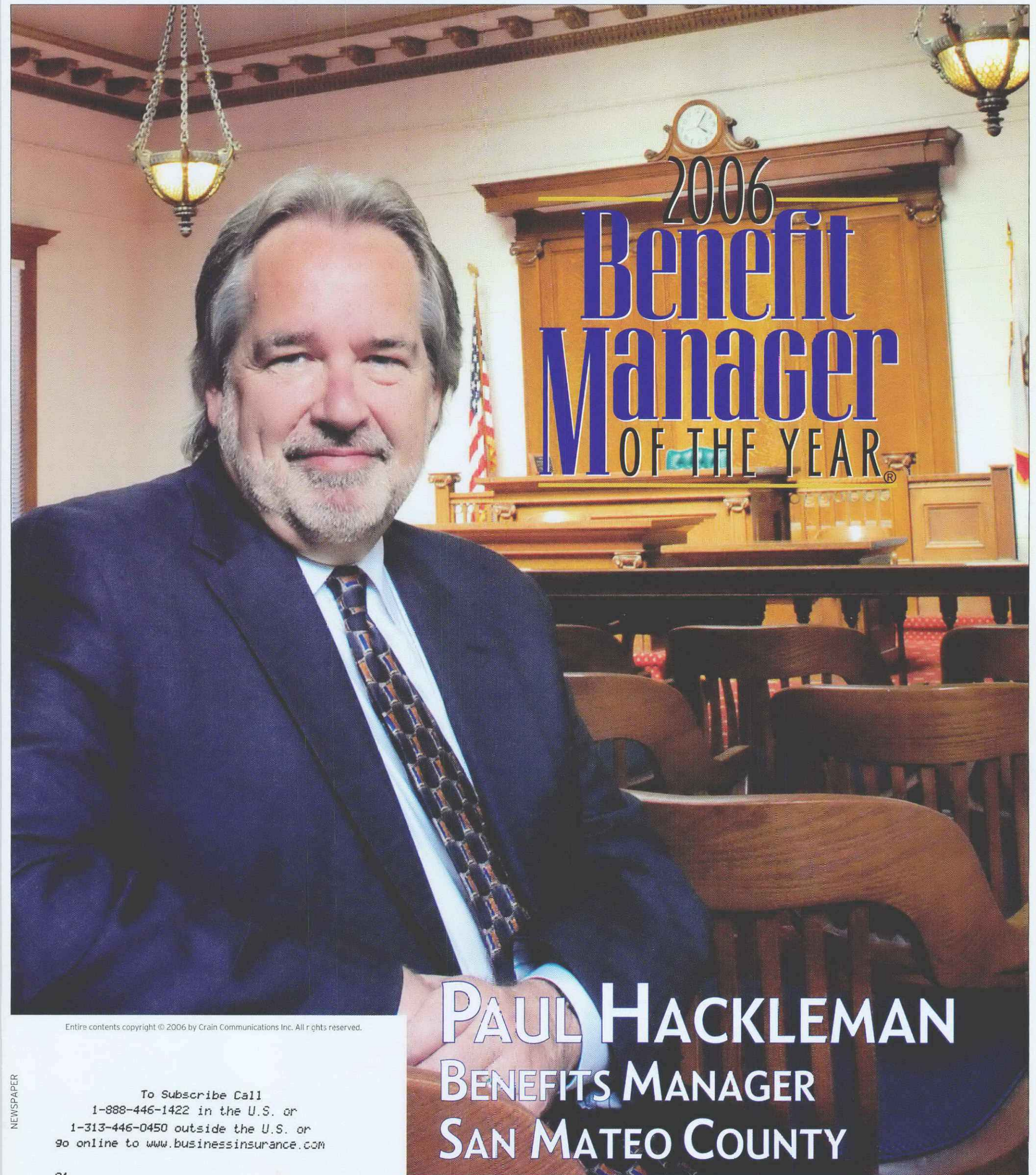


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Late News

AIG unit seeks ruling on diocese coverage

An American International Group Inc. unit is suing the Roman Catholic bishop of Fresno, Calif., for a ruling that it has no liability for sexual abuse claims against the Fresno Diocese. The diocese has demanded defense and indemnity coverage in some of these cases under a general liability policy that it says American Home Assurance Co. issued. The insurer contends in the coverage action that it never issued the insurance policy the diocese describes. Neither party has been able to find a copy of the policy.

Court hears arguments on 'Wal-Mart' law

A U.S. District Court in Baltimore last week heard oral arguments on a challenge to a Maryland law that requires employers with at least 10,000 employees in the state to spend an amount equal to least 8% of payroll on group health care benefits. The Retail Industry Leaders Assn. said the law, believed to target mega-retailer Wal-Mart Stores Inc., is illegal because it conflicts with the federal Employee Retirement Income Security Act, which pre-empts state regulations that relate to employee benefit plans. Defenders of the law say it is legal because it does not require employers to offer a specific benefit.

See **LATE NEWS**/page 27

Public entities profit from AIG-Starr war

Competition cutting prices

By **ROBERTO CENICEROS**

As American International Group Inc. and Starr International Co. Inc. continue their messy divorce in court, certain policyholders are benefiting from another battle over which of the former affiliates will keep their business.

Some large, self-insured public entities renewing their excess liability and reinsurance coverage for July 1 are enjoying price reductions as managing general agency C.V. Starr & Co. and AIG compete to retain business previously underwritten when the two were under the direction of AIG management, observers say.

Before Starr International and AIG split up, setting off their legal battles (*BI*, Feb. 6), AIG provided policies to public entities for which C.V. Starr & Co. provided underwriting services.

C.V. Starr & Co. is one of four

managing general agencies under C.V. Starr & Co. Inc., an independently owned New York-based holding company and unit of Starr International. The Starr companies

■ SICO sues to obtain documents from AIG
PAGE 28

■ Starr Aviation enters agreement with Chubb
PAGE 28

are run by Maurice R. Greenberg, the former chairman and chief executive officer of AIG, who was forced out in 2005 amid mounting investigations of the insurer's practices.

In the latest of their legal entanglements, Starr International last

See **STARR** / page 28

E&S market praises regulatory reform

Bill would add uniformity

By **MARK A. HOFMANN**

WASHINGTON—A bill designed to ease the regulatory burden that states impose on surplus lines insurers would make risk managers' jobs easier as well, according to a prominent risk manager.

The Nonadmitted and Reinsurance Reform Act of 2006, which U.S. Reps. Ginny Brown-Waite, R-Fla., and Dennis Moore, D-Kan., introduced earlier this month, "provides answers to problems commercial insurance buyers are experiencing in obtaining surplus lines insurance by placing authority in the home state of the insured," Janice Ochenkowski told the House Financial Services Committee's Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises last week. "We support this," said Ms. Ochenkowski, who testified on behalf of the New York-

based Risk & Insurance Management Society Inc., which she serves as vp.

The bill, H.R. 5637, seeks to set up a uniform system for regulating and taxing the surplus lines industry by making nonadmitted insurance subject only to regulation in the policyholder's home state. That would eliminate state-by-state oversight that surplus lines brokers and insurers have to deal with when providing coverage across multiple jurisdictions. The policyholder's home state would collect all surplus lines premium taxes, and individual states would be encouraged to enter into a compact to allocate the taxes among themselves.

In addition, the bill would allow "sophisticated" commercial policyholders that have unique or large risks that require surplus lines coverage to bypass what RIMS called in its prepared testimony "regulatory hurdles currently imposed by the states which add no meaningful value to the process." Risk man-

See **BILL** / page 27



PHOTO: BLOOMBERG NEWS/LANDOV

High court ruling broadens definition of retaliatory acts

By **SALLY ROBERTS**

WASHINGTON—A U.S. Supreme Court ruling that expanded an employee's ability to sue for retaliation under federal civil rights law "just made the (human resource) manager's job even tougher," an observer said of last week's decision.

In a unanimous ruling in the case of *Sheila White vs. Burlington Northern & Santa Fe Railway Co.*, the nation's highest court upheld a lower court decision that said reassigning Ms. White to a different job and temporarily suspending her pay were retaliatory acts for her earlier complaint of sexual harassment.

In doing so, the court set a national standard by defining retaliation as those employer actions that are "harmful to the point that they could well dissuade a reasonable worker from making or supporting a charge of discrimination." It also ruled that retaliatory actions are not limited to those that affect only the terms and conditions of employment.

The court said it decided on a "reasonable employee" standard and phrased the standard in "general terms" because judging harm

must be objective and "the significance of any given act of retaliation will often depend upon the particular circumstances."

While Title VII of the Civil Rights Act of 1964 prohibits retaliation against those who complain about discrimination, lower courts have been widely split over whether retaliatory actions must be employment-related and how harmful those actions must be to constitute retaliation.

The most pro-employer courts have used an "ultimate employment decision" standard, which limits actionable retaliatory conduct to acts such as hiring, discharging, promotion and compensation.

Employment attorneys say—by setting a broader standard as to what constitutes retaliation—employers may find it more difficult to make personnel decisions about current employees who have previously voiced discrimination complaints (*BI*, April 24).

"The Supreme Court's ruling just made the HR manager's job even tougher," said Gerald Maatman, a partner with Seyfarth Shaw L.L.P. in Chicago. "By ex-

See **RETALIATION** / page 28

Inside

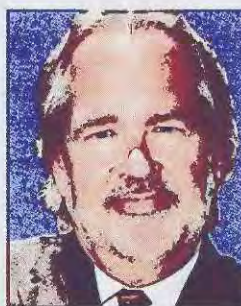


SPECTER OF REPEAL
Senator seeks evidence of antitrust reform need.

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RICO CHARGES
Judge drops racketeering claim against Gen Re.

PAGE 3



BENEFIT MANAGER OF THE YEAR

PAUL HACKLEMAN

Honored for making San Mateo County a trend-setter in benefit programs.

PAGE 10



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INSURING PROGRESSSM

Inside

Fitness, wellness programs more common

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Building a culture of respect in workplace

Teaching consideration can lower harassment, discrimination claims. **Page 4**

Incremental change better than none at all

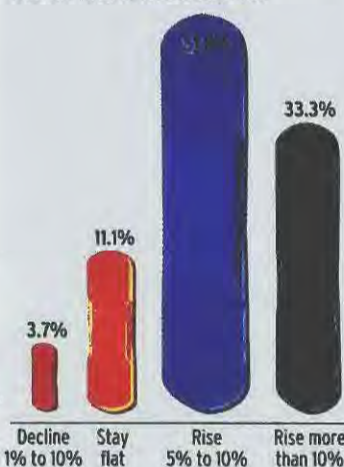
An editorial says measure would bring uniformity to regulation of nonadmitted market. **Page 8**

U.K. employers may face bigger asbestos liability

Government seeks to change law on how victims of mesothelioma are compensated. **Page 23**

Online poll [6/19-6/23]

For 2007, do you expect your health insurance costs to:



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Reporting on corporate risk and employee benefit management news

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Judge drops RICO charges against Gen Re

Ruling preserves pending suits over failure of ROA

By DOUGLAS McLEOD

MEMPHIS, Tenn.—A federal judge has thrown out civil racketeering charges filed against General Reinsurance Corp. by Virginia and Tennessee regulators that are liquidating professional liability insurer Reciprocal of America and its affiliates.

Regulators from the two states had charged that Gen Re, ROA's main reinsurer, participated with ROA management in a scheme to mask the insurer's deteriorating financial condition in the years before its 2003 collapse.

After more than 18 months of arguments and deliberation, though, U.S. District Judge J. Daniel Breen of the Western District of Tennessee ruled earlier this month that the state regulators failed to meet pleading requirements of the federal Racketeer Influenced and Corrupt Organizations statute.

In addition to dismissing the RICO claims against Gen Re, Judge Breen separately threw out similar charges against several former ROA officials and the law firm of ROA's former general counsel.

In response to the ruling, Virginia Insurance Commissioner Alfred W. Gross filed motions asking the judge to reconsider and, alternatively, to allow Virginia to file an amended complaint. Judge Breen has given Tennessee Insurance Commissioner Paula A. Flowers permission to amend her suit.

A Gen Re spokesman declined to comment on the decision.

Proposed class actions

The ruling does not affect similar RICO charges brought by policyholders against Gen Re and other defendants in several proposed class-action suits. Those suits have



been consolidated with the receivers' actions before Judge Breen. Motions by Gen Re and other defendants to dismiss the policyholder suits are pending.

The tangle of ROA litigation grew from the Virginia Bureau of Insurance's finding more than three years ago that the Glen Allen, Va.-based medical malpractice insurer was insolvent by at least \$209.6 million. That shortfall has since been estimated to exceed \$450 million.

Soon after Virginia regulators seized ROA, the Tennessee Department of Commerce and Insurance took over three risk retention groups—Doctors Insurance Reciprocal, American National Lawyers Insurance Reciprocal and The Reciprocal Alliance—that were under common management with ROA and wholly reinsured by the Virginia company.

Together, ROA and its risk retention group affiliates provided physician and hospital malpractice, workers compensation and lawyers' professional liability coverage to tens of thousands of policyholders in several states.

As they delved into ROA's operations, regulators concluded that the company had produced a series of falsified financial statements to keep itself afloat, and federal prose-

See GEN RE / page 26

Senator seeks evidence on antitrust exemption

Judiciary hearing stalemates as witnesses split evenly on repeal

By MARK A. HOFMANN

WASHINGTON—The chairman of the Senate Judiciary Committee wants more information before he proceeds with any changes to revise or repeal the limited federal antitrust exemption granted to insurers by the McCarran-Ferguson Act.

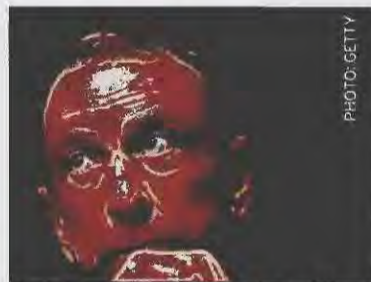
"If we're going to act, we're going to have to have more hard evidence" regarding the impact of the exemption on insurance markets, Judiciary Committee Chairman Arlen Specter, R-Pa., said near the end of a hearing last week. The panel consisted only of Sen. Specter and, for a time, Sen. Patrick Leahy, D-Vt., the committee's ranking minority member.

Six witnesses split evenly on whether the exemption should be retained or repealed.

Sen. Leahy introduced legislation last year that would repeal the antitrust exemption for medical malpractice insurers, but the bill, though mentioned at last week's hearing, has yet to undergo a formal hearing.

Sen. Specter said that the hearing would examine "whether regulation by the states is sufficient." Under McCarran-Ferguson Act of 1945, states bear primary responsibility for regulating insurance, including applying antitrust laws.

Elinor R. Hoffmann, a New York assistant attorney general, said that the lack of a single regulatory standard has created obstacles in prosecuting insurance wrongdoing. State



Sen. Specter grew impatient with lack of specifics at a recent hearing.

prosecutors trying to bring a case in a federal court under federal antitrust law are likely to encounter a defense under McCarran, which would delay or preclude civil settlements such as those New York Attorney General Eliot Spitzer won from insurers and brokers for alleged bid rigging, according to Ms. Hoffmann's testimony.

"This is not just a New York state problem; it is a pervasive national problem," she said. McCarran-Ferguson, she told the committee, "encourages inefficient multiple proceedings, under disparate laws, brought by diverse sets of public and private plaintiffs, with a clear potential for inconsistent results."

The president of the American Insurance Assn. told the committee that AIA opposes repealing McCarran-Ferguson under the existing system of state regulation. But AIA's member companies are willing to take "the risks inherent" in rescinding the partial exemption of federal antitrust regulation if they could be chartered by the federal, rather than state, governments, said AIA President Marc Racicot. The National Insurance Act of 2006—S. 2509—would permit such an optional fed-

Doctors' class suit ends as final defendants freed

By GLORIA GONZALEZ

MIAMI—A federal judge in Miami has dismissed the remaining defendants in a huge class-action lawsuit that pitted 700,000 doctors against most of the major managed care companies in a dispute over payment practices.

U.S. District Judge Federico A. Moreno of the Southern District Court of Florida last week dismissed Minnetonka, Minn.-based UnitedHealth Group Inc. and Bethesda, Md.-based Coventry Health Care Inc. from the litigation, which was consolidated in his court in 2000.

In his summary judgment order, Judge Moreno said that the plaintiffs did not submit evidence that would allow a jury to find reasonably that either UnitedHealth or Coventry was part of a conspiracy to underpay doctors or that either defendant aided and abetted in alleged violations of the Racketeer Influenced and Corrupt Organizations Act.

Despite his order, Judge Moreno said he was not giving his approval to the actions of the defendants or to the compensation received by their executives, but that any reform related to these practices must be handled by Congress or the free market. He noted, though, that the settlements with other defendants in the case will cause UnitedHealth and

Coventry to offer the physicians similarly efficient and fair service in order to remain competitive, thus diluting their legal victory obtained by his order.

In separate statements, both companies said they were pleased with Judge Moreno's decision to dismiss all remaining claims against them in the lawsuit.

In their litigation, the physicians charged that the managed care companies followed a pattern of routinely delaying or reducing claims payments.

The charges against UnitedHealth subsidiary PacifiCare Health Systems Inc. were dismissed in February, while the other health insurers agreed to settle the lawsuit.

Indianapolis-based WellPoint Inc. (\$198 million), Los Angeles-based Health Net Inc. (\$140 million) and Louisville, Kentucky-based Humana Inc. (\$58 million) all agreed to settle the charges last year, while Hartford, Conn.-based Aetna Inc. (\$170 million) and Philadelphia-based CIGNA Corp. (\$140 million) settled the lawsuit in 2003.

Some of the insurers also agreed to changes in their claims payment practices, including the use of automated adjudication of claims to speed payments to doctors and the establishment of independent external review boards to resolve billing disputes.

See ANTITRUST / page 26

Employers honored for promoting healthy lifestyles

NBGH cites efforts to fight obesity

By SALLY ROBERTS

WASHINGTON—From health risk appraisals to healthy lifestyle coaches, more employers are promoting and implementing comprehensive fitness and wellness programs in their workplaces as a means to address rising health care costs.

By doing so, these employers not only hope to change employee behavior, but also tackle the growing problem of obesity, an epidemic that affects nearly 36% of the adult U.S. population today and costs employers an estimated \$13 billion

a year in insurance and paid leave, according to government statistics.

Earlier this month, the National Business Group on Health honored 33 employers' innovative efforts to battle obesity and promote a healthy work environment with its second annual Best Employers for Healthy Lifestyles awards.

Winners were honored in one of three categories: platinum, for established programs with measurable success and documented outcomes; gold, for creating cultural and environmental changes that support employees who are com-



If employees "are not willing to really work at becoming healthier as individuals...then you're not going to do anything about medical claim costs. They are just going to keep climbing."

Helen Darling
National Business Group on Health

mitted to long-term behavioral changes; and silver, for employers that have launched programs or services to promote living a healthier lifestyle.

NBGH executives say more employers are getting serious about improving the health of their employees, which is evidenced by the 50% increase in the number of employers being honored this year vs. last year.

"I can't tell you how many times I have heard someone begin a sentence with: 'We've all come to realize that if you're going to control health care costs, you have to im-

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Gallagher's former CFO sues for consulting pay

By STEVE DANIELS

ITASCA, Ill.—Arthur J. Gallagher & Co.'s former chief financial officer has filed a \$13 million lawsuit against the brokerage, alleging it isn't honoring a 10-year employment contract under which he has served as a high-level adviser.

Michael Cloherty resigned the CFO post in 2002 after 21 years in the position and then became an adviser to the Itasca, Ill.-based company. He alleges that Gallagher isn't paying him the salary or bonus he's owed under his agreement.

A spokeswoman for Gallagher, the world's fourth-largest commercial insurance broker, said the company does not comment on pending litigation.

At issue is a \$2.5 million bonus that Mr. Cloherty claims was to be paid when he entered into a new contract with Gallagher in 2002. That money was set aside in an account originally controlled by Mr. Cloherty, but the company has cut off his access to the money, said James Pranger, a Chicago lawyer representing Mr. Cloherty.

In addition, the company currently isn't paying Mr. Cloherty the \$350,000 annual salary provided for in the advising contract, Mr. Pranger said.

According to Mr. Pranger, the company's justification for not paying Mr. Cloherty is tied to a \$120 million breach-of-contract settlement Gallagher reached last year with South Jordan, Utah-based Headwaters Inc., an alternative fuels company that licensed technology to Gallagher for some synthetic fuels plants Gallagher oper-

ates. That settlement, reached after an adverse jury verdict in February 2005, was one reason Gallagher's earnings last year fell to \$31 million from \$189 million in 2004.

Headwaters accused Gallagher of failing to pay royalties for use of some of its technology. Those investments in the plants, made to earn lucrative federal alternative fuels tax breaks, were engineered by a Gallagher unit that Mr. Cloherty headed until late 2002.

Mr. Pranger said Gallagher thinks it overpaid Mr. Cloherty. "They believe that over a five-year period, from 2000 to 2004, Cloherty was paid \$2.8 million in compensation that they claim was erroneous," Mr. Pranger says. "I'm not aware of any basis that allows them to claw that back."

The lawsuit, filed last month in Cook County Circuit Court, requests more than \$3 million for withholding the bonus and another \$10 million in pay and other compensation that Mr. Cloherty was scheduled to receive through 2012, when his contract expires.

The company "has decided not to honor its contractual obligations, refuses to pay the compensation promised in the employment agreement, claims to have unilaterally voided the previously fully funded and vested \$2,480,000 bonus and goes so far as to claim that Cloherty owes millions of dollars" to Gallagher, the lawsuit says. "All of (the company's) claims are completely without any legal basis."

Steve Daniels is a reporter for Crain's Chicago Business, a sister publication of Business Insurance.

Texas probe of insurer leads to suspension of executive

By DOUGLAS McLEOD

HAMILTON, Bermuda—The antitrust arm of the Texas attorney general's office is investigating Bermuda-based Allied World Assurance Co. Holdings Ltd., an inquiry that has already led to AWAC's suspension of its chief underwriting officer, the insurer disclosed.

AWAC reported the investigation in an amended share registration statement filed with the U.S. Securities and Exchange Commission last week. The insurer, which is planning an initial public offering of its stock, was formed in 2001 by American International Group Inc., Chubb Corp. and oth-

er investors.

According to the SEC filing, AWAC last November received a civil investigative demand from the Texas attorney general relating to an investigation into whether the insurer's relationships with AIG and Chubb restrained trade. The demand sought information about AIG's and Chubb's roles in AWAC's business and wanted to know whether the companies shared business information or had any agreements not to compete, the filing reported.

Texas officials also sought information about any contingent commission agreements AWAC may have entered into with brokers, and whether AWAC provid-

ed the kind of inflated bids that Marsh Inc. allegedly solicited from other insurers to rig bids, the filing said.

After discussions with the attorney general's office last month, AWAC expects the investigation to result in "litigation, enforcement proceedings or a voluntary settlement," the filing said. The outcome is likely to produce other investigations, civil suits and enforcement proceedings by other regulators and policyholders, it added.

The Texas investigation and AWAC's own review of "certain insurance brokerage practices" at

See AWAC / page 25

Culture of consideration can lessen harassment, discrimination claims

By MICHAEL BRADFORD

LAS VEGAS—Public entities that instill respect as a core value in the workplace will go a long way towards eliminating harassment and discrimination claims, risk management experts with a Tennessee municipal pool agree.

Teaching workers to show consideration for each other's differences and sensibilities lessens the chance that public entities and their insurance pools will face lawsuits and claims from employees, said Michael G. Fann, director of loss control with TML Risk Management Pool, a Brentwood, Tenn.-based insurer of municipalities in the state.

Mr. Fann, speaking earlier this month at the 27th Annual Conference held by the Public Risk Management Assn. in Las Vegas, stressed that instilling respect is not a one-shot affair for public entities.

"If you're going to build a culture of respect in the workplace, it has to be broad and it has to be value-based," said Mr. Fann. "It really has to be a daily approach to solving the work environment issues that all of us have to deal with in the risk management profession."



George D. Dalton, risk services consultant with TML, agreed that some public entities have their work cut out for them in making changes that emphasize respectfulness among workers.

"How many times have you heard, 'He's too old to do the job,

she got the job because she's black?'" or other disrespectful comments that could lead to legal action, Mr. Dalton asked. "There are some terrible things being said in the workplace."

Such comments often come from those with authority, Mr. Dalton pointed out.

He said he has heard discriminatory remarks from an office supervisor and a city mayor. "What sort of message does that send to an organization? It's acceptable, right?"

Such behavior has no place in the workplace, which has evolved to include more women, minorities, older and disabled workers, Mr. Dalton pointed out. "With respect to workplace diversity, no two people in any organization are alike. Everybody is different and we have to manage accordingly," he said.

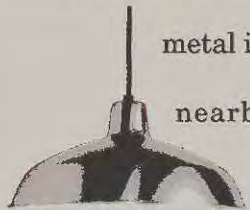
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Editorial

Impressive achievements lead to BMOY honors

CREATING INNOVATIVE employee benefit programs that improve health and save money takes leadership. Doing that within the budget constraints of a public entity is an even bigger feat.

Those are just a few of the accomplishments that earned Paul Hackleman, benefits manager for San Mateo County, Calif., the 2006 Benefit Manager of the Year award. Mr. Hackleman is the second winner of this annual award sponsored by *Business Insurance* to honor excellence in administering employee benefit programs.

Mr. Hackleman's achievements are impressive. Among other things, he has:

- Introduced a wide variety of wellness and work/life benefits before they caught on widely.
- Created a labor/management partnership to help contain health care cost increases.
- Persuaded the county to offer homebuyer assistance to employees, an especially valuable benefit as San Mateo County borders San Francisco, one of the nation's most costly housing markets.
- Engaged the county in research on disease prevention with Stanford University, becoming the first individual public employer to do so.
- Has helped other public entities to adopt similar successful strategies.

• Written books on various aspects of employee benefits, taught courses and consulted with other employers, sharing his successes with his peers.

In a report beginning on page 10, readers will see how Mr. Hackleman and his colleagues at San Mateo County have been able to control health care benefit costs, improve the health of benefit plan members and provide valuable assistance to help employees cope with professional and personal challenges. In many cases, Mr. Hackleman has been able to solve problems by trying new approaches, and he hasn't been afraid to make requests that others have not made.

The 2005 Benefit Manager of the Year, Chris McSwain, the director of compensation and benefits at SCANA Corp. in Columbia, S.C., helped the large private-sector utility company to achieve its goals through a similar combination of fresh thinking and strong communication with all levels of the company.

Whether public or private, employers face significant, ongoing challenges in providing cost-effective benefits. *Business Insurance* proudly salutes the Benefit Manager of the Year and all benefit managers who are helping their organizations, through innovative approaches, to keep employees healthy and productive, while holding benefit costs in check.

Pass surplus lines reform bill

WE'VE MADE NO SECRET of our support for comprehensive insurance regulation reform, including the creation of an optional federal chartering system for insurers and brokers.

But we also realize that sweeping reform is unlikely to occur in the current Congress and that truly comprehensive reform may take several Congresses to achieve.

Fortunately, Congress has the opportunity to approve a modest but meaningful insurance bill this year. That's the Nonadmitted and Reinsurance Reform Act of 2006, which was the subject of a House Financial Services' subcommittee hearing last week. As we report on page 1, the measure would bring much-needed uniformity to the taxation and regulation of nonadmitted insurers while giving risk managers a streamlined process for tapping that vital market. The measure would pre-empt the extraterritorial application of state law to reinsurers by making a reinsurer's domiciliary state its sole solvency regulator.

And the bill would do so without creating any new federal regulatory body, thus making it attractive to those on both sides of the optional federal charter debate.

Even opponents of the optional federal charter are demanding significant reform of the current state-based system of insurance regulation. The inconsistent statutes for collecting premium taxes on nonadmitted insurance and the unjustified burdens and expenses they place on risk managers provide a key example of why reform is needed, and needed now. The regulations limiting sophisticated buyers' immediate access to the nonadmitted market provide further evidence that reform is justified.

Swift passage of the Nonadmitted and Reinsurance Reform Act would further that cause. While we would prefer comprehensive insurance regulatory reform, including the optional federal charter, we support incremental change. Even a little reform is far better than none at all.

Schillerstrom



Letters

Complaints won't change lack of quality

To the editor: This letter is in response to the Commentary by Sally Roberts in the June 5 issue of *Business Insurance* dealing with "Quality Concerns Make a Comeback."

Just as Ms. Roberts mentioned in her commentary, "It's déjà vu all over again" for the Risk & Insurance Management Society Inc. and risk managers.

Again, it sounds like RIMS and most risk managers are doing nothing but complaining. The current RIMS president concedes as much with his comments on the RIMS quality survey. Just like when contingent commissions first appeared as an issue in the late '90s, most risk managers did nothing, so RIMS made an agreement with several brokers that the brokers would acknowledge what "contingent" payments they were taking. Several years later, regulators found that most brokers were not as transparent as they had promised to be. We have yet to hear from RIMS as to their thoughts of the brokers not living up to the agreement. In fact, most risk managers still are doing business with the brokers that totally ignored those agreements with RIMS.

Now quality becomes an issue again. But first, one correction to Ms. Roberts' comments, if I may. The Quality Insurance Congress was not killed by the insurance industry. The QIC was killed by risk managers. Just as the first Quality Scorecard was to be released at the RIMS Annual Conference in 1998, at a combined meeting of the RIMS executive committee and the QIC executive committee, the chairman of the QIC (who at that time was the president of CNA Insurance) told the RIMS executive committee that "if RIMS and risk managers did nothing with the data, the QIC effort would be in vain." Truer words were never spoken.

Once the results were released, several brokers and insurers complained about the scorecard, as their own surveys of risk managers produced different results. A second scorecard a year later produced basically the same results, with the brokers and insurers again complaining of the scorecard's findings. For some reason, risk managers responded differently to the QIC survey than

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By Andrew M. Reidy

D&O cover a valuable asset worth preserving

usually require there to be a judicial determination of such conduct before the exclusions can be invoked. Thus, even if there are allegations of fraud, dishonesty or illegal profit, a D&O insurer is obligated to pay for the defense of these claims.

A second common defense to these claims is rescission. Rescission is an equitable remedy whereby an insurer attempts to cancel the insurance policy based upon misrepresentation or concealment of material fact in the underwriting or application process. Specifically, rescission is designed to return the parties to

the positions they would have had if the insurance policy had not been issued. Oftentimes, D&O insurers attempt to invoke "unilateral rescission" by returning the policy premium along with a notice that the policy is void.

An insured that is faced with a "unilateral rescission" should reject the insurers' attempt to cancel the policy. Importantly, several courts have held that a D&O insurer cannot escape its defense obligation by asserting rescission. Moreover, courts have rejected rescission claims when there was no reliance

by the insurer on the insured's alleged false statements, when the statement was not made directly to the insurer or when the insurer knew or should have known of the events that it claims justify rescission.

Finally, once a claim is asserted, a legal analysis of the key coverage issues is very important because insurance law varies state by state. Moreover, the law is evolving and new decisions relating to D&O insurance are being issued regularly. Once the comprehensive analysis of the relevant coverage issues in the potential-

ly applicable jurisdictions is complete, an insured should analyze where litigation could be brought (if necessary) and select a forum to litigate its claim that is likely to apply a state's law that will maximize coverage.

In sum, while D&O insurance is a valuable asset, its value to the insured can be enhanced by thoughtful and deliberate handling of claims under the policy.

Andrew M. Reidy is a partner at law firm Howrey L.L.P. in Washington.

Enron's former Chief Executive Officer Jeffrey Skilling spent in excess of \$40 million on his defense in the recently concluded Enron trial. The remarkable part of this statement is not the amount of fees, but the fact that it is now common for individuals and corporations to spend such sums in the defense of corporate mismanagement claims.

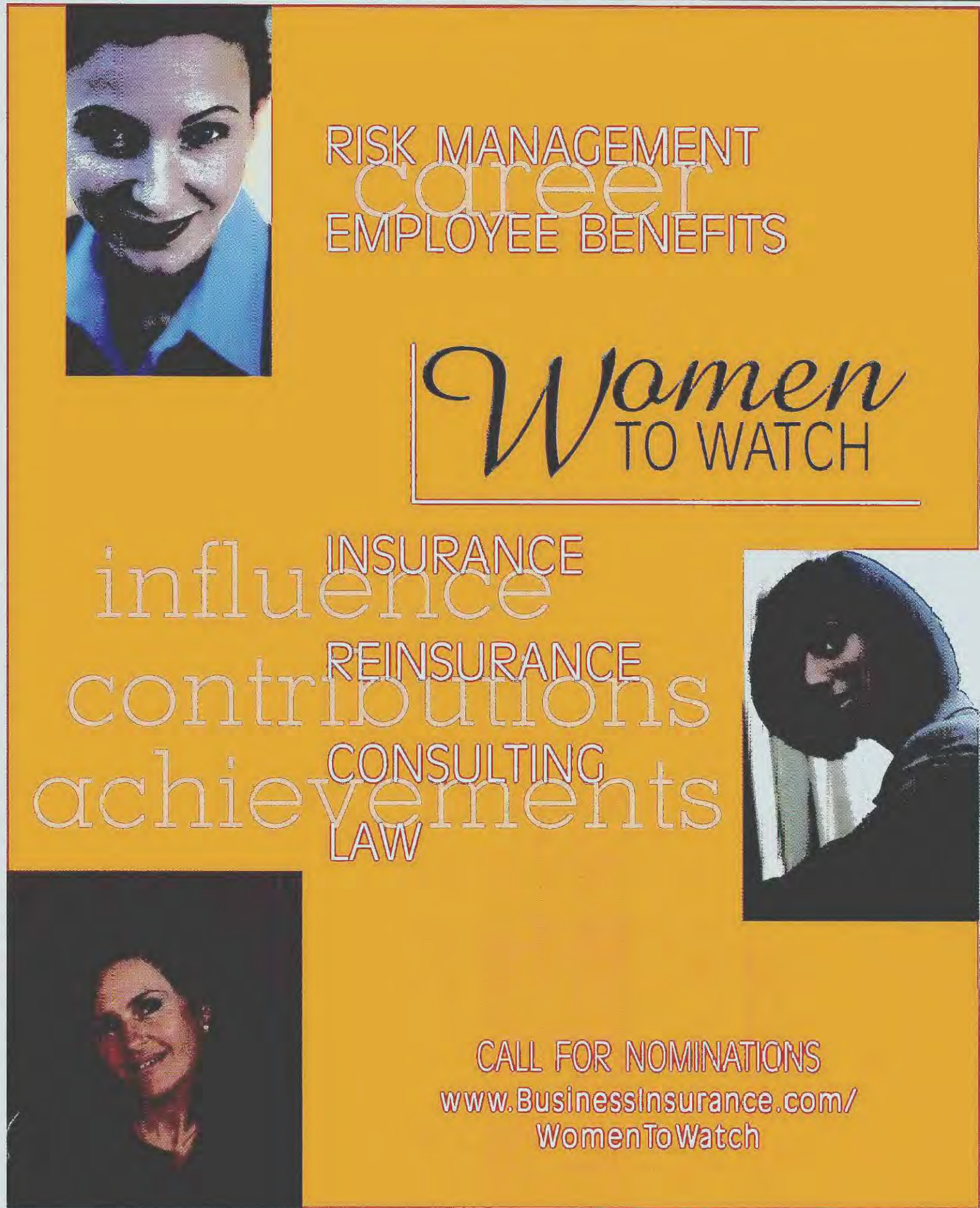
In the past few years, there have been an unprecedented number of claims against corporations and their directors and officers by governmental entities and private litigants (including class actions and derivative actions). Billions have been spent to defend or settle such claims. Fortunately, there is a valuable corporate asset to defray the cost of such claims—directors and officers insurance. D&O insurance is valuable not just because it helps mitigate the impact on a corporation's bottom line or the impact on an individual's personal assets, but because it also provides protection in the event that the solvency of the business is threatened by a corporate scandal.

Like any asset, D&O insurance has certain limitations and, in order to maximize the asset, one must be sure to take certain steps. The first step to maximize the D&O asset is to understand the nature and scope of the D&O policy purchased.

D&O insurance covers wrongful acts and is written on a claims-made basis. In other words, D&O policies often respond only to claims made against the policyholder during the policy period and reported to the insurer during the policy period. Claims that are related to a claim made during the policy period typically are deemed to have been made within the policy period. One of the most critical aspects of this type of insurance is that courts tend to strictly enforce the provisions requiring notice of claims or potential claims. Most of the time, the problem of untimely notice stems from the fact that different parts of a corporation receive relevant information about a claim and do not communicate it to the people responsible for providing notice to the insurer.

In order to preserve the valuable D&O insurance asset, the corporation should adopt a procedure whereby the legal department, the risk management department and management are directed to immediately report claims and potential claims to the risk manager. The risk manager then can ensure that claims are reported in a timely fashion under the correct policy.

Protecting the D&O insurance asset also requires the policyholder to be aware of the most common grounds insurers are relying on to deny coverage in corporate malfeasance cases: the "personal conduct" exclusions and rescission. Personal conduct exclusions typically exclude coverage if there is fraud, dishonesty or illegal profit. These exclusions



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Thinker, teacher, author, epicure

Paul Hackleman's other "extracurricular activities" include:

Member of International Foundation of Employee Benefit Plans board of directors, 2002-2004; chairman of the IFEBP Public Sector Board, 2004; faculty member for IFEBP programs covering health plan policy and the American Federation of Teachers' negotiators; designed IFEBP's "Public Sector Defined Contribution Management Strategies" course, which will be offered twice yearly starting in October 2006 for pub-

lic sector and school trustees, decision makers and administrators; faculty member for IFEBP's Canadian Advanced Trustee Management Standards Certification Program, 1999-2004.

He also has held board and committee posts with the International Personnel Management Assn., World at Work and the Bay Area Child Care Coordinating Council; he is a past graduate faculty member for Benefits Management for John F. Kennedy University; he has published three books

on public sector benefits: "Public Employee Benefits: From Inquiry to Strategy" (2000), "Defined Contribution Plans: New Rules/New Game" (2001) and "Defined Contribution Plans: The Education Challenge" (2004).

He also has written dozens of articles for numerous professional publications.

Mr. Hackleman is an avid reader and outdoorsman, and he is gourmet cook and wine connoisseur.

—By Joanne Wojcik

Hackleman: Viewing benefits strategically and philosophically

Continued from previous page

grow is endless, the opportunity to find something new is endless, the challenges will be endless, and they won't be the same ones again and again and again," he said.

Moreover, he believes his classical education—he studied such subjects as Greek philosophy and ancient civilizations—has enabled him to take both a strategic and philosophical view of the benefits offered by his organization, tailoring them to meet the needs of the county's employees so that they, too, can become productive, self-ac-

tualized individuals.

"I think if I were to apply for this position today, I can't really imagine that I would be hired," Mr. Hackleman said. "An employer would take a look (at my resume and say), 'How wonderful that you have European intellectual history. What does that have to do with employee benefits?'"

However, "I think I came to this position very well-rounded. I certainly didn't have a degree that helped me out in terms of the specifics of my career," he said.

Mr. Hackleman's undergraduate education at the University of the Pacific was intended to "raise a cadre of students or leaders who really have a very solid grounding in dramatically different cultures than their own," he explained.

"I think if I were to apply for this position today, I can't really imagine that I would be hired."

Paul Hackleman
San Mateo County, Calif.

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Likewise, the University of Chicago "took a broad-brush approach to the way in which man's mind changes over time as reflected in literature, poetry, science, architecture, music—any endeavor where man expands his knowledge or understanding of the world around him," he pointed out.

In fact, Mr. Hackleman credits his liberal arts background with making him a quick study. For example, he used that skill to learn enough about Canadian pensions to teach a course on them on behalf of the International Foundation of Employee Benefit Plans.

"I won't pretend that I was an expert. But there's enough common ground from the administrative perspective about how things are run in the United States and how things are run in Canada" to see parallels that Mr. Hackleman said enabled him to understand the system.

"What keeps me in this job" is "I never doubted that I'd always have fascinating things that I could get into here. And some of them I could get into myself. But there would be plenty of stuff that would come my way, the county would let me get involved with."

"The mediation and homebuyers programs are perfect examples of just getting into an area I wouldn't even pretend to have foresight about. They just arose and from them it seemed like here's an opportunity that we can leverage in some way," he said. "And I've always been interested in risk reduction strategies. I've always had that desire to really go at controlling costs in ways that I have thought, and still do think, are not artificial."

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200615-4-06

Persuasive benefit manager breaks through barriers

By JOANNE WOJCIK

REDWOOD CITY, Calif.—Paul Hackleman doesn't like to take no for an answer.

When his mind is made up, he can break through bureaucratic barriers, persuade vendors to provide additional services for free and win union backing when negotiating benefit plan changes.

But even though he may get his way most of the time, he does it with such finesse that all parties involved believe they've gotten something, too.

"Paul's very collaborative. He wants to work with you, and that's how he approaches negotiations for the renewal and so forth," said Rick Salow, senior account executive in San Francisco at Aetna Inc., which has provided San Mateo County employees access to its Simple Steps wellness program for the past two years at no additional charge to the county.

"We've given it to the county because they've been a long-term partner," Mr. Salow explained. "Because of some of the limitations that Paul has, as far as unions and so forth, he can't make a lot of changes and there will be times when he asks, 'Are there additional things you can do for us based on what we're currently paying you?'"

Aetna is also giving the county access to its patient safety system, MedQuery, at no additional cost, Mr. Salow added. Through the program, Aetna converts member health data into information that treating physicians can use to improve care and patient safety.

Although it took Mr. Hackleman awhile, he eventually persuaded the Redwood City office of Kaiser Permanente Medical Group Inc. to work on a joint venture with the county in combating diabetes and heart disease.

"Paul is very persistent in his advocacy for his employees in terms of health," said Dr. Timothy Wong, assistant physician-in-chief at the medical group's Redwood City, Calif., office, who also heads the county's PHASE program. PHASE stands for "Prevent Heart Attacks and Strokes Everyday" (see story,

page 21).

The county provided a registered nurse to assist with teaching the classes and Kaiser provided educational materials, physical space for classes, administrative support and two pharmacist care managers who provided individual counseling to 100 program participants who were selected based on their medical histories.

It was the first time Kaiser's Redwood City office collaborated on a health promotion program with an employer, according to Dr. Wong.

"Paul doesn't take no for an answer when he knows the organization can assist," said Mary Welch, the county's director of employee and public services.

Although Ms. Welch is Mr. Hackleman's supervisor, she said they often work together as peers.

"How the process works is, he'll usually talk about something we should be doing and we'll write up a proposal on how it might work, and if it does cost money, we need to get approval from the manager's office or potentially the Board of Supervisors. And then we meet with the unions. But, it's not that difficult to do. Paul is a great writer. He's brilliant. He has a great mind. And he's strategic," Ms. Welch described.

Mr. Hackleman decided to take the initiative and start assessing the county's retiree medical obligations in advance of the county's required implementation of the Government Accounting Standards Board Statement 34 in 2007 and get the go-ahead to commission an actuarial analysis last year. Governmental entities with total annual revenues between \$10 million and \$100 million are required, after Dec. 15, 2007, to implement this accounting recognition for post-retirement health benefits.

"He managed the whole thing and got it done early, got it done well," said Ms. Welch, who added that the responsibility for such a report would normally rest with another county department.

Mr. Hackleman also spearheaded the county's involvement in the HEART Program, which began as a study by Stanford University's Pre-

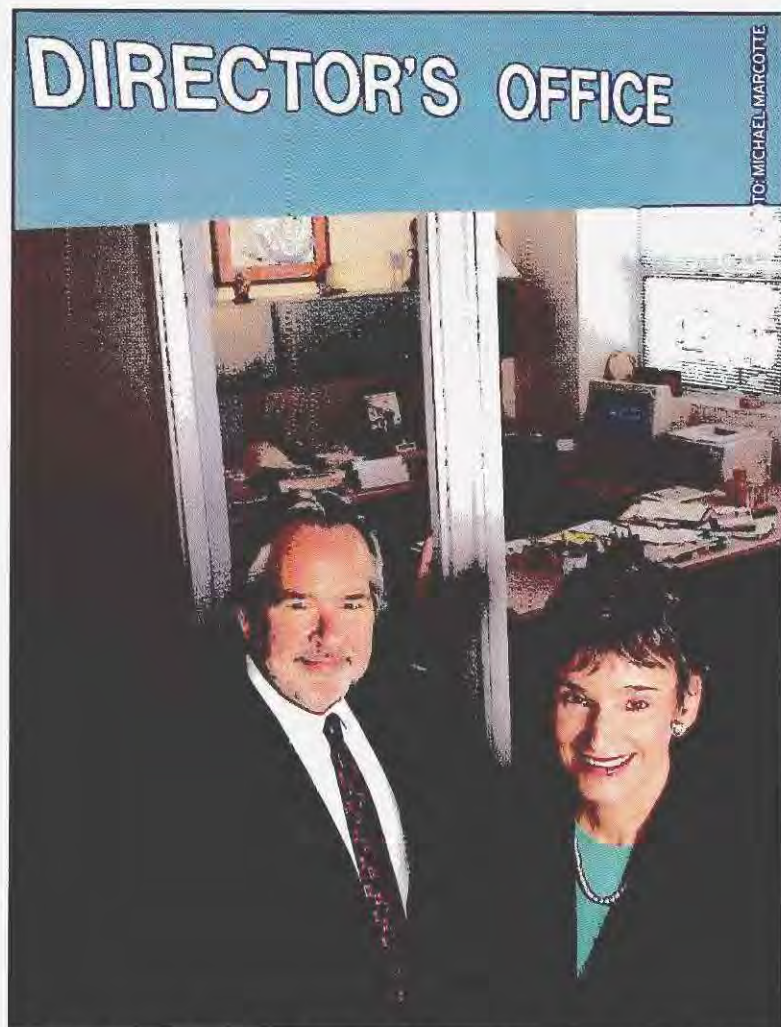
vention Research Center (see story, page 21).

"He's been a tremendous support of the program. He even went to the board and got this program funded as an employee benefit," said Susan Vana, the nurse coordinator of the program. "A lot of employers don't understand the benefit of this kind of program. He attends the meetings that we have with Stanford."

Walter Zhovreboff, president of San Francisco-based First Home Inc., which administers the San Mateo County Employee Homebuyers Education and Assistance Program, said that he is amazed at how well Mr. Hackleman navigates the political bureaucracy of county government.

"I'm used to the political bureaucracy where you have to go through just levels and levels and levels to get approval," he said. "Paul sat down and within an hour, an hour and a half, said, 'I want it. Draw up a proposal. Let's take it to Mary and everyone else.' And within two months we had this thing off the ground."

"I believe Paul has a really great capacity to bring people in to trust him and for him to trust people. He just has this great capacity to go over these boundaries. I think that he's an intelligent individual who



Paul Hackleman, San Mateo County, Calif., benefits manager, and Mary Welch, the county's director of employee and public services, often collaborate on bringing new health programs to employees.

quickly evaluates the people that he's working with. And, in so doing, if he makes a decision that this is someone he wants to work with it, he goes all the way," Mr. Zhovre-

boff said.

"At the same time, he makes it clear up front that he expects a very professional and high level of service," he added.

Opting to drop self-insurance proved advantageous to county

By JOANNE WOJCIK

REDWOOD CITY, Calif.—In the early 1990s, San Mateo County did the opposite of what many employers that were experiencing double-digit annual increases in the health care costs had done. It decided to get out of self-insurance.

Because of adverse selection, the cost of the county's self-funded preferred provider organization plan was growing at a faster clip than that of its fully insured health maintenance organization plans, according to Paul Hackleman, benefits manager.

"We would take a look each year at open enrollment at the people who left, and we found that from 1990 through 1993 most of those leaving were the lower utilizers," he said.

But rather than switch entirely to HMOs, which at the time had the lowest premiums, "we wanted to preserve where we could the ability for people to seek almost universal choice" and decided to replace the self-funded PPO with a point-of-service plan with similar benefits.

But, also unlike many private sector employers, the county couldn't just make the change. It first had to get approval from the labor unions that represented the majority of its workforce.

Fortunately for the county, however, Mr. Hackleman had the foresight to establish a joint Labor-Management Health Care Cost Containment Committee that was already aware of the problem.

"So we went to labor (unions) and said this wasn't going to serve

picked up 100% by the county, vs. 80% for represented employees, "there was a preponderance of management in the plan. In fact, when we had the discussion with labor it was clear that only a small pool of their members could afford to be in the plan," he said.

By comparison, the county pays 90% of the premiums for represented employees and their dependents who are enrolled in HMOs.

Nine insurers bid on the county's request for proposals for the new fully insured POS option, and Blue Shield of California was selected to underwrite the new plan beginning in 1994.

Since then, the average increase for all of the county's health plans combined has consistently been two or three percentage points lower than the average trend rate reported by U.S. employers nationally. As a result, Mr. Hackleman estimates the premiums paid by the county and its employees and retirees are about 11% less than they would have been had they not made the health plan changes and added the various health and fitness programs (see story, page 16).

In fact, a five-year analysis by Stanford University of the county's

Improving lives

A five-year analysis showed that San Mateo County's health and fitness programs:

Reduced health claims by 44%

Improved fitness by 37.5%

Improved nutrition status by 74.1%

Decreased the incidence of high blood pressure by 30%

Decreased cancer risk by 52.2%.

us long term, and if the objective was to retain a plan other than HMOs, we were going to lose that capability, so we needed a new model to work for all of the constituencies," Mr. Hackleman recounted.

Other research Mr. Hackleman conducted helped to seal the deal. His analysis found that participation in the self-insured PPO plan had dropped to just 16%, and because management employees' premiums for the plan were being

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Wellness programs serve as model for other employers

By JOANNE WOJCIK

REDWOOD CITY, Calif.—Wellness has been the primary mission of the San Mateo County Benefits Department since the beginning of Paul Hackleman's tenure there.

When Mr. Hackleman was named benefits manager 23 years ago, the county had just three health and fitness programs: blood pressure screenings performed by public health nurses, a tennis tournament and some aerobics classes.

Since then, the roster has grown

to include at least five preventive health screening programs, eight healthy lifestyle and wellness programs, 12 health improvement and risk reduction programs and five family-life education programs (see chart).

"Under his tutelage, it's really matured and evolved," said Pam Gibson, the county's health and fitness coordinator, who joined the department just a few months after Mr. Hackleman was named benefits manager. She oversees seven independent contractors hired on a part-time basis to lead the programs, most of which are offered as classes on county property. They include a nutritionist, physical activity coordinator, massage therapist, clinical screening company, nurse coordinator, computer ergonomics instructor and work/life coordinator.

Many of the San Mateo County health and fitness programs have served as models for other employers, being featured in numerous journals and magazines, including the American Journal of Health Promotion, Public Health Reports, Journal of Occupational & Environmental Medicine and Business & Health. The program even won the California Fit Business Award, which is granted by the state Legislature, in January 2004.

"He's done a lot for the employees here," said Susan Vana, nurse coordinator of the HEAR²T Program, a disease management program focusing on heart health. "I don't think there are a lot of places that have this much going on for the employees." HEAR²T is short for Health Education and Risk Reduction Training.

"Paul's philosophy is to reach out and impact the health of the people who work here," said Rick Salow, senior account executive at Aetna Inc. in San Francisco.

To promote the health, fitness and well-being of county employees, retirees and their dependents, the benefits department also sponsors numerous special events such as health fairs, health club discounts, bowling, basketball, volleyball and softball tournaments and a T.G.A.F. (Thank Goodness It's Alcohol-Free) Holiday Happy Hour.

"He's given me opportunities to make this program be what it is. What his contribution has been is to work on the strategy, to build the support within the organization, the political understanding where

the opportunities are, where the pitfalls are," Ms. Gibson said.

Whenever she has an idea, she'll bring it to Mr. Hackleman and "he'll run it up the flag pole," she said. Similarly, the two brainstorm together about program enhancements and fine-tuning.

The HeartCheck clinics, in which about 200 employees participate every six months at three county locations, have been one of the most popular programs to date, according to Ms. Gibson. The clinics also are among the longest running, having begun in the mid-1980s.

Variety attracts interest

But other programs have been catching on as well.

"At one point this year, we had five Weight Watchers classes going, and Weight Watchers requires a minimum of 15 to 18 people per class, so you can do the math and see how many people are going to programs," Ms. Gibson said.

On the recent day that a *Business Insurance* reporter arrived to interview Mr. Hackleman, 32 employees were scheduled for the ergonomics training program, which is conducted six times each year, training 200 to 250 people annually.

This year, the county introduced a healthier-aging program for individuals over age 50 who are planning to retire in the next three to five years.

The county was one of 10 employers participating in a pilot of Blue Shield of California's Healthy Lifestyle Rewards program. Last year, Aetna Inc. invited the county to participate in its Simple Steps to a Healthier Lifestyle program at no additional charge.

The county also has been offering health risk assessments since the mid-1980s.

Allergy and asthma classes, which are sponsored by Kaiser Permanente Medical Group Inc., are offered once a year, usually at the beginning of allergy season.

The county also has partnered with Kaiser's Redwood City, Calif., office to offer a heart disease and diabetes management program, called PHASE. The acronym stands for "Prevent Heart Attacks and Strokes Everyday" (see story, page 21).

Most of the health and fitness classes are offered on a rotating basis, usually in spring and fall, to let as many employees as possible participate. Employees also may attend



PHOTO: MICHAEL MARCOTTE

San Mateo, Calif., County Benefits Manager Paul Hackleman and the county's health and fitness coordinator, Pam Gibson, direct many programs designed to keep county employees healthy.

many of the programs on county time. Retirees and dependents also are welcome to join all but the HEAR²T program, which is restricted to employees because of funding constraints.

In 2005, Ms. Gibson documented a total of 3,382 participants in the county's health and fitness programs, or 2,283 individuals, representing 41% of the county's workforce.

"However, there are a number of programs for which we don't capture employee names, either due to the nature of the program or for confidentiality/privacy reasons," she said. Among them are: flu shots, which were given to 1,100 individuals; online health assessments, taken by 368 individuals; the HEAR²T program, in which 69 individuals are receiving counseling; health fairs, which were attended by 1,100 individuals; and health improvement initiatives with the county's three health plans, in which 371 individuals are participating. She did not have figures on participation rates in the various department events and training programs.

"The county tries to eliminate any barriers to access its wellness and risk reduction programs, whether it means making participation more convenient by allowing employees time off from work, or negotiating a discount to make participation more affordable," Mr. Hackleman said.

For example, this year the county introduced a "Heart Healthy Boot Camp," which consolidates the car-

diovascular/cholesterol class and the hypertension class and provides blood pressure cuffs to participants for \$25 apiece, which is half the usual retail price.

"We don't advertise that very much. We advertise that through our classes because we figured people who are in those classes are dealing with or are at risk for, or are concerned about, cardiovascular-related issues," Ms. Gibson said. "One of the things that I'm really very happy about is the fact that people really want to purchase blood pressure machines for themselves."

In fact, about 40 employees have purchased the monitors in the past two or three months, she said, and not all of them were at the Boot Camp.

"It's spreading by word of mouth," Ms. Gibson said.

In addition, the health plans provide glucose monitors free of charge to diabetics, she added.

This year the county began exploring the possibility of advanced classes for employees who have completed introductory classes and would like to learn more about a particular health condition or wellness activity.

"So people who know the basics about taking care of their heart may want to know more about C-reactive proteins or the calcium supplements or whatever. That keeps those who know the fundamentals engaged so they learn new skills or the latest information because ultimately this goes back to discussions with their doctor," Ms. Gibson said.

Health and wellness programs

San Mateo County offers the following programs to help workers, retirees and their dependents

Preventive health services:

- Blood pressure check-ups
- Bone density checks
- Flu immunization clinics
- HEAR²T Program
- Cancer screenings
- Allergy relief workshops
- Asthma self-management course
- Cholesterol and diabetes management courses
- Healthier back class

Healthy lifestyle and wellness services:

- Ergonomic classes
- Exercise classes, including ballroom dancing, tai chi and yoga
- Nutrition classes and healthy cooking demonstrations
- Health club information and discounts

Family-life education programs:

- Babies & You: What to Expect When You're Expecting
- Babies & You: What to Expect After Baby Comes Home
- Breast pump loaner program for return-to-work moms
- Eldercare: A Caregiver's Survival Guide
- Parenting workshops
- Onsite child care center

Insurance: End to self-funding yielded positives

Continued from page 14

first wave of health and fitness programs—showed that San Mateo County had reduced health care claims by 44%, improved fitness by 37.5%, improved nutrition status by 74.1%, decreased the incidence of high blood pressure by 30% and decreased cancer risk by 52.2%.

In addition to the Blue Shield POS plan, the county offers two health maintenance organizations: A staff-model HMO underwritten by Kaiser Permanente Medical

Group Inc. of Redwood City, Calif., and an independent practice association HMO underwritten by Hartford, Conn.-based Aetna Inc.

Approximately 130 county retirees and their dependents are enrolled in a Secure Horizons plan, which is underwritten by PacifiCare Health Systems, a division of UnitedHealth Group of Minnetonka, Minn.

The plans' contracts are reviewed every five years, except for Kaiser, which is the only staff-model HMO

operating in California, so it has no competition. Currently 51% of the county's employees are enrolled in the Kaiser plan. The rest are fairly evenly divided between Aetna and Blue Shield.

Currently, about 7,000 active employees and their dependents and about 2,500 retirees and their dependents are enrolled in the county's health benefit plans. The current benefits budget is \$55 million, while the county's total annual operating budget is \$1.5 billion.

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Feb	27	Voluntary Benefits
Mar	13	Health Care Coalitions*
Apr	17	Health Care Cost Control*
May	29	Regulatory & Legislative Developments
Jun	19	Work & Life Benefits*
Jul	10	Benefits Market Forecast
Aug	14	Consumer-Driven Health Plans*
Sep	18	Benefit Financing Strategies
Oct	16	Technology & Online Solutions*
Nov	27	Retiree Benefits: Pensions & Savings Plans*
Dec	11	Benefits Consulting & Outsourcing*

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Education key to workers' intelligent use of benefits

By JOANNE WOJCIK

San Mateo County, Calif., Benefits Manager Paul Hackleman originally intended to become a teacher after he graduated from college, so it's almost a given that the county's Benefits Department should have such a strong focus on education.

"In the entire realm of benefits, it seems to me the charge that all of us have is education. People use benefits intelligently if they're educated. They use them in their own best self-interest if they're educated, which I want them to do," he said.

"I'm always surprised that someone will tell me they were unaware that we had a specific program," he added. "I think the greatest challenge is to provide education. And the more I've grown up in this field, the more I've felt that that's the piece that's missing."

To this end, Mr. Hackleman has written a book that focuses on defined contribution plan education, titled "Defined Contribution Decisions: The Education Challenge," which was published in 2004 by the International Foundation of Employee Benefit Plans.

"Whatever you think about the merits of moving from a defined benefit to a defined contribution environment, if we move to a defined contribution environment and we haven't done a really thor-

ough job of education, we've really poorly handled a whole segment of our society," Mr. Hackleman said. "They're just not going to be appropriately equipped to meet their own needs, whatever those needs are. I don't think we can ever do enough education."

"Whether it's risk reduction services and how to take care of yourself or what constitutes proper nutrition or exercise or any of those kinds of things, there is just a big gap between what people know and what people need to know, and you need to do whatever you can to close that gap," he said.

It is a benefit professional's job "to educate people so that the benefits that you provide for them can be optimally used by them," he said.

Fortunately for Mr. Hackleman, teaching comes naturally. It was the profession he had intended to pursue while he was in college. However, his life took an abrupt turn as his wife wanted to return to California to be closer to family.

His biggest surprises and disappointments occur when county employees say they are unaware of programs that have been offered for several years.

"But it is not lost on me if there is a benefit that seems irrelevant" to a young employee, who may not be thinking about long-term care or

contributing to retirement plans, "then I just push it out of my mind," he acknowledged.

Likewise, "if I'm a single employee, the fact that the county has a

"I think the greatest challenge is to provide education.

And the more I've grown up in this field, the more I've felt that that's the piece that's missing."

Paul Hackleman

Babies and You program doesn't mean anything to me," he said.

Later when the employee gets married and has children, he or she may have forgotten that the program exists, he said.

Mr. Hackleman is also concerned that many employees do not know the specifics of their benefits, such as eligibility criteria or the process of using the benefits.

To address these voids, Mr. Hackleman has instructed his staff to provide more than the requested information whenever an employee inquires about benefits.

"Answer their question, but also let them know about the county's Internet site—that's 24/7—that's an amazing place to get information. We tried to design it so that it's very accessible, very useful," he said.

He acknowledges, however, that the Web site is not tapped by the entire workforce because about one-third of the county's employees do not use a computer in their work.

And while some employees may have computers at home, it may not be their preferred way of getting information. Some may prefer face-to-face or print communications.

To reach this noncomputer group, the county has meetings prior to open enrollment and, whenever it rolls out a new program, has several meetings prior to implementation.

The county also offers several programs in which employees can, at no cost, take courses online.

One course focuses on compliance with the Health Insurance Portability and Accountability Act for the county's hospital and clinic nurses and other employees who have access to confidential patient information.

The county also recently introduced a sexual harassment awareness training program online that includes video scenarios and interactive quizzes.

These two courses are offered at

two levels: A more intensive HIPAA course is offered for nurses who have direct patient involvement, while other employees who only occasionally have access to patient information may take a less-involved HIPAA training course.

Likewise, the sexual harassment awareness course provides a higher level of training for supervisors than for the employees they supervise.

Other e-learning courses include computer ergonomics and telecommuting.

"Increasingly, we see that e-learning is valuable because it clearly allows me to conduct a training without the expenditure and resources that would be required if you were trying to hold countywide group sessions," Mr. Hackleman said.

Employees are permitted to take the online courses during the workday, but the courses are designed to accommodate work interruptions.

"So I can start it, and if something comes up, I can stop, but I can go back to it and pick it up where I left off," he explained.

The e-learning courses also include examinations so employees can demonstrate their competency upon completion. While most of the courses are developed internally, some programs are contracted out to consultants, according to Mr. Hackleman.

Housing: From mortgage help to telecommuting

Continued from page 18

employees, staff members for non-profit enterprises that contract with the county are eligible to participate.

The county retirement board balked when Mr. Hackleman approached it about investing in the program. The board was concerned about risk, particularly because the proposal came shortly after the "dotcom bust," said Mary Welch, director of employee and public services for San Mateo County. But housing prices haven't fallen since 2000-2001, so it would have been a good investment, she said.

So Mr. Hackleman and Walter Zhovreboff, president of First Home, enlisted the support of MeriWest Credit Union in San Jose, Calif. MeriWest agreed to provide a first mortgage for county employees and insurance for a second mortgage, which the retirement board would finance.

"That virtually eliminates the element of risk for the seconds," said Mr. Zhovreboff. "Now we're going back to the board and say, 'We've taken care of the risks, so let's talk about the returns and the structuring of the program.'"

He and Mr. Hackleman will present the revamped plan to the board in November. The revised program is to include assistance for first-time home buyers from the California Housing Finance Agency, which is to help those with little or no downpayment obtain a loan using tax-exempt bond money.

Under the program, county employees would have to put 3%

down, "which in this region is still pretty substantive," Mr. Zhovreboff noted. Single-family homes in the San Francisco Bay Area start, on average, at \$650,000 and condominiums are \$400,000, he said.

The program is directed toward individuals with salaries starting at \$45,000.

"Paul had the insight from literally a phone call or a letter that I wrote him, which is really, really rare that an employee benefits manager or an HR director has that sort of insight, particularly going back five or six years," Mr. Zhovreboff recalled. The letter included a proposal for retaining employees amid rising housing prices, putting ownership out of reach for many.

A big part of the program is education about resources available to help them become homeowners. "What we found was the greatest deterrent to ownership is fear. So we decided we should start providing education and counseling," Mr. Zhovreboff said.

It began with workshops in county offices. Courses focused on financial self-sufficiency, including management of credit, savings, employment stability and family stability.

"One of the big benefits...was that some of these people who were not financially self-sufficient and were not managing their money all of a sudden had this goal, what they perceived to be a reachable goal, and started managing their credit and managing their finances," Mr. Zhovreboff said.

It also eliminated many of the financial tensions that employees of-

ten bring to work, which can affect performance, he said.

"One of the things that Paul and I have had numerous discussions about is not only are you creating homeowners, you're creating an overall more satisfied employee," Mr. Zhovreboff added.

Through the program, 10 county employees signed up for another local program sponsored by Redwood City, Calif., that offered up to \$100,000 in down payment assistance to first-time buyers, Mr. Zhovreboff said.

For those employees who live farther out, Mr. Hackleman arranged a telecommuting program that also helped the county meet its statewide transportation system management obligations to reduce vehicle traffic and emissions. About 10% of county employees reside in East Bay, where home prices are less expensive.

Initially, Mr. Hackleman obtained office space at no charge from the Fremont Library for several employees. But, since then, the library needed the space back, and those county workers must telecommute from home.

For these workers, Mr. Hackleman developed an e-learning program that prepares them for telecommuting. Among other things, the program includes a safety checklist with recommendations from the California Occupational Health and Safety Administration, forms that telecommuters must complete and give to their supervisors, sample work schedules and home office requirements.

Special leave bank accepts deposits

REDWOOD CITY, Calif.—San Mateo County added a catastrophic leave program in 1992 to help employees who had exhausted all of their paid leave due to a catastrophic illness or injury.

Benefits Manager Paul Hackleman developed the program that allows employees to donate some of their unused paid time off in response to discussions during collective bargaining that employees wanted to do something to help their fellow employees, he said.

"We set it up so vacation, holiday time, comp time for certain groups—which are all vested time that has to be paid out—that would be the contribution," he explained.

Under California law, all workers vest in their vacation, holiday and compensation time. Any unused time in a given year can be carried over into subsequent years or must be translated into cash when workers terminate employment. Sick time can accrue similarly but does not vest, and employers decide whether to cash out unused accrued sick time.

Under San Mateo County's program, employees are permitted to donate time to the catastrophic leave bank. Initial dona-

tions must be at least eight hours and subsequent donations must be in one-hour increments.

The county monitored the program for several years, due to uncertainty as to how this new benefit would play out. "One of things was that we found was that higher salaried individuals donated to lower salaried individuals, so that the county was inadvertently deriving a benefit from it, which wasn't our intent," Mr. Hackleman said.

The county then restructured the leave so that "for every four hours of (donated) vested time, you could contribute an hour of sick leave time," he said. "That was intended to offset that pattern" of the county benefiting from the program.

For example, if an individual terminates employment with 200 hours of sick leave on the books, he or she could contribute those 200 hours to the catastrophic leave bank. Otherwise, that time would expire upon termination.

Since 2001, 3,062 employee donors have given up 46,663 hours of their paid time off. Some 189 employees have taken advantage of the program.

—By Joanne Wojcik

County, health plans team up for disease management

Programs succeed in reducing health risks

By JOANNE WOJCIK

REDWOOD CITY, Calif.—As the benefits manager of San Mateo County, Calif., Paul Hackleman pioneered efforts with each of the county's health plans to devote financial and human resources to collaborative disease management programs that have helped to improve employee health.

A cornerstone of the initiatives is the county's HEAR²T Program, which began in 2001 after completion of a three-year Stanford University study in which the county was the lone public-sector participant.

Two initiatives involving Kaiser Permanente Medical Group Inc. of Redwood City, Calif., were also unique in that the health maintenance organization had previously not conducted research with individual employers.

Both Stanford and Kaiser were particularly interested in using the county for its heart research because the county's demographics were sufficiently diverse to represent a cross-section of its targeted population, said Mr. Hackleman. San Mateo County's workforce is 66% female, and 61% of employees are over age 40.

In 1997, Mr. Hackleman met with the director of Stanford's Center for Research in Disease Prevention to discuss a program that would feature the center's newly developed Cardiovascular Risk Assessment tool, which had success in clinical trials in predicting cardiovascular events, and is still being used by the county's Health Education and Risk Reduction Training

(HEAR²T) program today.

Mr. Hackleman also persuaded the county's three health plans to provide more than \$180,000 to help fund the county's participation.

Demographics

San Mateo County's workforce is **66% female**, and **61%** of employees are over age **40**.

First-year results showed significant improvement in smoking cessation, stress reduction, nutrition, physical activity and control of cholesterol and blood pressure.

In the second year, Mr. Hackleman negotiated comparable funding from the health plans and obtained a grant for continuation of the program and its migration from a Stanford-offered program to an internal county program in its third year. Today, Susan Vana serves as the nurse coordinator of the program, which has 50 participants. Sixty-six previous participants have been discharged, having met their cardiovascular health goals.

Although the savings attributable to the Stanford program were not analyzed for the county's specific program, the analysis of the entire clinical trials program reflected a 40% reduction in hospital usage by all participants. An analysis of the program in 2004 showed an additional 4% reduction in total cholesterol, a 19.5% reduction in triglyc-

erides and an average weight loss of eight pounds among participants.

Also as part of its participation in Stanford University's Corporate Health Program, the county engaged in a community clinical trial called the Comprehensive Health Action and Management Program for five years, which resulted in a 44% reduction in health care claims for county employees who participated in the program.

The county's inaugural work with the Stanford Center for Research in Disease Prevention resulted in the county receiving an honorable mention in 1993 for the C. Everett Koop Award, named for the former U.S. surgeon general.

In addition to its collaboration with Stanford, San Mateo County in 2005 entered into a first-of-its-kind partnership with Kaiser Permanente Medical Group Inc. of Redwood City, Calif., to reduce the risk of heart attack and stroke in the county's high-risk plan membership.

Like the HEAR²T Program, Kaiser's Prevent Heart Attacks and Strokes EveryDay Program focused on education of participants to take charge of their cardiovascular risk management by improving medication, diet and exercise management, through both individual counseling and classes. But instead of focusing on individuals who had high cholesterol or hypertension, the PHASE program targeted individuals with co-morbidity factors, including diabetes and heart disease in combination, which put them at increased risk for heart attacks and strokes.

As part of the collaboration, the



PHOTO: JOANNE WOJCIK

Susan Vana is the nurse coordinator of San Mateo County, Calif.'s, HEAR²T program, which has 50 participants.

PHASE results

San Mateo County saw a **20% improvement in LDL cholesterol** and a **17% improvement in blood pressure** among all participants in the PHASE program.

county provided a registered nurse to assist with teaching the classes, and Kaiser provided two pharmacist care managers, administrative support, educational materials, physical space for classes and individual meetings with members, as well as mailing expenses.

Overall, there was a 20% improvement in LDL cholesterol and a

17% improvement in blood pressure among all participants in the PHASE program. In addition, by the end of the program, 80% of the participants with diabetes had good glycemic control, compared to 71% initially.

Another risk reduction program the county conducted in conjunction with Kaiser focuses on asthma management. The two-year project, which was conducted in 1995 and 1996, resulted in a reduction of sick leave by 17.6%, and utilization of the county's inpatient respiratory care dropped by 31.9%. Kaiser cited the success of this program as the primary reason for a 5% reduction in the county's premiums in the late 1990s.

Collaborative approach aids county in labor negotiations

Hackleman credits IFEBP, LBJ for diplomacy skills

By JOANNE WOJCIK

REDWOOD CITY, Calif.—By being both forthright and fair, Paul Hackleman has helped San Mateo County forge a harmonious relationship with its labor organizations at a time when many unions are at odds with employers.

He attributes his skills at diplomacy to a lasting impression left by two people: Bill Hembree, director of the Health Research Institute at the International Foundation of Employee Benefit Plans and the late President Lyndon B. Johnson.

The first or second year that Mr. Hackleman was in his current position, he attended a seminar given by Mr. Hembree on collaborative labor-management approaches to controlling health care costs.

"I just remember being so bowled over by him, and he just absolutely won me over in terms of believing that it was absolutely right to take a more collaborative approach," Mr. Hackleman recalled. "I'd say that's a pretty core value to this organiza-

tion. With collaboration you can get so much more accomplished."

He learned about LBJ's approach during a speech given by biographer Doris Kearns Goodwin.

"She said LBJ once said to her, 'Darlin', if you want 'em with you at the landing, you better have 'em with you at the takeoff,'" Mr. Hackleman said.

"That just so thoroughly stuck with me because, I think...that whenever you're going to introduce change, and especially the more significant that change is, you have to invest time up front with identifying who your stakeholders are, and you need to get (them) represented in your process.... And you need to rely on them to give you the perspective that they will give you if they are a good representative of their constituency or group, and that you then need to involve them throughout the process.

"In this health policy certification course that I teach for the International Foundation, I have this continuum: issue identification, in-

formation gathering, consideration of options, identifying strengths and weaknesses of options, express-

Paul Hackleman is "absolutely open and will tell both the upside and the downside. As a result, he's perceived as being very forthright, which goes a long way in collective bargaining."

**Keith Fleming
Industrial Employers
& Distributors Assn.**

ing preferences for a particular option and communicating that, implementing that, and so forth.

"If you just involve people at the tail end, when you've already ar-

rived at those conclusions, at some point, especially if you're challenged, you're going to have to go back and re-create that progress that you made to arrive at the end.... If you just involve them up front, and you have them go with you (through the continuum), they're there at the end. And what I've found out—whether it's miraculous or whether I'm just lucky—it seems that allows you to always get to a place where you can get a mutually agreeable outcome. You grow with it together, you see what the issues are, you see what the information is," Mr. Hackleman said.

To that end, in the mid-1980s, Mr. Hackleman formed a standing health care cost containment committee made up of representatives of both labor and management that goes through the decision-making continuum. In addition, subcommittees periodically are formed to address specific issues, such as proposals for funding retiree health benefits and meeting the new Government Accounting Standards Board requirements for recognizing retiree health care obligations.

"He's been very successful forging a partnership with the unions," said Keith Fleming, president of the Industrial Employers & Distributors Assn., an Emeryville, Calif.-based organization that negotiates with unions on behalf of employers and represents San Mateo County at the bargaining table.

"He's not only working for the county, but he's working for the best interests of the employees," Mr. Fleming said. "He's very informative, and he makes sure people understand the reason he's seeking to do what he's trying to accomplish. He's very fact-based and always comes with a lot of information."

Mr. Hackleman also is "patient and very committed to making sure the right approach is achieved," Mr. Fleming added.

Moreover, "he's absolutely open and will tell both the upside and the downside. As a result, he's perceived as being very forthright, which goes a long way in collective bargaining. A lot of people in this business try to hide the ball when the facts aren't good for them," Mr. Fleming said.



Between the Lines

Compiled by Joanne Wojcik

Best two out of three?

Two Florida lawyers will face off at 4 p.m. on June 30 in a game of "rock, paper, scissors" to resolve a disagreement over where to conduct a deposition in an insurance coverage case.

The unique "alternative dispute resolution" was ordered by a federal judge in Orlando after the two lawyers could not agree whether to hold the deposition in the insurance defense counsel's office or in a court reporter's office.

Matti Leshem, co-commissioner of the USA Rock Paper Scissors League, the Los Angeles-based governing body of the sport, has offered to officiate the match.

"The official position of the league is that if we're not officiating, then it's not valid," he said, adding that he is waiting to hear from either lawyer to make it an official event.

But policyholder attorney David Pettinato, who represents Avista Management, a property management company that sued its insurer, Wausau Underwriters Insurance Co., for bad faith by underpaying several property damage claims from the 2004 hurricane season, says he's taking the order very seriously. In fact, he has even been practicing with his daughters, ages 5 and 9, who now won't even agree to brush their teeth without first playing a match with him.

Lee Craig, the second lawyer in the case, did not respond to *Business Insurance's* request for comment.

Deeds overwhelm Knight's defense coverage

The irascible Bobby Knight, whose famous incendiary temper cost him his job as head basketball coach at Indiana University, has also lost a battle with his insurer to recover the cost of defending and settling a lawsuit filed by a former assistant.

The Marion Superior Court in Indianapolis ruled earlier this month that Mr. Knight's insurance policy from Indiana Insurance Co. excluded coverage for any bodily harm that is "expected or intended."



Coach Knight

"The evidence shows nothing less than an obviously deliberate and angry physical contact from Knight," Judge David Dreyer wrote in his decision, describing the 1999 incident with his assistant, Ron Felling, that led to the litigation. Mr. Felling sued Mr. Knight for assaulting him after an incident in which Mr. Felling claimed Mr. Knight threw him off a chair and punched him in the chest after overhearing his side of a phone conversation in which he had criticized Mr.

Knight's coaching methods.

Mr. Knight, who now coaches basketball at Texas Tech University, was fired from IU in 2000 after a video was leaked to the media showing Mr. Knight striking and gripping player Neil Reed by the throat.

Insurance industry skimps on respect

In the inverse of Rodney Dangerfield's famous claim, the insurance industry apparently gives no respect—to customers on the Internet.

In fact, the industry received the lowest score of 12 industries studied by the Ipswich, Mass.-based Customer Respect Group, an international research and consulting firm that evaluates how corporations treat their online customers. It assigns to individual companies and entire industries a Customer Respect Index rating ranging from 4.0 (poor) to 7.0 (excellent) using such metrics as how easy it is to use their Web sites, how willing they are to engage in one-on-one communication to answer users' questions and whether their Web sites can be trusted with personal data.

To calculate the insurance industry's CRI rating, the Customer Respect Group reviewed 52 companies in three different industry sectors: health, life and property/casualty. Overall, the insurance industry scored just 5.1 (below average) against an average of 5.7 for all 12 industries examined. Bringing down the industry's score were health plans, which scored just 4.8 (needs improvement). Property/casualty companies did the best, though still scoring a below-average 5.3, while life insurers received an equally disheartening 5.2.

Scores for all 12 industries studied can be viewed online at www.customerrespect.com.

Tips and feedback from readers are welcome. Please send information to wojcik@businessinsurance.com.

Analysis of health care liabilities helped county alter benefit plan

By JOANNE WOJCICK

REDWOOD CITY, Calif.—San Mateo County Benefits Manager Paul Hackleman arranged for an early analysis of the county's retiree health care liabilities so that he would be armed with that knowledge when negotiating benefit changes with organized labor.

"I didn't want to be in a situation where we were making changes without being very clear on both sides what the impact fiscally was," he said.

It will also help explore new strategies for retiree health care in the wake of upcoming retiree health accounting rules promulgated by the Government Accounting Standards Board, he pointed out.

"I think retiree health is a difficult problem to solve because you've got two competing objectives. You've got the employer objective to really make sure they've got their GASB costs under some kind of control so that they can manage that financially. But you've got retirees who are on fixed incomes for whom health care continues to outstrip, at a pace of about three-to-one, what the cost is for anything else," he said.

"And so you've got this constant erosion of the pension because of retiree health. So you put (retirees) in a difficult bind," particularly if the pension is their sole retirement

income, he said.

"When we did our GASB analysis, we broke it out to see how the cost played out for different union groups," he said. "When we were bargaining with any particular group, we wanted to be able to go back and pretty quickly calculate what the impact would be if there were any change to that benefit."

By the end of this month, Mr. Hackleman expects to receive from Milliman Inc., the actuarial consultant selected to perform the GASB analysis, a summary of the strengths and weaknesses of various options including a voluntary employees' beneficiary association, a Section 115 integral trust and health savings accounts.

HSAs haven't gotten much traction with public employers because few offer the high-deductible health plans that must complement them. This is because labor has been very protective of its members' benefits and has resisted the cost-shifting inherent in HSAs, he said.

He will take this information to the negotiating table in November when the county begins contract talks with the unions representing 55% to 60% of its workforce. These include: the American Federation of State, County & Municipal Employees; the Service Employees International Union; Building and Construction Trades; and the Western Council of Engineers. The county

has already settled with the sheriffs, probation and detention officers, nurses and extra help employees.

Fortunately, the county already has an element of a defined contribution approach to accruing funds for retiree health benefits. When employees retire, any unused sick time that has accrued over the course of their careers is converted into dollars and used to offset their contribution to the cost of their retiree medical benefits. County employees accumulate one day's sick leave for every month of work.

"It's pretty unusual to link unused sick leave to some form of a retirement benefit. But we wanted to use that to incent people to save sick leave," he said.

"For the vast majority of represented employees—70% of our workforce—it is a specified dollar amount. And for most of the individuals who are in that group, there are actually two tiers: If at the time of retirement an employee has remaining 45% or more of what they could have accumulated in sick leave, he or she will receive \$195 toward each month's premiums for retiree health care coverage. If, on the other hand, the employee has less than 45%, they receive \$165 toward each month's premium," Mr. Hackleman said.

"There's a higher payment for people who conserve more of their unused sick leave," he said.

Benefit Manager of the Year information

Business Insurance's Benefit Manager of the Year competition seeks to recognize excellence in employee benefits management. Any full-time employee of a corporation, nonprofit or government entity who handles benefits is eligible for the award. A nominee need not manage benefits as a sole responsibility but must be a full-time employee of the organization.

The winner is selected each year by an independent panel of judges who include representatives from

leading benefit consulting firms, brokerages, managed care companies and other benefit service providers. Judges score nominees on the basis of seven criteria, with the highest-scoring candidate named Benefit Manager of the Year.

For more information and nomination forms, please visit www.BusinessInsurance.com/BMOY or request forms from BI Editor Regis Coccia at rcoccia@businessinsurance.com.

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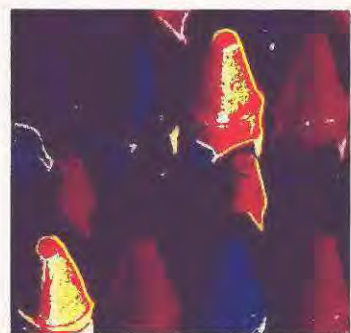
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U.K. seeks mesothelioma comp revisions

Plan may increase employers' asbestos-related claims

By SARAH VEYSEY

LONDON—U.K. employers could face a greater exposure to asbestos-related claims if the government succeeds in a legislative effort intended to reverse a recent court ruling on mesothelioma liability.

The Department for Constitutional Affairs, whose activities include improving the U.K. justice system, said last week that it would seek to change the law on how mesothelioma victims are compensated to introduce joint-and-several liability for such injuries.

Under the proposed change, in cases where a claimant had negligently been exposed to asbestos by more than one employer, a claimant could pursue damages against any of those companies, allowing him or her to seek full compensation from any former employer that remains solvent. Employers assigned liability could then attempt to recoup some of the compensation they have to pay from other negligent employers, though the government has not provided details on how that would work.

Such a change would effectively undo the House of Lords' recent decision in *Barker vs. Corus U.K. Ltd.*—a ruling that was welcomed by employers—in which the court ruled that liability of U.K. employers for compensation claims from employees who develop mesothelioma should be based on the length of time they negligently exposed the employees to asbestos.

The proposed legislative change was jointly announced by Lord Charles Falconer, who is secretary of state for constitutional affairs and lord chancellor, which involves presiding over the House of Lords; and John Hutton, secretary of state for the Department of Work and Pensions.

The government officials said the legislative effort was prompted by the House of Lords' ruling in the *Barker* case, which reduced the amount of compensation the widow of a mesothelioma victim was eligible to receive from one of the victim's former employers (*BI*, May 8).

"The government is acting quickly to help claimants suffering from

this terrible disease to receive the compensation to which they are entitled as soon as possible," Lord Falconer said in a statement. "I intend to bring forward an amendment to the Compensation Bill to provide that in these cases negligent employers should be jointly and severally liable, so that the claimant can recover full compensation from any relevant employer," he said.

The Compensation Bill, which currently is being debated by Parliament, would, among other things, provide a statutory framework for the regulation of claims management firms.

The *Barker* ruling clarified the so-called *Fairchild* ruling from 2002, which found that an employee is entitled to compensation when he or she has been exposed to asbestos by more than one employer but cannot prove which of those employers exposed him or her to the asbestos fiber that caused the disease (*BI*, July 1, 2002).

It is believed that mesothelioma,

See ASBESTOS / next page

Asbestos law history

May 2002

The House of Lords—the United Kingdom's highest court—ruled in the case of *Fairchild vs. Dovener, Waddingtons and Leeds City Council*, that an employee who has been negligently exposed to asbestos by two or more employers does not have to prove which of those employers caused his or her mesothelioma. Previously, an employee had to prove which period of exposure caused their disease. The court noted that mesothelioma can be caused by ingesting a single fiber of asbestos.

May 2006

The House of Lords ruled in the case of *Barker vs. Corus U.K. Ltd.* that compensation for mesothelioma claimants who have been exposed to asbestos by more than one employer should be proportionately shared between those employers. Periods of self-employment would be taken into account when allocating payments. The amount each employer would have to pay would be based upon the length of time they exposed the employee to asbestos.

Canada's tort shift may raise rates

Rulings going against insurers

By GLORIA GONZALEZ

LONDON, Ontario—Canadian insurers are facing a rapidly changing legal environment that may affect insurance rates.

Key changes in the Canadian legal system such as the expansion of the concept of bad faith, the increased potential for punitive and aggravated damages, and the development of class actions could impact the cost of liability insurance, according to a report written by three University of Western Ontario law professors, who were commissioned by the Insurance Bureau of Canada, the national trade association of the property/casualty insurance industry in Canada.

A key change in Canadian insurance law relates to developments that arguably expand an insurer's obligations under its policies and restrict its ability to deny claims. For example, the emergence of the concept of bad faith in handling claims is potentially problematic for insurers because court findings of bad faith have led to punitive and aggravated damage awards (see box, next page). Findings of bad faith can result in additional damages being awarded while the threat of punitive damages may induce insurers to settle some claims they would otherwise deny, ac-

ording to the report, "The Impact of Recent Legal Developments on Liability Insurance."

Cases in which punitive damages have been awarded against insurers for bad-faith claims handling have been relatively rare and the judicial system's approach to bad-faith claims and punitive damages has been balanced, the report found. In contrast, insurers are concerned about aggravated damages for wrongfully denied claims because it is not necessary for a court to determine that the insurer acted in bad faith in denying the claim before awarding such damages, the report said.

Some key developments in Canadian civil procedure are imitating concepts inherent in U.S. courts. For example, the development of class actions in Canada has exposed insurers to increased liabilities because they have broadened the scope for claims against insured defendants and claims by policyholders that challenge the way insurers do business, according to the report.

"That opens it up for insurers to have to pay more for those claims," said Stephen Pitel, an assistant professor of the Faculty of Law at the London, Ontario-based University of

See IBC / next page

Allianz, RSA to cut nearly 9,000 jobs

By SARAH VEYSEY

Two of Europe's largest insurance groups last week announced large-scale restructuring programs that will involve the elimination of many jobs.

Munich, Germany-based Allianz A.G. Holdings announced a swathe of job cuts in its German insurance and banking operations, as part of a major restructuring of those units.

Separately, London-based Royal & SunAlliance Insurance Group P.L.C. announced a cost-saving plan that will result in the elimination of about 1,500 jobs across various locations.

Allianz announced an overhaul of its banking division, Dresdner Bank A.G., and domestic personal lines insurance arm, Allianz Deutschland A.G., that is to eliminate some 7,480 jobs and is aimed at improving client service in Germany, the company said. Allianz said the planned moves are in line with its "3+One" modernization program—which was implemented in 2003 to reduce costs and set the company's future development—and they would be implemented by 2008.

As part of the new business model, administrative locations from which Allianz Deutschland operates are to be cut to 10 from the current 21.

Allianz said the planned reductions would affect about 5,000 of the 30,000 Allianz Deutschland workers, and about 2,480 of the 29,000 Dresdner Bank employees.

The company said the reorganization is expected to result in cost savings of €500 million to €600 million (\$631.1 million to \$757.4 million).

"For years Allianz has been losing

market share" in Germany and the reductions are intended to reverse the trend, Allianz said in a statement.

"These are painful but necessary steps to ensure a sustainable increase in Allianz's competitiveness," Gerhard Rupprecht, board chairman of Allianz Deutschland, said in the statement.

Allianz's commercial lines business in Germany likely will not be affected by the restructuring, said Lucio Di Geronimo, equity analyst at HypoVereinsbank in Munich.

"For commercial clients, I think that (Allianz's) structure already had been really efficient," Mr. Di Geronimo said. "Allianz was not losing any market share in industrial insurance or commercial insurance," he said.

Currently, the competitive pressure in Germany on large commercial lines business is less intense than for personal lines business, he noted.

Meanwhile, RSA also announced a restructuring program and the probable elimination of 1,500 jobs—1,000 of those in its home market in the United Kingdom.

The program is aimed at achieving annualized expense savings of £130 million (\$240.3 million) by mid-2008, the company said in a statement. RSA said the plan is designed to grow its business in the United Kingdom, Scandinavia and its international division, including Latin America and Canada.

The company will grow its positions in those markets in lines where it already has a significant market share, a spokesman said.

Rick Miller contributed to this report.

Updates

U.K. seeks comment on special-purpose rules

The U.K. insurance regulator is seeking public comment on proposals to ease rules governing insurance special-purpose vehicles set up in the United Kingdom. Under current rules, such vehicles—which typically are used for securitization deals—are regulated the same way as companies conducting traditional reinsurance business, according to the Financial Services Authority. The FSA said it proposed new rules under which authorization requirements for special-purpose vehicles would be relaxed to be "proportionate to the lower risks resulting from the structure" of ISPVs. The changes would be made as part of implementing the European Union reinsurance directive, with a likely December effective date.

Hardy to form second Lloyd's syndicate

Hardy Underwriting Group P.L.C. plans to set up a multiline Lloyd's of London syndicate to begin underwriting in 2007. Hardy, which already operates multiline syndicate 382, said the new nonmarine syndicate likely would have capacity of up to £75 million (\$138.0 million). Patrick Gage, currently the active underwriter of syndicate 1301, which is managed by Chaucer Syndicates Ltd., will become the active underwriter of Hardy's new syndicate. The move is subject to regulatory approval.

Odyssey Re sets up London casualty arm

Odyssey Re Holdings Corp. said it is setting up a London-based casualty insurance company. Stamford, Conn.-based Odyssey Re said it received FSA approval to set up Newline Insurance Co. Ltd. to write general liability, professional indemnity and directors and officers liability insurance in the United Kingdom and other European Union countries. A.M. Best Co. assigned a rating of A to Newline. Odyssey Re said Newline would replace the group's existing Lloyd's of London operation.

Swiss Re appoints former U.S. Fed official

Roger W. Ferguson Jr., a former vice chairman of the board of governors of the U.S. Federal Reserve, was named chairman of Swiss Re America Holding Corp. and made a member of Zurich-based Swiss Re's executive board. He will succeed Jacques Dubois, who will retire by the end of the year, Swiss Re said in a statement. Mr. Ferguson, who will be based in New York and Washington, also will become Swiss Re's financial market strategist, the reinsurer said.

IBC: Value of deductibles pose concerns to insurers

Continued from previous page

Western Ontario and one of the authors of the report. "There's a lot of upside room for further potential growth in class actions that could have implications for liability insurance," he said.

Insurers may also have to consider the value of deductibles in relation to class-action suits, which was called into question by a 1998 decision by the Ontario Court of Justice General Division in *Canadian Gas Assn. vs. Guardian Life Insurance Co. of Canada*. The association was a defendant in a class action involv-

ing a product liability claim and was insured under an errors and omissions policy with Guardian. The insurer accepted that the policy applied to the class-action claim but refused to defend, arguing the association's self-insured retention of \$25,000 applied to the claim of each individual member of the class. Guardian argued that because no individual claim would exceed the retention level, it had no exposure.

The court, however, ruled that the insurer was required to provide a defense to its policyholder and could be held responsible for

damages because the Ontario legislation governing class actions provided for the aggregate assessment of damages in certain circumstances rather than individual damages. The court, therefore, held that the retention was payable only once by the association with respect to the aggregation of the claims.

"That to me represents a significant possible concern that insurers might want to think about in terms of the effectiveness of their deductibles in the face of class actions," Mr. Pitel said.

Asbestos: Advocates anticipate clarification on amendment

Continued from previous page

an aggressive cancer, can be caused by exposure to a single fiber of asbestos and is not aggravated by continued exposure, the court noted in the *Fairchild* decision, while asbestosis, another asbestos-related disease, can be worsened by prolonged periods of exposure or other factors.

After the *Barker* ruling, worker advocates such as the London-based Trades Union Congress argued that claimants might end up getting less than 100% of the compensation awarded to them by the courts because some of their former employers might no longer be in existence.

While it is unclear what form the amendment to the Compensation Bill might take—and indeed, whether it will be adopted—imposing joint-and-several liability will make it more difficult for employers and their insurers to assess their potential exposures, noted Fiona Gill, a partner in the health and safety practice at London-based law firm Davies Arnold Cooper.

Any defendants still in existence at the time of a ruling "inevitably" will pay more under joint-and-several liability than they would if

compensation were allocated on a proportionate basis, said Rod Freeman, a partner in the product liability department of Lovells law firm in London.

The Assn. of British Insurers said it is "disappointed" with the proposed amendment which, it believes, "does not address the actual problem" of mesothelioma claimants not receiving compensation quickly enough, a spokesman said.

The London-based ABI will lobby the government on the form the amendment takes, he explained.

The London-based TUC welcomed the Department for Constitutional Affairs' announcement, and said in a statement that it looks forward to seeing the details of the proposed change.

It is not clear whether the implications of the *Barker* judgement and the proposed legislative change will affect other product liability claims that do not involve asbestos exposure, noted Mark Tyler, a partner at London-based law firm CMS Cameron McKenna L.L.P.

The impact could be wider, noted Lovells' Mr. Freeman, but it is likely that the amendment will be restricted to mesothelioma cases for the time being.

Tort rulings go against liability insurers in Canada

Several court rulings in Canada have developed or advanced important legal principles that may impact the pricing of insurance products:

• *Amaprop Canada Inc. vs. Guardian Insurance Co.* (2000), Ontario Superior Court of Justice, and *Ontario Inc. vs. Lloyd's London, Non-Marine Underwriters* (2000), Ontario Court of Appeal: Insurers must pay claims in a timely fashion if

there is no reason to contest the claims and must treat policyholders fairly throughout the process of investigating and assessing the claim and in deciding whether to pay.

• *Whiten vs. Pilot Insurance Co.* (2002), Supreme Court of Canada: A proportional approach should be used to assess the proper amount of punitive damages, which are intended to punish the insurer and deter it

and other insurers from repeating inappropriate conduct; and an insurer's failure to act in good faith is a separate, or independent, wrong rather than a mere breach of contract.

• *Fidler vs. Sun Life Assurance Co.* (2004), British Columbia Court of Appeal: Aggravated damages can be awarded in the absence of bad faith, merely on a finding that the claim had been wrongfully denied.

Source: "The Impact of Recent Legal Developments on Liability Insurance"

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NBGH award winners

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Novartis Pharmaceuticals
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SILVER

Blue Cross and Blue Shield
of Minnesota
The Boeing Co.
Campbell Soup Co.
CVS/pharmacy
Fiserv Inc.
General Mills
Massachusetts General Hospital
Quest Diagnostics
Target Corp.

Source: NBGH

NBGH: Empowering employees to lead healthy lifestyles

Continued from page 4

prove the health of your employees and their families," said Helen Darling, president of the Washington-based NBGH. "If you go back three years, people didn't begin statements with that."

Plan design and cost shifting, while important, will only go so far, she continued. If employees "are not willing to really work at becoming healthier as individuals...then you're not going to do anything about medical claim costs. They are just going to keep climbing."

The 33 award winners all recognize the connection between having a healthy workforce and employers' bottom lines, Ms. Darling said. When it comes to employer programs, "it's really the scale, the vision, the comprehensiveness and the integration that makes them different from just a collection of wellness benefits," she said.

Platinum award winner Aetna Inc., for example, launched its comprehensive incentive-based Healthy Lifestyles program in 2004 to complement its consumer-directed health care strategy, said Jane C. Hopkins, Aetna's director of benefits based in Hartford, Conn.

The program focuses on four areas: prevention, obesity, physical fitness and disease management. By registering and participating in the program, employees earn points, which translate into cash contributions from Aetna into a workers' health savings accounts or health reimbursement accounts, Ms. Hopkins said.

Most of Aetna's programs are worth \$20 to \$25 apiece, although employees do earn \$40 by completing a Weight Watchers course, Ms. Hopkins said.

Employees can earn up to \$600 a

year if they complete all of the offerings within the Healthy Lifestyles program, Ms. Hopkins said.

"What we're trying to do is to get the line of sight linked between change your behavior, do these things, get a reward and control your costs," she said. "And they get that."

On the prevention side, the number of flu shots that employees received in 2005 tripled vs. 2004, the number of mammograms doubled and the number of adult physicals doubled. "So we're getting the message out and people are doing it," Ms. Hopkins said.

With 7,600 employees registered in the program so far in 2006, Aetna is well on its way to reaching its goal of 10,000 by the end of the year, she said, noting that a big communications and marketing push every month helps advertise the program.

While the health insurer has yet to complete its three-year claims study into the return on investment from the program, she said she's confident that the plan will save the company money.

"I do believe if we continue to work this and continue to get peo-

ple to understand the behavior changes they need to make to stay healthy...we will have decreased costs," Ms. Hopkins said.

While Lyndhurst, N.J.-based Quest Diagnostics, an NBGH silver winner, also expects to see lower medical costs as a result of its recently launched HealthQuest initiative, it already has produced lower health care premiums for the company.

"We had over \$1 million knocked off our premium in 2006 just based on the design, the approach and leadership behind it," said Fred Williams, director of benefits and strategic alliances.

The drive behind HealthQuest is to motivate and empower employees to become more informed and proactive about their health, but the "magic" lies in the health promotion teams set up at each of Quest Diagnostic's 35 sites, he said. The teams support or initiate various efforts to improve physical fitness, weight and stress management, promote tobacco cessation and improve all onsite food offerings. Some 700 Quest Diagnostic employees have volunteered to be leaders or "champions" of these ef-

forts within the various health promotion teams, Mr. Williams said.

By leading by example and knowing firsthand how hard it is to quit smoking, for example, employees are helping fellow employees, he said. "It's the most beneficial thing we've done in a long time in terms of capturing the pride employees have in treating patients" and expanding that to treating each other as patients.

Another early goal of the initiative was to increase participation in the company's health risk assessment, Mr. Williams said. Offering employees \$10 off their health care premiums every two weeks for the entire year pushed participation from 11,000 to 29,000.

"Cash talks," Mr. Williams quipped.

"The savings will come out in the end, but in the meantime, if we can keep healthy people healthy or move at-risk people to a lower risk, we've done a good thing," he said.

More information about the Best Employers for Health Lifestyles awards, a complete list of the winners and a brief description of their programs is available at www.businessgrouphealth.org.

AWAC: Executive suspended over investigation

Continued from page 4

the insurer has led to the indefinite suspension of Chief Underwriting Officer Jordan M. Gantz, according to the SEC filing. Mr. Gantz, a former AIG officer, was one of AWAC's first four employees and was named chief underwriting officer last year, according to the insurer's Web site.

AWAC's SEC filing does not provide details of the reasons for Mr. Gantz's suspension or describe possible charges that could come out of the Texas attorney general's investigation.

Mr. Gantz and representatives of AWAC could not be reached for comment. The Texas attorney general's office declined to com-

ment.

AWAC was among 78 insurers and several brokers named in a lawsuit filed in April by corporate policyholders in federal court in Atlanta. The suit charges the defendants with participating in a scheme to drive up the cost of insurance by rigging bids and steering business to favored insurers.

COMINGS & GOINGS - INDUSTRY

Brokers:

Willis Group Holdings Ltd. has appointed **Kevin Downs** as leader of its North American health care practice in Chicago. Before his promotion, he was health care leader for the company's Midwest operations.

Chicago-based Aon Risk Services Americas has named **Alexander W. Vietor** as executive vp. Most recently, he was executive vp of Willis North America.

Roderick J. Hood has been named resident managing director of Aon Risk Services Minnesota, replacing Alan R. Diamond, who is retiring. Previously, Mr. Hood was senior vp and practice group leader for Aon's financial services group.

Integro Ltd. has appointed **Ruth Kilduff** as a managing principal, specializing in health care coverage, for the firm's New York office. Before joining Integro, she was a managing director of Marsh Inc.'s health care practice.

Also at Integro, **Timothy I. Rea** has been named Southeast marine

practice leader in the Atlanta office. Formerly, he was senior vp and Southeast marine practice leader for Marsh & McLennan Cos. Inc.

Insurers:

New York-based Zurich Global Energy has appointed **James Nawojchik** as senior vp, marine, replacing Roy Salley, who recently retired. Previously, Mr. Nawojchik was vp and chief operations officer for Zurich Global Energy's marine unit.

Managed care:

Patrick Boughey has been named Chicago-based president and general manager of CIGNA HealthCare's operations in Illinois, Indiana, Minnesota and Wisconsin. Before his promotion, he was senior sales leader.

Reinsurance:

Pembroke, Bermuda-based RenaissanceRe Holdings has named

Fred Donner executive vp and chief financial officer. He succeeds John Lummis, who is retiring.

Previously, Mr. Donner was senior audit partner and national insurance practice leader at KPMG L.L.P.

The Preferred Group has

named **Suzann B. Kemp** CFO.

Previously, she was reinsurance accounting manager and vp of the Columbia, S.C.-based reinsurance and insurance broker.

Aspen Insurance Holdings Ltd. in Hamilton,



Ms. Kemp



Mr. Boornazian

Bermuda, has appointed **Brian Boornazian** to the newly created position of head of reinsurance. He will retain his current position as president of Aspen Re America.

New York-based Guy Carpenter & Co. Inc. has made two senior-level appointments.

• **Brian Hanuschak** has been named managing director of the property and casualty treaty department in Norwalk, Conn. Previously, he was president of captive and property operations at Discover Re.

• **Brian Flynn** has been named managing director of the company's business development unit. Before joining Guy Carpenter, he was vp and treaty health care practice leader of General Re Corp.

Other providers:

Wellesley, Mass.-based Swerling Milton Winnick Public Insurance Adjusters has appointed **James Harlor** as a principal. Before his promotion, he was a building consultant.

Tressler, Soderstrom, Maloney & Priess has named **Joseph P. Monteleone** partner in the New York office. Formerly, he was a partner at Duane Morris L.L.P. Mr. Monteleone specializes in professional liability, errors and omissions, directors and officers, and employment practices liability.

Bloomington, Ill.-based Pinnacle Actuarial Resources Inc. has promoted **LeRoy Boison** and **Roosevelt Mosley** to principals. Previously, both were senior consulting actuaries.

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

Photos should be sent to: Kathy Barnes, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; kbarnes@businessinsurance.com.

Gen Re: Civil RICO charges dropped in ROA lawsuit

Continued from page 3

cutors in Richmond, Va., launched a criminal investigation.

Two former ROA executives—Kenneth R. Patterson, former president and chief executive officer, and Carolyn B. Hudgins, former executive vp—pleaded guilty last year to conspiracy to commit insurance fraud, and were sentenced to 12½ and five years in jail, respectively.

Virginia and Tennessee regulators, meanwhile, had launched civil RICO lawsuits against a wide range of defendants allegedly involved in the collapse. In addition to Mr. Patterson and Ms. Hudgins, defendants included John W. Crews, former ROA general counsel; Mr. Crews' Richmond-based law firm, Crews & Hancock; Judith A. Kelley, former executive vp of ROA; Gordon D. McLean, former ROA president; Gen Re, ROA's longtime reinsurer; and four Gen Re officials.

The suits charged that ROA officials conspired with Gen Re and others to disguise ROA's deteriorating financial state by doctoring reserve levels, recording false assets on ROA's books and entering into undisclosed side agreements under which reported reinsurance protection from Gen Re was "illusory."

Under ROA's corporate structure, the three Tennessee risk retention groups reinsured all of their business with ROA, which in turn ceded it to Gen Re. Starting in the 1990s, though, Gen Re acted only as a fronting company, retroceding all of the risk to First Virginia Reinsurance Ltd., a now-defunct Bermuda captive controlled by ROA officials.

As ROA's losses climbed—and as First Virginia Re continued to underfund claim trust accounts set up for Gen Re's benefit—Gen Re sought to reduce its exposure on the business. In 2000, it reached a deal with ROA that imposed an aggregate cap on its liabilities on business passed through to First Virginia Re under several in-force treaties. ROA received no considera-

tion for agreeing to the cap, and falsely reported to regulators that it had no such limitations in its treaties, the regulators' suits charged.

In 2002, Gen Re stopped assuming new business from ROA and commuted its treaties with First Virginia Re. In another unreported side deal, it imposed a new aggregate cap on liabilities from remaining in-force business, the suits alleged.

Gen Re and other defendants filed motions to dismiss the regulators' RICO charges soon after they were filed in late 2003, and Judge Breen this month granted the motions.

In dismissing the charges against Gen Re, Judge Breen found that the Virginia and Tennessee receivers failed to show that ROA itself relied to its detriment on false statements by Gen Re and its officials—a requirement of the RICO statute in the 6th Circuit U.S. Circuit Court of Appeals district, which includes Tennessee.

"At most, the complaint alleges that, had the regulators not been deceived by the Gen Re defendants and others as to the true financial status of (ROA), the regulators would have taken steps to prohibit (ROA) from incurring additional liabilities sooner than they ultimately did," the judge wrote.

Meeting requirements

While courts in several other federal circuits have similarly required RICO plaintiffs to show "detrimental reliance," others—notably the 1st U.S. Circuit Court of Appeals in Boston—have conversely found that RICO does not impose such a requirement, Judge Breen said.

In addition, some circuits that require a showing of reliance have allowed a so-called "target theory" exception, in which a plaintiff may simply show that it was the target of a fraud committed by a defendant against another party. Follow-

Rise and fall of ROA

1977: Reciprocal of America formed in Virginia as Virginia Hospital Insurance Reciprocal.

1984: ROA forms First Virginia Reinsurance Ltd. in Bermuda.

1990-1995: Three risk retention groups—Doctors Insurance Reciprocal, American National Lawyers Insurance Reciprocal and The Reciprocal Group—formed in Tennessee. They reinsure all their business with ROA.

1990s: General Re, already an ROA reinsurer, begins acting as a fronting company for ROA business ultimately ceded to First Virginia Re.

2000: General Re and ROA execute a side agreement imposing an aggregate cap on General Re liabilities on business it cedes to First Virginia Re. ROA does not report the side agreement in its statutory filings.

2002: General Re stops assuming new business from ROA and commutes its treaties with First Virginia Re. A second side agreement with ROA imposes a new aggregate cap on General Re's losses.

Source: Court documents

January 2003: Virginia regulators seize ROA, declaring it insolvent by more than \$209.6 million as of year-end 2002. Tennessee regulators take over the three risk retention groups. All of the companies, and First Virginia Re, later are ordered into liquidation.

November 2003: ROA's Virginia receiver files racketeering charges against General Re and others for allegedly concealing ROA's financial condition. The suit is later consolidated in a Memphis federal court with a similar suit by the risk retention groups' Tennessee receiver.

February 2005: Former ROA Chief Executive Officer Kenneth R. Patterson and former Executive Vp Carolyn B. Hudgins plead guilty to federal insurance fraud charges. They are sentenced later to 12½ and five years in jail, respectively.

June 2006: U.S. District Judge J. Daniel Breen dismisses the receivers' racketeering charges against General Re and several other defendants.

ing this theory, the ROA receivers suggested that ROA and the risk retention groups were damaged by Gen Re's fraudulent scheme to deceive regulators about ROA's financial condition, the judge noted.

The 6th Circuit, however, has not adopted the target theory, Judge Breen wrote in dismissing the RICO counts.

Virginia and Tennessee regulators also brought charges against Gen Re under state laws. Judge Breen dismissed the Virginia state-law

claims, declining to exercise jurisdiction in the absence of the federal RICO charges.

If his ruling stands, Virginia regulators could still pursue the charges in state court, lawyers familiar with the case say.

The judge said he would rule on the Tennessee state law claims later.

Meanwhile in separate opinions, Judge Breen similarly dismissed the receivers' RICO charges against Mr. Crews, Crews & Hancock, Ms. Kelley and Mr. McLean.

Antitrust: Exemption examined

Continued from page 3

eral charter. The bill was introduced in April, although no hearings on the matter have been scheduled.

"Since the McCarran-Ferguson Act only applies to the business of insurance regulated by the states, it obviously would not apply to pricing activities of federally chartered insurers operating under federal law," said Mr. Racicot. "Therefore, federal antitrust laws would apply to federally chartered insurers under S. 2509 to the extent that the states no longer regulate their activities."

He said AIA companies "are willing to take the risks inherent in this approach" to antitrust enforcement because they "so strongly believe that a competitive market, without government rate and price controls, is critical to being able to serve their customers in the years ahead," he said. He added, though, in his prepared testimony, that AIA does not believe "it is appropriate" to repeal McCarran-Ferguson "in the context of insurance pricing without initiating the paradigm shift that would result from S. 2509."

Sen. Specter repeatedly asked witnesses for more information and grew impatient and irritated when witnesses could not provide him with immediate answers. He asked for more information on such matters as where states failed to adequately pursue antitrust action and the specifics of New York's civil cases against insurers and brokers.

J. Robert Hunter, director of insurance for the Consumer Federation of America, and Donald C. Klawiter, chief of the American Bar Assn.'s antitrust law section, joined Ms. Hoffmann in testifying in favor of repealing the limited antitrust exemption.

Illinois Director of Insurance Michael McRaith, who spoke on behalf of the National Assn. of Insurance Commissioners, and Kevin Thompson, senior vp of the Insurance Services Office Inc., joined Mr. Racicot in defending the partial exemption under the current regulatory regime.

No further hearings on the matter have been scheduled.

Letters

Continued from page 8

they did to the insurers' and brokers' own surveys. Researchers of the Katie Insurance School at Illinois State University, who conducted two out of the three QIC quality surveys, said it was very surprising to them the number of calls or notes they received from risk managers wanting to be assured of anonymity for their answers before they completed the QIC survey.

The researchers received more of these comments and questions from risk managers than they did for any other survey they ran. Could it be that in the "private" voting booth, risk managers said what they really thought about brokers and insurers?

As broker and insurer representatives continued to question the data, and as risk managers were

doing nothing but continuing to complain about the lack of quality, the QIC was dissolved on a motion by a risk manager (Steve Wilder) and seconded by another risk manager (the undersigned) at a QIC executive committee meeting.

And here we are, seven years later and RIMS runs another quality survey. Finally, RIMS lived up to its promise to continue the scorecard to the two risk managers that started the process to end the QIC. And what do you know: the results of this survey are not much different than the previous two Quality Scorecards! And the response from RIMS and risk managers probably will be the same: do nothing (and maybe, this time, hope the regulators step in to help).

How can risk managers continue to complain about the quality pro-

vided by their suppliers, when just 9% have changed those suppliers in the past five years, according to the just-completed RIMS Quality Survey? And this in a period that saw regulators forcing brokers to finally come clean on contingent commissions and major problems on claim settlements resulting from the lack of policies issued before the 9/11 incident(s). The reason for that low rate of change should be the subject

of another article.

Maybe it is related to the different results of the brokers' and insurers' own surveys, compared to the results of the "anonymous" QIC Scorecard. Just maybe!

Henry Good
Bryn Mawr, Pa.

Editor's note: Mr. Good retired as director of insurance at Rohm & Haas Co. in 2005.

Write Us

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Bill: Surplus lines proposal would streamline regulation

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agers often have to prove that they have been declined multiple times by admitted insurers before they can tap the nonadmitted market.

The reinsurance portion of the bill would make a reinsurer's state of domicile the sole regulator of that reinsurance company's solvency, provided that the state is accredited by the National Assn. of Insurance Commissioners. All states, except New York, are currently accredited by the NAIC.

"As is evident, the differing state regulatory structure" impedes product development, said Rep. Richard Baker, R-La., the subcommittee's chairman and a co-sponsor of the bill. He added that the nonadmitted market has become increasingly important in providing coverage for the marketplace that has emerged since the terrorist attacks of Sept. 11, 2001. "Unfortunately, this last-resort market is—in my opinion—being hampered" by the state regulatory system that oversees the nonadmitted market, he said.

"I see every day numerous inefficiencies in the current" state-based regulatory system, said Ms. Ochenkowski, who is senior vp and director of global risk management for Chicago-based commercial real estate manager Jones Lang LaSalle Inc. She said there is confusion among agents and brokers placing surplus lines business because of differences among the states regarding premium tax allocation and remittance schedules.

"In some states, a broker or agent

Surplus lines bill

H.R. 5637, the Nonadmitted and Reinsurance Reform Act of 2006, would, among other things:

- Make the policyholder's home state solely responsible for regulation of nonadmitted insurance
- Make the policyholder's home state solely responsible for collecting premium taxes for nonadmitted insurance
- Create a streamlined application system for "exempt commercial insurance purchasers" to procure nonadmitted insurance
- Make the domiciliary state of a reinsurer the sole regulator of the reinsurer's solvency

calculates and sends taxes to the states as part of his transaction service on my behalf," said Ms. Ochenkowski. "In other states, the broker may calculate the tax due, but I must send it, while in a third type of state, I must calculate and send taxes."

E&S market applauds

The bill drew understandable plaudits from the surplus lines industry.

The measure "brings clarity and certainty to a system that is fundamentally flawed," Richard Bouhan, executive director of the Kansas City, Mo.-based National Assn. of

Professional Surplus Lines Offices Ltd., told the lawmakers. "This legislation is the right policy at the right time."

Bernd Heinze, executive director of King of Prussia, Pa.-based American Assn. of Managing General Agents, told the panel that the measure would achieve several goals. Among other things, the legislation would "enhance the speed to market of new and needed insurance products and services" and "establish and mandate a uniform, simple tax allocation formula and system for multistate risks, making the payment of proportionate tax more equitable and efficient," he said.

The reinsurance provision of the bill won praise from Frank Nutter, president of Washington-based Reinsurance Assn. of America.

Noting that reinsurance is a global marketplace, Mr. Nutter told the panel that "allowing the state of domicile of the reinsurance company to be the single regulator for solvency will help streamline reinsurance regulation significantly and will add much to the value of a U.S. license."

"Legislation in this area is long overdue," said Bob Bondi, managing principal of Aon Client Services in Chicago, during an interview after the hearing. "It has to not just be burdensome for brokers and brokers' clients but also for the states themselves. Most importantly, when you are spending so much money in terms of labor, in terms of time and in terms of effort in trying to remit taxes that are necessary to

collect, it's difficult for anyone to justify the cost of compliance, particularly for low-dollar payments," he said.

The bill stops short of creating a direct federal regulatory role such as would be created by legislation allowing insurers to seek federal rather than state charters. Such a move is supported by several insurance-related organizations, including RIMS. But advocates of an expanded federal role welcomed the surplus lines bill as a move in the right direction.

"Our preference continues to be an optional federal charter," said Melissa Shelk, vp-federal affairs for the Washington-based American Insurance Assn., during a brief interview after last week's hearing. "But this is a step that recognizes the problems involved in a state-based system."

Joel Wood, senior vp-government affairs at the Council of Insurance Agents & Brokers in Washington—which also supports the optional federal charter approach—said the bill would have no impact on that debate. He said, unlike other regulatory debates, the surplus lines debate doesn't involve duplication of state efforts.

"These are laws that cannot be reconciled and compliance is exceptionally difficult," said Mr. Wood. "The paperwork burden, the legal burden, the administrative hassle and the lack of coherency from state to state on surplus lines is a complete drag on the marketplace. Not only do we think this will save a lot of money and enhance compliance, we ultimately think that more premium taxes will be collected by the states and we think the surplus lines will be more vital as result of this. We think a lot of barriers will be removed."

Mr. Wood called the bill "absolutely" good news for buyers.

The president of an insurer trade group that strongly supports state regulation also said he believes that the surplus lines bill will have no impact on the optional federal charter debate.

"We're supportive" of the bill, said Ernie Csiszar, president of the Des Plaines, Ill.-based Property Casualty Insurers Assn. of America. He called the tax situation "a zoo" that demands a "national solution."

Mr. Csiszar said he prefers a broader solution to problems associated with state insurance regulation but added, "if you want to take it in pieces, this is not a bad piece to start."

Late News

Continued from page 1

Gerald Simons named president of the BII

The Bermuda Insurance Institute has named Gerald Simons as president for a two-year term. The former Bermuda cabinet minister and current president and chief executive officer of Bermuda-based Argus Group Holding Ltd. will be responsible for the strategic direction of the BII, the professional organization said in a statement.

Federal charter must include P/C: Senator

The co-sponsor of a bill that would allow insurers to choose to be chartered by the federal government rather than by state governments last week said he opposes any effort to limit federal charters to life insurers. While limiting federal charters to life insurers might be "easier" than including property/casualty insurance, Sen. John Sununu, R-N.H., said he would oppose any such effort. Sen. Sununu said that the U.S. Senate Banking, Housing and Urban Affairs Committee will hold hearings on his bill later this year.

CalPERS to increase HMO premiums

The California Public Employees' Retirement System last week adopted a health plan package that will increase its members' health maintenance organization premiums by an average of 11.6% for 2007. The CalPERS Board of Administration also approved a 12.61% premium increase for preferred provider networks and a 6.77% increase for Medicare PPO premiums. The board, however, declined to increase member copayments.

At BusinessInsurance.com

New Online Poll: Repealing the limited exemption from federal antitrust law provided under the McCarran-Ferguson Act would: lower insurance costs significantly, slightly, have no impact, increase costs slightly or increase costs significantly?

Emerging Risk Strategies

Business Insurance columnist John J. Hampton recently spoke with John Bayeux, executive vp and financial institutions industry practice leader at Willis Risk Solutions, and discussed Mr. Hampton's May 15 column in *Business Insurance*, which proposed dual positions of a chief strategy officer and non-financial chief risk officer. Mr. Bayeux has been keenly interested in enterprise risk management for some time and works with financial services clients in developing ERM programs.

To read Mr. Hampton's interview with Mr. Bayeux as well as prior columns and discussions, please visit www.BusinessInsurance.com/EmergingRiskStrategies.

BI Stock Index [6/19 - 6/23]

Up-to-the-minute data for all 85 companies that comprise the BI Stock Index can be found at www.businessinsurance.com

Percentage change of BI Stock Index vs. key indicators

BI Stock Index	
2796.62	-0.28
Dow Jones	
10989.09	-0.23
S&P 500	
1244.50	-0.56

Largest gains

NYMAGIC Inc.	5.62%
Humana Inc.	4.51%
Aetna Inc.	4.44%
Alleghany Corp.	4.07%
Aspen Insurance Holdings	3.54%

Largest losses

Fairfax Financial	-11.80%
Meadowbrook Insurance	-5.88%
American Safety	-5.48%
Philadelphia Consolidated	-5.08%
PMA Capital Corp.	-4.40%

Weekly change by market segment

Brokers	-1.16%
Insurers/Reinsurers	-1.13%
Managed Care Organizations	1.76%

Source: FinancialContent Inc. (<http://financialcontent.com>)



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Retaliation: Supreme Court ruling a blow for employers

Continued from page 1

panding the ability of plaintiffs to sue for retaliation, the ruling requires the HR department's decision-making to be more transparent in order to steer clear of lawsuits."

"Articulating and thoroughly documenting the basis for personnel decisions impacting employees with pre-existing (Equal Employment Opportunity Commission) charges is central to avoiding claims for retaliation," he added.

In the case, Sheila White, a forklift operator and the only woman working in the maintenance depart-

ment at the Tennessee yard of the Burlington Northern & Santa Fe Railway in Memphis, complained to company officials in 1997 of alleged sexual harassment by her supervisor. She later was reassigned to a different, more "arduous" track laborer position and then temporarily suspended without pay due to insubordination.

Ms. White sued BNSF in U.S. District Court in Memphis, claiming her job reassignment and pay suspension were retaliatory acts under Title VII.

A jury found in favor of Ms.

White, which a divided three-judge panel of the 6th U.S. Circuit Court of Appeals overturned. However, the full appeals court reversed the three-judge ruling and ruled the job reassignment and suspension were, indeed, adverse employment actions.

The Supreme Court last week upheld the appeals court ruling.

"Common sense suggests that one good way to discourage an employee such as (Ms.) White from bringing discrimination charges would be to insist that she spend more time performing the more arduous duties and less time perform-

ing those that are easier or more agreeable," Justice Stephen G. Breyer wrote in an 18-page opinion.

"To be sure, reassignment of job duties is not automatically actionable. Whether a particular reassignment is materially adverse depends upon the circumstances of the particular case and should be judged from the perspective of a reasonable person in the plaintiff's position," he wrote.

The court also determined that even though Ms. White was reinstated to her job after a 37-day suspension and received back pay,

"many reasonable employees would find a month without a paycheck to be a serious hardship."

The high court "went further to the left than many employees would have hoped," said Andy Scott, a partner in the Atlanta office of Fisher & Phillips L.L.P. "Employers were hoping (the Supreme Court) would adopt the standard that insulated them from liability to the greatest extent possible and they didn't do that."

A BNSF spokesman said only that the company was "disappointed" in the court's ruling.

Starr: Competition for public entity business benefiting policyholders

Continued from page 1

week sued AIG in Delaware's Court of Chancery to gain access to certain documents (see related story). Starr, which controls more than 300 million shares of AIG, filed its complaint as a shareholder. The suit claims that the documents may show that AIG mismanaged the \$1.64 billion settlement the insurer reached with New York Attorney General Eliot Spitzer and other officials in February.

But the courtroom is just one front in the struggle between AIG and its estranged former affiliate.

In the ongoing renewal competition against each other, AIG and C.V. Starr & Co. are pushing their prices down as each attempts to retain the pools, captives and other self-insured public entities that traditionally renew their coverage on July 1, several sources said.

In some cases, policyholders that initially were told they would receive flat renewal pricing are instead seeing discounts of up to 10%, said John Chino, area senior vp in Aliso Viejo, Calif., for Arthur J. Gallagher Risk Management Services Inc.

That is occurring in a market

where pricing has otherwise been creeping up gradually each year since 2001, Mr. Chino added.

"This is an unexpected bright spot in a public entity's renewal," Mr. Chino explained. "They weren't anticipating a 10% reduction in their liability program. They probably budgeted for a flat to small increase, so it's not dramatic, but it's better than what was expected."

The situation is adding a "bit of downward pressure" on pricing, said John Hayden, a regional partner in Columbus, Ohio, for Willis CAPS Pooling, a unit of Willis Group Holdings Ltd.

This competition is welcome, as the number of insurers providing coverage for public entities has steadily shrunk, Mr. Hayden said.

In some cases, public entity policyholders have a choice of only three major insurers, not including C.V. Starr or AIG, another broker said.

The separation of C.V. Starr & Co. from AIG creates an additional insurer from which policyholders can obtain a quote, Mr. Hayden said.

AIG in February announced the formation of AIG Specialty Access

to assume business previously handled by C.V. Starr & Co. Inc.

Mr. Hayden said there have been a couple of instances where other insurers lowered their public entity rates for pools to compete with the decreased pricing offered by AIG and C.V. Starr & Co. Generally, though, the additional pricing competition has remained between the two entities, he added.

William Weichold, president of C.V. Starr & Co. in San Francisco, said the agency provides very broad coverages to meet the needs of governmental agencies with the product and pricing customized for each client.

Sources also say C.V. Starr and AIG have eased their underwriting practices somewhat—though not drastically—by requiring less detailed submission information.

Agreeing that the situation is lowering pricing is the manager for a pool insuring municipalities that for several years has purchased excess and reinsurance policies provided by an AIG unit and underwritten by C.V. Starr.

Both C.V. Starr and AIG view that business as their renewal account, said the manager, who asked not to be identified because he is in nego-

tiations with both.

Their competition for his renewal business will prove beneficial, he added.

Because of past losses, the manager said he otherwise would expect to see his renewal rates climb. But he expects the competition between AIG and C.V. Starr "will beat down the price," and "the increases are not going to be what they would otherwise," he said.

To foster competition between the two for his account, the policyholder extended by several months his July 1 renewal date, he said. He did so after the "divorce" of C.V. Starr and AIG to ensure C.V. Starr would secure the insurer capacity needed to offer the coverage limits his large pool needs.

C.V. Starr announced in April that it had partnered with Liberty Corner, N.J.-based Everest National Insurance Co., a member of the Hamilton, Bermuda-based Everest Re Group, to write public entities and contractors. The deal offers \$10 million in underwriting capacity.

Who is incumbent?

While AIG and C.V. Starr vie for incumbent insurer status among

existing policyholders, the pool manager said he understands how they could both be considered incumbents.

AIG has provided his account the security of a stable insurer and paid his claims for years. Yet, like many savvy risk managers, he has formed a relationship with the underwriters at C.V. Starr.

"I tend to follow relationships when push comes to shove," he said. "So I might give a bit of an edge to C.V. Starr. But I think I could argue either side of it, really."

That is a common viewpoint among pool managers who regularly form bonds with their underwriters, brokers said.

Most clients have a neutral position on the issue, though they do ask for advice about which of the two entities deserves the courtesy often extended to the incumbent insurer, Gallagher's Mr. Chino said. He said he advises clients to look for distinctions in the arrangements the two entities are able to offer.

"This is a very strange situation, and both truly are still the incumbents and deserve the courtesy or business relationship that being an incumbent requires," he said.

SICO sues AIG for access to board documents

Starr International Co. is demanding American International Group Inc. documents needed to investigate whether AIG directors engaged in "mismanagement and/or improper transactions" related to the insurer's \$1.64 billion settlement reached in February with state and federal authorities.

In a lawsuit filed last week in Delaware's Court of Chancery, SICO seeks to force AIG to hand over minutes from board meetings, communications related to the meetings and other similar documentation.

SICO maintains in its lawsuit that as an AIG stockholder, it is entitled to the information under Delaware corporate law. The suit says that AIG refused to adequately reply to a shareholder demand letter seeking the information.

AIG and Starr International both declined to comment on the ongoing litigation.

SICO's lawsuit includes a copy of the demand letter, which cited an April 24 *Business Insurance* story about the settlement AIG reached with New York Attorney General Eliot Spitzer and federal regulators.

The April *BI* story reported that three states that AIG found eligible to receive a share of the \$1.64 billion settlement were questioning whether they deserved any of the money.

The AIG settlement calls for \$344 million of the \$1.64 billion to be distributed to states harmed by the insurer's alleged underpayment of workers compensation premium taxes and residual market assessments.

Three states listed in the settlement have monopoly workers compensation systems in which AIG has never been allowed to conduct business. The SICO lawsuit says that "by their own ad-

mission," the three states are not entitled to receive payments.

Starr International's demand letter also says that "other states have also expressed serious misgivings about the amount of workers compensation-related payments they are allocated under the settlement," according to the suit.

Those other states include Minnesota, which has already filed a suit against AIG; and Rhode Island, which is "considering administrative action against AIG," the lawsuit shows.

Also last week, a Delaware Chancery Court judge ruled that AIG shareholders can proceed with a lawsuit claiming that while at AIG, former chairman and CEO Maurice R. Greenberg operated Starr separately from the insurer to siphon money that should have remained with AIG.

—By Roberto Cenicerros

Starr, Chubb enter alliance MGA to write general aviation risks for insurer

ATLANTA—Starr Aviation Agency Inc. has entered into an agreement with Chubb Corp. to offer clients hull and liability and workers compensation coverages, the companies jointly announced last week.

Under the terms of their underwriting agreement, Warren, N.J.-based Chubb will provide hull and liability insurance to Starr Aviation's general aviation clients, as well as workers compensation coverage to its general and commercial aviation clients. Atlanta-based Starr Aviation is a unit of C.V. Starr & Co. Inc. of New York.

Among clients in the general aviation segment are: owners of corporate, private pleasure and small-business aircraft; municipalities that own aircraft; sightseeing and air taxi services; air-

craft service and maintenance firms; manufacturers of noncritical aircraft parts; and small regional airports.

Commercial airlines and manufacturers of airframes or critical aircraft parts are part of Starr Aviation's commercial aviation segment.

"This agreement provides Chubb with growth opportunities in the most attractive segment of the aviation insurance marketplace," Thomas F. Motamed, Chubb's vice chairman and chief operating officer, said in a statement.

In the statement, Starr Aviation President Steve Blakey noted that the partnership reflects the company's commitment to expand tailored products and services.

—By Rupal Parekh



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