock purchase price to be paid to Caremark stockholders if acquired by CVS, Mr. Paz said during a conference call.

PBM rival Medco's reaction to an Express Scripts/Caremark merger is another uncertainty. A Medco spokeswoman declined comment on the possible merger, but said Medco "is confident in its business model."

"If I'm Medco, I'm just sitting tight right now because there's so much confusion," Mr. Brandle said. "Maybe they're in a good position to actively benefit from all this turmoil happening around their major competitors."

Chubb: First insurer to eliminate contingent commissions entirely

CONTINUED FROM PAGE 1

tomer steering, improper finite reinsurance transactions, and other unlawful industry practices."

His investigation determined that "Chubb made undisclosed payments to insurance brokers and agents that encouraged them to steer business to Chubb," which created a conflict of interest for brokers and agents "who owed their clients fiduciary duties of care, full disclosure and loyalty."

While the attorneys general did not charge that Chubb participated in a pattern or practice of illegal bid rigging, the investigations did find that the insurer "benefited from and on a number of occasions acted consistently with the objectives articulated by participants in a Marsh-led scheme to rig the excess casualty insurance bidding process," according to the assurance of discontinuance Chubb signed as part of the settlement.

New York-based broker Marsh & McLennan Cos. Inc. last year agreed to pay \$850 million and to change its business practices to settle fraud and bid-rigging charges leveled by Mr. Spitzer.

Acknowledging that it appears that it "unknowingly benefited from the bid-rigging activities of others in the excess casualty market, which may have provided Chubb with an advantage in retain-

ing certain renewal business," Chubb agreed to pay \$15 million to its excess casualty policyholders who purchased their policies through Marsh between Jan. 1, 2000, and Sept. 30, 2004.

No more contingents

While other recent settlements various insurers have reached with Mr. Spitzer and other attorneys general included provisions that curtail the insurers' ability to pay contingents, Chubb is the first insurer to agree to eliminate them entirely as part of a settlement.

Chubb historically has been among the highest payers of contingent commissions in the industry, according to the attorneys general. From 1999 to 2004, Chubb paid nearly \$850 million in contingent commissions, with nearly \$100 million going to Marsh alone between 1999 and 2002, according to the settlement agreement.

ACE Ltd., American International Group Inc., St. Paul Travelers Cos. Inc. and Zurich American Insurance Co. Inc., for instance, agreed as part of settlements to cease paying contingents on excess casualty coverage and on any line, product or segment of business if insurers that represent 65% of the gross written premiums on that line—including direct writers—were not paying such commissions or were to reach

similar agreements. Those additional lines currently are homeowners multiperil, private passenger auto-

SETTLING WITH SPITZER

Property/casualty insurers have paid various amounts to settle Mr. Spitzer's investigations

AIG	\$1.6 billion
Zurich	\$153 million
ACE	\$80 million
St. Paul Travelers	\$77 million
Chubb	\$17 million

Source: Settlement documents

mobile physical damage, private passenger auto no-fault, private passenger auto liability, boiler and machinery, and financial guarantee (BI, Dec. 4).

ACE and AIG voluntarily ceased paying contingents in 2004 in the wake of Mr. Spitzer's suit against MMC, but historically never paid out significant amounts of contingent commissions.

A person in Mr. Spitzer's office familiar with the Chubb settlement said that the insurer came to the attorney general voluntarily and offered to cease paying contingent commissions on all insurance lines in the United States beginning in 2007 and, in return, asked for more

lenient settlement terms.

"I think we were more than willing to accommodate that to what ever degree we could," the person said. "That's why you're not seeing spectacular (settlement) numbers here." Other insurers allegedly implicated in the Marsh bid-rigging scheme have paid higher amounts (see chart).

New pay model

In its statement, Chubb said the insurer has voluntarily undertaken substantial business reforms over the past two years, culminating in its new producer compensation model.

While Chubb's statement did not provide many details about its new "supplemental compensation program," and a spokesman declined to elaborate, the insurer did note that it plans to "institute a program of predetermined supplemental compensation for our producers that will both compensate them for their contributions to Chubb's success and facilitate their communication with customers."

According to the settlement agreement, "a fixed commission paid to a producer, set prior to the sale of a particular insurance product, and that may be based on, among other things, the prior year's performance of the producer" is not considered contingent compensa-

tion and thus is permitted.

Because the fixed incentive compensation is retrospective or based on prior years' performance, steering concerns are eliminated, sources say. Contingent commission programs are more prospective in that they are contingent on meeting future volume- or profit-based targets and therefore have the appearance of creating a conflict of interest.

"I don't see any conflicts of interest or steering issues because it's retrospective instead of prospective," said Robert A. Rusbuldt, chief executive officer of the Alexandria, Va.-based Independent Insurance Agents & Brokers of America Inc.

While Mr. Rusbuldt said he opposes Mr. Spitzer intervening in compensation matters, Chubb's agreement on compensation practices is encouraging for agents and brokers, he said.

"In general, some companies have been very encouraging and very positive about what will take the place of contingency compensation and in fact we're encouraged that the Chubb plan in many respects will be better than contingency compensation," said Mr. Rusbuldt.

For example, because the incen-

See **CHUBB** next page

Acordia: Broker vows to battle charges it improperly steered business

CONTINUED FROM PAGE 1

reached settlements with various state authorities in which they've agreed to pay clients millions of dollars in restitution and change their business practices. Marsh, Aon, Willis and Gallagher also agreed to no longer accept contingent commissions on retail business.

A number of insurers, including ACE Ltd., American International Group Inc., St. Paul Travelers Cos. Inc. and Zurich Financial Services Group, also have settled numerous allegations leveled by state authorities, including steering charges, and have agreed to curtail their ability to pay contingent commissions on

certain lines of business. Chubb Corp. joined that group last week with a \$17 million settlement of investigations by Connecticut, Illinois and New York (see related story).

As for Liberty Mutual Group Inc., the broker—like Acordia—has opted to fight bid-rigging and steering allegations from the same attorneys general.

The Acordia suits seek restitution for clients, disgorgement of illegal profits, penalties and a change in the way Acordia does its business.

"We will vigorously defend against these allegations," a spokeswoman for San Francisco-based Wells Fargo said. "Contingent compensation agreements have been longstanding and well-known in the insurance industry and these commissions continue to be paid by insurers to hundreds of insurance agents and brokers throughout the country, including New York."

Acordia's decision to fight the allegations is consistent with its 2005 stance to fight a similar lawsuit filed by West Virginia Attorney General Darrell V. McGraw Jr., who charged that Acordia and its Acordia of West Virginia Inc. subsidiary violated state antitrust and consumer protection laws by accepting contingent commissions from insurers for steering business their way (BI, May 30, 2005).

That case is still pending, the Wells Fargo spokeswoman said.

The three suits filed last week charge that Acordia authorized and

participated in several steering schemes that improperly shifted Acordia's loyalty from its clients to insurers.

The alleged schemes include Acordia's Millennium Partnership Program, initiated in 1999 to con-

'This lawsuit brings us closer to ending the insurance industry's hidden pay-to-play game.'

Richard Blumenthal, Connecticut attorney general

solidate its insurance business with a handful of "preferred" insurers, the suits state. The preferred market partners—Atlantic Mutual Insurance Co., Chubb Group, Hartford Financial Services Group Inc., Royal & SunAlliance and St. Paul Travelers Cos. Inc.—each agreed to pay Acordia an extra override incentive of 1% of gross written premiums that Acordia placed in addition to the standard contingent commissions the insurers already were paying the brokerage, according to the suits.

While Acordia assured that its preferred partners' business increased within Acordia, it retaliated against those insurers that rejected its invitation to become a pre-

ferred partner, the attorneys general allege.

"CNA and Fireman's Fund have declined to support our financial plan without profitability stipulations. We are therefore not inclined to support any business growth with them at the detriment [sic] to our priority Millennium Partners," Charles Ruoff, Acordia's then-senior vp and chief marketing officer, said in a September 1999 e-mail sent to staff, court papers show.

In addition to the MPP program, Acordia and Hartford also put together a wide range of initiatives called Share Shift designed to double business Acordia steered to the Hartford over a three-year period, the suits allege.

Among those Share Shift initiatives was a cross-selling opportunity with Wells Fargo in which the bank agreed to mine its customer database, highlighting its middle-market business customers—those businesses with annual revenue between \$50 million and \$500 million—that fit within four industries that Hartford planned to target: business services, technology, communications/media and law firms. Wells Fargo referred those customers to Acordia ostensibly for unbiased insurance brokerage services, the suits allege. Acordia in turn, steered the customers to Hartford, regardless of whether it was the best option for the customer.

According to court papers, Hartford's management expected to

provide quotes on 75% of the business Acordia presented as part of the scheme—a rate 2.5 times better than Hartford's usual submission-to-quote ratio—and that it would win 50% of these Wells Fargo customers. Management at Hartford expected to increase middle-market business it wrote through Acordia by \$20 million, the suits say.

"This lawsuit brings us closer to ending the insurance industry's hidden pay-to-play game," Connecticut Attorney General Richard Blumenthal said in a statement. "For years, insurers secretly paid Acordia millions of dollars in return for Acordia steering clients to those selected insurers. Now they will have to answer in court where we will vigorously pursue money back to consumers, penalties and business reforms."

St. Paul Travelers agreed to pay \$77 million in August to end probes of improper business practices by the attorneys general in Connecticut, Illinois and New York.

A spokesperson for Chubb declined comment.

"We have and continue to offer regulators our full cooperation and are working actively with them to resolve these matters," said a spokesman for Hartford.

Spokespeople for Royal & SunAlliance and OneBeacon Insurance Co., which acquired the renewal rights to Atlantic Mutual's commercial insurance business in 2003, could not be reached for comment.

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News In Brief

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three catastrophe events this year have caused insured losses of more than \$1 billion, Swiss Re noted.

Munich Re, SCOR turn to cat bonds

Munich Reinsurance Co. has arranged a cat bond to provide \$190 million of California earthquake coverage for risks assumed from units of Switzerland's Zurich Financial Services Group. The issuer of the bond was Lakeside Re Ltd., a special-purpose reinsurance company domiciled in the Cayman Islands. Meanwhile, SCOR S.A. has secured a catastrophe bond from special-purpose vehicle Atlas Reinsurance III that will provide the Paris-based reinsurer with €120 million (\$156 million) of reinsurance protection for second and subsequent Europe windstorm or Japan earthquake events from 2007 to 2009.

CSR, ACE settle asbestos dispute

CSR Ltd. has reached a \$120 million settlement with Bermuda-based ACE Ltd. in connection with U.S. asbestos claims to end longstanding litigation. CSR began litigation in 1995 in New Jersey federal court against several insurers, seeking indemnity for U.S. asbestos claims, together with other damages and relief, under policies issued to the building products and sugar supplier from about 1978 to 1989. CSR formerly mined asbestos in western Australian and manufactured various products, many of which were exported to the United States. CSR previously settled with other insurers.

Aon buying RMIS vendor Valley Oak Systems

Aon Corp. plans to acquire San Ramon, Calif.-based risk management information system vendor Valley Oak Systems for an undisclosed amount. Valley Oak Systems will join Aon's RiskLab unit as part of its e-Solutions software group. Aon acquired Risk Laboratories L.L.C. in 2004 and phased out its own RMIS product in favor of RiskLab's RiskConsole system. Valley Oak's iVOS system provides claims administration, medical bill review, policy underwriting, case

management, billing and event management capabilities.

HCC to restate over options practices

HCC Insurance Holdings Inc. of Houston said it is restating several years of financial results and taking a \$30 million pretax charge after a review found HCC improperly accounted for employee stock options from 1997 through 2005 and that the majority of those option grants were retroactively priced. The insurer in a statement noted the findings of that review—completed last month—are what prompted HCC to accept resignations from certain members of management. HCC's founder and former chief executive, Stephen L. Way, resigned last month.

Harbor Point forms retro reinsurer

Harbor Point Ltd. has announced the formation of a new company in Bermuda dedicated to writing retrocessional business. Initial capitalization for the newly formed Class 3 reinsurer—called New Point Re Ltd.—is expected to be \$250 million, with Harbor Point as a minority investor in the venture. Capital will also be provided by institutional investors, a spokeswoman for Harbor Point said.

Wellington shareholders OK takeover by Catlin

Catlin Group Ltd. said it has received acceptance from shareholders in Wellington Underwriting P.L.C. to allow Catlin to buy the London-based company. Hamilton, Bermuda-based Catlin announced that Lloyd's of London had approved the cessation of Wellington's syndicate 2020, which will allow Catlin to enlarge its syndicate 2003. That syndicate will have capacity of £1.3 billion (\$2.6 billion) for 2007.

UnitedHealth ups backdating charges

UnitedHealth Group Inc. last week upped its estimated charges related to improper stock-option granting practices to between \$425 million and \$1.7 billion, finging upon the method of accounting used to calculate the charges. The insurer in May had placed the maximum impact stemming from options at no more than \$286 million. The company said its new estimates are subject to an accounting review by the Securities and Exchange Commission and may change once the company's previously announced restatement is completed.

Chubb: \$17M settlement resolves probes by states

CONTINUED FROM PREVIOUS PAGE

compensation is fixed, producers can more accurately budget for expected income, Mr. Rusbult said.

"So for the first time, this incentive compensation, which is retrospective and not prospective, can be budgeted for and will help agencies in their business planning in ways that contingencies were not useful," he said.

"We are grateful that Chubb has placed great emphasis on the issue of compensating agents and brokers on the basis of the value they provide in a transparent environment," Ken A. Crerar, president of the Council of Insurance Agents & Brokers in Washington, said in an e-mail.

"Throughout the past two years, we have been deeply concerned that changes in compensation at legal gunpoint might ultimately devalue the broker to the great detriment of insurance consumers," he said. "Like other carriers that have put the Spitzer investigations behind them, Chubb's changes appear to be very sensitive to those concerns," Mr. Crerar said.

In addition to Chubb, St. Paul Travelers also has given some indication to its agency force as to how it intends to compensate them going forward. St. Paul Travelers, whose settlement provisions contain the 55% rule, plans to continue to pay contingents on commercial lines where they are allowed, but will pay a new supplemental commission for personal lines, according to a December memo to its agency force.

"Given our size and financial strength, we can create a completely fixed program that differentiates for your business performance, allows you to run your businesses effectively, and does not jeopardize your profitability," St. Paul Travelers said in the memo.

A spokesperson for St. Paul Travelers declined to comment further about the plan except to say: "We remain committed in providing our agents with attractive overall compensation opportunity and will continue to offer a competitive compensation program."

IIABA's Mr. Rusbult for one thinks Chubb's and St. Paul Travelers' supplemental compensation program will become a model for the future.

"We know there are other companies out there that are in settle-

ment discussions. I believe now with Chubb and Travelers having traveled this route and coming up with very similar proposals on to how to fill in the contingency hole for their distribution force, it would be my guess that both the AGs and the companies involved would look to this as a template," he said.

Looking back

Chubb Corp.'s settlement with Eliot Spitzer and other states attorneys general comes nine years after the insurer was at the center of another controversy over contingent commissions it paid to Marsh & McLennan Cos. Inc.

In 1997, it was a leaked Marsh memo detailing the brokerage's commission arrangements with Chubb that sparked fears among risk managers over Marsh's use of its now disbanded Global Broking Center to maximize its contingent commission income (*BI*, Oct. 13, 1997).

In the memo, a Marsh executive issued a directive to regional managers instructing them to place the majority of their middle market property/casualty business with Chubb through the Global Broking Center to increase the unit's income from so-called placement service agreements.

Release of the memo ignited concerns over the use of centralized placements and contingent commissions among individual risk managers and the Risk & Insurance Management Society Inc. Those concerns led to discussions between the brokerage and RIMS that resulted in an agreement by Marsh to disclose, on request from policyholders, some information about its contingent commissions.

Over the next few years Marsh said few risk managers requested the information and the furor over contingent commissions subsided until it erupted with much more intensity when Mr. Spitzer filed suit against Marsh in 2004 charging the brokerage with fraud.

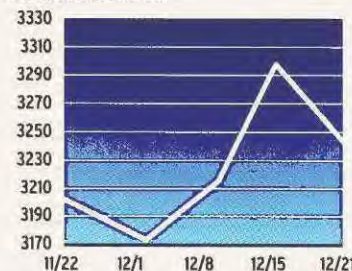
—By Gavin Souter

Stock Index

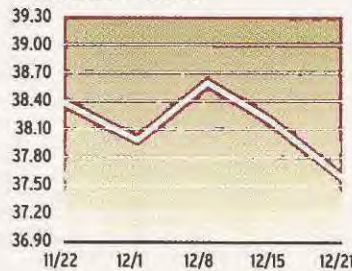
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Up-to-the-minute data for all 82 companies that comprise the BI Stock Index can be found at www.BusinessInsurance.com.

BI STOCK INDEX



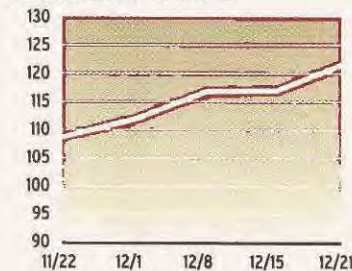
BI BROKERS INDEX



BI INSURER/REINSURERS INDEX



BI MANAGED CARE ORGANIZATIONS INDEX



Percentage change of BI Stock Index vs. key indicators

BI/STOCK INDEX	3245.65	↓ -1.07
DOW JONES	12421.25	↑ 0.04
S&P 500	1418.30	↓ -0.50

LARGEST GAINS

UnitedHealth Group Inc.	8.51%
Sierra Health Services Inc. ...	5.93%
Odyssey Re Holdings.	5.64%
PXRE Group Inc.	4.49%
Alleghany Corp.	3.78%

LARGEST LOSSES

CNA Surety Corp.	-3.69%
Tower Group Inc.	-3.39%
Navigators Group Inc.	-3.33%
EMC Insurance Group Inc. ...	-2.98%
MMC.	-2.94%

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REINSURANCE INTERMEDIARY

New hat: Attorney rolls out med mal coverage

Successful trial lawyers and presidents of fledgling medical malpractice insurance companies generally don't have much in common.

But if both happen to be Kim E. Presbrey, they have quite a bit in common. In fact, they're the same person.

Mr. Presbrey is an Aurora, Ill., attorney at Presbrey & Associates P.C. who specializes in workers compensation cases. He also is a past president of the Illinois Trial Lawyers Assn. and he recently founded a medical malpractice liability insurance company called Doctors Direct Inc.

State officials said recent legislative changes that increased oversight of doctors and insurers plus modest restrictions on litigation awards—in part due to doctors quitting the profession due to soaring insurance costs—have made Illinois a bit more attractive to underwriters.

Mr. Presbrey said in several published interviews that he believes he can make money underwriting med mal coverage while charging doctors lower rates than they have had to pay the state's dominant med mal insurer.

We can't wait to see whether those savings will be subject to contingent fees.

Business Insurance END PAGE

Dumpster diver snagged with MLB player data

A 38-year-old Chicago man was arrested last week for allegedly stealing folders filled with personal information from the trash—making off with pay stubs, financial records and Social Security numbers of hundreds of individuals, including a star-studded list of about 100 former and current Major League Baseball players.

Authorities working on the case say David Dright may not have known whose information he was taking out of a dumpster near the offices of Northbrook, Ill.-based SFX Baseball Group, which handles contracts for professional baseball players.

Among players whose information was found in Dright's home were: Chicago White Sox slugger Jim Thome, New York Mets outfielder Moises Alou and Mets ace Pedro Martinez.

"He was jumping into dumpsters and walking away with folders," said Detective Adam

Hyde with the Lincolnshire, Ill., Police Department, which worked with the U.S. Postal Service, Chicago Police Department and Secret Service to serve a search warrant at Mr. Dright's home, where they found hundreds of sensitive documents that had not been shredded.

Police did not find evidence that Mr. Dright has used the information to obtain credit cards.

As of Dec. 21, he was being held on \$225,000 bail in Lake County, Ill., and may face Cook County charges, authorities said.

In an e-mailed statement, Robert Greenwald, general counsel of SFX Baseball, said: "This is part of an ongoing criminal investigation for which an arrest has already been made. Fortunately, it does not appear that any of our clients have been adversely affected. We'd like to commend the Lincolnshire Police Department and Lake County State's attorney's office for all their efforts. We will continue to work to ensure that no identities were compromised."

Santa's whiskers protected

When Santa isn't supervising the elves, entertaining children at the mall or maneuvering his sled onto rooftops, he's negotiating insurance coverage for one of his most valuable assets.

At least that's the way it must be for one of America's most

sought after

Santas.

Lloyd's of

London says it

insures the

long white

beard

belonging to

Rhode Island

resident

Brady White.

Mr. White,

who bills

himself as

"Santa to the

Stars," has

portrayed St. Nicholas

in films, television, print

advertisements and live

appearances. The lengthy list of

corporate brands he has helped

promote or made appearances for

includes Cartier, Neiman Marcus,

Paramount Cards and Avon,

according to Mr. White's Web site.

His personal appearances have

included the homes of actors

Kirstie Alley, Rene Russo and

Pamela Anderson. Suppose he's

pry to whether they've been

naughty or nice?

A large part of his successful

career climb from generic mall

Santa is attributed to growing real

whiskers rather than relying on

the glue-on type, Mr. White told

Lloyd's.

So the Lloyd's underwriters

protect his beard should it get

damaged by children tugging on it

or singed while sliding down a

chimney.



LANDOV

Start the music, pour the drinks, buy the insurance

Millions of people planning to host a party this holiday season could be at risk of financial ruin, a U.S. study concludes.

If a party guest drinks alcohol, drives and causes an accident, party hosts can be held responsible in more than 30 states, according to Trusted Choice, the independent insurance agency brand supported by the Alexandria, Va.-based Independent Insurance Agents & Brokers of America Inc.

While most party hosts believe they should

be held responsible, many have not taken steps to protect themselves, the study finds.

According to the survey, 56% of those hosting a party between Thanksgiving and the Super Bowl either don't have umbrella coverage or do not know whether they have umbrella coverage, which provides extra liability coverage above homeowners insurance. This means that 28.5 million party hosts are underinsured this holiday season leaving themselves at risk of being sued should the

worst occur, Trusted Choice said.

"People don't buy umbrella policies because they think they have enough coverage from their homeowner and auto policies—but they don't," said Madelyn Flannagan, vp-education and research for the IIBA, in a statement. "The high dollar value of jury awards coupled with skyrocketing health care costs means one lawsuit can easily exceed the liability limits on the average policy."

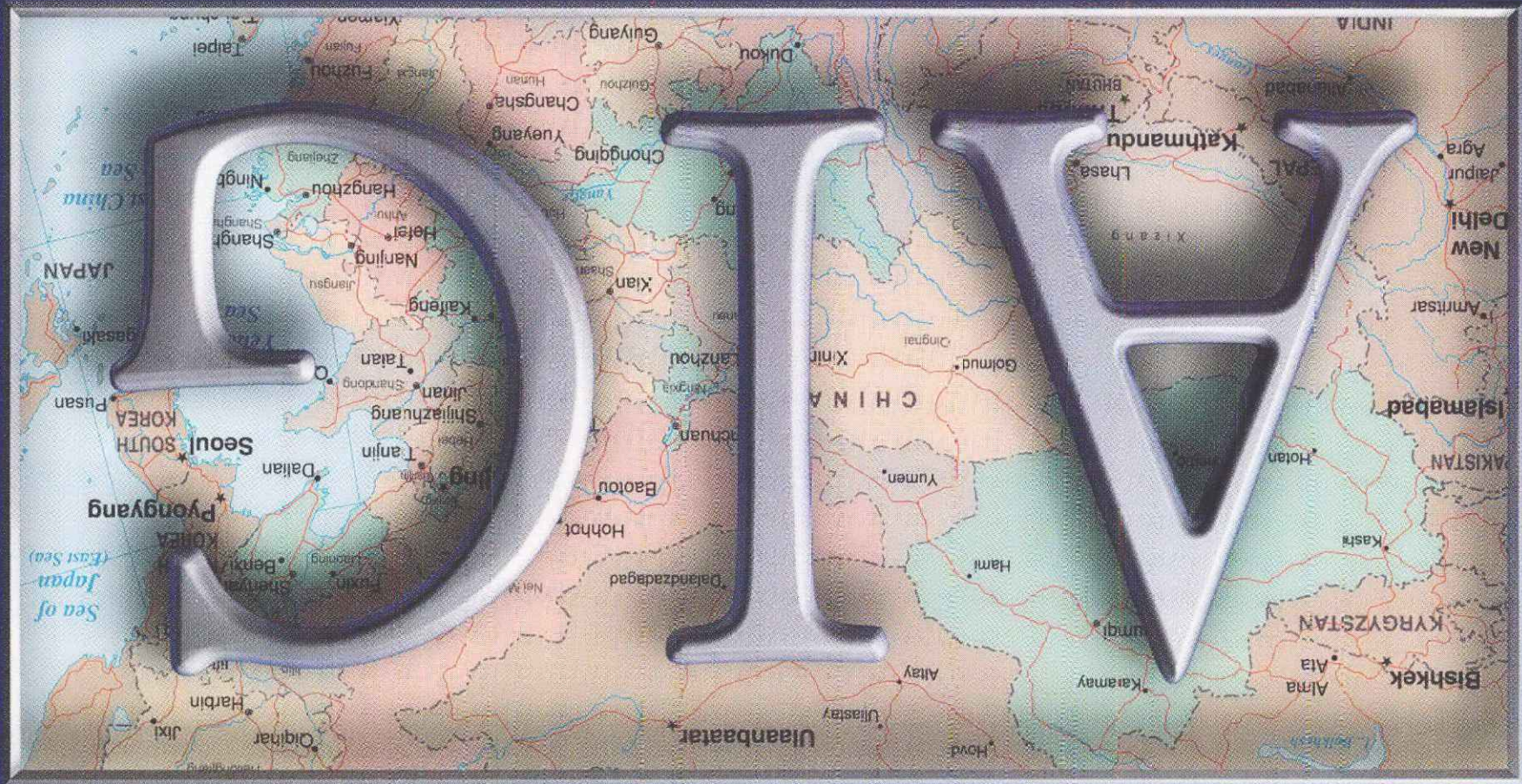
"While you'll never be able to entirely

eliminate risks, planning ahead and learning your responsibilities as a host is the best defense," Ms. Flannagan advised.

One way to reduce risk is to stop serving alcohol to party guests if they've had too much to drink, Ms. Flannagan said. "Asking guests to stop drinking at your holiday party can be very awkward. However, protecting your family and your guests is more important than an uncomfortable exchange at the neighborhood party."



SOURCING PRODUCTS IN CHINA? UNINSURED SUPPLIERS CAN COST YOU MILLIONS.



U.S. companies import billions of dollars in goods from China. Because many Chinese manufacturers don't carry product liability insurance, with these goods can come additional risk to you and your customers. Protect your company by insisting that your Chinese suppliers carry product liability insurance from the AIG companies. A pioneer in the Chinese market with an extensive local presence, the AIG companies have all the experience, knowledge and financial strength it takes to secure the future of your company and reduce both the risks and costs of doing business in China.

Call your broker or e-mail us at
china.products@aig.com



THE STRENGTH TO BE THERE.SM