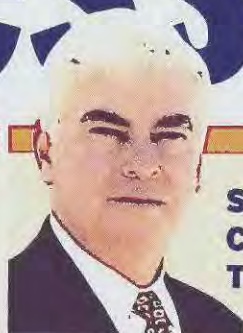


Business Insurance

February 12, 2007

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**LIFE INSURER BUCKS TREND,
OPTING FOR MODIFIED DB PLAN
OVER PHASEOUT / PAGE 3**



**SEN. DODD AND OTHERS
CONTINUE PUSH FOR
TRIA EXTENSION / PAGE 3**

**COVENTRY BIDS TO GROW
ITS COMP SERVICES WITH
DEAL FOR CONCENTRA / PAGE 4**

In Brief

RSA USA sale under review

A Delaware Insurance Department hearing commissioner has recommended that Commissioner Matthew Denn approve the controversial sale of Royal & SunAlliance USA Inc. to Arrowpoint Capital Corp., a vehicle established by RSA USA's management team. After release of a proposed order, Mr. Denn said that he intends to "begin a thorough review and to issue a timely decision." Previously, major policyholders objected to the deal saying that it would leave the U.S. operation with inadequate capital.

Wrongful death suit filed over plant blast

A wrongful death lawsuit filed on behalf of the families of three men killed at a Milwaukee manufacturing plant in

See **IN BRIEF** page 30

SPOTLIGHT CLAIMS MANAGEMENT

Claims adjusters step up efforts to offer creative solutions in wake of storms; insurers in runoff require change in approach from claimants; benefit TPAs share tech tools with clients; AIG claims exec talks about insurer's past image problems and current strategy to satisfy clients' claims needs. **Page 11**



WAL-MART CLASS ACTION

PLAINTIFFS: Class could include more than 1.5 million current and former female employees at one or more of Wal-Mart's 3,400 stores in 41 regions since 1998

CHARGES: Women employed by Wal-Mart are paid less than men in comparable positions, despite having higher performance ratings and greater seniority; and they receive fewer—and wait longer for—promotions to in-store management positions than do men

WHAT THEY WANT: Class-wide injunctive and declaratory relief, lost pay, and punitive damages but not compensatory damages

Source: Court papers



REUTERS

Biggest-ever bias suit may fuel tort trend

*More class actions
expected to flow from
Wal-Mart ruling*

By JUDY GREENWALD

SAN FRANCISCO—Employers are likely to face more class action lawsuits as the result of a federal appellate court decision that grants class action status to a sex discrimination lawsuit brought against Wal-Mart Stores Inc., say experts.

At the same time, observers say the split decision by the 9th U.S. Circuit Court of Appeals in San Francisco in *Betty Dukes vs. Wal-Mart Inc.*, does not break any new legal ground, although it could wind up costing the Bentonville, Ark.-based retailer billions.

Its primary significance, observers say, is the unprecedented size of the class action, which affects some 1.5 million employees (see story, page 29).

Wal-Mart plans to appeal the 2-1 decision, its attorney says.

The appellate decision upholds a lower court's 2004 ruling that granted class action status to the approximately 1.5 million women who work or have worked in one or more of Wal-Mart's 3,400 stores in 41 regions at any time since 1998.

The seven plaintiffs in the case had charged that women employed by Wal-Mart were paid less than men in comparable positions despite higher performance ratings and greater seniority and that they received fewer—and waited longer—for promotions to in-store management positions than did men. They are seeking injunctive and declaratory relief, lost pay and punitive damages.

The appellate court said its decision is based on a limited review as to whether the lower court abused its broad discretion in ruling the case should be granted class action

See **WAL-MART** page 29

Bush budget plan would boost HSAs

*Proposal deemed good
for employers, workers
but faces uphill battle*

By JERRY GEISEL

WASHINGTON—A new round of health savings accounts reforms proposed by the Bush administration last week as part of a federal budget package should ease the concerns of both employers and employees about HSAs and increase their adoption, industry experts say.

The latest reforms would build on a package passed by Congress last year. The administration plan would allow HSAs to be linked to health insurance plans other than those with big deductibles, easing lower-income employees' concerns of being exposed to large medical bills.

Other provisions would allow employees to withdraw HSA funds to pay for medical expenses incurred before they set up an HSA, as well as eliminate a current inequity in which an enrollee with family coverage is saddled with a bigger deductible than an enrollee

HSA CHANGES

How the Bush administration's proposed budget would make health savings accounts more attractive

- Make more health care plan designs eligible to be linked to HSAs.
- Allow funds to be withdrawn from an HSA to pay for health care expenses incurred before the HSA was set up.
- Permit individual embedded deductibles in high-deductible plans.
- Allow employees and spouses to make catch-up contributions to one HSA.

with single coverage.

The proposal also would make it easier for older enrollees to make catch-up HSA contributions and ease certain transitional issues when employers adopt HSA-linked plans and move away from plans that include flexible spending accounts and health reimbursement arrangements.

In all, the provisions, which

See **HSA** page 29

Public entities grapple with health cost hikes

*Municipalities look to
state purchasing pools,
but some risks seen*

By JOANNE WOJCIK

While Massachusetts lawmakers consider opening the state's health plan to other public entities, lawmakers in neighboring New Jersey are grappling with the unintended consequences of a similar pooling arrangement.

The legislation, which was introduced by Rep. Rachel Kaprielian, D-Watertown, and Sen. Richard Moore, D-Uxbridge, would permit

cities and towns to join Massachusetts' Group Insurance Commission—as long as representatives of employees and retirees agree. Communities would pay an administrative fee of 1% of premiums paid. While GIC would negotiate plan terms and rates, municipalities would bargain with unions to determine the employer-employee premium split.

The legislation was introduced earlier this month in response to recommendations of the state's Municipal Health Insurance Working Group, which has been meeting since September 2005 to try to find

See **PUBLIC** page 28

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QUESTIONS & ANSWERS

Leader of Beazley Group shares history, future



Beazley Group P.L.C. Co-Founder and Chief Executive Andrew Beazley discusses his company and its culture on page 6 and in

an expanded version online at www.BusinessInsurance.com/QandA.

EMERGING RISK STRATEGIES

An in-depth, two-part series on enterprise risk

Beginning Feb. 19, *BI* columnist John J. Hampton will discuss why it's important to align risk categories with a group's business model and why an ERM program must have a central risk function to coordinate responses to internal and external exposures.

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TRIA supporters confident of extension

House, Senate differ on whether to make backstop permanent

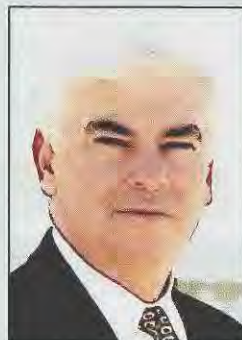
By MARK A. HOFMANN

WASHINGTON—The possibility that House and Senate committees could take differing approaches to extending the federal terrorism insurance backstop has not dampened supporters' hopes of winning an extension this year.

The differences were evident in remarks made by key lawmakers at the Council of Insurance Agents & Brokers' annual legislative summit last week on Capitol Hill.

While Senate Banking, Housing and Urban Affairs Committee Chairman Christopher Dodd, D-

On the nature of legislation extending the federal terrorism insurance backstop:



'We're going to have to do a permanent bill or we're going to move on.'

◆ Christopher Dodd, Senate Banking Committee Chairman

'Permanency is not where we're coming from at this point.'

Rep. Paul Kanjorski, D-Pa. ◆



LANDOV

Conn., and House Financial Services Committee Capital Markets, Insurance and Government Sponsored Enterprises Subcommittee

Chairman Paul Kanjorski, D-Pa., agreed that the program will be extended, they did not agree on the nature of the extension.

"I'm not going to do another temporary bill," said Sen. Dodd. "We're going to have a permanent bill or we're going to move on."

Sen. Dodd added that he thought the "administration is softening" its opposition to any extension. The White House vigorously supported the original Terrorism Risk Insurance Act, which created a program that was to end Dec. 31, 2005. But the Bush administration opposed extending the program unless the backstop was significantly scaled back, which it was in the Terrorism Risk Insurance Extension Act that keeps the program alive through the end of this year.

Sen. Dodd said he thought Treasury Secretary Henry Paulson might be of help in keeping the backstop

See **CIAB** page 28

Insurer shows support for defined benefit plan

Phoenix Cos. tweaks plan, bucks trend of DB phase outs

By JERRY GEISEL

HARTFORD, Conn.—Bucking a recent trend, a major life insurer and annuity provider is revamping its defined benefit pension plan rather than phasing it out.

Effective July 1, Hartford, Conn.-based Phoenix Cos. Inc. is converting its traditional final average pay plan to a pension equity plan, so named because the plans are designed to provide a relatively steady accrual of benefits.

Under Phoenix's plan, which Mercer Human Resource Consulting helped design, employees will receive annual credits that will increase with service. Employees will receive a 2% annual credit for the first four years of service, with the credit rising to 4% for each year from five to nine years of service and 6% for each year from 10 to 14 years of service. The annual credit will increase to 10% for between 15 and 19 years of service and 14% for 20 or more years of service.

To determine the benefit an employee is entitled to when he or she terminates employment or retires, the credits are added up and multiplied by the employee's final average pay, which is the average of the highest five consecutive years of annual total compensation out of the last 10 years of employment. The result would be payable as a lump sum benefit, which employees could take in cash or rollover into an individual retirement account, among other things.

The new design would apply to service starting on July 1 and cover all new employees and current employees under age 50 with less than 10 years of service. Employees

age 50 and older with at least 10 years of service will have a one-time choice to remain in the current plan or move to the new plan.

Phoenix's shift to a new defined benefit plan design comes at a time when a growing number of employers, including such well-known names as Hewlett-Packard Co., IBM Corp. and Lockheed-Martin Corp., have decided to phase out their defined benefit plans in favor of enhanced 401(k) plans.

While Phoenix, which has about 1,500 employees, also is sweetening its 401(k) plan, it says defined benefit plans still have a role.

"We believe retirement income planning is a shared responsibility and chose the defined benefit plan approach as our way of continuing to offer a company-provided base benefit," a Phoenix spokeswoman said.

From the perspective of employees, the new retirement program gives them greater flexibility and control, the spokeswoman noted.

From a corporate perspective, the principal benefit of the new design is that it reduces the volatility of pension plan expense, the spokeswoman added.

Pension equity plans can, for several reasons, have less volatility and risk than traditional final average pay plans, pension actuaries say. One reason is that the overwhelming majority of employees take their benefit as a lump sum rather than as a lifetime annuity paid starting at retirement.

That means changes in interest rate assumptions, as well as asset investment results, will have less of a financial impact compared to a traditional plan of the same size because fewer beneficiaries will remain as participants after they leave the company.

"Effectively, you have a smaller

See **BENEFITS** page 28

MIDDLE-MARKET BROKERS

For insurance buyers generating income between \$10 million and \$500 million



Note: The Broker Overall Quality Index score is based on a composite of all qualitative evaluations normalized by sales size and placed on a scale of 0 to 1,000.

Source: Greenwich Associates

Firm measures quality for mid-market buyers

Greenwich Associates releases benchmark of broker performance

By SALLY ROBERTS

Middle-market insurance buyers have a new tool to benchmark the service performance of the nation's largest insurance brokerages.

After unveiling its Carrier Quality Index last October, Greenwich, Conn.-based financial services research firm Greenwich Associates this week will release its Middle-Market Broker Quality Index.

Greenwich interviewed 13,472 insurance buyers whose companies generate between \$10 million and \$500 million in annual revenues for the index to obtain brokers' middle-market penetration. It then interviewed 1,330 of those buyers whose brokers were among the 100 largest in terms of U.S. business to evaluate the firms on 20 key quality mea-

surements. More than 1,100 of those buyers reported less than \$100 million in annual revenues.

The index was done in response to demand from buyers, insurers and brokers that want to know where brokers stand in relation to their peers in service quality, according to Bill Bruno, a Greenwich Associates senior vp and consultant.

"From the insured's perspective, this gives a very valuable benchmark of what their peers think of their service providers," he said.

The middle-market broker quality index benchmarks the 11 largest brokers and groups the remaining smaller regional firms into one "other regional brokers/agents" category.

From the largest broker's group, Greenwich did not identify brokers A, B, C, or D in the index to "protect those that are trying to improve," Mr. Bruno said. Those brokers are

See **GREENWICH** page 27

Coventry to buy Concentra's comp business for \$387.5M

By ROBERTO CENICEROS

ADDISON, Texas—Coventry Health Care Inc. has agreed to buy Concentra Inc.'s workers compensation business for \$387.5 million.

The deal marks further consolidation in the market for nationwide workers comp managed care service providers.

Coventry Health Care Inc. said last week that it has agreed on a cash deal to buy Addison, Texas-based Concentra's workers comp preferred provider organization, provider and bill review business, along with a pharmacy benefit

management unit, case management business and independent medical exam business. Concentra will retain ownership of its health centers and other businesses.

The deal will have its biggest impact on workers comp PPO services and bill review services, said Joseph Paduda, a health care and workers comp consultant and president of Health Strategy Associates in Madison, Conn.

Both Coventry and Concentra operate large medical provider networks.

Bethesda, Md.-based Coventry is a national managed health care

company that operates several health plans and insurance companies as well as providing managed care services.

Few companies compete with Concentra and Coventry in providing workers comp managed care services on a nationwide basis, Mr. Paduda said.

Coventry's announced purchase of Concentra comes two years after its purchase of Downers Grove, Ill.-based First Health Group Corp., which provides managed care services for the workers comp and group health industries (BI, Oct. 18, 2004).

"Now there is going to be a lot less competition," said Mr. Paduda.

Coventry declined to comment on the consolidation within the industry.

But Dale B. Wolfe, chief executive officer of Coventry, said in a statement that "Concentra's complementary businesses enhance our product portfolio to provide workers compensation services to a broad array of customers."

Coventry has successfully integrated past acquisition's, including First Health, said Sally Rosen, managing senior financial analyst

for A.M. Best Co. Inc. in Oldwick, N.J.

But service is likely to suffer as Coventry and Concentra work to integrate their systems and cultures, said William McDonough, managing principal in Boston for Integro Insurance Brokers' health care practice.

Eventually though, both entities have best practices that can help improve operations, Mr. McDonough said.

According to Coventry, in 2006, Concentra's workers comp managed care business generated \$324 million in fee-based revenue.

DUTY TO ACCOMMODATE

Key points in the Supreme Court of Canada ruling regarding an employer's duty to accommodate disabled employees:

- Parties to a collective bargaining agreement have a right to negotiate, in good faith, clauses to ensure employees attend work and do their work. Although time allowed off work is a factor, the accommodation of a disabled employee must be evaluated case by case.
- Parties to a collective bargaining agreement cannot agree to a level of protection that is less than that given to employees under human rights legislation.
- Undue hardship resulting from an employee's absence must be assessed from the beginning of the absence.
- An employee has a duty to provide evidence that he or she can return to work within a reasonable period of time.

Source: Supreme Court of Canada

Canadian court ruling seen as guidepost on firing injured workers

By GLORIA GONZALEZ

OTTAWA—A recent Supreme Court of Canada decision provides guidance for Canadian employers with unionized workforces about how far they must go to accommodate employees disabled by illness or injury before terminating them.

While the Supreme Court did not set a specific standard for reasonable accommodation and stated that each case must be decided individually, the decision provides employers with a broad outline of expectations regarding their duty to accommodate, lawyers say.

In its Jan. 26 decision in *McGill University Health Center vs. the Union of the Employees of Montreal General Hospital*, the Supreme Court validated a decision by McGill University Health Centre in Montreal to terminate a disabled employee due to her prolonged absence, finding that a termination clause in the collective bargaining agreement with the employee's union had been appropriately applied.

In March 2000, Alice Brady took a leave of absence as a medical secretary for McGill University hospital due to what court records described as a "nervous breakdown." When she tried a gradual return to work, the hospital reduced her schedule and extended her rehabilitation

period several times, despite the fact that the collective bargaining agreement negotiated by the hospital and her union allowed a maximum of six months. Even with the accommodations, Ms. Brady was unable to return to work full-time.

The collective bargaining agreement also included a clause that provided for automatic termination after an absence of 36 months. In March 2003, the hospital notified Ms. Brady that her employment would be terminated due to her prolonged absence, leading to a grievance dispute with the union.

A grievance arbitrator ruled in favor of the hospital and a Superior Court rejected the union's request for review. However, the Quebec Court of Appeal ruled against the hospital, leading to the Supreme Court appeal.

An automatic termination clause is a significant factor in assessing the employer's duty to accommodate, the Supreme Court ruled, because it is negotiated by parties representing different interests who are most familiar with the workplace.

Canadian employers have been puzzled by how long the employment relationship can continue without a return to work because

See CANADA page 28

OSHA offers advice on flu response

Planning deemed key to protect workforce against pandemic

By MARK A. HOFMANN

WASHINGTON—Employers should plan now for an influenza pandemic, according to the head of the U.S. Occupational Safety and Health Administration.

"A severe pandemic in our country could have a devastating effect on our nation's" workplaces, said Edwin G. Foulke Jr., the assistant secretary of labor in charge of OSHA. "Proper planning and preparation now saves lives in the future."

His comments came as OSHA released its "Guidance on Preparing Workplaces for an Influenza Pandemic" last week.

The guidance divides workplaces into four levels of risk ranging from "low" to "very high" based on proximity of workers to infected people. For example, health care facilities

GUIDANCE FOR EMPLOYERS

The Occupational Safety and Health Administration outlined steps for employers to reduce workplace exposure to pandemic influenza. These include:

- Encouraging sick employees to stay home.
- Encouraging employees to wash their hands frequently with soap and water or with hand sanitizer.
- Encouraging employees to cover coughs and sneezes with a tissue.
- Avoiding close contact with co-workers and customers, keeping at least 6 feet of separation.
- Regularly cleaning telephones, computers and other workplace

Source: U.S. Occupational Safety and Health Administration



surfaces and equipment.

- Discouraging employees from using other employees' phones or equipment.

that require workers to have direct contact with infected people would fall into the "high" or "very high" risk categories, according to the guidance. But most work environments would fall into the "low" or "medium" risk category, said OSHA Deputy Director Amanda Edens.

The guidance offers specific rec-

ommendations for each risk level as well as some general advice (see box).

In addition, employers should cross-train at least three employees to carry out critical business functions should a pandemic strike, Ms.

See FLU page 6

Employers get creative on Rx costs

Transparency, generic drug efforts help benefit managers take control

By GLORIA GONZALEZ

NEW YORK—Some benefit managers are exploring innovative ways to manage their pharmacy benefits, demanding enhanced performance from their pharmacy benefit managers and changing their employees' approach to managing their own health care.

By obtaining more program information from PBMs, structuring programs to promote the use of generics over brand name drugs, and promoting stricter adherence to health regimens, employers can gain greater control over their pharmacy costs, benefit managers say.

Cleveland-based KeyCorp, a commercial banking and financial services company, sought performance guarantees during negotiations with its new PBM—Franklin Lakes, N.J.-based Medco Health Solutions Inc., said Toby Fleis-

chman, vp, compensation and benefits for KeyCorp.

For example, the company obtained performance guarantees on generic dispensing rates based on individual classes of drugs rather than overall generic rates, she said. While getting the guarantees was "a bit of a fight," it was necessary

because the company did not want increases in one drug category to affect the average generic dispensing rate, which would limit the effectiveness of performance guarantees, Ms. Fleischman said.

Instead, individual guarantees require Medco to develop effective and targeted programs to promote

generic use among KeyCorp's employees, she told the 2007 Employee Healthcare Conference, presented by the Conference Board and sponsored by Towers Perrin HR Services.

"They need to ensure that enough generics get out the door to make sure our costs are controlled," Ms. Fleischman said.

Transparency and pass-through of all discounts, dispensing fees and rebates were issues for KeyCorp. While the company was able to secure some transparency guarantees from its PBM, full transparency is still difficult for plan sponsors wanting to know all about the relationship between their PBM and pharmaceutical companies, how the PBM is compensated and how that affects formulary decisions, Ms. Fleischman said.

See PHARMACY page 27

CONFERENCE COVERAGE CONTINUES: Employers find ways to inject consumer elements, but keep more traditional health plans. Page 27

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Health care is hard. It's hard for everyone: employers, patients, physicians, hospitals and, at times, even us.

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Business Insurance OPINIONS

HSA proposal packed with common sense

IF WE HAD TO DESCRIBE the new health savings account reform proposal advanced by the Bush administration in a word or two, it would be common sense.

As we report on page 1, the proposal in the administration's 2008 federal budget package unveiled last week includes several HSA-related changes that are so logical it would make one wonder why these were not included in the original 2003 HSA law.

For instance, take the most significant provision in the package that would allow employers to link employees' HSAs to a health care plan other than one that has a high deductible—as now is the case.

Under the proposal, a health care plan would be eligible to be linked to an HSA if it imposed at least a 50% coinsurance requirement.

That would be a welcome broadening of current law that says eligible HSA-linked health plans must have high deductibles. This year's minimum deductible is

\$1,100 for single coverage and \$2,200 for family coverage.

We understand the need for a high level of cost-sharing as that gives participants a powerful incentive to use health care services carefully. Still, the required deductibles may be intimidating, especially for lower-income workers who fear big medical bills.

Allowing a 50% coinsurance requirement—in lieu of a high-deductible plan—would reduce that fear, leading more employees to enroll in HSAs, while still, we believe, giving employees a sufficient incentive to use medical services prudently.

For many reasons, employees may not open HSAs simultaneously with their enrollment in the linked health plan. In such situations, it hardly seems fair to deny employees the right to cover medical expenses by withdrawal of contributions from their HSAs.

The proposed changes would make HSAs much more attractive to employees, which would increase enrollment. While we don't believe HSAs by themselves are the cure for all that ails the nation's health care system, we also know that consumer-driven plans are integral to shoring up the system and must be encouraged.

Consumer-driven plans are integral to shoring up the system and must be encouraged.

Post-Katrina examples burnish industry image

HUMAN NATURE SEEMS to make people focus on exceptions, rather than the rule. This is true of insurance claims, as we've seen since Hurricane Katrina devastated the Gulf Coast.

More than 90% of the hundreds of thousands of insured losses from that awful storm have been resolved, according to industry statistics. Still, the fraction of open claims has grabbed headlines and prompted investigations of insurers' claims-handling practices.

Our Spotlight report, beginning on page 11, shows most insurers go to great lengths to resolve claims. Lexington Insurance Co. used alternative methods to put money into policyholders' hands in the days after Katrina. Zurich Financial Services Group started alternative dispute resolution to settle claims and avoid costly litigation. In a flood unrelated to Katrina, FM Global used helicopters to rescue business equipment. These are just a few examples.

Disasters don't discriminate between policyholders and those that serve them. Many Katrina victims work in the insurance industry.

Undoubtedly, some insurers drag their feet, and those deserve to be investigated. But critics of the insurance sector ought to look at the big picture before painting the industry with a broad brush.



Letters

Battling terror with trade hits the bull's-eye

TO THE EDITOR: *Business Insurance's* Feb. 5 article by Stephen Patrick Cain, "Trade Is a Powerful Weapon in the War on Terror," brings some refreshing air to the present so-called war on terror.

This article touches upon the center of the problem. I was astonished to read the "Global Risk Network Report" (34 pages, available at www.weforum.org/pdf/CSI/Global_Risks_2007.pdf) prepared under the World Economic Forum this year. Under "Focus on Mitigation: International Terrorism," the "experts" of the Glob-

al Risk Network list 16 items concerning mitigation of terrorism. Not one item refers to what we should all know is the main source of terrorism, that is injustice and unfairness between the nations in trade, economics and social matters.

Mr. Cain did focus on the real problems in his article. It would be marvelous if our politicians and top business execs would all read *Business Insurance* and such a good article.

André Goyette
CGR
Montreal, Quebec

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Online Poll at www.businessinsurance.com

How serious is the risk that individuals and businesses can be liable for global warming?



NEXT WEEK'S POLL: *How would you rate the way your property insurer handled your most recent major claim?*

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*Erdos & Morgan Survey of 2005 RIMS Attendees.

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ZURICH HAS UNIQUE
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Photo: An inspector examined damaged property in St. Bernard Parish, La., after Katrina struck.

Creative solutions to tough problems

Innovative approaches aim to quickly meet post-disaster client needs

By MARK A. HOFMANN

It seems straightforward enough—to adjust a claim, start by getting a claims adjuster to a loss site. Then, pay the claim.

But in the aftermath of huge catastrophes, such as Hurricane Katrina in 2005, the claims handling process is anything but simple. Katrina—the worst natural disaster in recent U.S. history—tested adjusters and home-office claims staffs in a way they'd seldom been tested before: Adjusters had to be sheltered and fed where shelter and food were scarce, infrastructure from power grids to the U.S. mail was down and policyholders needed payment as quickly as possible.

"Katrina was a different kind of catastrophe," said Gerry Alonso, senior vp-claims, for Johnston, R.I.-based Factory Mutual Insurance Co., which does business as FM Global. Nevertheless, the insurer, which stationed many of its staff in Baton Rouge, La., had people on the ground within 2-1/2 hours of the hurricane and equipped them with badges and permits to allow them access to restricted areas.

Once at the sites, "we were the eyes and ears of our clients," Mr. Alonso said. Clients' employees had been evacuated or "were back home dealing with their housing tragedies."

"If there was any difficulty, it was

where to put our adjusters up as far as where they slept at night," he said. Evacuees and Federal Emergency Management Agency personnel competed for available hotel rooms. As a result, FM Global had "people sleeping on air mattresses in banquet halls and had people sleeping in RVs."

CLAIMS TIPS

Getting information into the right hands before a catastrophe occurs can help speed the claims process. Risk managers can take a couple of critical steps to get claims check sooner rather than later.

- Provide insurers with property values, including inventory, for each location.
- Provide insurers with information regarding how much income each location generates.

Gary Brown, senior vp and director-branch operations for independent adjuster McLarens Young International in Glendale, Calif., said the scope of the destruction meant adjusters had to stay far from their worksites. People drove from Mobile, Ala., into hurricane-devastated Mississippi every day, "a decent-sized drive before you could even start work," he said.

"One of the biggest challenges for us in this storm was the shortage of rental cars," Mr. Brown said. So

McLarens Young arranged "to pick a bunch of cars up in Georgia and return them in the affected area."

After large catastrophes, however, one of the biggest problems is that "everyone needs help at the same time," said Nick Ciabattone, vp-property claims operations for Hartford Financial Services Group in Hartford, Conn. "All the people you go to get that help from can be victims themselves," such as board-up companies. "Even if they are operational, you can guarantee that their phone's ringing off the hook."

Each customer has its own needs—electricity, phone service and temporary repairs, Mr. Ciabattone said. "How quickly can we get their business up and running" is the main question. "Once we understand their needs, we go about making it happen."

For workers compensation beneficiaries dependent on receiving their benefits checks by mail, the temporary shutdown of post offices in parts of the post-Katrina Gulf Coast was a major issue, said Michael Jaudon, client banking director at Sedgwick Claims Management Services Inc. in Memphis, Tenn. "We knew these injured workers needed their money more than ever," but many of the beneficiaries had been moved elsewhere, he said.

Sedgwick discovered that mail

See **CLAIMS** page 14

SPOTLIGHT

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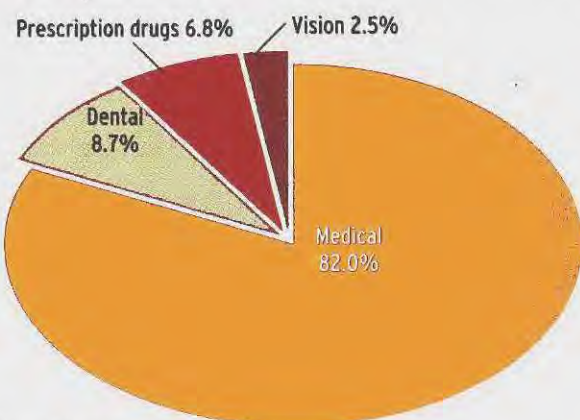
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HEALTH INSURANCE CLAIMS BY TYPE

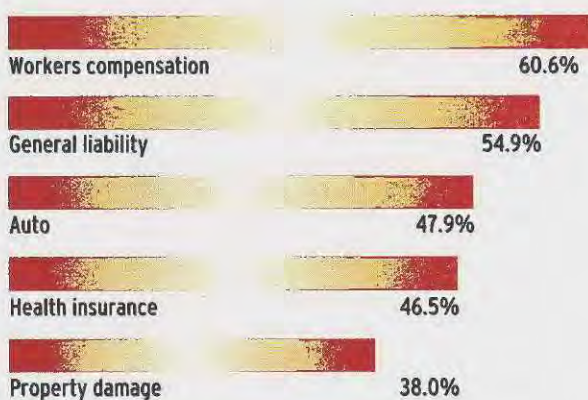
Percentage of companies that have a majority of health insurance claims



Source: BI survey

MOST PREVALENT CLAIMS

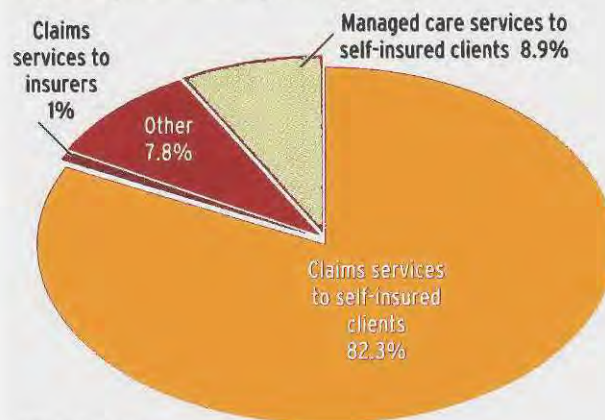
Percentage of all companies that provide the following types of claims administration



Source: BI survey

BREAKDOWN OF REVENUES

Top 10 companies' revenues by services provided



Source: BI survey

Ranking

Largest claims administrators

Ranked by 2006 revenues from claims handled for self-insured clients

Rank	Company/Address	Phone/Fax/Web site	Parent company	2006 revenues from self-insured clients	2006 claims paid to self-insurers	Total clients	Claims staff	Principal officer
1	Sedgwick Claims Management Services Inc. ¹ 1100 Ridgeway Loop, Memphis, Tenn. 38120	901-415-7400 Fax: 901-415-7406 www.sedgwickcms.com	Sedgwick CMS Holdings Inc.	\$556,400,000	\$5,248,672,493	1,043	5,527	David A. North, president/CEO
2	Broadspire Services Inc., a Crawford Co. ² 1601 S.W. 80 Terrace, Plantation, Fla. 33324	800-726-8898 Fax: 954-382-4585 www.choosebroadspire.com	Crawford & Co.	\$366,962,000	\$2,192,746,193	1,105	2,530	Dennis Replogle, president
3	Gallagher Bassett Services Inc. The Gallagher Centre, 2 Pierce Place, Itasca, Ill. 60143-3141	630-773-3800 Fax: 630-285-4000 www.gallagherbassett.com	Arthur J. Gallagher & Co.	\$357,000,000	\$4,400,000,000	2,931	2,400	Richard J. McKenna, president
4	Fiserv Health Inc. 5500 Wayzata Blvd., Suite 500, Minneapolis, Minn. 55416	763-549-3350 Fax: 763-549-3368 www.fiservhealth.com	Fiserv Inc.	\$282,000,000 ³	\$6,802,398,006	948	2,262	Mike Gantt, group president
5	Specialty Risk Services L.L.C. 225 Asylum St., Goodwin Square, 16th Floor, Hartford, Conn. 06103	888-236-4684 Fax: 860-520-2503 www.specialtyriskservices.com	The Hartford Financial Services Group Inc.	\$210,000,000	\$2,600,000,000	996	1,344	Joe Boures, president
6	Cambridge Integrated Services Group Inc. 340 Pemberwick Road, Second Floor, Greenwich, Conn. 06831	800-662-1170 Fax: 440-914-2591 www.cambridgeworldwide.com	Cambridge Solutions Ltd.	\$202,000,000	\$2,820,000,000	4,997	2,159	Chris Sinclair, executive chairman/CEO
7	ESIS Inc. 436 Walnut St., Philadelphia, Pa. 19106	215-640-1000 Fax: 215-640-5538 www.esis.com	ACE USA	\$200,200,000	\$2,288,000,000	779	1,312	David Patterson, president
8	The Principal Financial Group/ National Accounts 1275 N.W. 128th St., Suite 100, Clive, Iowa 50325	877-273-0900 Fax: 866-389-7671 www.principal.com	—	\$149,309,097	\$2,548,913,700	367	802	Chris Calos, vp
9	Meritain Health 300 Corporate Parkway, Amherst, N.Y. 14226	800-828-6922 Fax: 716-319-5725 www.meritain.com	Prodigy Health Group	\$141,000,000	\$1,700,000,000	1,400	262	Jake Canova, chairman/CEO
10	CoreSource Inc. 400 Field Drive, Lake Forest, Ill. 60045	800-832-3332 Fax: 847-615-3900 www.coresource.com	Trustmark Insurance Co. Inc.	\$115,769,000	\$2,540,000,000	1,628	1,210	Paul Lotharius, senior vp/COO

¹ Includes CompManagement Inc. and VPA Inc. ² Includes Broadspire Services Inc. and Crawford Integrated Services, which merged October 2006. ³ BI estimate

Source: BI survey

Researched by Kevin Edison and Karen Tucker

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An abstract painting on the left side of the page. It depicts a person wearing a white hard hat and a blue jacket, rendered in a painterly, expressive style with visible brushstrokes. The colors are muted, including greens, purples, and blues, creating a textured background for the text.

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Claims: Post-Katrina efforts range from helicopters to Western Union

CONTINUED FROM PAGE 11

was being held in bulk postal facilities in Texas, so it sent a communication to all its offices instructing them to contact headquarters once an injured worker contacted the local office and provided a temporary address. "We took those calls here in Memphis within the client banking group," Mr. Jaudon said.

In some cases, Sedgwick stopped payment on stalled checks and overnighted new ones to the injured workers. In other cases, money was wired to claimants' banks. "We wanted to do everything that was reasonably possible

to make a bad situation a little better," Mr. Jaudon said.

Call from dying cell phone

Dave Crowe, vp-claims for Lexington Insurance Co., a Boston-based unit of American International Group Inc., said one particular call from a personal lines customer in Mississippi led to a creative way of getting funds to clients. The policyholder called from "his dying cell phone, out of gas, out of money with his wife and two kids crying" wondering what to do. ATMs had no electricity and the policyholder had been driven from his home.

Mr. Crowe explained the situa-

tion to Lexington Chief Executive Officer Kevin Kelley and President Shaun Kelly, who immediately asked, "What about Western Union?"

Lexington transferred \$1 million to Western Union on the first day of the program. As policyholders called, they were told to go to the closest open Western Union office to get claims payments.

Paying claims of commercial clients was an easier transaction. During the first week after Katrina, Lexington wired about \$40 million to commercial policyholders, sent more than \$160 million in wire transfers and checks in the first 30

days, and more than \$300 million in the first 60 days, said Mr. Crowe.

Sometimes, adjusters have to take to the air. For example, Mr. Alonso noted that FM Global insured a facility in a flood-prone area. In an incident that did not involve Katrina, the building flooded. Equipment began oxidizing, but there was no way to remove it by truck. So FM Global cut a hole in the roof, rented a helicopter and airlifted the equipment out, he said.

Helicopters played a role in documenting post-Katrina damage when flooding barred access by car, said McLaren's Young's Mr. Brown. To deal with flooded tank farms, the

adjusting company had two helicopters "do flyovers to get as much photographic evidence as we could to try to document the losses."

But to effectively ensure that claims are paid speedily, policyholders should provide their insurers or adjusters with a full list of values in terms of both property and business income in a catastrophe-prone area, said Mr. Brown.

If a catastrophe wipes out a store or other facility, the insurer will already have a reasonable idea of the types and values of lost inventory and the levels of income that facilities generate, he said.

"If they have that information, it's much easier for an independent adjuster to get the insurance company to make a quick and substantial payment," he said.

Tactics depend on location

The task of adjusting remote claims often becomes even more complicated when an international element is thrown in to the mix.

Even under less than ideal circumstances, the United States "has a very good infrastructure," says Jeff Bowman, chief operating officer, global property and casualty services for Crawford & Co. in Atlanta. "We can get a satellite communication truck to an area pretty quickly after an event has happened."

But in the Caribbean, "there is a whole different scenario," as illustrated by the challenges facing adjusters after Hurricane Ivan struck the Cayman Islands in 2004, said Mr. Bowman.

The hurricane closed the airport to commercial jets for several days, authorities imposed a civilian curfew and there was no electricity. "They couldn't pump gas," Mr. Bowman said.

Still, Crawford had to get adjusters to the scene. The company told designated personnel to "get yourselves to Kingston, Jamaica." From there, Crawford hired small aircraft to fly them to Grand Cayman, Cayman Islands.

The adjusting firm, meanwhile, hired an undamaged dive boat docked in the Grand Cayman to use as base of operations, he said. The vessel had satellite links and "enough bedrooms to assure our adjusters were able to work," he said. The adjusters used bicycles and small mopeds to get around.

"We were up and running in 24 hours," Mr. Bowman said. "We handled a lot of very large claims there."

—By Mark A. Hofmann

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Claims disputes take alternate path in search of resolution

Zurich sets up unique program to handle 2005 hurricane losses

By MARK A. HOFMANN

SCHAUMBURG, Ill.—Disputes over claims sometimes are unavoidable, but that doesn't necessarily mean such disputes have only one place to end up—in court.

For Zurich Financial Services Group, a way to settle potentially contentious claims arising from the unusually destructive U.S. hurricane season in 2005 meant turning to alternative dispute resolution, said James Engel, executive vp customer services and chief claims officer for North America in Schaumburg, Ill.

The ADR effort, called the Gulf Coast Alternative Dispute Resolution Program, applies only to claim disputes stemming from hurricanes Katrina, Rita and Wilma.

'All litigation does is cost both parties, delays the outcome and our objective is to get our customers back in business.'

James Engel,
Zurich Financial Services Group

Zurich has been the only commercial U.S. insurer to use ADR in handling its 2005 Gulf Coast hurricane claims.

"We've actually resolved about 650 cases through that program," Mr. Engel said. "We think that's allowed us to avoid disputes that probably would have led to litigation. We just think that's been a tremendously successful program."

The destruction wrought by Hurricane Katrina presented particular claims challenges, Mr. Engel said. Zurich faced "the issue of whether the damage was generally uncovered water damage or generally covered wind damage. That issue created the potential for dispute."

Although some ADR techniques have been used in handling claims previously, Zurich's team of claims handlers wondered "shouldn't we set up some overall mechanism that deals with this on a much larger scale?" he said.

Zurich turned to an expert in the field—Kenneth Feinberg, who received national recognition as special master of the Victims Compensation Fund set up by Congress to deal with claims from the Sept. 11, 2001, terrorist attacks.

Zurich hired Mr. Feinberg—managing partner and founder of The Feinberg Group L.L.P., a law firm that specializes in resolving legal disputes—"to work on the program with us, to help us pick arbitrators, help work out some of the proto-

cols," Mr. Engel said.

All of Zurich's claims involved commercial lines, and larger customers tended to "understand mediation or arbitration better," he said. But there also were small commercial claims that entered the ADR process.

Zurich was able to use people in the hurricane-stricken Gulf Coast to run its ADR program.

"We asked Ken to access those accredited organizations" that would know accredited mediators and arbitrators, which led to the "creation of lists of qualified people," Mr. Engel said.

Policyholders could choose anyone from the lists, he said. If policyholders chose someone not on the list, the choice was accepted if vetted by Mr. Feinberg.

Three-stage process

The process has involved three stages. The first is a resolution meeting at which the claim is paid immediately if the parties reach agreement. The second stage is a nonbinding mediation, which—if unsuccessful—leads to the final stage, binding arbitration.

A Zurich policyholder called the process "very workable."

"Honestly, I didn't see any negatives about it," said Bill Roberts, who with wife Linda owns the Ocean Springs, Miss., building where she has offices as a certified public accountant.

"There wasn't really any dispute—it was more or less just getting the paperwork together to settle it," said Mr. Roberts. While Zurich wished to get the claim settled quickly, Mr. Roberts said he and his wife delayed compiling information for their claim as she concentrated in meeting clients' needs. "Effectively, we carved out a couple or three days" to put infor-

mation such as bank statements together. The actual meeting with Zurich lasted a couple hours and the couple left with a check, he said.

"I felt it would have been very workable" even if there had been a dispute, Mr. Roberts said.

"Relatively few cases have come out of ADR unsuccessfully," probably in the low single digits, Zurich's Mr. Engel said. In addition to the 650 cases resolved, an additional 200 or so remain in the process.

"All litigation does is cost both parties, delays the outcome and our objective is to get our customers back in business," he said.

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Policy buybacks call for cautious approach

Risk managers who are dealing with runoff insurers may want to consider policy buybacks, but they also should proceed cautiously, observers say.

Buybacks are contractual agreements under which the policyholder accepts a lump sum payment in exchange for giving up the rights to any future claims under the policy.

Runoff insurers encourage a policy buyback because it means they can take the potential liability off their books, say observers. But that does not necessarily mean it is always in an organization's best interest.

Risk managers should consider a policy buyback "if the claims haven't matured yet because, in general, most runoff companies either fail or make some kind of an arrangement with their creditors" that could limit how much a policyholder recovers, said Mary Caron Veed, an attorney with Arnstein & Lehr L.L.P. in Chicago.

If risk managers "have any concerns about whether they think (a runoff insurer) ultimately can succeed, can run off as a solvent entity, they probably need to think about policy buybacks, or getting their major claims out of the way," said Jonathan Bank, an attorney with Lord Bissell & Brook L.L.P. in Los Angeles.

"A policy buyback involves undertaking a realistic assessment of the economic viability of the insurance company," said Bruce

C. Shulan, managing director at the Stamford, Conn.-based Princeton Partnership L.L.C., which works with runoff insurers.

If it appears the runoff insurer can remain solvent and avoid rehabilitation or liquidation, then the risk manager must decide if he

"makes a lot of sense to negotiate a policy buyback so that the insured is getting some money, which can be used to defray future exposures," said Mr. Shulan.

"The problem is that it can be very difficult for an insured to undertake a realistic evaluation of what the true economic viability of the insurer is," although industry experts can help determine "whether a policy buyback makes sense" and at what price, Mr. Shulan said.

The advisability of a buyback could depend on the particular policy, said Rachel S. Kronowitz, an attorney with Gilbert Heintz & Randolph L.L.P. in Washington. If it is a primary policy providing coverage for multiple lines such as general liability, workers compensation and property, "I'd be very, very careful" in considering a buyback because there could be claims generated in the future, Ms. Kronowitz said.

"But if you're talking about a higher-level excess aggregate policy" with defense costs within the limits, the risk manager "can at least weigh the economic value of that policy and determine whether or not it makes sense to get paid today and get paid a few cents on the dollar" rather than take a chance that the insurer will become insolvent, which could lead to years of waiting for payment, Ms. Kronowitz said.

—By Judy Greenwald

TAKING ACTION

Steps that industry experts recommend risk managers take to be proactive in managing their organizations' claims

- Determine all of the organization's exposures.
- Develop a contingency plan to handle possible coverage gaps.
- Develop a relationship with claims examiners.
- Determine the runoff insurer's financial vulnerability.
- Consider policy buybacks.
- Get expert advice.

or she "would rather have the benefit of the return premium—recognizing that any future losses that would have been covered by that policy now belong to the insured"—or the benefit of knowing that any unforeseen losses would be insured, Mr. Shulan said.

If, though, it appears that the insurer will become insolvent, it

Runoffs no walk in the park, but planning smoothes path

By JUDY GREENWALD

Risk managers who find themselves dealing with a runoff insurer are seldom happy about it, but there are steps they can take to minimize their problems, say observers.

The first thing to keep in mind is to be proactive, observers say.

"The risk manager has to be much more involved than he is traditionally," said Dale Renner, Aon Corp.'s Philadelphia-based managing director of national casualty claims.

"It's like moving up from Risk Management 101 to a 500-level course. You're going to be much more intense," Mr. Renner said.

A proactive approach helped Fleetwood Enterprises Inc. in its negotiations of workers compensation claims with Kemper Insurance Cos. after the Long Grove, Ill.-based insurer was placed in runoff, said Bill McMahon, risk management director at the Riverside, Calif.-based manufacturer.

"We worked aggressively" with the claims manager to identify claims that could be settled, Mr. McMahon said.

"You have to be aware that it's the squeaky wheel that gets the grease," said Arthur Pritzker, managing director at Chicago-based Mesirow Financial Corp. "You have to stay all over them, basically."

Risk managers may also want to consider policy buybacks, according to observers (see related story).

But do not delay taking action, experts say. If it appears that an insurer is at risk of failing, risk managers should act sooner rather than later to try and get claims paid, said Bruce C. Shulan, managing director at the Stamford, Conn.-based Princeton Partnership L.L.C., which works with runoff insurers.

"We're trying to get the money out before there really isn't any money," said a risk manager for a firm that had Kemper workers comp coverage. The risk manager asked not to be identified. "We're beating hard on our (third-party administrator) and broker to close as many claims as possible before Kemper goes out for good."

Future claims analysis

In addition, risk managers should study their insurance policies carefully. "Invest the time and money in a comprehensive valuation of potential future claims under the policy so that you may come to the negotiating table with a well-supported settlement number," said Jonathan Terrell, president of Washington-based Kenesis Corporate & Information Con-

sulting L.L.C.

Also, "independently evaluate the financial vulnerability" of the runoff insurer, including the size of its surplus, said Mr. Terrell.

Contingent plans for any ongoing exposure also should be drafted, said William J. Berglund, owner of Claims Consulting and Advisory Services in Chicago. There could be coverage gaps, "so they've got to plan for that," he said.

Relationships do matter

And it is important for risk managers to maintain relationships with claims adjusters, say observers.

Carol A. Fox, senior director, risk management, with Cincinnati-based Convergys Corp., a software company that had coverage with Kemper, said when new adjusters were brought in or when cases were handed off to other adjusters, Convergys would work with them "bringing them up to speed (and) really having them understand what our needs are."

Fleetwood's Mr. McMahon said, "Even though you've lost those main contacts when people start disappearing, you have to remember to maintain an open line of communication with that insurer, or the people that are representing them now, and that's how you get things done."

Mr. McMahon added, "I know a lot of people get upset when this kind of thing happens, and it becomes a real, direct conflict in trying to get to negotiate or discuss things" with a runoff insurer. But, "You don't get anywhere by screaming and yelling."

"Be prepared to negotiate, but do it from strength," said Dennis L. Bennice, former risk manager at Toledo, Ohio-based Dana Corp., which reached a settlement with London-based Equitas Ltd. in 2005. "Remember, the insurers do this continuously. Be prepared for every conceivable delay," warned Mr. Bennice, who is now a vp at the Toledo-based Hylant Group.

Get expert help, observers suggest.

"Engage experienced coverage counsel to assist, especially with any overly aggressive claims handling practices by the runoff companies that may give rise to potential claims of bad faith," said Mr. Terrell. He recommended that risk managers also "be prepared to initiate litigation in support of well-founded and supported claims."

"It may not be necessary to go very far with prosecuting such litigation, but it is an important piece of the puzzle that should not be ignored," said Mr. Terrell.

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More third-party administrators sharing technology with customers

Turning data into practical information still biggest challenge

By GLORIA GONZALEZ

Third-party administrators have made strides in using technology to broaden the range of products and services they offer, but they need to work harder to make technology an asset for their customers, risk managers and brokers say.

TPAs have spent much time and effort on improving their technology, which has helped them move toward a paperless environment and provide easier access to information—a key factor in the early life of a claim when getting the right resources applied to a case is critical, said Mark Noonan, the Boston-based managing director and practice leader for workers compensation for Marsh Inc.

Beyond merely improving technology, the key issue for TPA customers is how well TPAs use technology to translate compiled data into practical information that improves the ability to measure outcomes, brokers say.

Some TPAs are moving rapidly to make technology an asset for their customers while others are not moving in that direction at all, said Neil Harrison, managing director, Aon Technical Services in New York. "It's a lack of focus in making the technology relevant to the customer."

The top TPAs are thoroughly ana-

lyzing the information and developing a plan to better manage large claims, said Karl Zimmer, director of risk management at Alberto-Culver Co., a personal care products manufacturer in Melrose Park, Ill. "It's come a long way."

Itasca, Ill.-based Gallagher Bassett Services Inc. and Memphis, Tenn.-based Sedgwick Claims Management Services Inc. have tended to be the leaders in using technology although some of their competitors are catching up, Mr. Zimmer said.

In the past year, several TPAs enhanced existing products or launched new ones.

In November, Philadelphia-based ESIS announced an enhancement of its ESIS Impact program that identifies certain claims earlier in the process, which allows clients and vendors to better manage those claims, said Nancy DiVincenzo, vp of ESIS product management.

Last year, Crawford & Co. rolled

See TPAs next page

LARGEST EMPLOYEE BENEFIT TPAs

TPAs that specialize in employee benefit claims administration

Company	2006 revenues from self-insured clients
Fiserv Health Inc.	\$282,000,000 ¹
The Principal Financial Group/National Accounts	\$149,309,097
Meritain Health Inc.	\$141,000,000
CoreSource Inc.	\$115,769,000
Alicare Inc.	\$51,806,000
American Administrative Group Inc.	\$51,020,000
CenBen USA Inc.	\$48,672,000
Brokerage Concepts Inc.	\$40,674,500
Group Resources Inc.	\$40,222,630
HealthPlan Holdings Inc.	\$19,000,000

¹ BI estimate
Source: BI survey



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TPAs: Improving claims technology to identify complex issues

CONTINUED FROM PREVIOUS PAGE

out its Claims Advantage tool nationally. The Web-based tool is designed to address core problems such as inconsistency in claims practices and failure to identify complex

cases early in the life of a claim. "It answers a lot of questions about consistency and quality and gets very quickly to what the issues are in a claim," said Larry Mattingly, senior vp and chief innovation officer at Plantation, Fla.-based Broadspire Ser-

vices Inc., which Atlanta-based Crawford acquired in October.

Empowering customers to be more productive and in control of their claims data was the thrust of the EYE Advisor tool launched last year by Parsippany, N.J.-based GAB

Robins North America Inc., said Tere Travaglia, product manager for EYE Advisor. The tool's Quick Track feature compiles data on a particular claim and a Quick Alert feature sends automatic e-mail notifications about significant events—defined and managed by the customer—that are triggered when data changes indicate an event has occurred.

TPAs also are applying existing technology to new lines of business.

Sedgwick, for example, entered the health care professional liability arena last year by acquiring TPA CompManagement Inc. Sedgwick plans to use its data warehouse technology developed for predictive modeling of general liability and workers compensation claims to cre-

ate a similar system for health care professional liability, said Paul Posey, Sedgwick's general counsel.

Lorie Kelly, director of risk management for Seattle-based Swedish Medical Center and a longtime CompManagement client, said risk managers need this type of information to benchmark their claims, both on a regional and national level, in the health care professional liability area.

"It's been a pretty closeted environment in terms of how claims are settled, what their values are and whether it's advisable to take them to trial," Ms. Kelly said.

One trend that is "detrimental"

Continued on next page

LARGEST WORKERS COMPENSATION TPAs

TPAs that specialize in workers compensation claims administration

Company	2006 claims paid to self-insurers	Percentage from workers compensation claims	2006 revenue from workers comp claims*
Sedgwick Claims Management Services Inc.	\$556,400,000	46%	\$255,944,000
Broadspire Services Inc., a Crawford Co.	\$366,962,000	69%	\$253,203,780
Gallagher Bassett Services Inc.	\$357,000,000	68%	\$242,760,000
Specialty Risk Services L.L.C.	\$210,000,000	81%	\$170,100,000
ESIS Inc.	\$200,200,000	77%	\$154,154,000
Cambridge Integrated Services Group Inc.	\$202,000,000	49%	\$98,980,000
Helmsman Management Services L.L.C.	\$67,591,000	70%	\$47,313,700
GAB Robins North America Inc.	\$54,000,000	63.3%	\$34,182,000
The Frank Gates Cos. Inc.	\$41,000,000	79%	\$32,390,000
Cannon Cochran Management Services Inc. dba CCMSI	\$48,544,000	65%	\$31,553,600

*BI estimate based on the percentage of workers compensation claims to self-insured clients.
Source: BI Survey

LARGEST PROPERTY/CASUALTY TPAs

TPAs that specialize in property/casualty claims administration

Company	2006 revenues from self-insured clients
Gallagher Bassett Services Inc.	\$357,000,000
Specialty Risk Services L.L.C.	\$210,000,000
Cambridge Integrated Services Group Inc.	\$202,000,000
ESIS Inc.	\$200,200,000
Helmsman Management Services L.L.C.	\$67,591,000
GAB Robins North America Inc.	\$54,000,000
The Frank Gates Cos. Inc.	\$41,000,000
Berkley Risk Administrators Co. L.L.C.	\$40,000,000
Risk Enterprise Management Ltd.	\$39,610,000
TRISTAR Risk Management	\$35,000,000

Source: BI survey

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TPAs promote consumerism with products and services

The ability to incorporate consumerist elements into their products and services is a major priority for many third-party administrators operating in the health care benefits area.

Helping employers provide the tools their workers need to lead healthier lifestyles and become more informed consumers is paramount, said Elliot Cooperstone, chief executive officer of Prodigy Health Group Inc., the parent company of Meritain Health Inc., based in Westport, Conn. "Our belief is that consumerism is critical," he said.

The company's Healthy Merits wellness program provides a recommended template for healthy living, focusing on areas that people have the most control over and that can have the greatest impact on improving their health, such as physical fitness and nutrition, Mr. Cooperstone said.

The company also has transformed its standard explanation-of-benefits form into a member statement summary that not only lists the health care products and services that employees have received and health care account amounts, but also highlights how much they spend on

prescription drugs, including the amount spent on brand-name drugs and how much they could save by choosing generics.

The expanded forms make employees better consumers, said Suzanne Parsons, director of human resources for the National DCP, a service and supply organization in Bellingham, Mass., owned collectively by Dunkin' Donuts franchises that launched a health insurance program last year with Meritain Health's help.

"I think they're keeping a better eye on the costs associated with visiting the doctor," Ms. Parsons said.

Technology is a key element in the ability to offer products and services that promote consumerism, TPAs say.

Minneapolis-based Fiserv Health Inc. acquired CareGain Inc. as part of Fiserv's efforts to help health plans and financial institutions manage consumer-driven health care plans and related health care spending accounts.

"Technology is really important," said Jay Anliker, division president of health plan services for Fiserv Health. "It's another way to help the consumers."

—By Gloria Gonzalez

CONTINUED FROM PREVIOUS PAGE

to progress in the development and use of technology to provide better solutions for clients is the ongoing consolidation in the TPA industry because it restrains the TPAs, Mr. Harrison said.

The impact of consolidation on technology and customer service depends on the execution of the merging of entities, Mr. Mattingly said. Crawford and Broadspire, for example, contacted customers for both entities to discuss their specific concerns and had a plan for evaluating all software, he said.

There are still areas that require the attention of the TPAs, brokers and risk managers say.

For example, TPAs need to continue to address ongoing issues such as heavy caseloads for their adjusters and high turnover, Mr. Zimmer said.

While every risk manager can speak of one or two TPAs that are not up to speed, the industry has made good strides over the last few years, he said. "It requires constant customer service, but I would say the industry has progressed and is doing a better job," Mr. Zimmer said.

LARGEST MULTILINE TPAs

TPAs that offer both employee benefits and property/casualty claims administration	
Company	2006 revenues from self-insured clients
Sedgwick Claims Management Services Inc. ¹	\$556,400,000
Broadspire Services Inc., a Crawford Co. ²	\$366,962,000
Wells Fargo Third Party Administrators and Wells Fargo Disability Management ³	\$60,639,000
Cannon Cochran Management Services Inc. dba CCMSI	\$48,544,000
Keenan & Associates	\$30,700,000
The Loomis Co.	\$27,899,580
F.A. Richard & Associates Inc. dba FARA	\$16,411,409
CAS-Claims Administrative Services Inc.	\$13,521,228
JI Specialty Services Inc.	\$9,518,000
Underwriters Safety & Claims Inc.	\$8,500,000

¹ Includes CompManagement Inc. and VPA Inc. ² Includes Broadspire Services Inc. and Crawford Integrated Services, which were merged October 2006. ³ Formerly Acordia Inc.
Source: BI survey

Products & Services

FM Global updates property loss catalog

JOHNSTON, R.I.—Factory Mutual Insurance Co. has issued its 2007 Property Loss Prevention Resource Catalog.

The catalog offers a selection of property loss prevention publications, learning kits, videos, CD-ROMs and training courses to help manage property-related threats, prevent facility damage and minimize business interruption. Materials and resources also cover construction and maintenance, equipment hazards, facility and warehouse protection, as well as emergency planning.

To order a free printed catalog, visit www.fmglobalcatalog.com or call Johnston, R.I.-based FM Global at 877-364-6726 from the United States and Canada, or at 401-477-7744 from outside North America.

ACE European expands IT security policy

LONDON—ACE European Group has launched an expanded information technology hardware and network

security policy, ComputerGuardPlus, available exclusively online.

The policy, which includes coverage for losses resulting from hacking, Web site defacement, denial-of-service attacks and viruses, is being offered through the SSP Sector and Acturis broker platforms.

ComputerGuardPlus combines ACE's existing ComputerGuard policy, which provides all-risk coverage on IT equipment, with coverage for financial losses as a result of crime or accidental damage to data and systems. Brokers can obtain quotes, bind coverage and organize midterm policy adjustments directly online.

Limits of up to £2 million (\$3.9 million) are available. For more information, contact Ian Harris, senior underwriter-technical lines, at 0-121-234-1128 or by e-mail at ian.harris@ace-ina.com or visit www.aceeurope.co.uk.

London American offers utility district program

HOUSTON—London American Risk Specialists Inc. in Houston is offering a comprehensive utility district program targeting companies serving 75,000 or fewer customers.

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NEW YORK—National Union Fire Insurance Co. of Pittsburgh, Pa., has introduced Financial Institutions Risk Protector, a package of management and professional liability insurance coverages for privately held financial institutions.

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Directors', officers' exposures grow

Top executives' pay seen as major factor in liability lawsuits

By RUPAL PAREKH

NEW YORK—Directors and officers insurance claims litigation may be waning, but D&O liability exposures continue to grow, with possible new sources of claims sprouting from issues concerning executive compensation and corporate governance, market experts say.

Panelists speaking at the Professional Liability Underwriting Society's 2007 D&O Liability and Insurance Issues Symposium reiterated

that message during the conference, which was held Jan. 31-Feb. 1 in New York.

Studies in 2006 showed a major decline in securities fraud class action filings, which dropped more than 40% over historical averages.

But the downward trend cannot be attributed to increased vigilance by auditors as some pundits have said, noted Denise M. Amantea, partner with Woodruff Sawyer & Co. in San Francisco. "I think the filings are down because Milberg Weiss got caught," she said.

Last year, plaintiff law firm Milberg Weiss Bershad & Schulman L.L.P. was indicted on federal charges for allegedly making secret payments to lead plaintiffs. That

indictment is the "single biggest reason class actions have dropped off," said Michael Mitrovic, president, worldwide financial services with American International Group Inc. in New York.

Before the indictment, various industry watchers estimated that Milberg Weiss was responsible for more than half of the annual securities class action filings.

Claims 'hotbed'

While the number of D&O suits has declined, new sources of claims continue to develop in the D&O world, panelists said.

A "hotbed for claims" can be found in companies' executive compensation practices, said Stephen J. Sills, president and chief executive officer of Darwin Professional Underwriters Inc. in Farmington, Conn.

Liz Smith, assistant vp, corporate governance, at Moody's Investor Service in New York, said 2007 will be a "watershed year" for investor outcry over companies' executive compensation practices—the most notable issue being the widespread options backdating scandal.

Although most shareholder lawsuits sparked by options-related problems at companies have been of a derivative nature, the increasing number of them means that some D&O underwriters could suffer, panelists said.

"The costs to defend these things are not cheap," said Kevin P. Gadbois, executive vp at Schaumburg,

PLUS D&O Symposium draws nearly 1,400 to New York

The Professional Liability Underwriting Society's annual D&O Symposium drew nearly 1,400 attorneys and insurance, reinsurance and brokerage representatives from countries including the United States, Australia, Bermuda, Canada, France and the United Kingdom.

Held Jan. 31-Feb. 1 at the Marriott Marquis in New York, the event featured panel discussions and interactive sessions that delved into topics in directors and officers exposures, such as

the stock-options backdating scandal, executive compensation and private equity-related D&O risks.

Keynote speakers for the event were Chubb Corp. Vice Chairman John J. Degnan and former U.S. Sen. George J. Mitchell, D-Maine, who now is chairman of the board at law firm DLA Piper U.S. L.L.P.

The 2008 PLUS D&O Symposium will be held Feb. 5-6 at the Marriott Marquis in New York.

—By Rupal Parekh

See PLUS page 24

'Stealth restatements' warrant underwriter scrutiny

By RUPAL PAREKH

NEW YORK—Directors and officers liability insurance underwriters are faced with increased exposures stemming from a growing frequency in accounting mistakes and subsequent earnings restatements by U.S. public companies, market experts say.

"We still have a lot of issues surrounding the quality of financial disclosure," said Keith M. Thomas, senior vp, commercial markets, in the man-

That means that nearly 9% of all U.S. public companies made earnings restatements last year, Mr. Weil said, many of which fit the category of so-called "stealth restatements."

Rather than being prominently announced, stealth restatements are tucked into a company's 10Q or 10K report filed with the Securities and Exchange Commission (see box).

Companies that choose to make stealth restatements should be carefully scrutinized by underwriters, said Mr. Weil.

One red flag underwriters can look out for is "when a company shifts their metrics," or makes changes to earnings guidance, or reporting procedures, said Marc Seigel, who is global director of research at the Center for Financial Research and

RESTATEMENTS



Source: Glass Lewis & Co. L.L.C.

agement solutions group of Zurich American Insurance Co. in New York.

He was speaking during a session at the Professional Liability Underwriting Society's D&O Symposium held recently in New York.

Last year was a record year for financial restatements, noted Jonathan Weil, a managing director at Bloomfield, Conn.-based research firm Glass Lewis & Co. L.L.C.

In 2006, 1,422 restatements were made by 1,246 companies, compared with 1,254 restatements made by 1,158 companies in 2005, according to Glass Lewis.

Analysis based in Rockville, Md.

Additionally, mergers and acquisitions can elevate the likelihood of a company having to restate, due to potential disruptions in internal controls, the experts noted.

Martin F. Baumann, deputy director of the Public Company Accounting Oversight Board in New York, said the majority of earnings restatements aren't linked to corporate scandals, but are "technical restatements" brought on by complex accounting rules enforced by regulators under the Sarbanes-Oxley Act and Financial Accounting Standards Board rules.

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THE BENEFITS OF BETTER COVERAGE.

PLUS: Board, management splits grow

CONTINUED FROM PAGE 22

Ill.-based Great American Insurance Group. "It could take a major hit to the D&O industry to get these things out of the system."

While certain directors and officers may be forced to disgorge any allegedly ill-gotten gains, outside directors have a "very low likelihood" of having to pay out of pocket as a result of those cases, said Michael Klausner, a business and law professor at Stanford, Calif.-based Stanford Law School.

'It could take a major hit to the D&O industry to get these (lawsuits) out of the system.'

Kevin P. Gadbois,
Great American Insurance Group

Another potential source of D&O claims will revolve around corporate governance, the panelists said.

Anthony S. Galban, senior vp and D&O underwriting manager for Chubb Specialty Insurance in Warren, N.J., said possible exposures can be found in rising animosity between boards and managements at public companies, brought on largely by Sarbanes-Oxley Act requirements for directors to report any illegal behavior.

Protecting outside directors

Dan Bailey, an attorney with Bailey Cavalieri L.L.C. in Columbus, Ohio, suggested that D&O policies need to evolve to account for this "growing wedge" between boards and senior management, and called on the insurance industry to devise better ways to structure policies and ensure that outside directors are getting educated on exposures and the types of insurance that can respond.

Additionally, the increasing role of private investor financing in public companies—with more and more representatives from private equity firms and hedge funds being included on boards of directors—is leading to conflicts of interest where D&O claims can follow, the speakers said.

Whether there is actually wrongdoing, private equity firms are getting named in suits because the firms have "deep pockets" and the cost of defending those claims is expensive for D&O underwriters, said Mark Vandevanter, vp at XL USA in Hartford, Conn.

Speakers during the conference stressed that D&O exposures are arising in jurisdictions outside the United States. Countries to watch for increasing D&O litigation risks include Germany, the Netherlands, Spain, Sweden and the United Kingdom because systems already are in place that allow collective action by multiple claimants.

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International NEWS

Soft market to continue in Russia

International insurers cautious despite growth opportunities

By RICHARD MILLER

MOSCOW—Russia has seen an insurance buyer's market for a few years running, and the trend is expected to continue with some insurers reconsidering their position in certain lines, according to industry players.

"The market has been soft in most commercial lines for the last three years," said Nikolai Dmitriev, president of AIG Insurance and Reinsurance Co., a unit of American International Group Inc., in Moscow. "We expect the rates will continue to decline, but at a smaller pace in 2007."

The most softening will occur in property/casualty, contractors' all-risks policies, and directors and officers liability insurance due to big treaty capacities and increasing competition, Mr. Dmitriev said.

Rates in some commercial lines have declined to a point that Zurich Russia, part of Zurich Financial Services, will not write the business if it does not meet its return expectations for underwriting profit.

"If the rate is unquestionably low, we would rather not participate than try to get it at any cost," said Dimitry Ignatiev, Zurich Russia's chief executive officer.

AIG says it takes the same approach.

The Russian insurance market did not follow the hardening trend of the European and U.S. markets from 2002 to 2003, he said. "When the international property market was hardening, the Russian market continued to soften, and as a result, in certain industries, rates in Russia today are too low from our point of view," Mr. Ignatiev said.



The Kremlin: Despite the Russian market's growth potential, some international insurers have concerns over political uncertainties.

Three major Russian losses last year—industrial losses totaling \$100 million—do not appear to have had any impact on rates through increased treaty renewal costs, said Andreas Wania, CEO/country manager for ACE Insurance Co. CJSC in Moscow, a unit of ACE Ltd.

Despite the low rates, international insurers in Russia continue to experience growth across all business and personal lines. AIG Russia saw a 40% increase in gross premiums in 2006 from the previous year, while Zurich said it experienced "double-digit" growth. Both expect the growth trend to continue.

Sales of property insurance dominate the corporate market, due in part to the fact that foreign banks insist on the coverage as a requirement for credit, experts said. Liability coverage is not growing as quickly, with local companies insuring to minimal limits, some said.

"There aren't that many sophisticated buyers in Russia," said Boris

Korchemkin, chief executive officer of Aon Rus L.L.C., a unit of Aon Corp. "On the other hand, property insurance is something which is easy to understand."

Still, on a percentage basis, D&O is one of the fastest-growing lines in Russia, several experts said. Demand is being driven largely by initial public offerings of Russian companies, which are obligated to buy the coverage. Some 70 companies have plans for IPOs in 2007, according to Zurich.

Other lines seeing the most growth are construction, aviation, motor third-party liability and compulsory liability, said Mr. Wania of ACE.

While 2006 sales figures are not yet available, Deutsche UFG, part of Deutsche Bank Group, issued a forecast last August, saying that the nonlife market in Russia would increase by 33% to reach \$12.5 bil-

See **RUSSIA** next page



LANDOV

Swiss Re sells London HQ

Swiss Reinsurance Co. has agreed to sell its iconic London headquarters to an affiliate of the real estate company IVG Immobilien A.G. for £600 million (\$1.18 billion). The 30 St Mary Axe building, nicknamed "The Gherkin," was designed by London-based architectural firm Foster & Partners and opened in 2004. Swiss Re will remain the principal tenant.

French risk managers shut out of many M&A deal discussions

Lack of access could derail transactions, observers warn

By RICK MITCHELL

NANTES, France—French corporations often neglect to include risk managers on teams negotiating mergers, acquisitions and divestitures, an omission that can have deal-breaking consequences, according to a panel of experts at this year's gathering of the Association pour le

Management des Risques et des Assurances de l'Entreprise.

"Many factors could cause a deal to fail in today's environment. Deals are more complex, competition is more and more intense, and risk of loss and litigation is higher than ever," said Humbert d'Autichamp, managing director of Marsh's Private Equity and M&A Practice, a division of Marsh Inc.

Mr. d'Autichamp was speaking during a panel discussion at AMRAE's conference in late January.

Mr. d'Autichamp said recent



RISKS: As litigation increases and technology develops, risk managers face challenges. **Page 26.**

management and insurance can

French and European legislation and regulations require more complete disclosure of risks and insurance coverage to counterparties in a transaction. "Risks can impact every aspect of a deal, and neglecting aspects of risk

transform a good deal into a bad deal," he said.

The panel discussed barriers that risk managers face. Frédéric Duponchel, president of Accuracy, a Levallois-Perret, France-based unit of Aon Corp., said that "in a big transaction, the allegiance of certain key management personnel can shift from the selling company to the buying company. This poses a risk of loss of critical information, such as sales and contract information, and other company secrets."

Ironically, this risk could contribute to the risk manager's exclu-

sion from the negotiating team, he said. In fact, "risk managers have an important role to play," he said.

The risk manager can keep track of company secrets and also the many players involved in a deal, such as banks, auditors, consultants, lawyers and intermediaries. "The risk manager can analyze potential conflicts and divergences of interest," said Mr. Duponchel, who noted that three out of four such deals fail in France.

In fact, risk managers are often

See **MERGERS** next page

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Commentary

Gun industry doesn't deserve legal shield

A week before Christmas, a 20-year-old man was shot to death on the front lawn of our neighbor's house right outside of our suburban cul-de-sac. It was one of those senseless killings that seem to have become all too common in today's society: A group of young people gather for a party, an argument ensues, a gun is drawn and a young man's life is cut short in an instant.

An 18-year-old male was arrested a few days later and was being held on first-degree murder charges in addition to unrelated warrants for assault, domestic violence, violation of a restraining order and contempt of court in two Colorado counties.

Two weeks after that incident, 24-year-old Denver Broncos cornerback Darrent Williams was gunned down as he sat in a Hummer limousine with friends in the early hours of New Year's Day. More than a dozen bullets were fired into the Hummer shortly after an argument occurred outside a nightclub near downtown Denver.

Police sources have said that three gang members were being sought in connection with Mr. Williams' death. One 23-year-old male had been arrested on a parole violation and was questioned about the shooting.

The latter shooting took place about four blocks from my prior residence before moving out of Denver about six years ago and into a safer suburban neighborhood—about two miles from Columbine High School, home of the worst school shooting in our nation's history.

My point is not to be flippant, but I don't think there is any truly safe place to raise children anymore. And part of the reason for that is the pervasiveness of guns among young people in this country and this barbaric attitude among some that taking another person's life is somehow the ultimate way to get in the last word.

While the number of gun-related killings among young people between the ages of 15-29 in the United States has remained relatively stable over the last few years, there still were 6,190 killed in 2004 and an additional 28,641 injured in gun assaults, according to the Centers for Disease Control and Prevention.

The CDC doesn't say how many of those homicides and assaults were committed by people of the same age group, but a 2006 report by the Office of Juvenile Justice and Delinquency Prevention shows that 51% of the homicide victims killed by juvenile offenders from 1992 through 2002 were between the ages of 13-24. And a firearm was used in 74%



SALLY ROBERTS

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of the cases.

Times have certainly changed, and a host of factors from family values to violent video games play a part in the problem. But the recent incidents that hit so close to home have me thinking about what could have been if President Bush had not signed the Protection of Lawful Commerce in Arms Act in 2005 that basically gave the gun industry immunity from liability suits stemming from shooting deaths and injuries.

I've never been a big fan of product liability litigation—whether it's tobacco, Big Macs or guns.

I've never been a big fan of such litigation—whether it's tobacco, Big Macs or guns—believing that we should take personal responsibility for our actions and not blame others.

But holding some in the gun industry accountable for distribution practices that put guns into criminals' hands—including young criminals—or for shoddy business practices that do not keep track of lost or stolen firearm inventory—as some of the lawsuits from a few years ago alleged—is a bit more palatable to me now.

Guns certainly don't kill people; people kill people and we need to do more to prevent those young people who have the capacity to kill from accessing guns so easily.

While lawsuits against gun manufacturers and dealers in and of themselves will not make guns safer, they do tend to force businesses to change their practices and to follow rules more closely.

Whether they would ultimately result in fewer murders among our young people is debatable, but Congress made sure we will never know.

Russia: Some insurers still cautious

CONTINUED FROM PAGE 25

lion in gross written premiums in 2006, up from \$9.4 billion in 2005.

Deutsche UFG's long-term forecast was for \$106 billion in 2016, based on higher than previously projected nominal gross domestic product, which itself is largely driven by Deutsche's long-term oil price forecasts and resultant ruble appreciation.

The Deutsche analysis predicted nonlife penetration in Russia would rise to 2.67% of GDP in 2016, from 1.24% of GDP in 2005, in line with several Western European countries at present. Competition among insurers has increased, with ACE starting to write business in March 2005. There is an expectation that two more Western nonlife insurers will enter the market this year, according to Mr. Wania.

Changes in Russian regulations will give international insurers an edge, according to Zurich's Mr. Ignatiev. Solvency capital requirements coming into effect in July will "put pressure on small local players which are not properly capitalized" and "significant consolidation" is expected.

"So international players, given their capital strength and their global presence and expertise, will be able to win and to participate in this market growth, while small local players might disappear," he said.

Despite the growth potential, some international insurers are guarded when doing business in Russia. Concerns have been raised about political uncertainty and corrupt business practices, although some view those threats as exaggerated.

Swiss Reinsurance Co. in Zurich is

being selective of the business it writes in Russia, choosing only that which is "transparent" and "has a proper wording," said Martin Oesterreicher, Swiss Re's head of casualty.

"Russia is still an arms-length situation, especially with developments we have seen over the last two to three years where it has not been as stable as you probably hoped some four years ago," he said.

Meanwhile, finding capacity is not a problem in the Russian market, noted Mr. Korchemkin of Aon. "Of course, the capacity of the pure Russian market is still fairly limited, but we have access to international markets and international markets have great interest in underwriting Russian risks on a reinsurance basis," he said, explaining that insurance buyers must have a local Russian policy by law.

Emerging risks create challenges

Too much emphasis on physical risks, not enough on liability

By SARAH VEYSEY

NANTES, France—Emerging risks and changing attitudes toward risk present a challenge to risk managers, insurers and government, according to speakers at this year's annual conference of the Association pour le Management des Risques et des Assurances de l'Entreprise.

The theme of the conference, held in Nantes, France, last month, was "The New Risk Engineering."

Addressing delegates at the conference, Michel Yarhi, outgoing president of the French risk management association AMRAE and group insurance manager of Paris-based bank Société Générale, said that society has become more risk averse and that risk managers have a role to play in this "evolution."

And increasing litigiousness on the part of the public means that companies are more likely to find themselves compensating claimants—regardless of whether or not they are at fault—simply because they are solvent, he noted.

In addition, new technologies

and developments give rise to future risks in which risk managers are unaware of at the time, he noted, citing the examples of asbestos and animal feeds that gave rise to variant Creutzfeldt-Jakob disease.

Today, for example, he said, nobody can really be sure whether there are health risks associated with the use of cell phones.

Technology risk, reputation risk, and intangible risks are all matters of concern for today's risk managers, he noted.

And while some risks can be assumed by governments, state programs cannot take them all on, said Xavier Musca, director general of the treasury and economic policy department of the French Ministry of the Economy, Finance and Industry.

The government will, therefore, attempt to find different responses to emerging risks. For example, by trying to enable "financial actors" to address them, he said, noting that the insurance market is more efficient at dealing with risk than is the state.

Underwriters would like risk managers to more closely evaluate the relative attention paid to liability risks within their organizations compared with that given to physical loss, according to Alexander Baugh, president of AIG Europe S.A.

There often seems to be much more emphasis on physical risks than liability threats, he noted, adding that the trend of liability losses in Europe, and in particular France, is growing, he said.

One phenomenon increasingly being seen is "European copycat claims" whereby once a legal action has been settled in the United States, for example, European shareholders decide that they too should be compensated, said Mr. Baugh.

Other potential areas of increased liability include employment practices and global warming, he noted.

Over 1,400 attend event

NANTES, France—About 1,480 people attended the 15th annual meeting of the Association pour le Management des Risques et des Assurances de l'Entreprise, the French risk management association, in Nantes, France, Jan. 24-26, 2007.

Next year's conference will be held from Jan. 23-Jan. 25 in Deauville, France.

Mergers: Involve risk managers early on

CONTINUED FROM PAGE 25

left out of the picture until it's too late, said Mr. d'Autichamp.

A common scenario is that the risk manager receives a telephone call the night before the deal's completion is announced, asking for assessment of the target company's insurance coverage. "The risk manager's expertise has to be consulted much earlier," he said.

Héloise Husson-Dumoutier, underwriting manager for mergers and acquisitions insurance at Paris-

based AIG Europe S.A., said the risk manager should get involved early on in a deal at the due diligence disclosure on the target company's insurance, or when the selling company cancels insurance contracts on the company it is selling.

"It's important to ensure that the subject of insurance is part of the beginning of negotiations on selling or acquisition contracts," she said.

Ms. Husson-Dumoutier discussed what she called transactional risks,

noting that specialized insurance coverage exists to eliminate certain obstacles, to maximize the selling price or the value of a deal to a buyer.

For example, a buyer's policy could cover losses resulting from inaccuracies in the seller's coverage declaration. A seller's policy could cover the seller for buyer's demands resulting from inadequate coverage or incorrect declarations of coverage. Another policy would allow transfer of a particular environmental risk.

Embracing consumerism helps employers extend benefits

Linking CDHPs to traditional plans can ease challenge

By GLORIA GONZALEZ

NEW YORK—Employers with traditional health care plans can still embrace consumerism by introducing consumer-driven health plan options that have familiar elements of traditional plans.

Although employees may resist changes to their health care benefits, employers should introduce consumerism to ensure the long-term future of their benefit programs, benefit managers say.

New York Life Insurance Co. faced challenges when it considered changes to its medical plans. The company offered primarily managed care plans, with 88% of employees participating in health maintenance organizations or point-of-service plans that provided 100% in-network coverage after nominal copayments. The HMO plans, though, did not engage employees in health care management and benefit officials

were concerned because of projected double-digit cost increases, Maria Mauceri, corporate vp, said during the 2007 Employee Healthcare Conference, presented by the Conference Board Inc. and sponsored by Towers Perrin HR Services.

Fundamental changes were required to ensure the long-term sustainability of New York Life's benefit program, but the benefits staff also knew that senior management had a paternalistic attitude and that employees would be resistant to change, Ms. Mauceri said.

"Embracing the consumerism movement at New York Life was a really big challenge for us," she said.

The New York-based company created four new medical plan options that sought to strike a balance between retaining elements of the previous plans while introducing consumer-driven health plan options. The company decided to offer one HMO-only plan, but introduced coinsurance into the plan, she said.

New York Life also introduced three CDHP options linked to traditional health plans. The plan with the lowest annual employee contri-

bution is an HMO combined with a health reimbursement account. The plan features an upfront deductible of \$100, with an employer-funded HRA that covers the next \$1,000 in medical costs. After that, there is a secondary deductible of \$500, followed by 90% coinsurance for in-network services until an out-of-pocket maximum of \$3,000 is reached. "It was designed to encourage our HMO participants, particularly those with low medical expenses, to consider an account-based plan," she said.

The company also implemented two preferred provider options, one combined with a health savings account and one linked to an HRA. The plans launched Jan. 1.

While the HMO-only plan had the highest enrollment at 40%, the HRA-linked HMO had 38% enrollment. "We were very happy with the enrollment results we achieved," she said.

CNH Case New Holland, which manufactures agriculture and construction equipment, also was concerned about rising health care costs after employees began paying 60% of cost increases, said Amy Kesler,

director of corporate communications, who is responsible for internal benefit communications at the Racine, Wis.-based company.

The company wanted to create a health care program that increases employee's accountability for their health and their health care purchasing decisions, while reducing yearly cost increases and protecting employees from catastrophic loss, she said.

The company offered four health plans in 2007: a traditional PPO, two HRA-based plans featuring employer-funded accounts and a traditional HSA-linked plan.

"We considered a full replacement strategy, but we were concerned that employees would feel threatened," Ms. Kesler said. "We wanted them to have something familiar."

The medical plans were designed after an internal study found that 50% of CNH's employees were incurring \$1,000 or less in medical claims annually, but were paying family coverage premiums of around \$2,600 a year, she said. The HRA plans have deductibles of \$250 and \$500 for employee-only and family coverage respectively, and the

company contributes \$1,000 for employee-only coverage and \$2,000 for family coverage to the HRA. There is then a secondary deductible of between \$750 and \$1,500, depending on the plan selected, followed by 90% coinsurance until the out-of-pocket maximums are reached.

Having a secondary deductible helps influence health care decisions, Ms. Kesler said. Although the secondary gap was one of the hardest things to communicate, she did not hear negative comments from employees, likely because the majority of employees would never reach the gap and those that would generally are able to plan appropriately, she said. The company found that average contributions to flexible spending accounts increased by 22.4% during last year's enrollment.

"Change is very hard, especially when it comes in an area such as benefits, which is very personal to employees," she said. "It's part of their compensation and when you alter that, in essence you're altering how you pay them, so we knew the change would be difficult for employees."

Pharmacy: Managing costs

CONTINUED FROM PAGE 4

Becoming more involved in formulary decisions will be a key priority for Waltham, Mass.-based Thermo Fisher Scientific Inc. in 2007, said Jim McGrail, director of corporate benefits.

The company plans to review new drugs quarterly, meaning benefits officials no longer will simply sign off on decisions made by Medco. This is a "tough" issue because the PBM is not used to having employers involved in discussions about whether drugs should be added to the formulary, he said. "It will be much more restricted," Mr. McGrail said. "It's not automatic to add a drug."

Changing employees' approach to managing their health also is a key factor in managing pharmacy benefits, employers say.

Prior to the November merger that created the current Thermo Fisher, Fisher Scientific encouraged healthy behavior among its employees in an effort that included eliminating copayments for generic asthma and diabetes drugs. By doing so, the company sent a "clear message" to employees about the importance of taking care of their health and adhering to treatment regimens, Mr. McGrail said.

Although Thermo Fisher expects an increase in the costs of asthma and diabetes medications, it also expects total medical spending to fall due to fewer emergency room visits and other reduced costs, he said. The company plans to evaluate the outcomes of its diabetes and asthma management programs to see if they should be refined or expanded, he said.

KeyCorp also redesigned its pharmacy program to introduce consumerism and manage costs, Ms. Fleischman said. The company implemented a 10% coinsurance for generic drugs with no minimum out-of-pocket contributions. Under the new system, employees have paid as little as 50 cents for generic drug prescriptions, she said.

The company has 30% coinsurance levels for preferred and non-preferred brand-name drugs, but the out-of-pocket minimum contributions are higher for nonpreferred brand drugs, which promotes consumerism, she said.

KeyCorp estimates the cost of lowering generic drug coinsurance at about \$570,000, but company officials said the migration from brand-name drugs to generics as well as the employee trust earned through the program is important, Ms. Fleischman said.

RenRe: Civil fraud charges still pending

CONTINUED FROM PAGE 6

fraud," Mark K. Schonfeld, director of the SEC's Northeast regional office in New York, said in a statement. "In this case, RenRe essentially played a shell game with its revenue—hiding it in one year when it was not needed, only to reveal it in a later year when it would improve the bottom line."

The reinsurer did not admit or deny any wrongdoing as part of the agreement.

"We are pleased to have put this difficult chapter in our company's history behind us," Neill A. Currie, RenaissanceRe's chief executive officer, said in a statement. "Throughout the settlement process, a transition of leadership at the company and a volatile market environment, our company continued to serve its clients and deliver value to shareholders on an uninterrupted basis."

Delayed settlement

Robert J. Keyes, assistant regional director in the SEC's Northeast regional office declined to com-

ment on why the settlement—the terms of which were originally announced by RenaissanceRe in July 2006—took several months to be approved by regulators.

"While there may have been and probably was a logical administrative reason for the unusually long delay, it's certainly not helpful to a company that has agreed to terms and is trying to put an investigation in its past," said Jacob S. Frenkel, a former SEC enforcement lawyer who is now a partner at Shulman, Rogers, Gandal, Pordy & Ecker P.A. in Rockville, Md.

In addition, it remains unclear whether the \$15 million penalty—for which RenaissanceRe previously set aside reserves—will be made available to injured investors.

"We will evaluate what would be the best way to distribute the fund, and if we conclude that a distribution to investors is feasible and appropriate, we will propose a plan of distribution to the court," Mr. Keyes said.

Meanwhile, RenaissanceRe continues to face shareholder litigation. "The SEC settlement does not dis-

pose of the consolidated securities class action lawsuit pending against the company and certain of its current and former officers. This class action lawsuit, if adversely determined or resolved, could subject the company to a material loss," according to Renaissance Re's 10K statement filed with the SEC last week.

The settlement also has no effect on civil fraud charges still pending in a Manhattan court against three former top RenaissanceRe executives—former Chairman and CEO James N. Stanard, former Controller Martin J. Merritt, and former Senior Vp Michael W. Cash—for their alleged roles in orchestrating the Inter-Ocean deal.

Of the trio, Mr. Merritt is the only one to have agreed to a partial settlement in September with the SEC. As part of his settlement agreement, Mr. Merritt neither admitted nor denied any wrongdoing, and he consented to the entry of an antifraud injunction and other relief, deferring the settlement of any monetary charges (*BI*, Oct. 2, 2006).

Greenwich: Broker performance measured

CONTINUED FROM PAGE 3

Marsh Inc., Aon Corp., Willis Group Holdings Ltd. and Brown & Brown Inc., although not necessarily in that order. The index plots specific brokers' quality scores ranging from 0 to 1,000 against the brokers' market penetration.

For example, the 2007 BQI found that Briarcliff Manor, N.Y.-based USI Holdings Corp. had the highest quality score, but was used by only a 1% of the more than 13,000 buyers polled. Conversely, "other

regional brokers/agents" represented the vast majority of middle-market buyers, but they scored behind the middle of the quality score range.

"What we see happening is, as the market is getting more and more sophisticated over the last several years... (buyers') demands are outstripping the available resources of the regional brokers and agents," Mr. Bruno said. As a result, there is a "tremendous opportunity" for the big national and global brokers to tap into this

market, as evidenced by the index, he said.

Respondents said the most important quality measurements were: overall customer service, the ability to provide value through useful and creative advice, the ability to provide customized and tailored solutions, and the ability to provide objective evaluations of underwriters.

For more information on the Broker Quality Index, contact Greenwich Associates at contactus@greenwich.com.

Health care event draws 360

NEW YORK—About 360 people attended the 2007 Employee Healthcare Conference that was presented by the Conference Board Inc. and sponsored by Towers Perrin HR Services.

The theme of the conference, held Feb. 1-2 in New York, was "Building a Culture of

Health: Making Change Work." The conference featured discussions on consumerism, retiree medical and pharmacy benefits, and innovations in benefit designs.

Plans for next year's conference have not been finalized.

—By Gloria Gonzalez

Public: Mass., N.J. paths diverging in employee health insurance pools

CONTINUED FROM PAGE 1

a way to slow the rate of increase in municipal employee health insurance rates, which climbed 63% in a four-year period (see chart).

The group's recommended solution would allow the public entities to participate in the GIC, which provides health insurance and other benefits for 266,000 state employees, retirees and their families. GIC health insurance rates have increased about half as much as those of many municipalities.

"Our track record has been better than that of municipalities," said Dolores Mitchell, chief executive officer of the Boston-based GIC. She estimated the city of Boston, for example, would have paid \$38 million less for health benefits this year had it been able to buy through the GIC.

"They are much bigger than any of the purchasing groups we have in

the state and can negotiate better deals," said Sanford Pooler, chief administrative officer for Newton, Mass., which averaged 10% annual health care premium increases for the last decade. By contrast, the GIC has experienced an annual average increase of just 6.6% since 2001.

Springfield, Mass., joined the GIC Jan. 1 under an emergency regulation responding to its dire financial situation. The town of Saugus, facing a \$2.5 million health insurance trust fund deficit, is seeking permission to join.

New Jersey's experience

But pooling health care purchasing of public employees has had just the opposite effect in New Jersey, where public entities that participate in the State Health Benefits System are required to offer a uniform level of benefits, resulting in a 150% cost increase over five years—in large part because unions resisted

increased cost-sharing. Just last week, the New Jersey Legislature passed legislation to allow public entities to negotiate benefit packages locally.

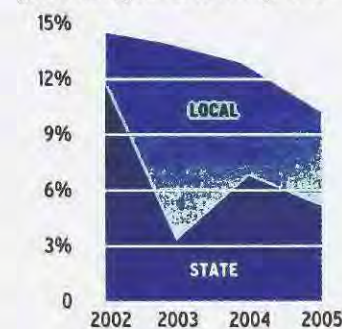
"Once upon a time, everyone was part of the State Health Benefits System—teachers included," explained L. Mason Neely, finance director for East Brunswick, N.J., and chairman of the League of Municipalities' pension and health benefits committee. "If a public entity withdraws from the state health benefits system, it would have to maintain the benefit levels."

With the just-passed legislation allowing withdrawal from the state fund, Mr. Neely estimates public entities would save \$34 million the first year alone—primarily from reduced benefits and increased cost-sharing.

Concern about groups coming and going in response to market fluctuations has led many states to

MASSACHUSETTS GROWTH

Increase in employee health costs for Massachusetts local and state government, fiscal 2002 through 2005.



TOTAL INCREASE: LOCAL 13%, STATE 6.6%

Source: Massachusetts Municipal Assn., Massachusetts Taxpayers Foundation.

unstable and, therefore, unattractive to insurers."

New Jersey's situation also shows how large benefit purchasing cooperatives can sometimes reach a point of diminishing returns, said Paul Hackleman, director of benefits for San Mateo County, Calif. (see sidebar)

He cited the California Public Employees' Retirement System, the nation's largest statewide purchasing agent, which can no longer control costs as well as it once did.

"Their strategy focused singularly on using economies of scale. That was a dead-end strategy," Mr. Hackleman said. "That precluded them from doing what many of us who weren't the gorilla on the block were doing," such as wellness programs and disease management.

A spokeswoman for Sacramento-based CalPERS was unavailable for comment.

Darrell Wells, director of risk management and benefits for Odessa, Texas, agreed that savings from pooling are not always sustainable.

"Group purchasing and pooling, per se, do nothing to control claim costs," which represent more than 90% of the total cost of health benefit programs, Mr. Wells said.

"Even if successful, all you've done is reduce the administrative portion of the cost—not the huge, untouched, mass of claims," Mr. Wells said.

Cheaper health premiums eluding big groups

By JOANNE WOJCIK

Buying in bulk may be a good idea for warehouse shoppers, but it may not always work for purchasing health benefits for public employees.

"The era of using economies of scale—if it isn't well past its end, it's close to its end," said Paul Hackleman, director of benefits for San Mateo County, Calif.

Mr. Hackleman said that several years ago, the county considered, and then decided against, purchasing health benefits for some of its employees through the California Public Employees' Retirement System, the nation's largest state health plan.

One particular stumbling block was a CalPERS requirement that public entity participants provide the same level of benefits to retirees as to active employees, Mr. Hackleman said.

"We felt we were being locked into a benefit structure vastly dif-

ferent from our own and that over the long term it would be more expensive," he said.

Marc Waldman, treasurer/collector for the city of Wellesley, Mass., has similar reservations about participating in the Group Insurance Commission, which would be permitted under a bill pending in the Massachusetts Legislature.

Though the proposal would allow public entities to continue to set employer and employee premium contribution levels locally, it would require that the selection of benefit plans offered be governed by the GIC.

"Many municipalities are very leery of losing local control," Mr. Waldman said.

Moreover, public entities would be able to participate only if their unions approve of the move, he said.

"We're still obligated by law to bargain any changes with our unions," Mr. Waldman said.

By contrast, when the GIC was created, the Legislature gave it the authority to change benefits as necessary to meet state budget constraints without having to enter into collective bargaining agreements with unions that represent state workers, Mr. Waldman said.

"That has a lot to do with why their costs are lower," he said.

At least one executive of a union that represents more than 1.4 million public workers said his members would be hesitant to relinquish control over benefit plan content to a higher authority.

"Our concern is losing the right to collectively bargain at a local level to tailor plans to different groups," said Steve Kreisberg, collective bargaining director for the American Federation of State, County and Municipal Employees in Washington, which represents about half of the nation's public employees.

Benefits: Redesign focuses on change, not elimination

CONTINUED FROM PAGE 3

plan," said Kevin Wagner, a senior consultant in the Atlanta office of Watson Wyatt Worldwide.

Additionally, because most pension equity plan participants take their benefits as a lump sum, the company does not face so-called longevity risk—the risk that retirees live longer than expected.

Pension equity plans emerged in the early 1990s as an alternative to cash balance and traditional final average pay plans. Employers

adopting them said the plans, with their smooth benefit accruals, would be fairest to increasingly diverse workforces comprising a mix of short-service, midcareer hires and longer-service employees.

Still, while some major employers adopted the plans, pension equity plans never achieved the popularity of cash balance plans at least in part because their benefit formulas were not as easy for employees to understand, said Sheldon Gamzon, a principal with PricewaterhouseCoopers L.L.P. in New York.

Canada: Ruling on accommodating workers instructive for employers

CONTINUED FROM PAGE 4

human rights laws regarding the duty to accommodate are "very demanding on employers," said Douglas Gilbert, a Toronto-based partner in the labor and employment group of Heenan Blaikie L.L.P.

The Supreme Court's recognition of the relevance of automatic termination provisions to the employer's duty to accommodate provides unionized employers with a partial understanding of what the expectations are for them, he said. "I think it's most important for the recognition it gives to paying attention to what unions and employers have defined as a reasonable absence," Mr. Gilbert said.

The court expressly stated that automatic termination clauses do not definitively determine the specific accommodation measure an employee is entitled to, because each case must be evaluated separately.

The court did rule, though, that the three-year period provided for in the union contract represented a reasonable accommodation. If there are future challenges relating to the duty to accommodate time frame, it is likely that arbitrators will view three years as a reasonable standard, Mr. Gilbert said.

Three years, though, is not as relevant as the court's recognition that parties to a collective bargaining agreement—because of their extensive knowledge of the particular

workplace—have the right to negotiate clauses to ensure employee attendance, said Connie Reeve, senior partner in the labor and employment practice of Blake, Cassels & Graydon L.L.P. in Toronto. The duty-to-accommodate provision in human rights legislation was an area of law where there was some doubt as to how much weight could be given to automatic termination clauses, she said.

The case reinforces for employers that automatic termination clauses should have fairly lengthy time frames, said Jacques Laurin, a Montreal-based labor and employment lawyer with Colby, Monet, Demers, Delage & Crevier L.L.P., who represented the hospital.

An employer, though, must review each situation individually to determine if accommodating an employee would cause undue hardship for the employer—the standard in many provincial human rights laws, including the Quebec law in this case, employment lawyers say. "Whether or not undue hardship is created is a question of fact," Ms. Reeve said.

Nonunion employees

While the case relates specifically to automatic termination clauses in collective bargaining agreements, the Supreme Court's reasoning has implications for nonunion employees, employment lawyers say.

For example, provisions defining

the consequence of absence for a fixed period are found in employment contracts and human resources policies, and the McGill University case would be relevant to provisions addressing the direct termination of employment or any reduction of benefits, Mr. Gilbert said. In a nonunion relationship, though, a court likely would be more vigilant to ensure the accommodation is reasonable and adequate for the employee's circumstances given his or her relative lack of bargaining power, he said.

McGill University Health Center vs. the Union of the Employees of Montreal General Hospital, 2007 SCC 4; Jan. 26, 2007.

HSA: Bush budget plan

CONTINUED FROM PAGE 1

observers say face an uphill battle to win congressional approval, would ease employees' concerns about HSAs and make them an easier sell for employers.

"These would be very significant improvements and greatly facilitate movement to the arrangements," said Jay Savan, a principal with Towers Perrin in St. Louis.

The most significant provision involves the design of health insurance plans linked to HSAs. Under current law, an HSA must be linked to a high-deductible health insurance plan, which in 2007 is one with a deductible of at least \$1,100 for single coverage and \$2,200 for family coverage.

In the administration proposal, HSAs also could be paired with insurance plans with a coinsurance requirement of at least 50%. As under current law, the maximum out-of-pocket limit for single coverage would be \$5,500 and \$11,000 for family coverage.

Benefit experts say such a design would eliminate a big barrier to HSA enrollment: the fear of lower-income employees that they could face big medical bills without insurance coverage.

"A lot of employees are allergic to such a big out-of-pocket hit," said Andy Anderson, of counsel to Morgan, Lewis & Bockius L.L.P. in Chicago, referring to the impact of high-deductible HSA-linked health insurance plans.

A 50% coinsurance alternative would certainly broaden the appeal of HSAs," Mr. Anderson said.

At the same time, an alternative design would ease another problem associated with high-deductible plans: the fear of employers that employees, now used to small copayments for prescription drugs, will stop taking needed medications if they have to pay the full cost.

Under Treasury Department guidance, prescription drugs other than preventive medicines cannot be covered by the linked insurance plan until the deductible is met. That means employees could have to pay—either out of their pocket or from their HSA—for more than \$1,000 of prescription drug bills before their health insurance cover-

age kicks in.

"It becomes a big cost compared to where people are today" with typical drug copayments, said Scott Keyes, a Watson Wyatt Worldwide senior consultant in Stamford, Conn.

A 50% coinsurance arrangement would ease employer concerns that employees won't have prescriptions filled, Mr. Keyes said.

Another provision in the Bush package would eliminate a problem that now can make HSAs less valuable. Under current rules, HSA enrollees can tap their accounts only to pay for medical expenses incurred after the HSA is set up.

In many cases—perhaps 60% or more—employees don't establish HSAs in tandem with their enrollment in a high-deductible plan, said Tom Hrick, national director-HSA product distribution with ACS/Mellon Financial Corp. in Pittsburgh.

That can happen for a variety of reasons, such as a paperwork glitch or employees needing more time to evaluate HSA vendors. The result, though, is employees have to use aftertax dollars to pay for a health care bill.

The administration would resolve this problem by making clear that HSA funds could be used to pay for a health care bill incurred on or after coverage in the linked health insurance plan began, so long as the HSA was established no later than the date an employee filed an income tax return.

"It is a real common-sense answer," said Jeff Munn, a consultant in the Falls Church, Va., office of Hewitt Associates Inc.

The Bush package would eliminate yet another barrier—involving so-called "embedded deductibles"—to HSA enrollment.

Under current rules, employers with HSAs have to structure family coverage deductibles in the linked health insurance plan in a way that results in less coverage than in traditional plans.

In traditional plans, an overall deductible is set for family coverage. Additionally, such plans typically use a per person, or embedded, deductible that often is equal to the deductible for individual coverage. For example, if an employer offers a health insurance plan with a \$1,000 deductible for individual coverage and a \$2,000 deductible for family coverage, the plan typically would include a \$1,000 per person embedded deductible.

The intent of the embedded deductible is to ensure that an individual with family coverage will have the same level of coverage as an employee with individual coverage. Current HSA law allows embedded deductibles for family coverage, but they can't be less than the deductible for family coverage.

The administration package would eliminate that inequity by allowing plans offering family coverage to provide individual embedded deductibles at least equal to the deductible for individual coverage, a change that would provide hundreds of dollars of additional insurance coverage each year and make the design of HSA-linked plans more in line with traditional plans.

Companies urged to examine employment practices

The class certification approved by a federal appellate court of 1.5 million current and former female Wal-Mart Stores Inc. workers is the largest U.S. employment class action ever, but the ruling breaks no new legal ground, say most observers.

The lawsuit alleges gender-based discrimination in pay and promotions.

Even so, experts say it behooves employers to re-examine their own employment practices.

Last week's 2-1 ruling by a panel of the 9th U.S. Circuit Court of Appeals in San Francisco in *Betty Dukes vs. Wal-Mart Inc.* focuses on whether the lower court abused its broad discretion in granting class action status.

Brad Seligman, executive director of the Berkeley, Calif.-based Impact Fund, who represents the plaintiffs in the Wal-Mart case said, "We weren't trying to create new law here. We're trying to apply well-established rules and laws dealing with discrimination."

"What the decision does from a legal standpoint may not be new at all," said Michael Kun, an employer attorney with Epstein Becker & Green P.C. in Los Angeles. "What it does is serve as a reminder" of the trial court's broad discretion in deciding whether a case is a class action.

"It's unclear whether the legal

issues are so novel that it will attract enough votes to garner an en banc review" by the appeals court, said D. Gregory Valenza, an employment attorney with Shaw Valenza L.L.P. in San Francisco.

However, Anthony J. Oncidi, an employer attorney with Proskauer Rose L.L.P. in Los Angeles, said Judge Andrew J. Kleinfeld's strong dissent indicates "there are probably other judges in the 9th Circuit who believe as he does, that this is not really the appropriate ruling in this case," and could lead to a re-examination by the full appellate court.

The U.S. Supreme Court ultimately may respond to business community demands that it "tighten up class certification" in the same way it tightened rules on punitive damages, said Anthony J. Sebok, a professor at Brooklyn Law School in New York.

Regardless of its legal significance, observers say the decision means employers may want to reconsider their practices.

"The huge potential liability of this case represents an expansion of the class action vehicle as a weapon of attack against employers, and it should cause all companies of any size to review their own hiring and promotional practices," said Susie Gibbons, an attorney with Poyner & Spruill L.L.P. in Raleigh, N.C. "If

I were a risk manager at a company, I would want to analyze this case to look at what the vulnerabilities were that ended up causing this problem for Wal-Mart."

Observers noted that the district court in its ruling relied heavily on the use of statistical evidence presented by plaintiffs to determine that all 1.5 million female workers had enough "commonality" to be considered a class.

Cary G. Palmer, an attorney with Jackson Lewis L.L.P. in Sacramento, said the decision "underscores for employers that they would be well-advised to carefully assess statistical data for evidence of an inference of disparate-impact discrimination."

"Any large employer is going to have to be much more mindful of statistics" as a result of the ruling, said Lloyd C. Loomis, an attorney with Lewis, Brisbois, Bisgaard & Smith L.L.P. in Los Angeles.

The subjective decision-making allegedly permitted by Wal-Mart managers was a factor in the decision as well, say observers. Because of this, "employers would be well-advised to strive to eliminate, or at least minimize as much as possible, subjective decision-making in the workplace" in pay and promotion decisions, said Mr. Palmer.

—By Judy Greenwald

Wal-Mart: Bias suit may fuel tort trend

CONTINUED FROM PAGE 1

status.

The lower court "acted within its broad discretion in concluding that it would be better to handle this case as a class action instead of clogging the federal courts with innumerable individual suits litigating the same issues repeatedly," said the appellate panel.

Wal-Mart "failed to point to any specific management problems that would render a class action impracticable in this case, and the district court has the discretion to modify or decertify the class should it become unmanageable," the decision says. "Although the size of this class action is large, mere size does not render a case unmanageable."

However, in a strongly worded dissent, Judge Andrew J. Kleinfeld said the appellate decision "poses a considerable risk of enriching underserving class members and counsel, but depriving thousands of women actually injured by sex discrimination their just due."

Wal-Mart attorney Theodore J. Boutros Jr., with Gibson, Dunn & Crutcher L.L.P. in Los Angeles, said, "We recognize this is another step in what is going to be a long process. It's a technical legal ruling" that only certifies the lawsuit as a class action, but does not address its merits, said Mr. Boutros.

"We think we have a very strong argument to obtain further review" from either the full 9th Circuit court or the U.S. Supreme Court, because the majority rule conflicts with many Supreme Court decisions as well as many recent decisions from other appellate courts around the country that "have rejected precisely the direction taken by the court," Mr. Boutros said. "We think we're correct on the law," he added.

However, Brad Seligman, executive director of The Impact Fund, based in Berkeley, Calif., who represents the Wal-Mart plaintiffs, said the appellate court is now the second court to rule on the class certification issue and "it's clear Wal-Mart is going to have to face the music and justify its practices, and we are very optimistic this case will ultimately be returned to trial."

The decision also may leave other employers more vulnerable to class action suits, which can be very costly, say some observers. If the principles endorsed by the appellate panel are applied elsewhere, it "would significantly broaden the class certification for employment actions against employers all around the country," said Mr. Boutros.

A major issue in the decision is whether Wal-Mart's female workers had enough "commonality" to be placed within the same class. Wal-

Mart had argued they did not, but the appellate and district courts disagreed.

Michael Kun, an employer attorney with Epstein, Becker & Green P.C. in Los Angeles, said many plaintiff lawyers will be emboldened by this decision, and ask themselves the question, "Why file a single or small class action. Why not go for broke and file an enormous class action?" and hope it is certified. In many ways, he said, the Wal-Mart case provides a "road map for how to do it."

Decisions such as these tell plaintiffs and their attorneys that there "may be blood in the water" and more suits like it may very well follow, said Anthony J. Oncidi, an employer attorney with Proskauer Rose L.L.P. in Los Angeles.

Susie Gibbons, an employer attorney with Poyner & Spruill L.L.P. in Raleigh, N.C., said the decision "does not bode well" for large employers. "I see this as the bellwether of the next wave of unfortunate events for employers," she said.

Betty Dukes; Patricia Surgeson; Cleo Page; Deborah Gunter; Karen Williamson; Christine Kwapnoski; Edith Arana, Plaintiffs-Appellees, vs. Wal-Mart Inc., Defendant-Appellant, 9th U.S. Court of Appeals, No. 04-1668; Feb. 6, 2007.

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News In Brief

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December 2006 when a liquid propane heating system exploded, seeks damages from engineering firm J.M. Brennan Inc. and its errors and omissions insurer. Brennan installed the system at Falk Corp. approximately 18 years ago, and it was conducting a system startup test when a pipeline leak led to the explosion. Brennan's E&O insurer is ACUITY, a Mutual Insurance Co. Also named as a defendant is Falk's workers compensation insurer, American Home Assurance Co., a subsidiary of American International Group Inc. In a statement, Brennan said: "We are confident that the results of the official investigations will show that the work of J.M. Brennan was reasonable and did not cause the explosion."

Soft market persists in 4Q: RIMS survey

The soft market continued in most lines in last year's fourth quarter, according to the RIMS Benchmark Survey released by the Risk & Insurance Management Society Inc. In last year's fourth quarter, directors and officers liability insurance and workers compensation premium rates dropped by an average of 5.1% and 7.4%, respectively, compared with the same period in 2005. General liability premiums, meanwhile, were down 2.6%, while property insurance bucked the general trend and increased 6.6%. "This sharp increase was caused by the continuing legacy of the 2005 hurricane season," RIMS noted in a statement.

Judge rejects Congoleum reorganization plan

A federal bankruptcy judge has rejected Congoleum Corp.'s 10th attempt at a Chapter 11 reorganization plan to resolve hundreds of millions of dollars of asbestos claims, citing its unequal treatment of claimants and other flaws. At the same time, the judge turned away an alternate plan offered by units of CNA Financial Corp. and rejected that plan's creation of a class of insurance company claimants in the bankruptcy proceeding. Congoleum, a Mercerville, N.J.-based flooring

manufacturer, said it will return to negotiations with asbestos claimants and other parties, and hopes to have a revised plan ready by the end of September.

South Carolina replaces insurance commissioner

South Carolina Gov. Mark Sanford has named state Sen. Scott Richardson as the new director of the Department of Insurance, pending confirmation by the state Senate. Mr. Richardson succeeds Eleanor Kitzman, who resigned, a department spokeswoman said. Ms. Kitzman's resignation signals the governor's desire for a new direction in handling the state's coastal insurance problems, which include enormous premium increases and policy cancellations, a spokesman for the governor said.

Measure calls for NFIP to offer multiperil cover

Rep. Gene Taylor, D-Miss., has drafted legislation that would create a multiperil insurance program—including commercial insurance—within the National Flood Insurance Program. According to a letter to colleagues circulated by Rep. Taylor, the optional program would offer coverage of wind and flood damage in one insurance policy. Nonresidential properties could be covered up to \$1 million for structure and \$750,000 for contents and business interruption. Lower limits would be available on personal lines policies. Premiums would be risk-based, said Rep. Taylor's letter.

Noted

Wells Fargo & Co. is changing its commercial insurance brokerage unit's name from **Acordia Inc.** to Wells Fargo Insurance Services. Wells Fargo acquired Acordia in May 2001....Meanwhile, Wells Fargo has received final U.S. Labor Department approval to fund benefit risks through its Vermont captive....Peter Eckert is retiring as group chief operating officer of **Zurich Financial Services Group**, effective Feb. 28....The Insurance Services Office Inc.'s Property Claim Services unit has declared the recent **Florida tornadoes** a catastrophe, meaning the storms caused at least \$25 million in insured property damage....William Jewett has been appointed president and chief executive officer of **Endurance Specialty Holdings Ltd.**'s reinsurance business. He is the first to hold the position, which was created last year, said a spokeswoman for the Pembroke Bermuda-based company.

Concerning passage of surplus lines and reinsurance regulatory reform bill:



'I think the prospects are pretty good.'

House Minority Leader
♦ John Boehner, R-Ohio.



'I'm confident this will become law this year.'

Rep. Dennis Moore,
D-Kan. ♦

REUTERS

CO

CIAB: Lawmakers support longer-term terror backstop

CONTINUED FROM PAGE 3

in place. As former chief executive officer of Goldman Sachs Group Inc., Mr. Paulson had numbered among the backstop's supporters.

"Permanency is not where we're coming from at this point," said Rep. Kanjorski. The House Committee probably would consider an extension of six to 16 years, he said. "We're certainly not going to do this year-to-year nonsense."

Rep. Kanjorski said Financial Services Committee Chairman Barney Frank, D-Mass., has said he wants a bill out of the full committee by April 2.

"There's no question we are going to have an extension," said Rep. Kanjorski.

'Different way to skin the cat'

Backstop supporters played down the importance of having a program that is long-term rather than permanent.

"I would characterize their differences as 'great news' and 'even greater news,' and not necessarily as inconsistent as you might think," said Joel Wood, senior vp of the CIAB. "I think Chairman Kanjorski was referencing a longer-lasting version of the same TRIA framework, whereas Chairman Dodd was indicating his openness to a different way to skin the cat. I'm confident that the depth of commitment from both leaders is sufficient to come to an excellent result for policyholders. The only caveat is that we—the industry, policyholders, other stakeholders—have to do our job."

"We've long advocated a permanent solution to this problem," said Martin DuPoy, steering committee coordinator of the Coalition to Insure Against Terrorism, a Washington-based group that represents policyholders.

"The politics of Congress and the

administration interacting may result in something short of that. At the very least, the program needs to be of long duration. Having a program that expires every two years is very disruptive of business cycles," Mr. DuPoy said.

Although the industry would like a permanent program, "it would not be a deal breaker to have a long-term extension—the longer the better," said Frank Nutter, president of the Reinsurance Assn. of America in Washington. "In this town, six to 16 years is about as close to permanent as it gets."

While "I think we all would like a permanent program, Congress can always revisit legislation to tweak it if circumstances change," said Mr. Nutter, who noted the rationale for a long-term or permanent program is that much insurance coverage is tied to real estate financing mechanisms that are themselves long-term.

"It's encouraging they're talking about this early and, as for the details, Congress will work that out," said a spokesman for the American Insurance Assn. in Washington.

Regarding passage of a bill dealing with another high-profile insurance issue, key lawmakers from both sides of the aisle agreed that streamlining the regulation of reinsurers and surplus lines insurers is likely to enjoy broad support, at least in the House.

"I think the prospects are pretty good," said House Minority Leader John Boehner, R-Ohio.

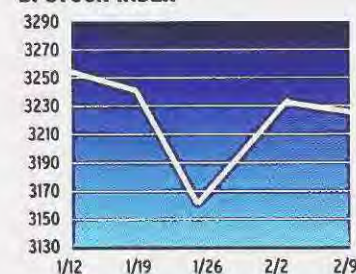
"I'm confident this will become law this year," said Rep. Dennis Moore, D-Kan., who co-sponsored the Nonadmitted and Reinsurance Reform Act in the last Congress. The bill passed the House 417-0, but did not receive Senate action. Rep. Moore said he plans to reintroduce the bill "within the next few days."

Stock Index

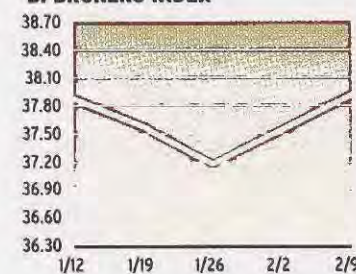
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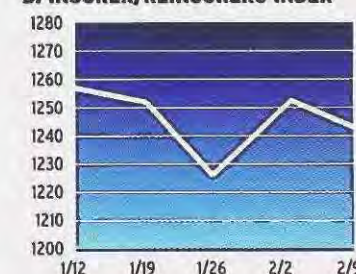
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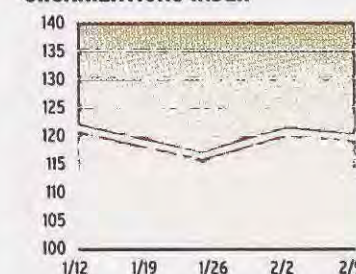
BI BROKERS INDEX



BI INSURER/REINSURERS INDEX



BI MANAGED CARE ORGANIZATIONS INDEX



Percentage change of BI Stock Index vs. key indicators

BI STOCK INDEX	3229.22	↓ -0.16%
DOW JONES	12580.83	↓ -0.57%
S&P 500	1438.06	↓ -0.71%

LARGEST GAINS

Argonaut Group Inc.	9.01%
Ohio Casualty Corp.	7.66%
Health Net Inc.	6.72%
Alleghany Corp.	5.21%
Humana Inc.	4.01%

LARGEST LOSSES

Unitrin Inc.	-6.92%
Meadowbrook Insurance	-6.57%
CNA Surety Corp.	-5.22%
Cincinnati Financial	-4.40%
UNICO American Corp.	-4.21%

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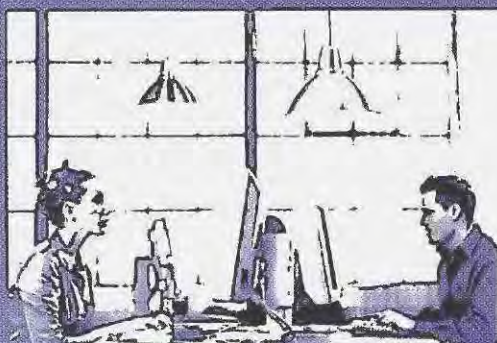
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Contributing: Regis Coccia, Mark A. Hofmann,
Rupal Parekh, Dave Lenckus

Hillary, Harry and Louise set to bury the hatchet?

Here's another addition to the always growing politics-makes-strange-bedfellows file.

According to federal election information available at www.opensecrets.org, the political action committee of Washington-based trade group America's Health Insurance Plans donated \$3,000 to the 2006 re-election campaign of U.S. Sen. Hillary R. Clinton, D-N.Y.

This is the same Hillary Clinton that the Health Insurance Assn. of America—which later merged with American Assn. of Health Plans to create AHIP—targeted in its famous “Harry and Louise” advertising campaign in 1993, when then-First Lady Clinton helped husband President Bill Clinton craft his ill-fated plan to provide health insurance to all.

“The industry’s giving through our PAC has been very much focused on congressional leaders on our issues,” said a spokesman for AHIP about the donation. “We want to work with those leaders and encourage them to stay in Congress because they are getting a much deeper understanding of how our issues work.”

Still, there’s no word whether Harry and Louise will emerge from retirement to film a spot endorsing Sen. Clinton’s presidential bid.



REUTERS

Sen. Clinton's formerly frosty relations with health insurers appears to have thawed a little.

Take a walk on the bouncy side in Philadelphia

Philadelphia may be the latest city on its way to making sidewalks safer for pedestrians—by putting a little bounce in their step.

A city official there recently announced a resolution to consider replacing concrete pavement with recycled rubber.

“Rubber sidewalks provide a softer surface in the event of a pedestrian fall,” and, “they also help to reduce the number of falls in general because they eliminate the cracks and rises in the sidewalk caused from cold weather and from unearthed tree roots,” Councilman Jim Kenney said in a statement.

Preventing accidents—and the costly personal injury lawsuits that often follow—is one of the top reasons several cities and municipalities around the country are forgoing concrete for rubberized sidewalks, said Dan Joyce, vp of sales and marketing for Rubbersidewalks Inc. in Huntington Beach, Calif.

“We’ve found an average claim per city is around \$50,000 on trip-and-fall claims...they look at those kinds of costs and work it into the cost of installation,” Mr. Joyce said.

Partner of Mr. Dow & Mr. Jones gets name recognition

When it comes to naming a captive, owners often choose monikers that reflect some element of their business. Hence, American Airlines’ parent launched a captive called Avion Assurance Ltd., Ralston Purina’s famous logo was reflected in the former Checkerboard Insurance Co. Ltd. and jeweler Cartier owns Diamond Re.

But Dow Jones & Co., which formed a New York-domiciled captive last week, took a different path. Bergstresser Insurance Inc. bears a name of historical significance to the parent of The Wall Street Journal.

Charles Bergstresser was a business partner of reporters Charles Dow and Edward Jones, who founded Dow Jones in 1882 after working for a New York news agency. Mr. Bergstresser, also a reporter, provided the capital to launch their firm. His money kept Dow Jones afloat in the years before it began publishing the Journal in 1889.

The captive will write terrorism coverage. A spokesman for Dow Jones confirmed the captive is named in Mr. Bergstresser’s honor.

Jody Wald, captives coordinator in the New York Insurance Department, would not disclose how much coverage the captive is licensed to write.

Prop. 103 advocates line up for fight with the Governor

A consumer advocacy group whose founder spearheaded a ballot initiative that brought landmark property/casualty insurance rate regulation reform to California nearly 20 years ago is turning its attention to health care insurance.

A ballot initiative on health insurance rates—including the stop-loss coverage that employers purchase for their self-funded plans—is a certainty if California legislators enact Gov.

Arnold Schwarzenegger’s plan to cover the state’s uninsured without also modifying rate regulation, said Jerry Flanagan, health care policy director for The Foundation for Taxpayer and Consumer Rights.

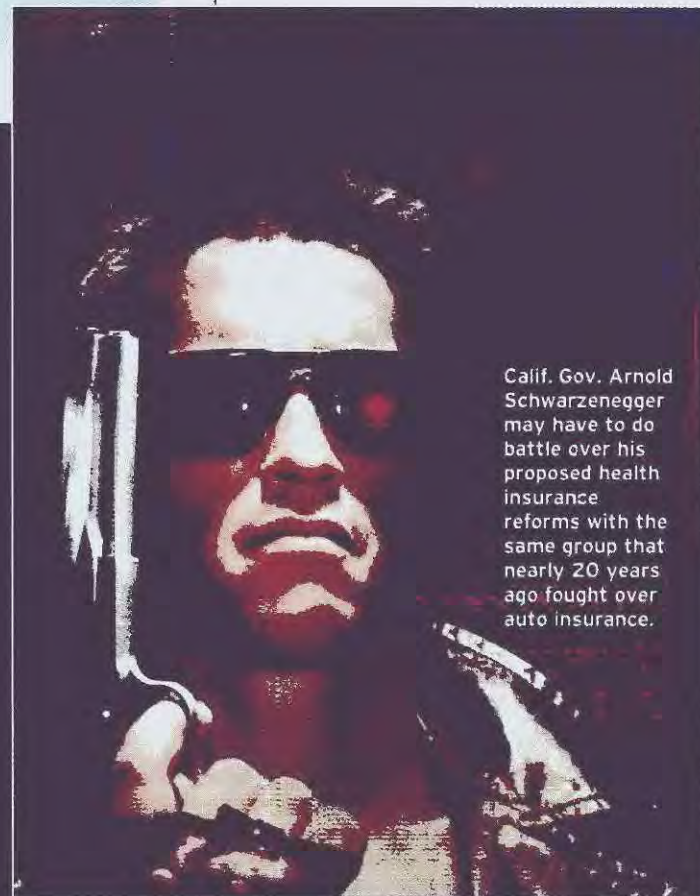
The FTCR is asking state lawmakers to add rate regulation to the governor’s plan, because the organization asserts the plan is setting up Californians for potentially significant health insurance cost increases. To curb health care insurance costs, the governor’s plan would require that 85% of insurers’ premiums represent health care expenses. But Mr. Flanagan, and the FTCR in a letter to the state’s top lawmakers, contend that requirement would only drive up health costs by encouraging insurers to pay health care providers more and charge policyholders higher premiums.

Similarly, the state’s mandate that all residents purchase auto insurance—

with no controls on rates—would have driven up the state’s already hefty insurance rates in the late 1980s, Mr. Flanagan said. That fueled voters’ passage of the 1988 ballot initiative Proposition 103—authored by FTCR founder Harvey Rosenfeld—which required property/casualty insurers to justify their rates.

Consumer groups say Proposition 103 has saved California insurance buyers billions of dollars, but the insurance industry credits other factors.

If lawmakers approve the governor’s plan without rate regulation, “I guarantee you there will be a ballot initiative” on it, Mr. Flanagan said.



Calif. Gov. Arnold Schwarzenegger may have to do battle over his proposed health insurance reforms with the same group that nearly 20 years ago fought over auto insurance.

REUTERS/LANDOV

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