

Business Insurance

March 13, 2006

www.businessinsurance.com

\$5

Late News

Spitzer reportedly nears more settlements

New York Attorney General Eliot Spitzer is reportedly in the late stages of talks with various U.S. and non-U.S. insurers and brokers to settle investigations related to contingent commissions and the misuse of finite insurance products. Late Friday, Reuters quoted an unnamed source as saying that the attorney general expects to begin announcing related settlements "in the next month or so." A spokesman for Mr. Spitzer would say only that "the office is seeking to resolve its ongoing investigations into bid rigging and finite reinsurance."

Aon expands layoff plans

Aon Corp. intends to lay off an additional 400 employees as part of its three-year restructuring plan, the Chicago-based brokerage said in a Securities and Exchange Commission filing. Aon said its restructuring initiatives are now expected to result in the elimination of approximately 1,800 positions by the end of 2007, up from its initial

See **LATE NEWS**/page 23

Inside



OUTSIDE TALENT

Lloyd's recruits new CEO from energy market.

PAGE 3

HSA SURGE

Large employers lead rise in enrollment.

PAGE 3

Public employers cut health benefits

Workers turn to aid programs as employee contributions rise

By **JOANNE WOJCIK**

While state lawmakers target private employers for not providing health care coverage, a similar issue may be brewing in many of their own backyards.

In addition to being taxed by having to provide public health assistance to a growing number of working poor, government budgets are also being squeezed by their own employees' escalating health care costs, forcing them to shift more of the expense onto those employees. Those employees, in some cases, then turn to public health programs.

For example, while Canton, Mass.-based Dunkin' Donuts Inc. may be No. 1 on the Massachusetts' Executive Office of Health and Human Services' list of employers with

50 or more employees using public health assistance, the city of Boston is not far behind, ranking sixth on the list.

In Texas, 15 of the 20 employers identified in the state's Health and Human Services Commission report of employers identified by individuals enrolling in the Children's Health Insurance Program, were public employers—mostly school districts.

How can it be that public employers, which once made up for paying low wages by offering comprehensive benefits, are now beginning to contribute to the nation's uninsured working population?

It's the same reason states are seeking reimbursement from pri-

See **UNINSURED** / page 22

GM retools pensions for salaried employees

Decision may drive others

By **JERRY GEISEL**

DETROIT—The decision by General Motors Corp. to phase out its traditional defined benefit pension plan for its salaried employees could set the stage for GM, other big automakers and other large, old-line manufacturers to try to do the same thing to the pension plans covering their union employees.

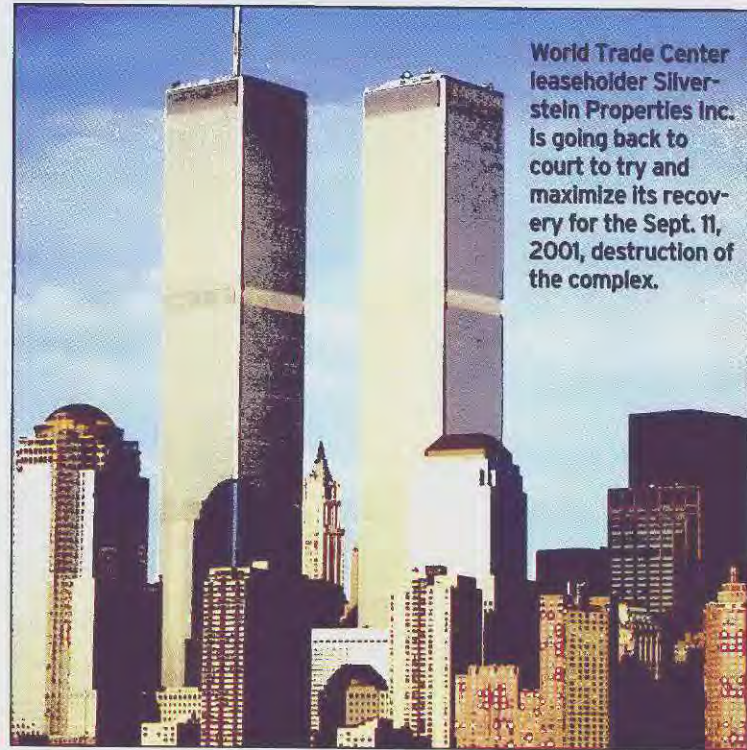
Last week, GM joined a long and growing list of employers that are moving away from defined benefit

plans. Those changes will affect about 42,000 GM salaried employees in the United States, as well as its future employees. Those changes, which go into effect Jan. 1, 2007, include:

- GM's salaried employees who were hired on or after Jan. 1, 2001, and who are covered in a cash balance plan will stop earning pay credits under the plan. Instead, GM will contribute an amount equal to 4% of each employee's base annual pay to a 401(k) plan. Employees, though, will continue to earn interest credits on their cash balance accounts.

- Salaried employees who were

See **PENSIONS** / page 22



World Trade Center leaseholder Silverstein Properties Inc. is going back to court to try and maximize its recovery for the Sept. 11, 2001, destruction of the complex.

WTC leaseholder renews court fight over coverage limit

By **DOUGLAS McLEOD**

NEW YORK—Silverstein Properties Inc. and several of its insurers last week asked a federal appeals court to overturn various portions of split-jury verdicts that awarded Silverstein up to \$4.68 billion for the Sept. 11, 2001, destruction of the World Trade Center.

A panel of the 2nd U.S. Circuit Court of Appeals heard arguments over a pair of 2004 verdicts in a two-phase trial in which Silverstein contended that the WTC loss represented two occurrences under its \$3.55 billion property program.

A jury in the first phase found that nearly half of the WTC leaseholder's two dozen property insurers were liable for only one occurrence limit. A separate jury in the second phase of the trial concluded that nine of the insurers were liable for two occurrences.

Silverstein is asking the appellate panel to rule that the insurers

in "Phase I" must also treat the twin towers' destruction as two events or that there should be a new trial of the coverage issues. The nine insurers that lost the Phase II verdict, meanwhile, argue that they also should be liable for only one occurrence limit in the case.

A ruling by the three-judge panel is expected sometime this summer.

Silverstein took control of the WTC complex under a 99-year lease signed only weeks before Al Qaeda terrorists piloted two hijacked jets into the towers, killing more than 2,700 people and wiping out a 16-acre swath of lower Manhattan.

The insurance dispute arose from the fact that no final policy had been issued at the time of the attack, despite Silverstein and broker Willis Group Holdings Ltd. having placed the coverage two months before.

See **SILVERSTEIN** / page 23



BENEFITS MANAGEMENT

HEALTH CARE COALITIONS

Coalitions grow into a national force; overview of coalitions around the country; pushing for quality care.

PAGE 9

To Subscribe Call

1-888-446-1422 in the U.S. or
1-313-446-0450 outside the U.S. or
go online to www.businessinsurance.com

AON

Focus

www.aon.com/focus

Companies considering an Rx coalition should determine whether it presents a comprehensive value proposition that is both qualitative and quantitative.

MARCH 13, 2006

Rx coalition purchasing can reduce plan cost and improve performance for employer and employee



Gerald Smith is a vice president of Aon Consulting's Coalition Purchasing Group, providing consulting expertise to benefits managers in the purchase and management support of group employee benefits. Gerald can be reached at gerald_r_smith@aon.com.

Benefits managers overseeing employee benefits plans face the challenges of rapidly rising health care costs and the increasing complexity of benefits programs. These professionals know that of the many factors contributing to a program's increased cost and intricacy, prescription drugs are particularly relevant, representing as much as 15 percent to 20 percent of a company's total health care spend.

In the mid-1990s, many organizations formed health care coalitions, strategic buying arrangements in which groups of major national employers came together to negotiate optimal terms, pricing and an arrangement better than any one company could achieve on its own. In recent years, prescription drug coalitions have emerged as initiatives that not only improve contract arrangements, pricing and terms, but can also result in a broad range of favorable outcomes for an organization, such as improved drug plan performance, stronger partnerships with Rx vendors, leading-edge features, better market leverage and enhanced customer service that results in improved employee satisfaction.

Prescription drug coalitions typically include a pharmacy benefits manager (PBM) who provides programs and services for its clients and the members of its prescription benefits plans, as well as for physicians and pharmacies for the members' use. A PBM offers various programs and services, including plan design, clinical and pharmacy management, physician services and Web-based services. However, while PBMs are a central component of many coalitions, it is critical to determine whether the PBM is adequately transparent to the employer and whether or not it represents the coalition members to the best of its abilities.

Companies considering a coalition should determine whether the coalition presents a comprehensive value proposition that is both quantitative and qualitative, and

superior to any existing negotiated contracts. Additionally, benefits managers should benchmark their current Rx plan arrangements against industry standards and explore key questions, such as how to optimize provisions and options for the company.

The significant results an organization can achieve through Rx coalition purchasing include reducing prescription drug-related expenditures, establishing best-in-class terms and conditions, incorporating innovative best practices into existing processes and creating information-sharing opportunities with other leading companies. Ultimately, the organization can realize its goal of reducing drug trend lines and improving plan performance with an Rx benefits program.

Additionally, while a coalition provides industry-leading features, terms and arrangements for employers, those features will change over time. Member organizations should establish best practices and information sharing to keep the coalition agile and aligned with its mission and strategy.

For organizations seeking to implement prescription drug coalition purchasing, an independent third-party advocate or partner can help manage the comprehensive nature of the coalition infrastructure and optimize its purchasing power. Independent advocates ensure that all the interests of the coalition members are represented. To establish and maintain a successful coalition, companies must sharpen their focus on issues and metrics that impact Rx plan performance, such as moving from brand drug use to greater use of generic or over-the-counter drugs, full transparency and disclosure, specialty drugs, Medicare Part D and clinical programs.

Go to www.aon.com/focus to receive "Aon Focus" by e-mail.

Putting employees in control of benefits increases participation, lowers plan costs

The trend of self-powered employee benefits is gaining more traction as companies require employees to take greater control of their health, financial and personal wealth benefits through self-education, monitoring and management. Employers who educate employees on why and how to control their benefits can achieve significant ROI, such as employees who understand changes in the employee-employer contract relating to benefits; increased participation in self-powered benefits, including 401(k) plans, health savings accounts and voluntary benefits; lower plan costs through increased consumerism; a healthier workforce; and reduced administrative burden with a less dependent workforce. To learn more, visit www.aon.com/focus.

All employers must understand and comply with new military leave rules

Although the Uniformed Services Employment and Reemployment Rights Act (USERRA) was enacted in 1994, the Department of Labor has recently issued final regulations interpreting the law, effective January 18, 2006. USERRA applies to all employers. The regulations provide guidance on the employment and benefits rights of reservists on active duty. Some critical areas covered include employee benefits for those on military leave and anti-discrimination rules regarding employees serving in the military. Importantly, health or pension plans will not be in conflict with applicable code requirements. For further insights and information, visit www.aon.com/focus.

"Is there really a way to control benefits costs while enhancing plan delivery and performance?"



Today's employers struggle to reduce benefits plan costs and improve performance while evaluating other options for their benefits strategies.

Aon's Coalition Purchasing Group has helped many of the nation's largest employers control benefits costs and improve plan quality and can help you in the same way—by using the buying leverage of millions of participants to grow your influence in the benefits marketplace.

With 500 offices and 47,000 professionals in the United States and abroad, Aon is one of the world's leading providers of risk management, insurance and reinsurance brokerage, and human capital consulting services.

+1-866.4AONNOW or www.aon.com

AON

Inside

Ohio Supreme Court ruling limits med mal damages

State's top court gives narrow ruling on liability in "wrongful birth" case.
Page 4

Greenberg wins access to AIG accounts report

AIG turns over internal report to former chief after court battle.
Page 4

Managed care companies post solid 2005 profits

Cost-control efforts help tame premium increases for policyholders.
Page 4

BI launches column on emerging risk strategies

A leading risk management thinker writes about issues in enterprise risk.
Page 19

Online poll - [3/6 - 3/10]

How effective are wellness programs in reducing health care costs and improving productivity at your organization?



Participate in BI's online polls at www.businessinsurance.com.

Departments

Advertiser Index	22
Business Resources	16
Commentary	16
International	17
Letters	8
Opinions	8
Products & Services	19
Professional MarketPlace	18
Ticker	23
Paul Winston	6
World Updates	17

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

Business Insurance (ISSN 0007-6864) Vol. 40, No. 11, is published weekly by Crain Communications Inc., 360 N. Michigan Ave., Chicago, Ill. 60601-3806. Periodicals postage is paid at Chicago and at additional mailing offices. POSTMASTER: Send address changes to Business Insurance Circulation Department, 1155 Gratiot Ave. Detroit, Mich. 48207-2912. \$5 a copy and \$97 a year in the U.S. \$130 in Canada and Mexico (includes GST). All other countries, \$230 a year (includes expedited air delivery). Canadian Post International Publications Mail Product (Canadian Distribution) Sales Agreement No. 40012850, GST No. 136760444, Canadian return address: 4960-2 Walker Road, Windsor, ON N9A6J3. Printed in U.S.A. Copyright © 2006 by Crain Communications Inc.

New Lloyd's chief set to lead reforms

Outsider brings background in electronic trading

By SARAH VEYSEY

LONDON—Lloyd's of London's appointment of former energy exchange head Richard Ward as its next chief executive officer will likely aid the Lloyd's market as it embarks on a three-year modernization effort, market observers say.

Mr. Ward, who will take up the post next month, succeeds Nick Prettejohn, who left Lloyd's in January to become chief executive of the U.K. insurance operations of Prudential P.L.C. Luke Savage, Lloyd's director of finance and risk management, has been acting as the market's interim chief executive.

Mr. Ward currently is vice chairman of the ICE Futures arm of Intercontinental Exchange Inc. and previously was CEO of the International Petroleum Exchange, which was rebranded as ICE when it listed on



Mr. Ward

the New York Stock Exchange in November 2005.

During Mr. Ward's tenure, ICE, formerly an open-outcry—or nonautomated—energy futures exchange, became fully electronic in 2005. In addition, he had senior roles at financial and commodity brokerage Tradition Financial Services, as well as at oil company BP P.L.C.

Mr. Ward joins Lloyd's at a time when the market is implementing a three-year strategic plan aimed at helping it remain competitive, setting out performance standards for businesses in the market and reducing the cost of doing business at Lloyd's, among other changes (BI, Jan. 23).

"I am delighted that Richard has agreed to join Lloyd's at such a critical time for the market. Lloyd's

See LLOYD'S / page 20

HSA enrollment leaps as plan options grow

By JERRY GEISEL

Employer adoption of health savings accounts linked to high-deductible health insurance plans is fueling much of the growth in the HSA market, a survey shows.

The survey, conducted by the Washington-based trade association America's Health Insurance Plans and released last week, found that as of January, more than 3 million people were enrolled in HSA-linked high-deductible plans, up from just over 1 million in March 2005. The survey results reflect the responses of 96 AHIP members that comprise nearly all health insurers offering the arrangements.

While enrollment leaped in all three market segments studied—employers with more than 50 employees, those with 50 or fewer employees, and the individual market—HSA growth was greatest among employers with more than 50 employees.

As of January, 679,000 people were enrolled in HSA products offered by employers with more than 50 employees, which AHIP defines as the large employer market, up roughly 320% from March 2005.

During that same six-month period, HSA enrollment in the small group market—businesses with 50 or fewer employees—climbed to 510,000, up nearly 250%, AHIP found. In the individual market, enrollment swelled to 855,000, up 53.8%.

"These are very significant increases," said AHIP President and CEO Karen Ignagni.

While HSAs, authorized by Congress under a 2003 law, have been available since Jan. 1, 2004, many employers waited to offer the plans until the Treasury Department issued guidance in August 2004 that resolved many of the operational concerns that had been raised

about HSAs, Ms. Ignagni said. Additionally, employers have needed time to design and produce communications and enrollment materials before they could offer a new health care plan. As a result, many larger employers waited until this January to begin offering HSAs.

Amid sharp enrollment gains, the percentage of HSA enrollees who receive coverage from larger employers is increasing.

For example, as of January 2006, 33% of the nearly 3.2 million people enrolled in HSAs received coverage from employers with more than 50 employees, up sharply from 19% in March 2005, and just 3% in September 2004. By contrast, in January 2006, 42% of enrollees received coverage through the individual market, down from 64% in March 2005 and 79% in September 2004.

Certainly, the lower cost of HSA-linked high-deductible plans is attracting purchasers. The AHIP survey found that the annual premium on their best-selling HSA-linked plan offered to larger employers averaged \$6,715 for family coverage. By contrast, a Kaiser Family Foundation survey found that last year, the average annual premium for family coverage through preferred provider organizations linked to plans with more traditional cost-sharing requirements averaged just over \$11,000. The premium costs of the HSA-linked plans do not, however, include any contributions made by employers to the HSA itself.

The reason for the sharply lower premium cost of an HSA-linked insurance policy is obvious: Employees, through big deductibles, are taking on much more liability compared with those in more traditional plans. For example, the AHIP survey

Mandatory marine coverage?

Under legislation proposed by New York Gov. George E. Pataki, public vessels operating on state waters would be required to buy marine and indemnity insurance as follows:

PHOTO: LANDOV



The 2005 capsizing of tour boat *Ethan Allen* triggered reforms.

Source: New York State Governor's Office

No. of passengers	Minimum insurance limit
1 to 10	\$1 million
11 to 20	\$2 million
21 to 50	\$5 million
51 to 100	\$7 million
More than 100	\$10 million

N.Y. boat operators face coverage law

By RUPAL PAREKH

ALBANY, N.Y.—Commercial boat operators in New York may be compelled to buy marine liability coverage, under legislation being considered in the state.

New York lawmakers this month announced competing plans for commercial boat insurance reform—moves which stem from the October 2005 capsizing of the *Ethan Allen* tour boat on Lake George, which killed 20 passengers, and for which there was allegedly inadequate liability coverage.

The boat's owner, Lake George, N.Y.-based Shoreline Cruises Inc., and at least one of its insurers, Global Property Owners Assn., are being investigated by the New York state insurance department. Calls to Shoreline seeking comment were not returned.

New York law does not require liability insurance for public vessels operating on the state's waterways—nor are those carrying such coverage subject to review of those policies. Public vessels are defined as any vessel operated for commercial purposes on navigable waters of the state.

A bill introduced last week by

New York Assemblyman Peter Grannis calls for minimum standards of liability insurance for public vessels to be set at the discretion of the state superintendent of insurance. "The bill is aimed at all commercial boat operators who would not otherwise secure their own liability coverage," a spokesman for Mr. Grannis said.

Additionally, the bill seeks to require state insurance department approval of marine liability policies, and would prevent public vessels from obtaining an inspection certificate without proof of liability security.

Meanwhile, Gov. George E. Pataki proposed similar legislation this month that aims to establish liability insurance limits for public vessels based upon numbers of passengers (see chart). Mr. Pataki's proposed rules further contain requirements for added safety measures, including making it unlawful to operate a public vessel with less than the required crew. Currently, The New York State Office of Parks, Recreation & Historic Preservation is the regulatory agency that oversees commercial public vessels and it

See BOATING / page 6

See AHIP / page 6

Ohio court limits relief for fetal testing error

Compensation denied for costs of raising disabled child

By JUDY GREENWALD

COLUMBUS, Ohio—An Ohio Supreme Court's decision in a so-called "wrongful birth" case that limits damages to the cost of pregnancy and birth expenses, finds liability on much narrower grounds than have several other state courts that have addressed the issue.

In its March 3 decision in *Schirmer vs. Mt. Auburn*, the high court ruled that when a disabled child is born following negligent genetic testing, the medical providers involved should not have to compensate the parents for the

economic costs of raising the child or pay noneconomic damages.

Observers say other courts have held in similar medical malpractice cases that health care providers are at least liable for the economic costs associated with raising disabled children until they reach 18 or 21. Some have also awarded associated noneconomic damages, including the emotional and physical tolls involved, say observers.

The narrow approach taken by the Ohio Supreme Court in its 4-3 opinion may reflect its reluctance to tackle the politically volatile issue of "wrongful life," according to



observers.

According to the opinion, pre-pregnancy testing had indicated

that Helen Schirmer had a chromosomal condition that put her at risk of bearing children with serious birth defects.

After she became pregnant, Ms. Schirmer underwent genetic testing, and was told the child was a female who would develop normally. But in 1997 she gave birth to a boy, Matthew Schirmer, with an inherited, structurally abnormal, extra chromosome. He remains unable to speak, stand or crawl independently or to feed, bathe or use the bathroom himself, according to court papers.

Ms. Schirmer and her husband say the genetic testing may have erroneously sampled Ms. Schirmer's tissue rather than that of the fetus.

They claim they would have terminated the pregnancy had they been given accurate information about the child's genetic abnormality.

The court's majority opinion says that while the Schirmers can recover for Ms. Schirmer's pregnancy and birth costs, the couple cannot recover either the economic or noneconomic costs of raising a disabled child. The decision partially overturns an appellate court decision that said the Schirmers could recover the actual economic costs of the child's care.

There "was no tort committed here that resulted in the damages to Matthew's genes," says the deci-

See MED MAL / page 20

Greenberg obtains AIG internal report

By RUPAL PAREKH

NEW YORK—After a series of courtroom battles, American International Group Inc. has turned over an internal AIG report to its former chairman and chief executive officer, Maurice R. Greenberg.

Mr. Greenberg and his attorneys obtained the nearly 170-page report analyzing the insurer's accounting problems that was prepared by AIG's lawyers and auditor—on March 6, a spokeswoman for Mr. Greenberg said.

For months, Mr. Greenberg has been trying to gain access to the document to bolster the former AIG executive's defense against civil fraud charges filed by New York Attorney General Eliot Spitzer and the New York state Insurance Department. The regulators last May accused Mr. Greenberg—who resigned from AIG nearly one year ago amid mounting probes into AIG—along with former AIG Chief Financial Officer Howard I. Smith, of regularly engaging in phony transactions to artificially inflate AIG's earnings.

AIG had sought to keep the investigative report private, though its efforts were twice thwarted by the New York state Supreme Court and a New York state appeals court, which ordered AIG to hand over the report no later than March 6.

The U.S. Department of Justice also moved to halt the release of the report, arguing that making it available to Mr. Greenberg and his legal team could undermine the government's criminal probe of three for-

mer General Re Corp. executives and one former AIG officer—who have pleaded not guilty to conspiracy to commit fraud charges and will face trial in May.

"That investigative report contains the substance of interviews that AIG's attorneys conducted during their internal investigation," Michael S. Dry, an attorney with the U.S. attorney's office in the

Eastern District of Virginia, argued in court earlier this month, according to court papers. "Basically, what the criminal prosecution will face is civil discovery of their trial witnesses before trial, which is in direct contravention with the federal rules of criminal procedure," the court papers say.

Following the federal prosecutor's arguments, New York state Supreme Court Justice Charles E. Ramos agreed to reconsider his earlier decision and postponed a hearing on Mr. Dry's request until March 13. But after Justice Ramos' motion for a stay expired, AIG was forced to release the report, a source familiar with the matter said.

A spokeswoman for Mr. Greenberg would not comment on the contents of the report, whether the version obtained omitted any portions or whether he was forced to sign a confidentiality agreement.

An AIG spokesman declined to comment. AIG, which was also named in Mr. Spitzer's lawsuit, resolved charges against it by agreeing to pay a \$1.64 billion settlement and to reform certain business practices.



Mr. Greenberg

Errors & omissions

• A March 6 story on Dublin's captive market incorrectly listed the minimum guaranty funds required

of reinsurance captives. Such captives must post 1 million euros (\$1.2 million).

Tort reform advocates criticize proposal to criminalize defects

By MARK A. HOFMANN

WASHINGTON—A proposal to impose criminal sanctions on executives whose companies make defective products is drawing a mixed reaction.

U.S. Senate Judiciary Committee Chairman Arlen Specter, R-Pa., has prepared draft language of a bill that would impose a prison term of up to 15 years for an individual who knows that a product is defective yet introduces it into interstate commerce, resulting in a death related to the product.

According to the undated draft, such terms could also be imposed on "any person who has authority to introduce a product into interstate commerce, withdraw or recall a product...or otherwise has authority for the manufacturing, assembly, importing or sale of a product" and who knows of the dangers of a product but does not disclose these dangers to the appropriate



Sen. Specter

regulator when a product results in the death of a consumer.

But some witnesses who testified at a March 10 Judiciary Committee hearing questioned whether criminalizing a matter already dealt with in the civil system is sound public policy.

John Engler, president of the Washington-based National Assn. of Manufacturers, said that while the proposal

See PRODUCTS / page 23

Moderating pharmacy cost trends help boost managed care earnings

By GLORIA GONZALEZ

Managed care companies reported solid earnings growth in 2005 as commercial health care costs were kept in check by the implementation of a range of cost-control efforts.

As a result of those efforts, commercial policyholders have seen cost trend increases settle in the 7% to 9% range, which, while still higher than general inflation, is substantially lower than the increases of the past several years.

Moderation in pricing was apparent at WellPoint Inc., the largest managed care organization in terms of membership, which said its medical cost trend was less than 8.5% for 2005—compared to just under 10% in 2004—with pricing slightly above that figure. The Indianapolis-based managed care company said it expects its cost trend in 2006 to be just under 8%, driven by factors such as new benefit designs and successful care management programs.

Aetna Inc. said its commercial

risk medical cost trend for 2005 was at the low end of an 8% to 8.5% range, in large part due to its medical management efforts. The company said it expects its medical cost trend to remain stable at approximately 8% in 2006. "Our pricing discipline is unchanged,"

with commercial premium increases expected to be in line with cost trends, Ron Williams said during Aetna's recent earnings conference call. Mr. Williams recently was appointed chief executive offi-

See RESULTS / page 20

Cost-control efforts pay off

Managed care companies ranked by net income. Dollar figures in millions.

Company	Net income 2005	% increase (decrease)	Revenues 2005	% increase (decrease)
UnitedHealth Group ¹	\$3,300.0	28.0%	\$45,400.0	22.0%
WellPoint Inc. ²	2,500.0	156.6	45,100.0	116.8
Aetna Inc.	1,630.0	(28.0)	22,500.0	13.0
CIGNA Corp.	1,625.0	11.5	16,600.0	(8.2)
Kaiser Permanente	1,000.0	(37.5)	31,100.0	10.0
Coventry Health Care Inc. ³	501.0	32.8	6,600.0	19.7
Humana Inc.	308.0	9.1	14,418.0	9.1
Health Net Inc. ⁴	229.8	NM	12,000.0	2.5

¹ Figures include results from the acquisition of PacificCare Health Systems Inc. as of Dec. 20, 2005, the date the transaction closed. ² Figures do not include results from WellChoice Inc. operations, which merged with WellPoint on Dec. 31, 2005. ³ Figures include results from Coventry's First Health Inc. acquisition as of Jan. 28, 2005, the date the transaction closed. ⁴ Net income comparison to prior-year period not meaningful because Health Net posted net income of \$42.6 million in 2004. Source: Company reports



THE XL INSURANCE COMPANIES are chosen by the world's leading firms not only for the strength of our capital and the depth of our experience, but also for the quality and variety of our products:

PROPERTY

Global All Risk Property Damage & Business Interruption | Energy & Construction All Risk | Fine Art | Cash In Transit

CASUALTY

Primary Liability | Global Public & Products Liability | Automobile Liability | Umbrella & Excess Liability

PROFESSIONAL

Directors & Officers | Employment Practices Liability | Errors & Omissions

SPECIALTY

Aviation & Space | Environmental Liability | Equine | Marine & Marine Cargo | Programs

Ultimately, it is the dedication of our people creating tailored solutions and services to meet your individual insurance requirements. If you expect more, visit: www.xlinsurance.com or call us toll-free: 800-609-2518.

The XL Insurance companies have one or more of the following ratings:

A+ by A.M. Best

AA- by Standard & Poor's

Aa3 by Moody's

The fundamental strength to deliver customized insurance solutions.

XL INSURANCE
FUNDAMENTAL STRENGTH – CAPITAL AND PEOPLE

"XL Insurance" is a registered trademark of XL Capital Ltd. XL Insurance is the global brand used by member insurers of the XL Capital Ltd group of companies. In the US, the XL Insurance companies are: Greenwich Insurance Company, Indian Harbor Insurance Company, XL Insurance America, Inc., XL Insurance Company of New York Inc., XL Select Insurance Company, and XL Specialty Insurance Company. Not all of the insurers listed above do business in all jurisdictions, nor is coverage available in all jurisdictions.

AHIP: HSA enrollment leaps at large employers

Continued from page 3

found that the annual deductible for individual coverage imposed in insurers' best-selling policies in the large-group market averaged \$1,754. That is roughly five to six times higher than typical deductibles for more traditional plans.

The survey also found that 44% of HSA enrollees in plans offered by employers with 50 or more workers were age 40 or older. That contradicts earlier widespread predictions in the health policy community that HSA enrollment would be overwhelmingly concentrated among individuals in their 20s and 30s, Ms. Ignagni said.

Copies of the survey results are available at www.ahip.org.

Enrollment increases

HSA enrollment in the employer market takes off



Source: America's Health Insurance Plans

Boats: Mandatory insurance coverage proposed

Continued from page 3

would be overseeing compliance to this proposal as well.

If state law is amended to mandate liability coverage for commercial boats, "it can be an opportunity for the insurance industry," said Rich DeSimone, president of the ocean marine unit at St. Paul Travelers Cos. Inc. in New York, though many of the larger or more sophisticated owners likely already carry such insurance, and those who do not may have a tougher time trying to secure coverage, he said.

Richard Deegan, president of Grand Island, N.Y.-based Grand Lady Cruises Inc. and president of the New York Tour Boat Assn.—a trade group for commercial tour boat operators, with about 35 member companies around the state—said that while the association supports the idea of mandatory liability insurance for public vessels, it opposes the legislation that has been announced by Messrs. Grannis and Pataki. "The governor's proposed legislation we do not like at all in reference to the insurance

limit requirements, and Assemblyman Grannis' we don't like because he leaves the limits up to the superintendent," Mr. Deegan said.

According to Mr. Deegan, the level of limits required under the proposed laws could be "devastating" to the boat industry.

"My premium would more than triple under the governor's proposal where I'd be required to carry over \$10 million of coverage," he said. "The increased cost would probably put some of us operators out of business, myself included."



PAUL WINSTON

Editorial Director

Curbing the threat of wild spring break

As I write this, only 10 more days, four hours, nine minutes and 57 seconds remain until the first day of spring arrives. And only 15 days, 12 hours, eight minutes and 46 seconds until my spring vacation officially begins (but who's counting).

This is the time of year when schools in the United States, primary through college, release students, teachers and parents from the rigors of academic life for a week. It's a much-needed vacation to recharge batteries before that last push to the finish line, the end of the school year. It is a week in which to gently nag children to apply sunscreen, rather than harass them to start their homework before 11 p.m. It is a week to think about the office in only abstract terms, like that faraway place where my e-mail is accumulating (unless I cheat and log on during vacation) faster than sunburned body parts.

Each spring, we take advantage of my in-laws' decision to retire to Florida to visit them on the beach before hurricane season commences. We've been doing this for 15 years now, the last 13 with our daughters. Soon, I know, we'll be lucky if our daughters still enjoy vacationing with us. It's getting to the point where it's not cool any more, but for now they don't have a choice.

Eventually, I expect spring vacation will become less a vacation and more a tension-filled battle of the wills and generations. And the day will come, too soon for my wallet, when my daughters will be off to college and spring break will take on new meaning for them when they must make their own choices.

A new study of spring break behaviors by the American Medical Assn. has me reaching for the antacids a few years early.

The AMA study of 644 women enrolled in U.S. colleges finds that for a majority, spring break is a booze- and sex-filled binge, putting their health and wellbeing at severe risk. The AMA found that 83% reported more, or heavier, drinking on spring break, compared with drinking when on campus (which is really saying something), and 74% said spring break was accompanied by increased sexual activity.

Nearly three-quarters of the respondents said women use drinking as an excuse for "outrageous

behavior" on spring break, such as public nudity, dancing on tables and bars and competing in drinking contests. And 57% said that being promiscuous is a way to fit in with the crowd. Sex with strangers, sometimes not consensual, is a common theme.

The survey goes on and on, and it doesn't get any prettier. You can see it for yourself at www.ama-assn.org/ama/pub/category/16083.html.

The AMA is concerned because of the health risks associated with this pervasive behavior, including blackouts, sexually transmitted diseases and violence. The study is part of a larger AMA effort to reduce high-risk drinking on campuses in general.

As greater attention is focused on the risks of wild spring break behavior—either due to this study, or if something tragic should occur to a student or students on holiday—no doubt some will call for litigation to curb this threat to our daughters. Entities that are seen to encourage spring break excesses and profit from it—such as hotel chains, restaurants and bars, travel firms, breweries and distilleries and media and entertainment companies—could be hit with claims. So, too, could others with a less active link to college spring break, such as college and university officials and state and local officials.

While those entities may bear some limited culpability for enabling this behavior, in most cases it is not their negligence that causes it and it would be silly to hold them liable. Rather, it's more often these kids' own poor choices to succumb to mindless peer pressure that causes them to embrace stupid and destructive behavior on spring break.

As a parent, the best risk management I can adopt will be to educate my daughters to make better choices for themselves—at all times, not just on spring break. Easier said than done, I know, but if I can instill plenty of self-esteem in them, there's a better chance they will make smart decisions in their best interests, rather than engaging in idiotic and risky activities to impress the herd.

Including time already spent, I figure I have five years, give or take a few days, hours and minutes, in which to accomplish this before their first spring break on their own.

Editorial Director Paul Winston's commentary appears fortnightly. He can be reached at pwinston@businessinsurance.com

"By understanding how we make our money,
Dempsey, Myers made an intangible – the loss of revenue – tangible."

KEEP IT REAL



Dempsey, Myers & Company LLP
WE KNOW WHAT'S ON THE LINE.

Visit dempseymyers.com or call 800.762.5052.

YOUR PROJECT SPANS
TWO OCEANS, FIVE TIME ZONES,
EIGHT BORDERS AND THREE
LANGUAGES.

FORTUNATELY, YOU CAN BEGIN
BY MAKING ONE PHONE CALL.

FROM COMPLEXITY TO CLARITY

A MILLIMAN GLOBAL FIRM



Milliman
Consultants and Actuaries

www.milliman.com
Offices in principal cities worldwide

employee benefits | health | life insurance & financial services | property & casualty

Editorial

RRG problems averted

IF RISK MANAGERS NEED proof that early intervention in the legislative process can prevent problems later on, they need only look at the lobbying by the risk retention group industry on a sloppily drafted bill introduced in the Mississippi Legislature.

As we have reported, the measure, introduced in the state's House of Representatives at the request of the Mississippi Department of Insurance, would require out-of-state risk retention groups to be licensed annually by the insurance department before they could do business in the state.

On its face, the legislation is a blatant violation of the Risk Retention Act, the federal law that authorized RRGs. The federal law clearly lays out the limited regulatory rights of nondomiciliary states.

But an out-of-state regulator cannot impose a licensing requirement on RRGs. Indeed, the whole point of Congress in passing the Act was to allow one stop shopping, that is, an RRG, after meeting the licensing requirements of any one state, can write policies for members in any state.

The Mississippi bill flew in the face of that one-state licensing requirement. Once

aware of the Mississippi measure, the National Risk Retention Assn. quickly acted. The group advised legislators and the insurance department that the bill, as drafted, was pre-empted by federal law.

It didn't take long or much—a couple of letters and phone calls—to get results. When the bill reached the state Senate, it was amended to not only eliminate the licensing requirement, but also to strip a current requirement that out-of-state RRGs pay a \$500 annual registration fee to the insurance department, which a top state insurance regulator said was their intent from the beginning.

No doubt, the problem was a result of careless legislative language drafting rather than an attempt to flout federal law.

Whatever the cause, it is a lot easier to fix a problem while a bill is still moving through the legislature than after it is enacted. The lesson from the Mississippi situation is employers have to stay on top of what is going on in their state legislatures and, when necessary, get involved early—not late—in the legislative arena. You can make a difference.

Airline ruling is sensible

A RECENT RULING by the Virginia Supreme Court barring an airline from essentially recovering for losses twice under federal assistance and its insurance policies is sensible, but it raises some key questions.

As we reported in the March 6 issue, the Virginia high court reversed a lower court ruling that US Airways did not have to deduct from its insurance claims any recoveries it received under the federal Air Transportation Safety and Stabilization Act, which Congress passed to assist airlines after the Sept. 11, 2001, attacks.

Is this ruling good policy? We think it is, though the case does raise questions about the interplay of federal aid and private insurance following megacatastrophes.

The 9/11 attacks were an extreme example, but they clearly could have been a death blow to airlines, most of which still are struggling. Without federal assistance and private insurance after the terrorist attacks, many airlines could have failed, with serious consequences for other industries dependent on aviation.

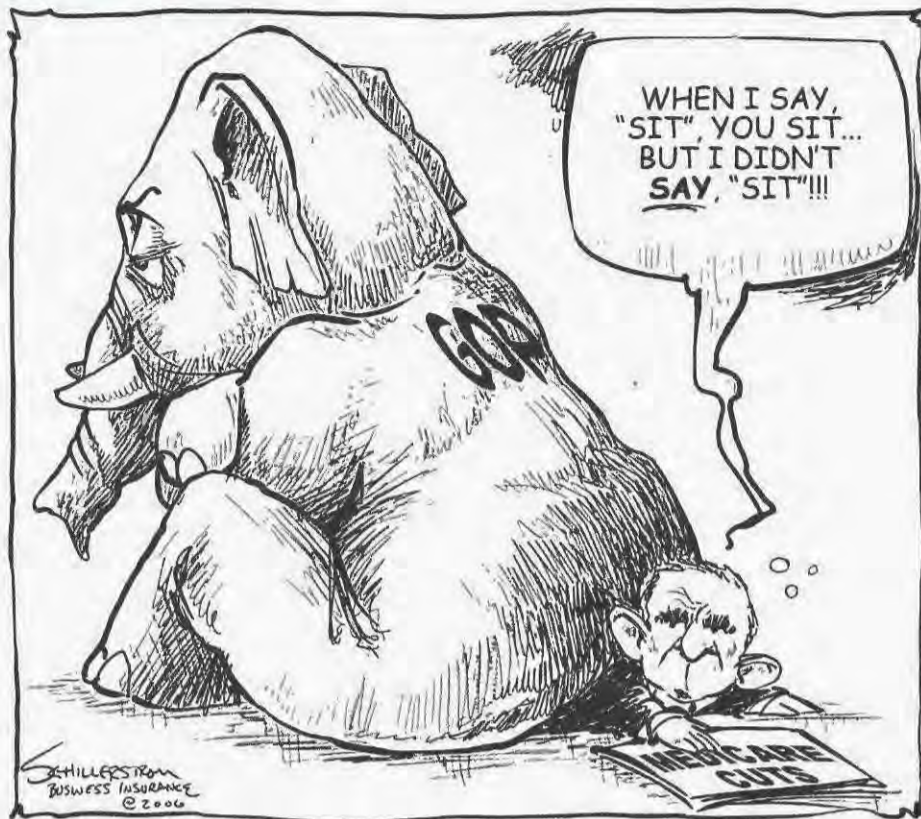
If this sounds familiar, it is. The insur-

ance industry has been making much the same argument in seeking a public/private solution to terrorism risk. But the fact remains, there is an urgent need for a federal government role in protecting the nation against losses that private industry cannot absorb.

Critics of the Terrorism Risk Insurance Act imply that TRIA is a handout to a single industry. We generally do not favor legislation directed at specific industries, but look at what's at stake. The aviation and insurance industries are two critical components of our nation's business infrastructure. Without air transportation, goods and services could not be distributed quickly. Without insurance, businesses could not function effectively, and many projects—and the economic opportunities those would offer—could never be undertaken.

In our opinion, the Virginia ruling does not suggest that federal assistance replace insurance. Instead, it signals a need to create a system in which private coverage and public aid complement each other when havoc strikes.

Schillerstrom



Letters

Something missing in Greenberg story

To the editor: Was the Feb. 13 question-and-answer interview with Maurice R. Greenberg, chairman and chief executive officer of C.V. Starr & Co., supposed to be a fluff piece or something a bit more probing? If it was the former, mission accomplished. It is so refreshing to hear that Mr. Greenberg was able to cope with the rough year of 2005 by skiing and playing tennis while he has "a very good team of lawyers working on things." And how do I contact C.V. Starr to get my account rolling there? If there was anything more important to be gleaned from the interview, I'm sorry, I didn't catch it.

Bill Shadburne
Louisville, Ky.

Write Us

Business Insurance welcomes letters to the editor. The section is intended to be a forum for readers' opinions and comments. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters.

Interact with peers in online forums

Connect with other risk and benefits management professionals in the *BusinessInsurance.com* Community Forums.

This online discussion board is a great resource for asking questions, exchanging ideas and voicing your opinions among your peers about a variety of topics. The Community Forums offer several topic-focused categories, including: Risk Managers Forum, Benefits Managers Forum, In the News, Industry Focus Forum and The Lighter Side. Visit www.BusinessInsurance.com today and check out the Community Forums.



Business Insurance

Vice President/Publisher: Martin J. Ross III (New York)

Associate Publisher/Editorial Director: Paul D. Winston (Chicago)

Editor: Regis J. Coccia (Chicago)

Editor-at-Large: Jerry Geisel (Washington)

Managing Editor: Gavin Souter (Chicago)

Assistant Managing Editor - Graphics: Kathy L. Barnes (Chicago)

News Editor: Matt Scroggins (Chicago)

Senior Editors: Michael Bradford (New Orleans); Roberto Ceniceros (Los Angeles); Meg Fletcher, A.R.M. (Chicago); Judy Greenwald (San Jose); Mark A. Hofmann (Washington); Dave Lenckus (Tucson); Douglas McLeod (New York); Sally Roberts (Denver); Joanne Wojcik (Denver); Rodd Zolkos-Industry Focus (Chicago)

Bureau Chief: Sarah Veysey (London)

Associate Editors: Gloria Gonzalez (New York); Rupal Parekh (New York)

Correspondents: Carolyn Aldred (England); Elizabeth Fry (Australia)

Deputy Graphics Editor: William Murphy (Chicago)

Copy Editors: Mary B. Nick (Chicago); Joe Walker (Chicago)

Assistant Copy Editor: Carrie A. Peinado (Chicago)

Directory Editor: Kevin P. Edison (Chicago)

Research Editor: Karen Brown Tucker (Chicago)

Online Editor: Kathy Downing (Chicago)

Online Producer: Amy R. Curtis (Olathe)

Editorial Cartoonist: Roger Schillerstrom (Chicago)

Advertising Director: Kenneth F. Luker Jr. (New York)

Director - Business Development: Robert L. Niesse (Chicago)

District Managers: Laura Booth (Irvine)

Ron Kolgraf (Boston); William J. McGuire (Chicago); Robert B. Murray (New York); John L. Phillips (Chicago)

Classified Advertising Manager: Tina Vasilakis (Chicago)

Assistant to the Publisher: Pat Ghazvini (New York)

Advertising Traffic: Monique Murray (New York)

Production Manager: J. Thomas Janka (Chicago)

Circulation Manager: John Azua (New York)

Circulation Coordinator: Craig Bowman (Detroit)

Director of Communications: Ronnie I. Drachman (New York)

Promotion Manager: Michael Ambrosio (New York)

Promotion Coordinator: Barbara O'Brien (New York)

EDITORIAL: Chicago: 312-649-5200; Denver: 303-282-4260; London: 44-207-457-1400; Los Angeles: 323-370-2455; New Orleans: 985-871-1090; New York: 212-210-0100; San Jose: 408-774-1500; Tucson: 520-579-1937; Washington: 202-662-7200

ADVERTISING: Boston: 617-292-4856; Chicago: 312-649-5276; Irvine CA: 949-255-5355; New York: 212-210-0133

SUBSCRIPTIONS: Detroit: 888-446-1422

Business Insurance is published by Crain Communications Inc.

Chairman: Keith E. Crain

President: Rance Crain

Secretary: Merrilee Crain

Treasurer: Mary Kay Crain

Executive Vice President/Operations: William A. Morrow

Senior Vice President/Group Publisher: Gloria Scoby

Group Vice President/Technology, Circulation,

Manufacturing: Robert C. Adams

Vice President/Production & Manufacturing: Dave Kamis

Crain's Corporate Circulation Director: Patrick Sheposh

G.D. Crain Jr. Founder (1885-1973)

Mrs. G.D. Crain Jr. Chairman (1911-1996)

S.R. Bernstein Chairman-executive committee (1907-1993)

Published weekly at 360 N. Michigan Ave., Chicago, Ill. 60601-3806. Fax: 312-280-3174. biweb@crain.com. Offices: 711 Third Ave., New York, N.Y. 10017-5806. Fax: 212-210-0704; 7121 Minkler St., Abita Springs, La. 70420; Fax: 985-871-4006; Suite 814, National Press Building, Washington, D.C. 20045-1801. Fax: 202-638-3155; 6500 Wilshire Blvd., Suite 2300, Los Angeles, Calif. 90048-4947. Fax: 323-655-8157; 967 Bermuda Court, Sunnyvale, Calif. 94086-6750. Fax: 408-774-1155; 34 Southwark Bridge Road, London SE1 9EU. Fax: +44-(0)20-7457-1440; 7300 N. San Anna Drive, Tucson, Ariz. 85704. Fax: 520-579-3476; 1746 Cole Blvd., Suite 150, Golden, Colo. 80401. Fax: 303-733-9941; 12524 Acuff Court, Olathe, Kan. 66062. Fax: 312-280-3174. 77 Franklin St., Suite 809, Boston, Mass. 02110-1510. Fax: 212-210-0704. 4 Executive Circle, Suite 185, Irvine, Calif. 92614-6791. \$5 a copy and \$97 a year in the U.S., \$130 in Canada and Mexico (includes GST). All other countries, \$230 a year (includes expedited air delivery). John Azua, circulation manager. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, *Business Insurance*, 711 Third Avenue, New York, N.Y. 10017-5806. Microfilm copies available: University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For reprints or reprint permission: Reprint Management Services, 1808 Colonial Village Lane, Lancaster, PA 17601; 800-290-5460, ext. 160; BusinessInsurance@reprintbuyer.com.

To subscribe, call 888-446-1422 or 313-446-0450 outside the U.S. www.businessinsurance.com



BENEFITS MANAGEMENT

HEALTH CARE COALITIONS

Coalitions' reports encourage providers to improve performance
Page 12

Program trains benefit managers on purchasing quality care
Page 12

More coalitions trying pay-for-performance incentives
Page 14

Coalitions seeking correct mix on health care issues

Groups emphasize value in drive to reform system

By LOUISE KERTESZ

Escalating health care costs over the past three decades have given employers the impetus to transform the health care coalition movement from local organizations that aim to improve community-based health resources into a national force that is driving health reform.

While the first coalition—the Greater Detroit Area Health Council, whose predecessor group was formed in 1944—had just a handful of employer members, today thousands of employers participate in as many as 74 coalitions across the country, whose missions vary from teaching members to become more savvy purchasers of health care to driving community-wide improvements in health care quality through pay-for-performance programs.

Though varied in their pursuits, all of the coalitions were formed with the realization that one employer working alone cannot achieve nearly as much as many employers working together.

"Coalitions are all very much alike in the sense that they are formed because they want clout," said Marianne Fazen, executive director of the Dallas-Fort Worth Business Group on Health and chairman of the board of the National Business Coalition on Health.

"We all have the same mission, to help employers be better purchasers of health care and to use the collective leverage to improve the quality of care in the community," she said.

In addition to participating in local coalitions, many employers also belong to other coalition-like

organizations, the National Business Group on Health—which works to reform health care at the national level—and the National Business Coalition on Health—an umbrella group that supports regional coalitions and works for national health care reform.

The National Business Group on Health doesn't consider itself to be a coalition, but rather a membership organization of large, national employers focused on national issues, according to Helen Darling, president of the Washington-based group.

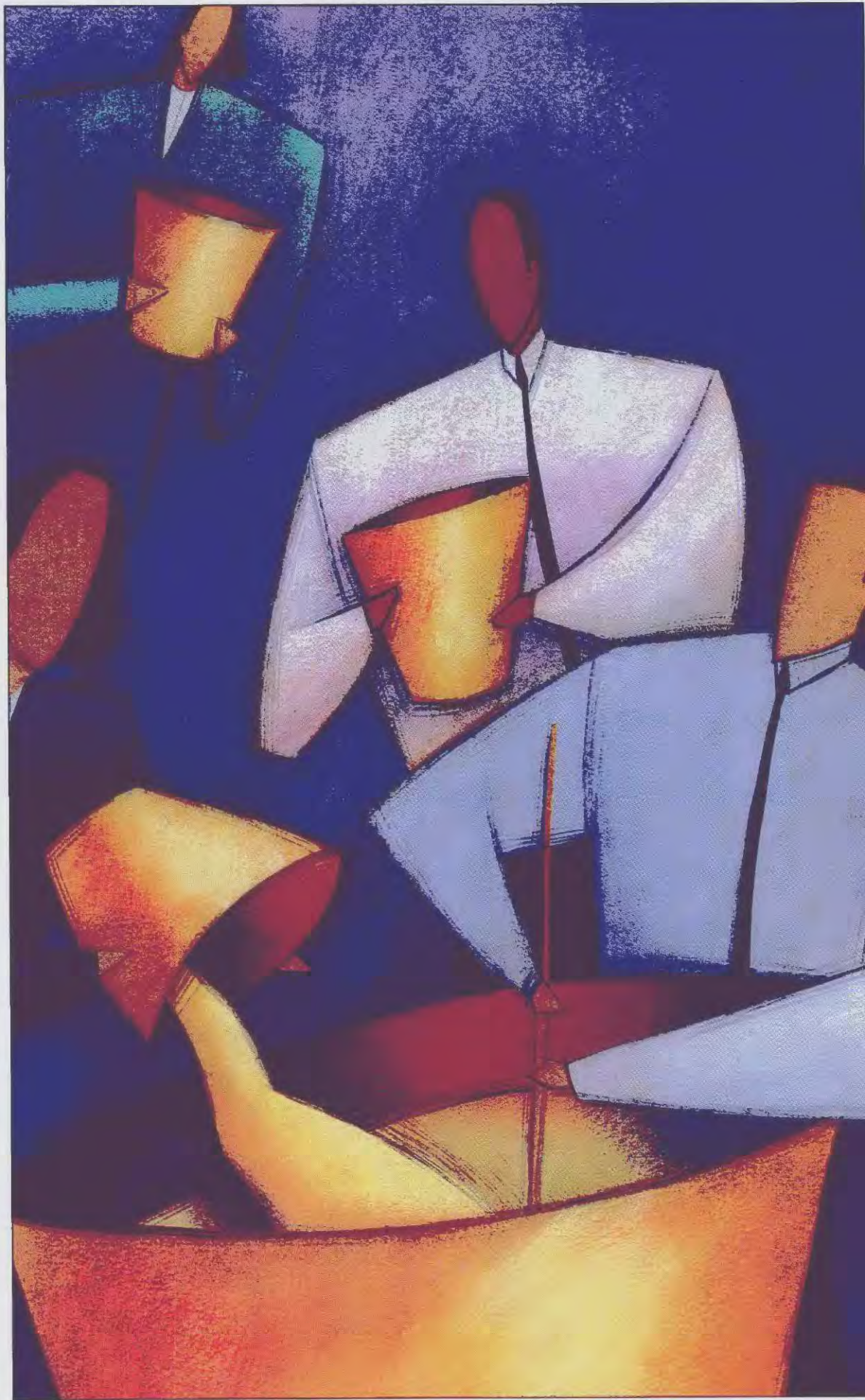
To demonstrate its objective, the organization changed its name to the National Business Group on Health from the Washington Business Group on Health in 1992.

The NBGH's membership comprises corporations and others considered special industry members involved in health care—such as insurers, benefits consultants and pharmaceutical companies. Some of the corporation members are senior benefits and human resources officers that make up the group's board.

The National Business Coalition on Health is "a coalition of coalitions," said Andrew Webber, president and CEO.

The organization is made up of 74 member coalitions and it has an annual budget of about \$2 million. It recently launched a research, evaluation and training affiliate, the Community Coalition Health Institute, whose mission is to evaluate and identify best practices in value-based purchasing strategies, Mr. Webber said.

The NBCH's services to member coalitions include negotiating



See COALITIONS / page 16

BI DIRECTORY

Health care coalitions around the nation

As health care benefit issues continue to gain strategic importance for employers of all sizes, *Business Insurance* has compiled its first Directory of Health Care Coalitions, as a resource for employers nationwide.

The directory is intended to assist employers in identifying coalitions they can join to learn more about value-based health care pur-

chasing, controlling the cost of providing health care benefits, improving medical outcomes and understanding community health care issues.

The map below lists the coalitions that completed a *Business Insurance* survey. These groups represent a significant number of employers and covered lives nationally. In a departure from other

Business Insurance directories, the magazine has not attempted to create a ranking for health care coalitions.

Due to great variety in their services, objectives and even membership requirements, health care coalitions are not easily compared. Such groups generally reflect the communities in which they're based. Although coalitions typical-

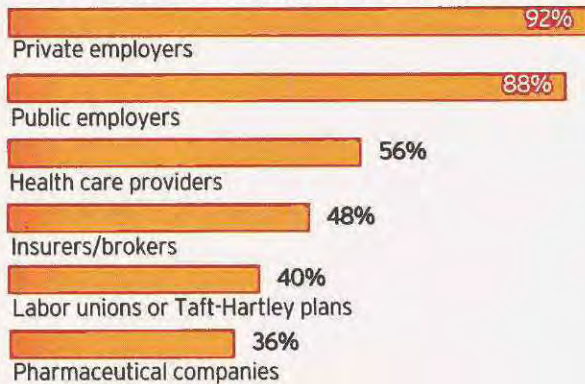
ly promote value-based health care purchasing, not all such groups actually purchase care on behalf of members (see charts). In addition, some multistate employers may belong to more than one coalition, and some coalitions permit health care providers to become members while others mainly comprise employers.

Research for the Directory of

Health Care Coalitions was conducted by Carrie Peinado, Karen Tucker and Kevin Edison. *BI* also gratefully acknowledges the assistance of the National Business Coalition on Health, a Washington-based membership organization of coalitions, as well as Larry S. Boress, president of the Chicago-based Midwest Business Group on Health.

Who's in the club

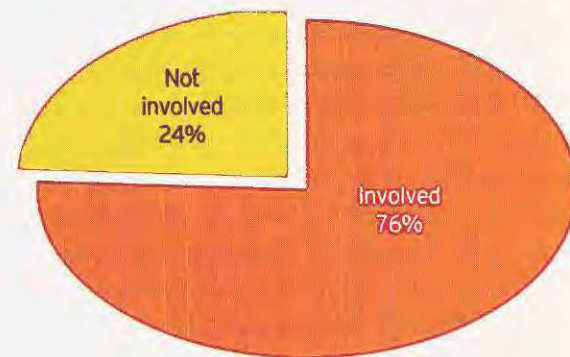
Most common members of health care coalitions



Source: BI survey

Purchasing or just looking?

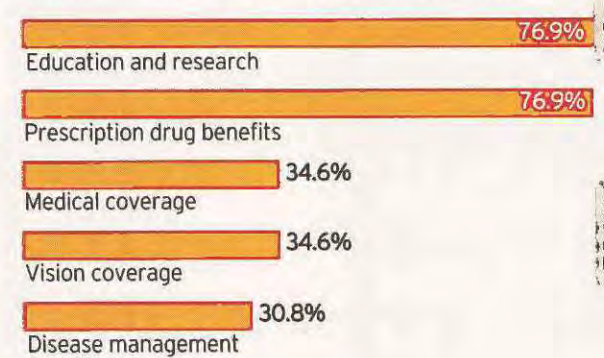
Percentage of coalitions in group insurance purchasing



Source: BI survey

Services provided

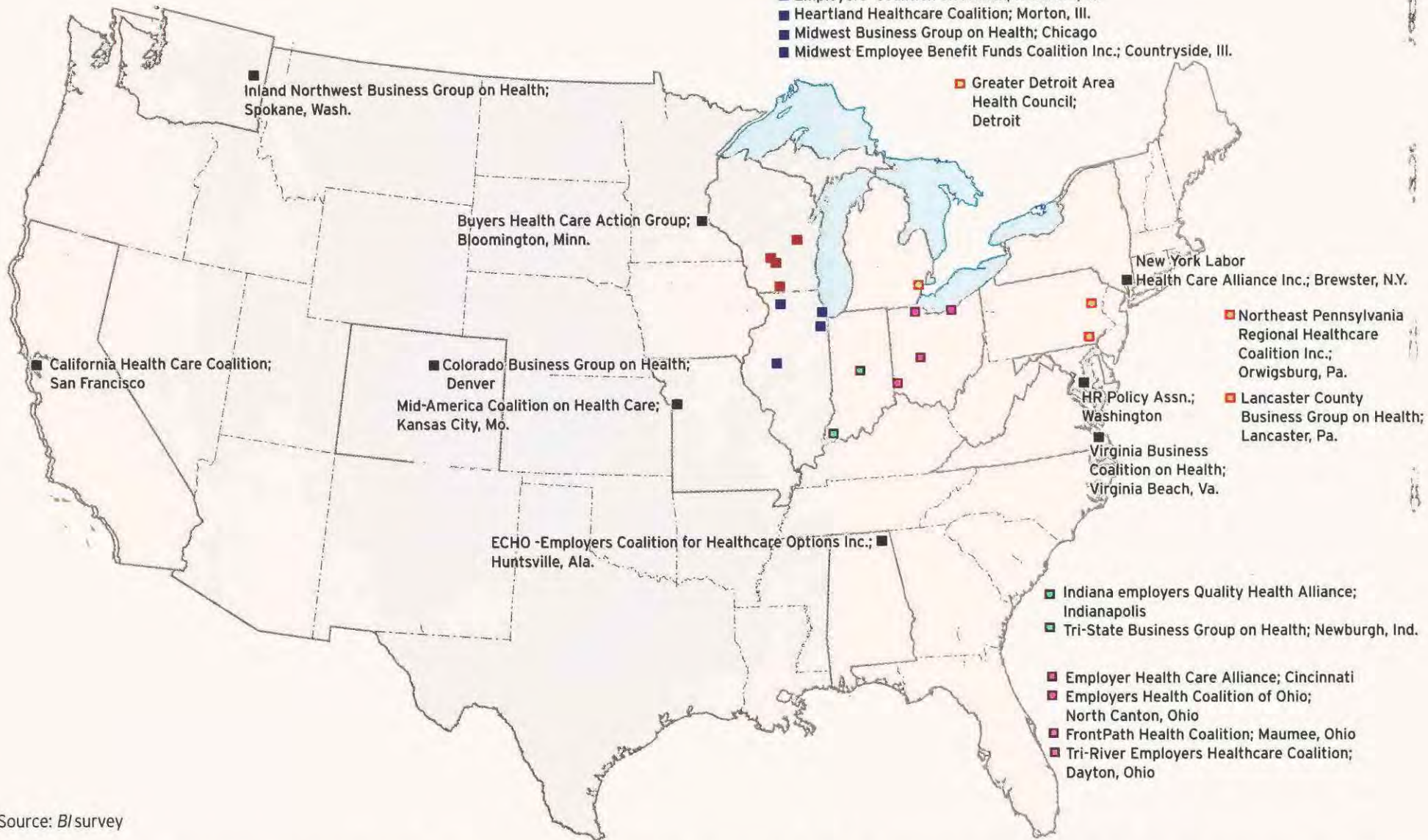
Most common services provided by health care coalitions



Source: BI survey

- Fond du Lac Area Businesses on Health; Fond du Lac, Wis.
- Wisconsin Rx dba National Cooperative Rx; Madison, Wis.
- The Alliance, Employer Health Care Alliance Cooperative; Madison, Wis.
- Employers Health Cooperative; Janesville, Wis.

- Employers' Coalition on Health; Rockford, Ill.
- Heartland Healthcare Coalition; Morton, Ill.
- Midwest Business Group on Health; Chicago
- Midwest Employee Benefit Funds Coalition Inc.; Countryside, Ill.



Source: BI survey

Visit www.businessinsurance.com for more information and to access the full searchable Directory of Health Care Coalitions. *Business Insurance* now offers the option to purchase the entire directory as an Excel download from our Web site.

We
want
you to
know

Aetna's Information



"By far the richest
online selection
of the Big Three."

—*BusinessWeek*

In *BusinessWeek* magazine's recent comparison of Web sites and information tools offered by the top three national health insurers, Aetna received the highest marks. According to their article, they "found the richest set of offerings at Aetna's site." And Aetna's online survey to help members evaluate and manage their health was said to be "the most comprehensive." To learn more about how our information can help your employees make better health care decisions, call your broker, Aetna representative, or visit us online at aetna.com.

We want you to knowSM



Health
Dental
Pharmacy
Behavioral Health
Long Term Care
Disability
Life

©2006 Aetna Inc. Plans are offered by Aetna Life Insurance Company. Health insurance plans contain exclusions and limitations. From *BusinessWeek* article, February 20, 2006, copyright by The McGraw-Hill Companies, Inc., comparing Aetna, UnitedHealth, and Wellpoint member Web sites. Policy form numbers include GR-29 and GR-700-W. 200615

Provider performance reports benefit employers

Measurement efforts urge improvement in value of care

By GLORIA GONZALEZ

As part of their efforts to improve the quality of health care, a handful of health care coalitions are creating and distributing reports measuring the performance of physicians and hospitals.

The reports create a powerful incentive for providers to improve the quality of care they provide, according to coalition officials. And employer coalition members say the reports give employees an important tool to help make health care decisions and enhance dialogue on quality care issues.

About four or five coalitions in the United States measure physician performance and fewer than 10 coalitions have separate hospital performance measurement systems, according to Dennis White, senior vp of the Washington-based National Business Coalition on Health, a nonprofit organization of nearly 80 employer-based health care coalitions, representing more than 10,000 employers in the United States.

The main goal of provider performance measurement is to give employees and other health care users better information to help them choose providers and help employers make better decisions on plan design and other aspects of health care, said Cheryl DeMars, CEO of Employer Health Care Alliance Cooperative in Madison, Wis. "There's an awareness-raising component and also helping people use that information to make more informed decisions about their care," she said.

Performance measurement efforts also encourage providers to improve the value of the care they deliver, she said. The act of collecting and publicly reporting provider information "creates some pretty powerful incentives for providers to improve," Ms. DeMars said.

Most efforts on measuring provider performance focus on specific areas of health care, particularly treatment for chronic conditions because these conditions are often costly for purchasers of health care, Mr. White said.

This spring, the Alliance will publish its next "Quality Counts" re-

port, which will measure hospital performance in overall care, maternity care and cardiac care because these are areas of importance to members of the Alliance as they spend large amounts on treatment in these areas, Ms. DeMars said. "We're interested in branching out to other areas of care in the future," she added.

The Quality Counts report compares how often mistakes, complications and deaths occur with how often they can be expected to occur in light of the conditions of the patients, and it gives each hospital a symbol rating based on their performance in each area. For example, a hospital that encounters fewer mistakes, complications and

hospital associations on the production of a report detailing how often hospitals provide recommended care for heart attacks, heart failure and pneumonia. The organization chose to focus on those conditions because Kansas City hospitals were already reporting data on the conditions to the Centers for Medicare & Medicaid Services, said William T. Bruning, president of the Kansas City, Mo.-based coalition.

"One of the things we didn't want to do was create a whole new reporting burden because there would be a whole lot of pushback on that," he said. "For us, it gets over the barrier of hospitals simply refusing to report. We found another way to get all the hospitals engaged."

While the organization used data that hospitals were already reporting to CMS, it reformatted the data into three graphs, making it less complex than the government's method of reporting the data, he said. "There's a real value in making it more consumer-friendly than CMS makes it," Mr. Bruning said.

For example, one of the graphs in the report measured how often Kansas City hospitals followed current guidelines for treating heart attack patients, such as providing aspirin and beta-blockers at arrival and discharge. The report found that three local hospitals followed these guidelines 100% of the time in a six-month period ending March 31, 2004. In contrast, one hospital followed these guidelines 80% of the time during the same time period.

Provider	Guideline	Actual	Expected	Rating
Hennepin County Hospital	Aspirin at arrival	100%	100%	A
	Beta-blocker at arrival	100%	100%	A
	Beta-blocker at discharge	100%	100%	A
University of Minnesota	Aspirin at arrival	100%	100%	A
	Beta-blocker at arrival	100%	100%	A
	Beta-blocker at discharge	100%	100%	A
St. Mary's Hospital	Aspirin at arrival	100%	100%	A
	Beta-blocker at arrival	100%	100%	A
	Beta-blocker at discharge	100%	100%	A
St. Joseph's Hospital	Aspirin at arrival	80%	100%	B
	Beta-blocker at arrival	80%	100%	B
	Beta-blocker at discharge	80%	100%	B

Mid-America Coalition on Health Care teamed up with local hospital associations to create performance reports on specific conditions.

deaths than expected receives a plus rating while a hospital that encounters more of these problems receives a minus rating.

Coalitions have several sources they use for the data in compiling reports on provider performance. The Alliance uses information from The Leapfrog Group, an organization that promotes health care quality and billing data that hospitals are required to submit to the State of Wisconsin Bureau of Health Information in its performance measurement efforts.

Publicly reported data is a key part of the initiative to measure provider performance. For example, the Mid-America Coalition on Health Care collaborated with local

Program aids benefit managers in buying quality health care

By JUDY GREENWALD

The College for Advanced Management of Health Benefits' name may not fit neatly on a sweatshirt, but it more than fulfills its mission of helping benefit managers make better health care purchasing decisions, say participants.

The college, which held its first four-day session in 2004, is intended to encourage benefit managers to pursue quality, as well as price, in purchasing health care, said Jerry Burgess, president and chief executive officer of the Knoxville, Tenn.-based HealthCare 21 Business Coalition, who originally came up with the idea for the college.

In addition to HealthCare 21, the college is co-sponsored by the Washington-based National Business Coalition on Health and the Jefferson Medical College's Department of Health Policy in Philadelphia.

"It was honestly the best benefits seminar or conference that I have ever attended and I have pretty high expectations," said Bonnie

The Mid-America Coalition made its report available on a Web site called healthykansascity.org, which is run by a local medical foundation. The hits on the Web site were averaging 250 a day prior to the release of the report. After the organization posted the hospital quality data and began a publicity campaign, the number of hits soared to 3,700 the first day and held in that range for a week. "We clearly were driving people to the data," Mr. Bruning said.

The Alliance provides its members with hard copies of its report and is looking into providing password-protected Internet access, Ms. DeMars said. The organization conducted an evaluation that found that its employer members were keen to distribute the information to their employees, which they often do via employee meetings. "I think there are a number of creative ways employers have to get out information to their employees," Ms. DeMars said.

Employers say they find these tools to be useful. Winterthur North America has provided the Quality Counts report to its employees, primarily through the company intranet, although paper copies were available as well, said Jennifer Tratnyek, benefits analyst for Winterthur in Sun Prairie, Wis. The company has received some positive feedback on the report from a handful of employees and it will make the updated report available to its employees, she said. "I think people always appreciate that kind of information," Ms. Tratnyek said.

The Quality Counts report features a tear-off postcard for

employees and other users to provide feedback, Ms. DeMars said. About 81% of those who read the report said they found it useful. More than 250 respondents said they would use it to pick a hospital, according to data received from the post cards.

Sprint Nextel Corp. has not provided the report to its employees, but has used the report when discussing and debating the issue of measuring provider performance, said Collier Case, the company's director of health and productivity benefits in Overland Park, Kan. "We have not used it for employee communication, but we have used it with respect to having a dialogue with other groups," Mr. Case said.

The dialogue is part of an effort by employers to encourage providers to be more open with respect to performance reporting. "That's certainly our desire, that we have more transparency on performance data," Mr. Case said.

Measuring the cost impact of performance reporting is a challenge. Return on investment is a long-term objective that is difficult to isolate to just the report, but the report creates a pretty strong incentive for providers to improve care, which results in savings for employers, Ms. DeMars said.

The next step for coalitions is to find a way to take the data and to further analyze and benchmark performance, Mr. Bruning said. "It's getting tougher to see real measurable, statistically significant differences among the hospitals," he said. "Once you start reporting the numbers (the hospitals) get, they get really into improving the numbers."

What are your benefits worth?

Chances are your employees don't know!

We can help

From printed statements to online portals

See our solutions at www.bsiweb.com

Benefit SOFTWARE

212 COTTAGE GROVE, SUITE A
SANTA BARBARA, CA 93101
800.533.1388

© 2002-2005 Benefit Software Inc.

Curran, benefits manager for the Knox County government in Knoxville, Tenn.

The college's purpose is to convey the concept of value-based purchasing in health care, "which means...not only how do you get it at the best price, but how do you get the best quality out of your doctors and your hospitals and your insurance company," said Mr. Burgess.

This requires a move away from benefit managers just arranging for health insurance, said Mr. Burgess. "What you should really be concerned about is, are my employees motivated to healthy behavior, and if they have diseases, are they motivated to take care of that disease?" said Mr. Burgess.

He said the college is unique, both in its focus on the move toward value-based purchasing, and its emphasis on practical solutions.

The college got its start when "it became very clear to me about four, five years ago that maybe the biggest barrier to resolving the health care crisis in America...is

probably not the hospital or the doctor or the insurance company. It is that the person buying the benefit continues to do it the way they have in the past years and they could probably effect the most change in the system," he said.

Mr. Burgess developed a curriculum designed to help benefit managers think differently about their health care purchasing, "but it really didn't go anywhere" until researchers from the Jefferson Medical College's Department of Health Policy interviewed Mr. Burgess in connection with its research. Discussions with the medical school ultimately led to the foundation of the college.

During the college's four-day sessions—which include homework assignments—students cover topics including the history of insurance, value-based purchasing, how hospital and physician performance is measured, how to work with brokers and consultants, how to manage drugs, how to motivate employ-



MIDDLETON SPELLING BEE

The word hippopotamus gave Gary a lifelong obsession with Errors & Omissions.

Nowadays, a little mistake can cause more than embarrassment. It can lead to a costly lawsuit and a severely damaged reputation. But not if Gary Dubois and the team at Liberty International Underwriters can help it. They've spent virtually a lifetime identifying potential exposure to Errors & Omissions. And their breadth of experience enables them to recognize the unique nature of each profession, so they can develop the right insurance program. Because you never know when something like a hippopotamus will come along and ruin your day. *To find out more about Professional Liability coverage, visit www.libertyiu.com*



Liberty
International
Underwriters

LIU

THE PEOPLE, THE PRODUCTS, THE CAPACITY.
LIBERTY IS RATED A (EXCELLENT) BY A.M. BEST.

© 2006 Liberty Mutual Group

Education: Understanding value

Continued from page 12

ees and how to negotiate," said Mr. Burgess.

Students are also asked to complete two projects: a group case study and an actual "plan of action on what they're going to do when they go home. We call that the Customized Action Plan," said Mr. Burgess. "It's a very busy four days," he added.

"We continue to revise the program and the agenda according to the recommendations of the folks who are attending, trying to do as much case studies and plans as possible," said Susan Dorsey, the NBCH's director of education and program development.

Originally intended for benefit managers, the college has since expanded its scope to include brokers and consultants. "We are rather restrictive about the audience," said Mr. Burgess, however. "We want the audience to be people who are involved in benefits, because the idea is to reform the market, and that's whom you want to change."

The program is aimed at benefit managers at companies with 500 to 5,000 employees, "which is kind of the backbone of health benefits in America," although others are welcome as well. "Typically, we like to have 25 to 40 attend to keep it small and personal," said Mr. Burgess.

Faculty members have included Mr. Burgess; Neil Goldfarb, research director at Jefferson Medical College's Department of Health Policy; Dr. David B. Nash, Jefferson's department chairman; and NECH President and CEO Andrew Weber, among other experts. The college is held at locations around the country, each time under the auspices of a local health care coalition.

Attendees are enthusiastic about the college. Brian Mitchell, compensation and benefits manager for Collegeville, Tenn.-based McKee Corp., who attended the first session in November 2004, said, "We certainly came away with a variety of tools ... we could explore on our own." He said he recommends the program to others. "I think it is a good starting point to bring somebody's education up a great deal in a very short period of time."

"I think it's a very valuable program," said Louis Lazovsky, VP of human resources for the Jewish Federation of Metropolitan Chicago

and board chairman of the Midwest Business Group on Health. Mr. Lazovsky said he has learned new things from attending. Furthermore, "I have sent my staff members to it, and they have had a great deal of benefit" from it as well, he said.

Ms. Curran of the Knox County government said, "It was very inspiring, I think, for most benefit managers to go back and to really take another look at what they're doing and to evaluate how effective they are in managing their benefits. It definitely propelled me to come back and dig a little deeper," said Ms. Curran.

Follow-up evaluations indicate that "people do, in fact, follow up on their training and try to make purchases based on value, not just cost," said Mr. Goldfarb. "I think also the fact that we're getting so much business from people referring friends at work, colleagues, to the program, speaks to its value."

"I think it's been very successful for a new program," he said. "The biggest challenge that we've had is marketing, getting our name out and convincing people that this is a program that's worth their time, because it's a pretty significant commitment to take a week off from your job to go to a training program."

The college has also launched its own electronic journal, called Value-Based Purchasing, which will provide updates about the college, as well as articles by former speakers. It can be accessed by anyone at jlc.jefferson.edu/vbp/

The college may expand its offerings, perhaps adding special topic courses on productivity or wellness. Another possibility is condensing the college into a one-day course "for certain people, say high-level executives," who cannot stay for the full four days, said Mr. Burgess.

There are no plans to expand the basic course, though, beyond four days, said Mr. Burgess. "I think the four days is about as much as you can get people away from work. They're all busy doing their jobs."

The next sessions are scheduled for April 24-27 in Philadelphia, and Sept. 18-21 in Charlotte, N.C. The fee is \$1,500 for members of health care coalitions and \$2,000 for nonmembers. For further information, contact Mr. Goldfarb at neil.goldfarb@jefferson.edu or 215-955-0427.

Incentives urge providers to practice better medicine

Coalitions taking part in pay for performance

By JOANNE WOJCIK

Many employer coalitions have begun dabbling with pay-for-performance with the hope that providing financial incentives to providers will encourage them to practice better medicine.

Perhaps the oldest of the coalition-inspired pay-for-performance projects is P4P, the brainchild of the Pacific Business Group on Health that was taken over by the Integrated Healthcare Assn. five years ago. The initiative is financed by seven of the state's health plans.

"PBGH first demanded pay-for-performance in 1998, but the health plans said they weren't prepared to do so. So this provided the catalyst for the IHA's P4P program," explained Peter Lee, chief executive officer of the San Francisco-based PBGH, which has 50 employer members covering 3 million lives.

P4P operates statewide, involving 225 physician groups with approximately 35,000 doctors who provide care for 6.2 million health maintenance organization plan members, many of whom are participants in PBGH-member health plans.

Though the project began in 2001, it did not begin making payments until last year. The payments were based on three years' of provider performance data involving several clinical measures: preventive services, such as breast can-

cer and cervical cancer screenings; childhood immunizations; and care for chronic illnesses, including asthma, diabetes and heart disease.

To date, physicians collectively have received approximately \$90 million. Payments for 2005 perfor-

measures including patient satisfaction, patient safety, efficiency, cost and utilization.

To fund the incentives, hospitals are contributing 1% of the dollars that participating employers spend in those hospitals. The nine employers are contributing 1% of the dollars they each spend at all of the participating hospitals.

The physician pay-for-performance program, which has been funded with \$400,000 of employer money, evaluates doctors based on three categories: office systems, process measures and diabetes and cardiac care outcomes. Bonus payments will be made to medical practices that are awarded three blue ribbons—one for each category—and the results posted on the coalition's Web site.

The Portland, Maine-based coalition has 26 employer members that collectively provide health care coverage for approximately 200,000 individuals.

In an effort to bring pay-for-performance into the nation's heartland, the National Business Coalition on Health, a Washington-based consortium of employer coalitions, selected four of its members to become test sites for a three-year demonstration project using the methodology developed by the Bridges to Excellence program.

BTE is a nonprofit organization of employers, providers and health plans that was started in 2002 in response to the Institute of Medicine's 2001 report, "Crossing the Quality Chasm: A New Health System for the 21st Century."

Under BTE, employers, providers and health plans work together to implement the IOM recommendation to create a health care system that provides care that is safe, timely, effective, equitable and patient-centered. It does this by rewarding providers in three incentive programs: Diabetes Care Link, Cardiac Care Link and Physician Office Link. Participating physicians get a bonus for each diabetic or cardiac patient they treat if they meet standardized performance measures developed in conjunction with the National Committee for Quality Assurance and panels of health care experts. Physicians are eligible for an additional payment if they meet preset standards for office systems, also developed by BTE.

The Colorado Business Group on Health is perhaps the furthest along of the four coalitions involved in the BTE project, having gotten commitments from employers in Colorado Springs, Colo., where the project will be focused.

"My employers are solid, they're in the game," said Donna Marshall, CBGH's executive director. "We have physicians in the process of working on recognition status and employers who are ready to pay

"My employers are solid, they're in the game. We have physicians in the process of working on recognition status and employers who are ready to pay rewards."

Donna Marshall

Colorado Business Group on Health

mance will be made later this year.

The Maine Health Management Coalition is conducting two statewide pay-for-performance initiatives, one involving hospitals and another involving physicians, according to Executive Director Doug Libby.

Ten hospitals and nine employers, which collectively have put up about \$1 million, are participating in the hospital initiative, which rates hospitals based on their performance in between 30 and 35

BHCAG effort identifies steps communities can take

In addition to working with providers to improve health care quality, the Buyers Health Care Action Group is working with health plans to identify communitywide opportunities for improvement.

The effort is being facilitated by a tool called eValue8 that was developed about 10 years ago by several coalitions and large employers to evaluate the performance of health maintenance organizations, according to Carolyn Pare, chief executive officer of Bloomington, Minn.-based BHCAG.

"BHCAG wanted to do more than just compare plans," Ms. Pare said. "It also wanted to use it to identify communitywide opportunities for improvement. For instance, if we all throw enough money, time, energy and resources toward development of an IT infrastructure for health, wouldn't that be a better use of our money as a community?"

More than 100 health plans across the country now participate in the eValue8 process,

which establishes benchmarks for health information technology, member and provider communications, disease management, program administration, provider performance, patient safety, pharmacy management, behavioral health and financial stability.

Once the health plans have electronically submitted their data, a certified eValue8 scoring team verifies the information. The team also conducts site visits. Detailed findings are shared with health care purchasers.

Among other things, employers can use the information to decide whether to contract with a particular plan, whether to build financial incentives to steer employees toward higher-performing plans, or to work on quality improvement with the plans they want to continue to use but may need some help with, Ms. Pare explained.

For more information about how BHCAG is using eValue8, visit the coalition's Web site at www.bhcag.com.

—By Joanne Wojcik



SOFTWARE, INC.
INTERNATIONAL INSURANCE SOFTWARE SPECIALISTS

Solutions
Claims Management Software Including:

- Health Claims Management
- HIPAA - EDI/Auto Adjudication
- Claims Processing - Claims Editing - Integrated Billing
- Workers' Compensation Claims Management
- ODBC/Open Relational Database

Direction
NT Based Solutions Utilizing:

- Internet Connectivity - EDI Web Enabling
- Integrated Systems - Scanning/OCR
- Mailroom Outsourcing - Customer Service

WWW.WLTSOFTWARE.COM 877-807-4730

Continued on next page

Continued from previous page
rewards.”

Coalition members are contributing \$100 per diabetic patient to doctors who meet the NCQA performance requirements.

The Employers Health Coalition in Fort Smith, Ark., had been slated to launch a program involving all three of the BTE links on Jan. 1, 2006, but the startup has been pushed back to May 1 because of unrelated contracting issues involving other coalition projects, according to Caryol Hendricks, chief executive officer.

“I really underestimated how much time it would take, and this was negotiation time. And to go right from a negotiation into pay-for-performance, we thought giving it a quarter to calm down was the right thing to do,” Ms. Hendricks said.

The project will encompass 100 providers who collectively treat about 20,000 diabetic and cardiac patients. The annual incentive payments will be \$80 per diabetic and \$80 per heart/stroke patient. If the providers achieve “super star status”

Coalition project cost an obstacle for employers

While this handful of coalitions has gotten the employer buy-in needed to launch, employers’ reluctance to pay more for health care services has been one of the biggest obstacles to many coalition-led pay-for-performance projects.

In fact, the Employers Health Purchasing Corp. of Ohio in North Canton, Ohio, is funding its Bridges to Excellence project out of its own annual budget, according to Mike Stull, director, programs and government affairs.

“This eliminates a barrier to participation on the employer’s part,” he explained.

“The vast majority of private employers are very, very similar to the Office of Management and Budget. They want it to be budget-neutral,” observed Peter Lee, chief executive officer of the Pacific Business Group on Health in San Francisco.

Employers prefer that “we change the shape of the pie—don’t make it bigger—by redistributing the money that’s already in the system. So there’s no real ‘new money’ coming in,” he said.

“Our philosophy’s a little different. You’ve got to do something to break the inertia,” said Carolyn Pare, chief executive officer of the Bloomington, Minn.-based Buyers Health Care Action Group.

“You need somebody to go first, and we call the employers that take the lead ‘champions,’” she said.

—By Joanne Wojcik

by meeting a higher level of accountability standards, such as keeping patients’ blood pressure and cholesterol within a narrower range, they will receive another \$80 per patient per year. Since the coalition is also using the physician office link measure, doctors who qualify will receive an additional \$50 per patient, regardless of their diagnosis.

The coalition has 80 employer members, but only a handful of employers represent the majority of the patients whose care will be measured, Ms. Hendricks said.

The two other coalitions are off to a slower start.

The Tri-State Health Care Coalition in Quincy, Ill., is “still working out the local obstacles” before it can

begin its BTE program involving the diabetes link, according to Executive Director Bev Rossmiller.

Meanwhile, in Morton, Ill., the Heartland Healthcare Coalition is having trouble assembling a large enough block of lives to make its BTE diabetes link program work, according to Executive Director Jerry Custer.

“It’s not enough that one or two or three employers say they want to do this, you also have to add up the number of lives they represent. We’re operating on the basis that to launch this we have to have at least 20,000 lives involved. That’s why it takes a little longer than most people realize,” Mr. Custer explained.

Another coalition that is doing a

BTE-modeled diabetes link, though not in connection with the CBGH pilot project, is the Employers Health Purchasing Corp. of Ohio in North Canton, Ohio, which is already scoring doctors and expects to begin making payments of \$100 per diabetic patient this fall, according to Mike Stull, director, programs and government affairs.

The coalition has 100 members in northeast Ohio, as well as about 20 others from out of state.

The Buyers Health Care Action Group in Bloomington, Minn. is incorporating clinical guidelines that were developed by the state’s Institute for Clinical Systems Improvement into its pay-for-performance initiative, according to Carolyn Pare, chief executive

officer.

For physicians to be paid, their patients must meet five minimum thresholds: blood pressure less than 130/80; Hemoglobin A1-c less than 7; LDL less than 100; nonsmoking status achieved; and, if a patient is 40 or older, daily aspirin use.

The guidelines were developed by the Minnesota Community Measurement Project, in which all of the health plans operating in the state pooled their claims data, with the results published on the Internet, Ms. Pare said.

Six employers are currently participating, collectively contributing about \$100,000. Doctors who meet the five criteria will receive \$100 per qualifying patient later this year, she said.



ACCREDITED

QUALIFIED HELP IS HARD TO FIND.

Understanding defined contribution healthcare options and finding solutions can be confusing. Mistakes are costly.

To ensure that employers are working with the most qualified practitioners, the Employers Council on Flexible Compensation—the leading group in the defined contribution field—has authorized the Alliance for Affinity Security to establish an accreditation program for service providers.

The organizations listed here have qualified for provisional accreditation. During 2006, they will work to complete the accreditation process.

- **Admin America**
Roswell, GA 30077
770-992-5959
- **ADP Benefit Services**
Alpharetta, GA 30033
770-360-3355
- **AFLAC**
Columbus, GA 31999
706-660-7765
- **All American Benefits, Inc.**
Dallas, TX 75240
972-788-2686
- **American Express**
New York, NY 10285
212-640-1790
- **American Fidelity Assurance Company**
Oklahoma City, OK 73125
888-577-5555
- **Benefit Coordinators, Inc.**
Columbia, SC 29221
803-772-0110
- **Benefit Planning Consultants, Inc.**
Champaign, IL 61826
217-355-2300
- **Benevations, Inc.**
Chicago, IL 60611
312-573-0603
- **CONEXIS**
Irving, TX 75038
214-596-6913
- **Creative Benefits, Inc.**
Vista, CA 92085
760-509-0118
- **DataPath, Inc.**
Little Rock, AR 72204
800-633-6841
- **Elkin & Associates, LLC**
Charlotte, NC 28235
704-334-5517
- **Evolution Benefits**
Avon, CT 06001
860-678-5562
- **First Financial Administrators, Inc.**
Houston, TX 77267
281-847-8422
- **FlexChecks, Inc.**
Grand Rapids, MI 49514
616-791-7900
- **Flex HSA**
Rosemont, IL 60018
847-699-6900
- **Humana Insurance Company**
Louisville, KY 40202
502-580-1845
- **LaRhetta Manin Benefits Service Group**
Wellesley, MA 02481
781-237-2291
- **Mastercard International**
Purchase, NY 10577
415-368-0323
- **Metavante Healthcare Payment Solutions**
Waltham, MA 02451
781-895-4900
- **MHM Resources, Inc.**
Leawood, KS 66211
913-234-1083
- **My FSA Link, LLC**
Lincoln Park, NJ 07035
973-709-9706
- **National Benefit Services, LLC**
Sandy, UT 84070
801-532-4000
- **P + W Software, Inc.**
Westlake Village, CA 91362
818-707-7690
- **Southern Administrators & Benefit Consultants**
Madison, MS 39130
601-856-9933
- **Taxsaver Plan**
Dallas, TX 75204
214-559-0472
- **Tri-Star Systems, home of EzFlex4U**
Chesterfield, MO 63017
816-460-0407
- **Union Service Corporation**
Moorestown, NJ 08057
856-778-4257
- **Visa USA**
San Francisco, CA 94119
415-932-2357

If you want to work with an organization committed to the highest business and professional standards, you will want to contact one of these firms.

Employers Council on Flexible Compensation
202 659-4300
ecfc.org

Alliance for Affinity Security
202 371-0125
allianceforaffinitysecurity.org



COMMENTARY

Senior Editor Mark A. Hofmann

Shrinking asbestos liability reform

One of the more curious aspects of official Washington is that an issue can take up a good deal of Congress' time and energy for years and then seemingly vanish as if it never existed.

Of course, these don't tend to be issues involving life and death and war and peace. Instead, they're "who pays what" issues; in other words, the kind of issues that guarantee lobbyists' personal prosperity for decades.

A case in point was Superfund liability reform, an issue that sprang up sporadically from the enactment of Superfund in 1980 through the mid-1990s. Businesses, insurers, environmentalists and regulators all battled over the details of liability reform. An internal dispute involving a proposed tax to pay for cleanup split the insurance industry. Then, after the congressional elections of 1994, the issue receded and has never regained the prominence it once enjoyed. The fact that an increasing number of the worst Superfund sites actually got cleaned up helped push the controversial program off political center stage.

Much the same happened with federal product liability reform efforts, which arose repeatedly from the 1970s through the 1990s. After a series of close brushes with victory, supporters appeared to have the votes for a compromise bill in 1998 but it was the business community's turn to splinter. One faction yet again allowed the perfect to be the enemy of the good, and the effort foundered. Supporters turned to other, more successful tort reform efforts and the drive for federal product liability faded into the legislative history books.

Both of these efforts came to mind as this Congress continues to grapple with the issue of asbestos liability reform. Thanks in large part to the unstinting efforts of Senate Judiciary Committee Chairman Arlen Specter, R-Pa., a measure that would create a privately funded trust fund to replace the courtroom as a way to compensate victims of asbestosis and other asbestos-related disease actually made it to the Senate floor. And there it stayed, victim of a budgetary point of order that brought usually antagonistic lawmakers from both poles of the political spectrum together to block the proposal for mutually exclusive philosophical reasons.

Even if supporters of the bill break the impasse, the outlook for the trust fund becoming law in this

Congress remains dim. The House isn't interested in the trust fund approach and the White House, which has given its qualified endorsement to the trust fund, isn't likely to spend much of its shrunken purse of political capital to win passage of a bill with which it has serious reservations. And Sen. Specter himself has said that if the trust fund doesn't become law in this Congress, further federal action would probably be pushed off for some time.

So what could happen if, as looks likely, Congress doesn't move on asbestos liability this year is that the issue could become one of the incredible shrinking federal issues like Superfund reform within a relatively short period of time. There are additional reasons besides Sen. Specter's own read for this being a real possibility.

The first and more significant is that an ever increasing number of states are now following the lead of several individual judicial districts and taking steps to assure that only the truly impaired get to pursue their asbestos cases in court. They do so by requiring the claimants manifest specific symptoms before their cases can proceed. As of now, four states have adopted such rules, and legislation that would set medical criteria or other screening systems has been introduced in about half a dozen other states. If enough states follow suit, the need for federal action will be greatly diminished.

Meanwhile, the other reason that federal asbestos liability reform may fade is the heightened scrutiny some judges are giving dubious mass medical screenings of people allegedly harmed by asbestos or silica. U.S. District Court Judge Janis Graham Jack in Texas won deserved praise for cracking down on what she thought were fraudulent claims of silica impairment.

Tighter standards and heightened scrutiny of claims would by definition help drain the pool of potential claimants while not denying anyone who was truly impaired the right to seek redress. While a federal solution of some sort could well prove tidier, state actions that achieve the same goal of timely and equitable compensation of those sickened by asbestos may ultimately consign federal action to the legislative limbo where ideas like Superfund liability reform and national product liability now rest.

Coalitions: Similar goals but differences remain

Continued from page 9

contracts with preferred vendors for pharmacy and other benefits, which individual coalitions may choose to make available to their employers.

While coalitions are united in purpose, distinctions remain among the numerous coalitions operating around the country.

For example, some coalitions, including the MidAmerica Coalition on Health Care in Kansas City, Mo., include multistakeholders on their boards. Originally formed with an all-employer board 28 years ago, MidAmerica "evolved about 15 years ago into a truly collaborative model," which is "employer-driven" but also includes hospitals, health plans, medical schools, medical societies, labor organizations and government entities, said William L. Bruning, president and CEO. Coalition members believe giving every stakeholder "an equal voice" produces the best results in their marketplace, he said.

On the other hand, according to a NBCH survey, most coalitions do not include non-employers on their boards. "We feel we would dilute our clout or leverage if we included health providers and plans on our board," said the Dallas-Fort Worth coalition's Ms. Fazen.

Some coalitions, like the Employer Health Care Alliance Cooperative, in Madison, Wis., exclude non-employers from their membership, and the Pacific Business Group on Health in San Francisco excludes companies that are part of the health care industry. However, "most coalitions will invite the health care community to participate in the membership," often as associate members, Ms. Fazen said.

Among the diverse coalitions, Employers Health Coalition of Ohio is unusual in that it has

formed a for-profit subsidiary licensed as an insurance agency, Employers Health Purchasing Corp. of Ohio.

We all have the same mission, to help employers be better purchasers of health care and to use the collective leverage to improve the quality of care in the community.

Marianne Fazen
Dallas-Fort Worth Business
Group on Health

The group obtained the license because one insurance company made licensing a requirement for the coalition to receive administrative fees for its group purchasing activities, said Christopher Goff, CEO.

The Employers Health Coalition has an annual budget of about \$28 million, mostly derived from group purchasing, and it is building a 10,000-square-foot office building in Canton, Ohio, Mr. Goff said.

By contrast, most coalitions operate on modest annual budgets, often under \$1 million, based on dues, fees for educational services, administrative fees and grants.

The Alliance has a "pretty humble" annual operating budget of about \$3 million, said Cheryl DeMars, CEO. It evolved from an all-stakeholder coalition into one that is owned by self-funded employers; it is organized under Chapter 185 of the Wisconsin statutes, she said. About 160 participating employers each bought one share of the company for \$10 and also bought capital stock at \$10 per enrolled em-

ployee.

On behalf of its employer members, the coalition contracts with providers for a range of health services at what it determines is "fair market value." When an employee receives care from a contracted provider, employers pay the coalition a "retainage" fee that represents part of the savings to the employer, Ms. DeMars said. Employers also pay an access fee of \$1 per employee per month. "At the end of the year we return any leftover dollars back to our members," she said.

The Buyers Health Care Action Group in Bloomington, Minn., is one coalition that evolved from an all-employer purchasing coalition into an all-stakeholder group, albeit with only employers on its board. Once a for-profit organization, BHCAG formed Choice Plus in 1997 as a direct contracting program between employers and physicians. However, "it took too much time and energy to run a product that was seen as a competing health plan," so the coalition sold it five years ago, said Carolyn Pare, CEO.

BHCAG, with an annual budget of less than \$500,000, functions as a "community convener," Ms. Pare said. "We bring together everyone who can help reform the system," working together on initiatives including pay-for-performance, quality improvement and improved consumer knowledge and self reliance.

In addition, BHCAG has two subsidiaries. One is for-profit BHCAG Inc., and the other is a nonprofit foundation, BHCAG Foundation, she said.

Ms. Pare said BHCAG's goal is "to improve the system instead of trying to capture revenue from a particular space. Coalitions look long term, for something that will take hold."

Business Resources

To place your ad, contact **Tina Vasilakis** at (312) 649-5340 / fax: (312) 649-7937 / E-mail: tvasilakis@BusinessInsurance.com
Business Insurance, Business Resources, 360 N. Michigan Ave., Chicago, IL 60601-3806.

EDUCATION & TRAINING

CPCU® AIC, ARM, IIA,
CLU/ChFC, and
CIC candidates

You'll learn more faster and you'll pass the first time or your money back. Guaranteed!

www.BurnhamSystem.com

Call 1-888-BURNHAM Now!



Some things just work better in color.

Like your BUSINESS RESOURCES ad in Business Insurance. Contact Tina Vasilakis at 312-649-5340.

Mark Your Calendar...

Business Insurance will once again publish four special issues devoted to coverage of the RIMS 2006 Annual Conference & Exhibition

April 10, 2006

**RIMS 2006 & Honolulu
Conference Preview**

Ad Close: April 4

May 1, 2006

**RIMS Conference -
News**

Ad Close: April 25

April 24, 2006

**Risk Manager
of the Year™**

Ad Close: April 18

May 8, 2006

**RIMS Conference -
Trends &
Developments**

Ad Close: May 2

Contact Tina at 312-649-5340 to advertise in BI's Business Resources.

JLT launches review of business

By SARAH VEYSEY

LONDON—Jardine Lloyd Thompson Group P.L.C. is undergoing a review as it faces tougher operating conditions in the wake of U.S. probes into brokerage practices.

The London-based broker was not forced to make the large settlement offers to clients that some of its larger rivals were, but the decision by the broker to shed some income from contingent commissions, as well as the current competitive marketplace, have made conditions challenging for JLT, its new Chief Executive Officer Dominic Burke said in announcing a 23.3% drop in pretax profits for 2005, to £73.8 million (\$126.8 million).

Mr. Burke, who became CEO in December, said he had instigated

an ongoing operational review at JLT to "evaluate prospective developments in the broking industry and enable us to clarify and refine our strategy to better equip the group for the challenges the business faces today."

A team headed by William Nabarro, executive chairman of JLT's employee benefits division, will carry out that review.

JLT said last week that, in light of that ongoing review, it is merging its corporate risks brokerage unit—which largely deals with midsize U.K. clients—with its risk solutions division, which services mainly large clients and operates in both retail and wholesale markets, largely in London and Bermuda.

This move will enable JLT to present a single brand to its clients in

the United Kingdom and overseas, the company said in a statement.

Mr. Burke said he could not comment on potential job losses or further changes but added the broker was exploring all ways to achieve operational efficiencies. A JLT spokesman said there are no plans for either unit to shed any clients.

Mr. Burke described JLT's 2005 results as "disappointing" and "unsatisfactory" and attributed the fall in profits, in part, to a reduction in contingent commission income, as well as to currency fluctuations and a competitive market.

JLT's revenues from fees and commissions increased 3% in 2005 to £484.4 million (\$832.6 million), but its contingent commission income fell to £4.9 million (\$8.4 million) from £11.3 million (\$21.7

million) in 2004.

Many of the world's largest brokerages agreed to abolish contingent commissions in the wake of investigations and settlements with officials in the United States.

JLT did not face charges in those investigations, but it has ceased to accept such payments on large, commercial business as part of an effort to become more transparent. JLT, though, still collects contingent commissions on some business—mainly U.K. regional business—in which it competes with regional brokers that are still using such commission structures.

JLT's benefits business saw a 5% increase in pretax profit in 2005 to £13.8 million (\$23.7 million), while revenues increased 6% to £87.7 million (\$150.7 million).

Should excess capital aid risk managers?

Panel discusses options for insurers

By SARAH VEYSEY

LONDON—Insurers should use excess capital to reduce premiums for policyholders or to subsidize loss prevention programs, a leading European risk manager said.

Such actions would ease pressure on risk managers from senior executives at policyholder companies to explore alternatives to commercial coverage, said Marie-Gemma Dequae, group insurance and risk manager of the Kortrijk, Belgium-based metal company N.V. Bekaert S.A. and president of the Brussels, Belgium-based Federation of European Risk Management Assns.

But insurers have other options in efficiently managing their capital, and reducing premiums may not always be in their best interests, a financial analyst added.

They were speaking at the European Insurance Symposium, sponsored by Standard & Poor's Corp. in London earlier this month.

Ms. Dequae said insurers must be mindful that buying coverage is only one way of transferring risk, and if risk managers' bosses see insurers making large profits but rates remain high, then risk managers may be less able to buy large quantities of insurance.

Risk managers would like insurers to use their profits to reduce rates or help risk managers invest in loss prevention—which is "a very important part of the cost of risk." And it could "be good for insurers because it gives them a guarantee for future good results and helps their profits in the future," she said.

While insurers also could use their profitability to reduce deductibles, this would not be a visible benefit to buyers unless a claim occurs, Ms. Dequae said.

In addition, insurers could use their excess capital to increase policy limits for buyers, but again this

would only be a quantifiable benefit to risk managers in the case of claims, she said.

William Hawkins, senior vp of research at investment bank Keefe, Bruyette & Woods in London, said that at different points during the insurance cycle, insurers could opt for one of several ways to manage their capital including: cutting premiums, writing more business, keeping capital to manage cycles, returning money to shareholders or making an acquisition. Different circumstances would determine what should be the best option, he said.

But Mr. Hawkins said he was "convinced that the recipe for the long-term health of any company is the (efficient) management of capital," and that returning capital to shareholders is one part of an efficient capital management strategy.

Excess capital is capital that a company believes it cannot deploy efficiently, he said, and arguably companies have a fiduciary duty to return such capital to shareholders.

If insurers returned capital to shareholders more frequently, hard market conditions would be more sustainable and insurers profits would increase, Mr. Hawkins said.

Christian Dinesen, head of European credit research at Merrill Lynch in London, argued that if insurers keep excess capital then they will be able to provide policyholders and bondholders with greater stability over the insurance cycle.

And Chris Klein, head of counterparty risk at broker Benfield Group Ltd., said that insurers should use excess capital to write more business. "The number one concern of our customers, year in year out, is cost," he said.

And if there is a lot of supply in the market then prices charged to clients will be reduced, he said.

Buyers disagree on broker pay: Poll

By SARAH VEYSEY

About half of U.K. corporate insurance buyers would favor mandatory disclosure of broker commissions, but only about one-fifth are aware that brokers can receive volume- or profit-based commissions in addition to standard commissions, according to a survey.

The survey—commissioned by the International Underwriting Assn., which represents London company insurance market underwriters, and the Lloyd's Market Assn., which represents underwriters at Lloyd's of London—54% of buyers support mandatory disclosure. The survey polled 501 U.K. insurance buyers of various sizes.

Currently, the Financial Services Authority requires that brokers disclose the amount of commission they receive only if the client requests that information.

But 71% of buyers surveyed were not aware of the FSA's position. Only 10% were aware of this requirement, the survey found, while 10% thought commission disclosure was mandatory, 6% believed no disclosure was required, and 3% were "not bothered."

Sixty-eight percent believed it was relevant for them to know the total income their broker earns on their business, while 27% deemed it irrelevant and 5% did not know.

Only about 20% of buyers were aware that some brokers earn contingent commissions beyond their standard commission. More than half, 51%, said they were unaware that brokers could earn additional commissions, while 30% believed there were no other ways that brokers earned commissions.

Of the respondents, 61% pay fees, 24% pay commissions and 12% pay a combination of fees and commissions, the survey found.

David Gamble, executive director of the London-based Assn. of Insurance & Risk Managers, said the sur-

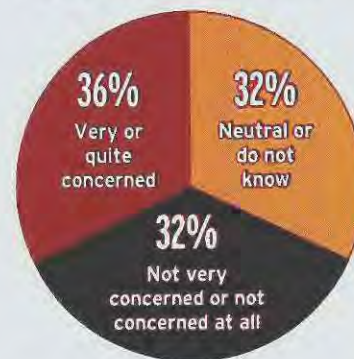
vey "supports our long-stated call for full transparency."

"Our research has already demonstrated that insurance buyers at the largest U.K. companies overwhelmingly desire automatic disclosure of payments made by insurers to brokers," he said in a statement.

"Not only do the IUA-LMA findings confirm this view, they go further in that they also cover small and medium-sized employers. It is now apparent, therefore, that this

Split on commissions

A survey of 501 U.K. insurance buyers found them divided on the issue of whether brokers earning contingent commissions from underwriters poses a concern.



desire for automatic transparency applies right across all sizes of commercial insurance buyer."

Tony Medniuk, chairman of the IUA and chief executive officer and chief underwriting officer of London-based Global Aerospace Underwriting Managers Ltd., said the survey "clearly demonstrates a need for complete transparency and accountability felt by the insurance industry's commercial customers."

The survey, "Attitudes of U.K. Corporates to Commission Disclosure," was conducted by Pickering, England-based research company Insurance Research & Strategy and London-based FWD Financial Services Marketing Ltd.

Updates

Tribunal upholds exec's disqualification

The Australian Administrative Appeals Tribunal has upheld the disqualification of David Slee, a former consulting actuary to the failed HIH Insurance Ltd., from holding the position of actuary at any property/casualty insurer in Australia. Mr. Slee—banned by the Australian Prudential Regulation Authority from being an actuary at an insurer in October 2004 for using unrealistic assumptions in his reports to HIH—had appealed to the tribunal in October for his disqualification to be reviewed. The tribunal, however, upheld the ban. HIH's 2001 collapse was Australia's largest.

U.K. nonlife outlook remains stable

Standard & Poor's Corp. is maintaining its stable outlook on the United Kingdom's nonlife insurance industry. In a report on the U.K. nonlife industry—which does not include London market insurers or reinsurers, according to S&P criteria—the rating agency said stable economic growth and low inflation, "very strong and improving insurance regulation," and improving enterprise risk management are among the positive factors supporting the rating outlook. On the other hand, S&P said, increasing price competition, low interest rates and changing distribution channels all pose challenges to the industry in the near future.

S&P issues updated syndicate assessments

Standard & Poor's Corp. has issued updated Lloyd's Syndicate Assessments, ratings based on publicly available information that measure the level of dependency a syndicate has on Lloyd's of London's central resources. Currently, S&P said, eight syndicates have a syndicate assessment of 1, indicating the lowest level of dependency. Ten syndicates have an assessment of 2, 18 have a 3 rating, six have a 4 rating and one is rated 5.

Heath Lambert sued in contract dispute

Aon Ltd. has filed a lawsuit in the High Court against fellow broker Heath Lambert Group and seven former employees in its Newcastle, England, office, whom it alleges broke their contracts when moving to Heath Lambert's Newcastle arm. An Aon spokesman declined to comment further on the suit. A spokesman for Heath Lambert said "Heath Lambert denies that we have procured any breach of contract or that the people concerned breached any of their contracts with Aon." He added that the broker would "vigorously defend" the suit.

Professional MarketPlace

To place your ad, contact **Tina Vasilakis** at (312) 649-5340 / fax: (312) 649-7937 / E-mail: tvasilakis@BusinessInsurance.com
Business Insurance, Classified Department, 360 N. Michigan Ave., Chicago, IL 60601-3806. Call for details on blind box and internet advertising

GROUP HEALTH

Producers/Reinsurers/TPA's

As an appointed general agency, we are currently interviewing business for our client, a B+ rated, multi-state licensed US Based Health Insurer. We are investigating opportunities in MEWA, Association, Union, PEO and other program business. We are accepting inquiries from Third Party Administrators, Reinsurers, Reinsurance Intermediaries, MGU's and in-force Brokers of Record. Please call 1-888-842-6020 with inquiries

HELP WANTED

CORPORATE ASSOCIATE

The New York office of a large full-service international law firm seeks a corporate associate with 3 to 6 years of corporate insurance regulatory and transactional experience.

Reply in confidence to:
Business Insurance, Box 3243
360 N. Michigan Avenue,
Chicago, IL 60601

Email: bibox3243@BusinessInsurance.com

Looking to fill a job opening? Call 312-649-5340 to place your ad in BI's Professional MarketPlace.

REQUEST FOR PROPOSALS

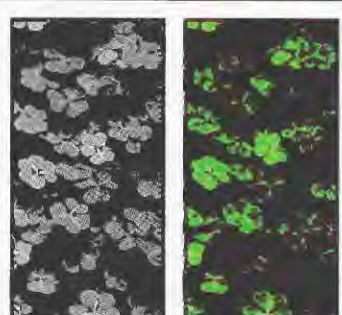
The Medical Malpractice Joint Underwriting Association of Rhode Island

Request for Proposals ("RFP")—Servicing Carrier

The Medical Malpractice Joint Underwriting Association of Rhode Island ("JUA") was established by the laws and regulations of Rhode Island for the purpose of providing medical malpractice insurance for licensed physicians, hospitals and other licensed health care providers.

The JUA is seeking proposals to secure an entity to act as a Servicing Carrier, Central Processing Agent, and Manager for the JUA, for a three (3) year term, commencing on January 1, 2007, in return for mutually agreed upon compensation.

To secure a copy of the RFP, please send an e-mail message to David P. Whitman, Esq., Counsel to the JUA, at dpw@hansoncurran.com or a written request may be sent to David P. Whitman, Esq., Hanson Curran LLP, 146 Westminster Street, Providence, RI 02903.



Some things just work better in color.

Like your PROFESSIONAL MARKETPLACE ad in Business Insurance. Contact Tina Vasilakis at 312 649-5340.

LEGAL NOTICE

NOTICE OF MEETINGS OF SCHEME CREDITORS IN THE HIGH COURT OF JUSTICE CHANCERY DIVISION COMPANIES COURT No. 1166 of 2006 IN THE MATTER OF **AA MUTUAL INTERNATIONAL INSURANCE COMPANY LIMITED** (IN ADMINISTRATION) and IN THE MATTER OF THE COMPANIES ACT 1985

NOTICE IS HEREBY GIVEN that by an Order dated 28 February 2006 the High Court of Justice in England and Wales has directed that separate Meetings of Scheme Creditors (as defined in the Proposed Scheme) of AA Mutual International Insurance Company Limited (in administration) ("the Company") are to be held on 26 April 2006 at PricewaterhouseCoopers LLP, Plumtree Court, London EC4A 4HT commencing at 11:00 am. All Scheme Creditors are requested to attend at such place and time either in person or by proxy. Please allow adequate time for registration prior to the meetings.

The purpose of the Meetings of Scheme Creditors will be to consider and, if thought fit, to approve (with or without modification) a scheme of arrangement proposed to be made between the Company and the Scheme Creditors pursuant to s425 of the Companies Act 1985 ("the Proposed Scheme").

Two separate meetings of Scheme Creditors are to be held as follows:

- a meeting of all Direct Claim Creditors, defined in the Proposed Scheme as Scheme Creditors with claims arising out of an insurance contract entered into with the Company by a Scheme Creditor other than in the capacity of insurer, reinsurer or retrocessionaire ceding business to the Company; and
- a meeting of all other Scheme Creditors of the Company.

Claims which arise in respect of a liability insured by the Company and required to be covered under section 1 of the Employer's Liability (Compulsory Insurance) Act 1969 or Article 5 of the Employer's Liability Order (Defective Equipment and Compulsory Insurance) (Northern Ireland) Order 1972 (defined in the Proposed Scheme as "UK EL Claims") are not Scheme Creditors for the purposes of the Proposed Scheme, and creditors of the Company are not Scheme Creditors in respect of such claims.

A short statement explaining the effect of the Scheme, as required to be provided to Scheme Creditors by section 426 of the Companies Act 1985, together with a Voting Form and Form of Proxy for use at the Meetings of Scheme Creditors, is being sent to known Scheme Creditors as well as to known brokers who have been asked to notify the proposed Scheme to any of their clients who may be Scheme Creditors and inform them how to obtain copies of the various Scheme documents. Copies of the Proposed Scheme, Explanatory Statement, Voting Form and Form of Proxy may be downloaded from www.pwc.com/uk/aamii, or are available from the Joint Administrators by post or email on request to Caroline Turnbull (caroline.j.turnbul@uk.pwc.com) or to the address given below.

Scheme Creditors may vote in person at the Meetings of Scheme Creditors or they may appoint another person, whether a Scheme Creditor or not, as their proxy to attend and vote in their place.

Completed Voting Forms and Forms of Proxy should be lodged with the Joint Administrators, AA Mutual International Insurance Company Limited, c/o Caroline Turnbull at PricewaterhouseCoopers LLP, Plumtree Court, London, EC4A 4HT, Fax: +44 (0)207 804 5203 as soon as possible and no later than 4pm (London time) on 25 April 2006. Faxed copies will be accepted if legible. Voting Forms and Forms of Proxy may also be handed in at the registration desk at the Meetings of Scheme Creditors prior to their commencement.

By its Order, the Court has appointed Douglas Nigel Rackham of PricewaterhouseCoopers LLP, Plumtree Court, London EC4A 4HT, United Kingdom, or failing him Dan Yoram Schwarzmann of PricewaterhouseCoopers LLP, Plumtree Court, London EC4A 4HT, United Kingdom, or in the absence of both of them their alternate or a partner of PricewaterhouseCoopers LLP, to act as Chairman of the Meetings of Scheme Creditors and has directed the Chairman to report the result of the Meetings of Scheme Creditors to the Court.

In the event that the Scheme Creditors vote in favour of the Scheme, it will be subject to the subsequent approval of the Court. Dated this 28 day of February 2006.

CHARLES RUSSELL, 8-10 Fetter Lane, London EC4A 1RS United Kingdom (Ref: Tobey Butcher)
Solicitors for the Joint Administrators of AA Mutual International Insurance Company Limited

LEGAL NOTICE

IN THE SUPREME COURT OF BERMUDA COMPANIES (WINDING-UP) No. 411 of 2003 IN THE MATTER OF THE COMPANIES ACT 1981 AND IN THE MATTER OF **FIRST VIRGINIA REINSURANCE LTD.** NOTICE TO CREDITORS TO SUBMIT PROOF OF DEBT AND NOTICE TO CREDITORS OF INTENTION TO DECLARE DIVIDEND

(Under the order for winding-up of the above-named Company dated 7th day of November 2003)

NOTICE IS HEREBY GIVEN that the Creditors of the above named Company, which is in liquidation, are required on or before April 3, 2006 to send their full Christian and Surnames, their addresses and descriptions, full particulars of their debts or claims, and the names and addresses of their solicitors (if any) to Mike Morrison and Malcolm Butterfield at KPMG Financial Advisory Services Limited, PO Box HM 906, Hamilton HM DX, Bermuda, the Joint Liquidators of the said Company, and if so required by notice in writing from the said Joint Liquidators, and personally or by their solicitors, to come in and prove their debts or claims at such time as shall be specified in such notice, or in default thereof they will be excluded from the benefit of any distribution made before such debts are proved.

A final dividend is intended to be declared in the above matter. If you believe you are a Creditor of the Company and have not already filed a proof of debt, as described above, you must do so or you will be excluded from this dividend.

Dated this 6th day of March, 2006.

Malcolm Butterfield and Mike Morrison
Joint Liquidators

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

LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT - SOUTHERN DISTRICT OF NEW YORK

In re Petition of John C. McKenna and Gareth H. Hughes, as Joint Liquidators of **NEW CAP REINSURANCE CORPORATION (BERMUDA) LIMITED**, Debtor in a Foreign Proceeding. In a Proceeding Under Section 304 of the Bankruptcy Code. Case No. 99-B-42745 (SMB)

NOTICE IS HEREBY GIVEN THAT, on March 1, 2006, the United States Bankruptcy Court for the Southern District of New York (the "Bankruptcy Court") issued an Amended Permanent Injunction and Order Pursuant to Section 304 Giving Effect to Scheme of Arrangement Between New Cap Reinsurance Corporation (Bermuda) Limited and its Scheme Creditors in the United States (the "Order") in connection with the Motion for Amended Permanent Injunction and Order Pursuant to Section 304 of the Bankruptcy Code Granting Recognition, and Giving Full Force and Effect, to Scheme of Arrangement (the "Motion") of John C. McKenna and Gareth H. Hughes, appointed by the Supreme Court of Bermuda, as the Joint Liquidators of New Cap Reinsurance Corporation (Bermuda) Limited ("New Cap Bermuda"), in their capacity as Joint Liquidators authorized to act as the foreign representatives of New Cap Bermuda (the "Petitioners"). The Order, among other things:

- Provides that the Permanent Injunction Order Pursuant to Section 304 dated July 18, 2000 issued with respect to New Cap Bermuda is amended and modified in accordance with the terms set forth in the Order;
- Provides that the Scheme of Arrangement (as defined in the Order) shall be given full force and effect in the United States, and shall be binding on and enforceable against all Scheme Creditors (as defined in the Order) in the United States;
- Permanently enjoins all persons and entities, including, without limitation, all Scheme Creditors, from taking any action in contravention of, or inconsistent with, the Scheme of Arrangement;
- Permanently enjoins all persons and entities, including, without limitation, all Scheme Creditors, from seizing, repossessing, transferring, relinquishing or disposing of any property of the Company in the United States and its territories, or the proceeds thereof, to any person or entity other than the Petitioners;
- Permanently enjoins all persons and entities, including, without limitation, all Scheme Creditors, from: (a) commencing or continuing any act, action or any legal or equitable action or proceeding (including, without limitation, arbitration, mediation, or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever), including by way of counterclaim, against the Company, or any of its property in the United States and its territories that is involved in the foreign proceeding, or any proceeds thereof, and seeking discovery of any nature against the Company; (b) enforcing any judicial, quasi-judicial, administrative or regulatory judgment, assessment or order, or arbitration award or commencing or continuing any act, action or legal or equitable action or proceeding (including, without limitation, arbitration, mediation or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever), including by way of counterclaim to create, perfect or enforce any lien, attachment, garnishment, setoff or other claim against the Company or any of its property in the United States or its territories, or any proceeds thereof, including, without limitation, rights under reinsurance or retrocession contracts; (c) invoking, enforcing or relying on the benefits of any statute, rule or requirement of federal, state, or local law or regulation requiring the Company to establish or post security in the form of a bond, letter of credit or otherwise as a condition of prosecuting or defending any proceedings (including, without limitation, arbitration, mediation or any judicial, quasi-judicial, administrative or regulatory action, proceedings or process whatsoever) and such statute, rule or requirement will be rendered null and void for proceedings; (d) drawing down any letter of credit established by, on behalf of, or at the request of, the Company, in excess of amounts expressly authorized by the terms of the contract or other agreement pursuant to which such letter of credit has been established; and (e) withdrawing from, setting off against, or otherwise applying property that is the subject of any trust or escrow agreement or similar arrangement in which the Company has an interest in excess of amounts expressly authorized by the terms of the contract or any related trust or other agreement pursuant to which such letter of credit, trust, escrow, or similar arrangement has been established; provided, however, no drawing against any letter of credit shall be made in connection with any commutation unless the amount has been agreed in writing with the Petitioners or permitted by further Order of the Bankruptcy Court;
- Requires that all persons and entities, including without limitation, all Scheme Creditors, in possession, custody or control of the Company's property in the United States or the proceeds thereof, turn over and account for such property or its proceeds to the Petitioners;
- Requires that all persons and entities including, without limitation, all Scheme Creditors, that are beneficiaries of letters of credit established by, on behalf of or at the request of the Company or parties to any trust, escrow or similar arrangement in which the Company has an interest, to: (a) provide notice to the Petitioners' United States counsel of any drawdown on any letter of credit established by, on behalf of or at the request of the Company, or any withdrawal from, setoff against, or other application of property that is the subject of any trust or escrow agreement or similar arrangement in which the Company has an interest, together with information sufficient to permit the Petitioners to assess the propriety of such drawdown, withdrawal, setoff or other application, including, without limitation, the date and amount of such drawdown, withdrawal, setoff or other application and a copy of any contract, related trust or other agreement pursuant to which any such drawdown, withdrawal, setoff, or other application was made, and provide such notice and other information contemporaneously therewith; and (b) turn over and account to the Petitioners for all funds resulting from such drawdown, withdrawal, setoff, or other application in excess of amounts expressly authorized by the terms of the contract, any related trust or other agreement pursuant to which such letter of credit, trust, escrow or similar arrangement has been established unless such Scheme Creditor has a bona fide defense to this obligation to turn over;
- Requires that every person and entity, including without limitation, every Scheme Creditor, that has a claim of any nature or source and that is a party to any action or other legal proceeding (including, without limitation, arbitration or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) in which the Company is or was named as a party, or as a result of which a liability of the Company may be established, to place the Petitioners' United States counsel (Chadbourne & Parke LLP, 30 Rockefeller Plaza, New York, NY 10112, Attn: Francisco Vazquez, Esq.) on the master service list of any such action or other legal proceeding, and to take such other steps as may be necessary to ensure that such counsel receives: (a) copies of any and all documents served by the parties to such action or other legal proceeding or issued by the court, arbitrator, administrator, regulator or similar official having jurisdiction over such action or legal proceeding; and (b) any and all correspondence, or other documents circulated to parties named in the master service list.

Copies of the Motion, the Order and the Scheme of Arrangement are available upon written request to the undersigned counsel:

CHADBOURNE & PARKE LLP • Attorneys for the Petitioners • 30 Rockefeller Plaza
New York, New York 10112 • (212) 408-5100 • Attn: Howard Seife, Esq. and Francisco Vazquez, Esq.

www.BusinessInsurance.com/Notices

LEGAL NOTICE

IN THE HIGH COURT OF JUSTICE CHANCERY DIVISION COMPANIES COURT NO. 1128 of 2006 IN THE MATTER OF **NRG FENCHURCH INSURANCE COMPANY LIMITED** and IN THE MATTER OF **NRG LONDON REINSURANCE COMPANY LIMITED** and IN THE MATTER OF **THE FINANCIAL SERVICES AND MARKETS ACT 2000**

NOTICE IS HEREBY GIVEN that NRG Fenchurch Insurance Company Limited ("NRG Fenchurch") and NRG London Reinsurance Company Limited ("NRG London") presented an application to the High Court of England and Wales (the "Application") pursuant to Part VII of the Financial Services and Markets Act 2000 (the "FSMA") for an order:

- under section 111 of the FSMA sanctioning the scheme ("Scheme") for the transfer to NRG London of the direct and facultative reinsurance business (the "Transferring Business") effected and/or carried out by NRG Fenchurch in the United Kingdom; and
- under section 112 of the FSMA making ancillary provisions to implement the Scheme.

A copy of the report (the "Report") prepared by an independent expert, Mr David Slater of Watson Wyatt, Fellow of the Institute of Actuaries, in pursuance of section 109 of the FSMA and of a statement setting out the terms of the Scheme and a summary of the Report will be made available free of charge to anyone requesting such copies by contacting Mrs Pat Henley, by telephone on +44 (0) 1233 722600, by email to part7.transfer@nrgv.co.uk or in writing to NRG Fenchurch's head office at 5th Floor West, Charter House, Park Street, Ashford, Kent, TN24 8EQ, from the date of publication of this notice until the date on which the Application will be heard before the Court.

All claims currently being dealt with by or on behalf of NRG Fenchurch will, after the proposed transfer be handled by or on behalf of NRG London. Future claims arising under the Policies comprised in the Transferring Business will be similarly dealt with by or on behalf of NRG London. The proposed transfer will secure the continuation by or against NRG London of any legal proceedings by or against NRG Fenchurch that relate to the rights and obligations in respect of the Transferring Business of NRG Fenchurch.

The Application is directed to be heard before a Judge of the Chancery Division at the Royal Courts of Justice, The Strand, London, WC2A 2LL on 22 May 2006 and any person, including any employee of NRG Fenchurch and NRG London, who claims to be adversely affected by the carrying out of the Scheme may appear at the time of the hearing in person or by Counsel. Any person who intends so to appear, and any policyholder of NRG Fenchurch and NRG London who dissents from the Scheme but does not intend so to appear, should give not less than two clear days prior notice in writing of such intention or dissent, and the reasons therefore, to the Solicitors named below.

Dated this March 13, 2006

Clifford Chance Limited Liability Partnership of 10 Upper Bank Street, London E14 5JJ, Solicitors of NRG Fenchurch Insurance Company Limited and NRG London Reinsurance Company Limited (Attention: Ref: GXB/TACP/70-40006486)

LEGAL NOTICE

For 2006 BI Rates or Editorial Calendar

e-mail: tvasilakis@BusinessInsurance.com

Emerging Risk Strategies

Business Insurance will feature a series of columns in 2006 on the topic of "Emerging Risk Strategies" written by John J. Hampton, a professor of enterprise risk management and former executive director of the Risk & Insurance Management Society Inc.

Mr. Hampton is the KPMG Professor of Business and Director of Graduate Business

Programs at Saint Peter's College in Jersey City, N.J.

He previously served as dean of the business schools at Seton Hall University and Connecticut State University and was a professor of risk management at The College of Insurance, now the School of Risk Management at St. John's University. He was the ex-

ecutive director of RIMS from 2000 to 2004.

In this edition of *BI*, Mr. Hampton explores issues relating to enterprise risk management and how organizations can create a strong culture that fosters compliance with corporate governance requirements. In the column, Mr. Hampton discusses how Tyco International Ltd. changed its culture and

created a successful ERM program.

Beginning Wednesday, March 15, www.BusinessInsurance.com will feature an interview between Mr. Hampton and Tyco's risk manager. Readers are encouraged to offer their comments and questions in an online discussion forum at the site or to jhampton@spc.edu.

'Push' and 'pull' in enterprise risk management

By John J. Hampton

Everybody knows risks must be managed in an integrated program across the enterprise. Silos do not encourage a broad perspective on risk. Concurrently, members of boards of directors are intrigued by efforts to avoid the debacles of Enron, WorldCom, Tyco and others. Brokers, accounting firms and risk managers



Mr. Hampton

"push" the idea of enterprise risk management. For the most part, companies have been lukewarm to respond.

Contrast ERM efforts with those being taken in the name of "compliance." Thanks to the Sarbanes-Oxley Act, the Securities and Exchange Commission and the Basel II Capital Accord, companies are spending a fortune on internal controls and other processes that add only a negligible value to governance, risk management and accurate reporting of financial results. Compliance has "pull" and the resources needed to fulfill the external regulatory agenda.

The sad part of the story is that the cart is pulling the horse. We don't need compliance programs to manage the risk of misbehavior. We need ERM to coordinate all risk management, and compli-

ance will follow effortlessly.

This point can be illustrated with the whistleblower requirements of Sarbanes-Oxley. Audit committees of publicly traded companies must establish procedures for receiving and handling complaints from any source concerning accounting, internal accounting controls or auditing. Further, these firms must provide a channel—for example, a toll-free number—so employees can submit confidentially and anonymously their concerns about accounting or auditing matters.

There is nothing wrong with protecting whistleblowers. The problem is that ERM advocates—brokers, consultants, risk managers, internal auditors—know the need for whistleblowers is also the failure of governance and risk management. With an effective ERM system, the whistleblower should be redundant. Everybody would be empowered to report wrongdoing and unethical or illegal behavior. ERM drives compliance, not vice versa.

So why are discussions about ERM highly vocal but often ineffective, even as it lives in the shadow of compliance? Part of the problem is the failure to distinguish between horizontal and vertical risk management. Horizontal risk management deals with exposures in company operations. On a continuum from left to right, a firm faces risks in producing, distributing and marketing products and services. The focus of traditional risk management is to avoid disruption to the process of making profits while meeting the needs of buyers of

products or services. We manage risks involving suppliers, customers, partners and employees.

Companies have developed extensive financial and other rewards for executives to "pull" horizontal risk management. A disruption to the process of earning profits will be felt by employees in all areas, from bonuses to layoffs. Workers lose jobs when production dips, supply or distribution channels are blocked, products fail to sell or prices fall. The entire organization is energized to mitigate risk.

The same situation does not exist for most companies with respect to governance, culture and the firm's appetite for risk. We might call this vertical risk management, as it links the board of directors at the top with front-line employees on the bottom of the hierarchy. The board may spell out the desired risk framework. Senior management disperses it downward.

What happens next? Not much, if incentives do not support building a culture that carries risk management across the internal boundaries of operating units and staff cubbyholes. Stated simply, we cannot have ERM if employees lack incentives for improving business ethics and organizational governance.

Having said this, we only have to look as far as Tyco for a "pull" system for governance and ethical behavior. The story has been widely reported. Dennis Kozlowski became the chief executive officer of Tyco International Ltd. in 1992 and presided over a rapid growth in assets, earnings and

stock price. Over a 10-year period, Tyco used creative accounting to boost profit margins, moved its headquarters to Bermuda, set up a European finance subsidiary and created more than 100 subsidiaries to hide fund transfers and complicate an understanding of its finances. In 2002, following SEC investigations and a precipitous drop in stock price, Mr. Kozlowski was indicted.

At that point, Tyco had a strong sense of urgency to institute a pull system for vertical risk management, the start of meaningful ERM. In July 2002, Tyco appointed Edward D. Breen, Motorola's president, as its new CEO. One of his first acts was to appoint Eric Pillmore as senior vp of corporate governance, reporting directly to the board. In subsequent months, Mr. Breen replaced all the directors and recruited a new and independent board. At the same time, he dismissed the entire headquarters staff of 125 people. Think about that for a method of changing a corporate culture! Finally, in January 2003, Tyco hired Laurie Siegal as senior vp of human resources, to set up corporate governance and compensation systems and controls. Tyco is now a model of vertical risk management, built on integrity, excellence, teamwork and accountability.

This is a "pull" system across the enterprise. Accountability and excellence include financial and other incentives to make a unit perform in the market. Horizontal risk management is still in place. Integrity and teamwork promote a culture where misbehavior is not tolerated, ethical behavior is

encouraged, and managers must consider how their actions affect and endanger other units and the overall corporate reputation. Vertical risk management has been added to the measurement of management performance and reward mechanisms.

ERM will not be successful if a company thinks it is the job for a risk manager who is trained in loss control, insurance, safety or general administration. Nor will it work effectively if senior executives meet a few times a year as a central risk committee discussing risk mitigation and integration. Neither is it enough to bring in a consultant to develop a corporate-wide risk management program. All these actions can help, but first, the entity needs an internal structure that pulls rather than pushes risk management.

This is a good time to get ERM right. Compliance pressures now have the attention of the board, senior management and shareholders. Tyco and others seem to have the right model. Companies now have a model to follow and create their own customized programs of vertical risk management. Changes in culture and incentives will soon be followed by real enterprise risk management.

John J. Hampton is the KPMG Professor of Business and Director of Graduate Business Programs at Saint Peter's College in Jersey City, N.J. He specializes in business ethics, legal liability and enterprise risk management. He is a former executive director of the Risk & Insurance Management Society Inc.

PRODUCTS & SERVICES

Hartford adds E&O cover for real estate brokers

HARTFORD, Conn.—The Hartford Financial Services Group Inc. is offering an errors and omissions policy for small to midsize real estate brokers.

The real estate E&O liability product was designed to offer broad coverage to real estate firms engaging in residential sales, commercial sales, property leasing, appraisal and third-party property management. It provides protection from liability arising from an action or a failure to take action—resulting in injury or financial damage to a client. Some of the policy features include

payment for defense costs in disciplinary proceedings, coverage for sale of agent-owned residential property and defense coverage for discrimination charges.

The Hartford Financial Products division underwrites the policies.

For more information, contact Patricia Fitzgerald, national marketing director for Hartford Financial Products, at 212-277-0457 or visit www.hfpinsurance.com.

Guided2Health starts wellness program

MINNEAPOLIS—Guided2Health, an integrated medical management program provider, has introduced a

wellness program for self-insured employers.

The wellness program consists of five components that can be purchased separately or as a complete package. They include Wellness Online, featuring health risk assessments, cost management tools and employee newsletters; Wellness Coaching for Change, consisting of personalized nurse phone coaching; Wellness At Work, providing onsite health fairs and lab screenings; Results, offering integrated reporting of health risk assessments and ranking against benchmarks; and Wellness Support, offering support from clinical account coordinators and

participating tracking for incentive programs.

To learn more about Guided2Health's wellness program, telephone the company at 866-808-2609 or visit www.guided2health.com.

AIG unit introduces special-events program

NEW YORK—AI Risk Specialist Insurance Inc., a member company of American International Group Inc., has launched a special-events liability insurance program.

The program is available to special events with up to 10,000 spectators, including corporate outings, concerts and parties. It provides general

liability and accidental death and dismemberment coverage.

The available limits are \$1 million per occurrence/\$2 million aggregate.

For more information, contact Terri Moran, vp-marketing for AIG programs, at 415-836-7251 or at terri.moran@aig.com.

We'd like to report on new risk management and employee benefit products and services offered by your company. Send information to: Carrie A. Peinado, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; 312-649-5313; fax: 312-649-7801; e-mail: cpeinado@businessinsurance.com.

Lloyd's: Outsider will take over as CEO, leading market reforms

Continued from page 3

has made huge progress in recent years and is in good shape, but we are clear there is still much to do to improve the market's efficiency and move to the next level," Lord Peter Levene, chairman of Lloyd's, said in a statement announcing the appointment.

"At the IPE, he won consensus among market participants with often-divergent interests. Those skills will be invaluable in his new role where the key task is to provide the market with an efficient, modern platform," Lord Levene added.

"The market is in a strong financial position but is ambitious to move forward to the next stage. I am delighted to have the opportunity to lead Lloyd's on that journey," Mr. Ward said in the statement.

Lloyd's has previously appointed market outsiders to the CEO post.

Peter Middleton, who was named chief executive of Lloyd's in 1992, previously had been CEO of travel group Thomas Cook Ltd. Upon his resignation in 1995, Lloyd's named

as its CEO Ron Sandler, who had been at Lloyd's for only eight months in the position of director of special markets. Before joining Lloyd's, Mr. Sandler had served as

"We are clear there is still much to do to improve the market's efficiency and move to the next level."

Lord Peter Levene
Lloyd's of London

CEO of money brokerage Martin Bierbaum Group and securities brokerage Exco P.L.C.

Mr. Prettejohn, who succeeded Mr. Sandler as CEO in 1999, joined Lloyd's in 1995 from transportation company NFC P.L.C. Prior to being named CEO of Lloyd's, he worked

on the reconstruction and renewal effort and served as head of strategy, director of business develop-

ment, and head of the market's U.S. unit.

A spokesman for the Assn. of Lloyd's Members, which represents individual investors at Lloyd's, said that the names' association welcomed Mr. Ward's appointment.

"(We are) by no means concerned that he has come from outside" the insurance market, he noted. "Lloyd's is not an insurance company, it is a marketplace, and the skills he has demonstrated at the IPE are probably skills that will be useful at Lloyd's, the spokesman said.

Dave Matcham, CEO of the International Underwriting Assn., which represents London company market insurers, hailed Mr. Ward's appointment. "We look forward to working closely with Mr. Ward on joint market initiatives, as we have a shared interest in creating the best possible business environment in the London market," he said.

One Lloyd's market observer, who asked not to be named, said that, arguably, it is Lloyd's director of franchise performance, Rolf

Tolle, who is in charge of overseeing underwriting in the market, while the CEO role is one of "regulator and facilitator." The market needs someone to run an efficient platform and sort out the market's information technology needs, the source said.

Another London market source, who also asked to remain anonymous, said that, "on face value," it appears that Mr. Ward "has been brought in to take Lloyd's electronic," given his work at ICE Futures.

A previous effort to introduce a marketwide electronic trading platform was abandoned earlier this year (BI, Jan 30). In January, Lloyd's said it was closing its Internet-based risk data platform, Kinnect, after five years and an estimated cost of about £70 million (\$124.9 million).

Another market source said that "it is good to have new blood" brought in to lead the market but pointed out that Lloyd's is not a commoditized marketplace like the exchanges at which Mr. Ward previously has worked, and that "Lloyd's is very technical."

Lloyd's CEO's resume

Richard Ward, 49, previously worked in the energy industry, where he held senior positions at trading exchanges. Prior to his work in the energy industry, Mr. Ward obtained a doctorate in physical chemistry from Exeter University in Exeter, England, in 1982.

2005-06: London-based vice chairman of ICE Futures, part of Intercontinental Exchange Inc.

1999-2005: Chief executive of the International Petroleum Exchange (later rebranded as ICE Futures).

1996-99: Executive vp, the International Petroleum Exchange.

1995-96: Director of product development and research, the International Petroleum Exchange.

1994-95: Head of marketing and business development at Tradition Financial Services, a London-based financial and commodity brokerage.

1991-94: Head of business development and marketing at BP Oil Trading International, a London-based division of oil company BP P.L.C.

1988-91: Senior manager at BP research.

1982-88: Senior physicist at the United Kingdom's Science & Engineering Council, a government-funded research and training agency.

Results: Cost trends in managed care moderate

Continued from page 4

cer for the Hartford, Conn.-based managed care company.

"I think pricing is going to be pretty consistent," said Sally Rosen, a senior financial analyst with Oldwick, N.J.-based A.M. Best Co. Inc. "We see companies pricing close to trend. That's what they did in '05, and we expect to see the same in '06."

Cost trends have moderated partly because of moderating pharmacy cost trends, insurers say. Pharmacy spending increases were in the double digits in previous years, mostly due to the increased utilization of expensive, heavily marketed brand-name drugs. But a push by insurers and employers—propelled by incentives such as lower co-payments—to encourage employees to use generic drugs and expiring patent protection for some of the most commonly prescribed medications have helped drive down pharmacy costs.

Pharmacy spending is expected to continue to decline this year as popular medications such as the cholesterol-reducing drug Zocor and antidepressant Zoloft will lose patent protection, insurers say. WellPoint has already sent letters to its members announcing the waiving of co-payments for generic Zocor once a generic becomes available.

Los Angeles-based Health Net Inc. said it expects the pharmacy cost increase trend to be in the 8% to 9% range for 2006 with some relief because of the expected influx of generic drugs.

With cost trends in a fairly predictable range, insurers are becoming more confident of their ability to estimate costs and price their products appropriately, resulting in most companies reporting solid earnings in 2005 (see chart, page 4). "I think, overall, the earnings were still good," Ms. Rosen said.

Most of the managed care companies also reported solid membership

gains in 2005, the exceptions being Philadelphia-based CIGNA Corp. and Health Net. Both companies showed progress in reversing membership declines in the second half of last year, but Health Net recently stated that first-quarter 2006 membership will be between 3% to 4% lower than at the end of 2005 because the company was "cautious in our pricing" in its large group segment, said Chief Financial Officer Buddy Pizel.

"That caution, while good for margins, did cause us to lose select large January renewals where our pricing was not as competitive," Mr. Pizel said during the company's recent earnings conference call.

"The biggest challenge for these companies is adding membership," said Joseph Marinucci, credit analyst with New York-based Standard & Poor's Corp. "The commercial market is stagnant to shrinking. Many small groups are being priced out of the market. How do you grow commercial membership when (the companies) are basically stealing accounts from each other?"

Membership figures for some of the largest managed care organizations have been bolstered by mergers and acquisitions over the past year. Minneapolis-based UnitedHealth Group gained 3 million members with its purchase of Cypress, Calif.-based PacificCare Health Systems Inc. while rival WellPoint added about 5 million members in the New York region via its acquisition of New York-based WellChoice Inc.

With these acquisitions, the two largest managed care companies have clearly distanced themselves from competitors such as Aetna and CIGNA, but both Aetna and CIGNA have relatively strong positions, Mr. Marinucci said. "I don't think they feel obligated to do anything, but at some point there clearly is momentum toward future consolidation,"

he said.

While Ms. Rosen acknowledged there are some larger acquisitions that could occur, she said she believes the trend will be toward smaller acquisitions focusing on particular targets such as specialty drug companies.

In an effort to add to their membership rolls and revenues, managed care companies are increasingly turning their attention to the government segment of the marketplace, with a strong focus on Medicare Part D and Medicare Advantage plans. Louisville, Ky.-based Humana Inc., an early entrant into the revamped Medicare programs, has seen Medicare membership rise 48% since year-end 2004. As of Jan. 1, the company has 1.4 million Medicare prescription drug members and 640,000 Medicare Advantage members. Humana expects Medicare membership growth to accelerate in both 2006 and 2007.

"Humana is clearly taking advantage of their leading presence in that market," Mr. Marinucci said. "The government-sponsored health care markets are where the opportunities are."

Meanwhile, the emphasis on consumerism and related product offerings is likely to continue as the managed care companies try to make further strides in controlling cost trends. Aetna, the first national carrier to enter the CDHP market, now has more than 450,000 members in these plans. Aetna's CDHP products are performing well with respect to cost trends, and its members are not forgoing needed medications and preventive services, a key concern about these products, company officials say.

"So we do see the product has legs," Mr. Williams said. "It's working very well. And it is producing a lower cost trend consistent with our expectations."

Med mal: Narrow relief offered in birth case

Continued from page 4

sion. It is "simplistic to state merely that the damages are based upon the expenses incurred in raising Matthew with a disability over and above those expenses that his parents would incur if he were not disabled," says the opinion.

"We cannot simply skirt that claim and award damages based on a calculation of life versus impaired life because unimpaired life was never a possibility in this situation," says the opinion.

"We find that the consequential economic and noneconomic damages suffered by the Schirmers lack a causal link to the alleged negligence of defendants in this case, but that pregnancy—and birth-related costs—are sufficiently linked to allow recovery."

The decision notes, though, that in earlier proceedings, the Schirmers dismissed their claim for these damages, and so they cannot recover for even those injuries.

Commenting on the decision, Frank C. Woodside III, an attorney with Dinsmore & Shohl L.L.P. in Cincinnati who represented Children's Hospital Medical Center in Cincinnati and another defendant in the case, said it "was a logical extension for the case law in Ohio."

However, others say the decision is narrower than the opinions of many other state courts on this issue. A dissenting opinion supported by two judges on the court, for instance, says: "Ohio has staked out a unique position in regard to damages in this type of cases."

"Leading treatises suggest that Ohio will be the only state that recognizes a cause of action in negligent prenatal counseling cases...but limits damages to the costs arising from the pregnancy and the birth

of the child."

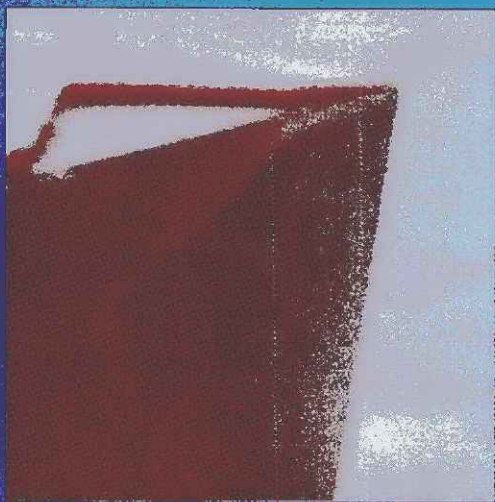
Alan Meisel, director of the University of Pittsburgh's Center for Bioethics & Health Law, said, "The courts are split. Some give economic damages, some give damages for pain and suffering, some give both," but the Ohio decision "is at one end of the spectrum in really providing the narrowest form of relief," said Mr. Meisel.

John A. Day, a plaintiff attorney with Brentwood, Tenn.-based Branham & Day, said, "Most states would recognize, at a minimum, the extra expense attendant to the caring of a disabled child over the caring of a nondisabled child as part of the elements of damage in this case."

David A. Larson, a professor at the Hamline University School of Law in St. Paul, Minn., said, "This probably represents maybe a middle ground in that it recognizes there is a cause of action for wrongful birth but then they restrict it" to the cost of birth and pregnancy, and avoids addressing the philosophical question concerning the sanctity of life.

Daly D.E. Temchine, an attorney with Epstein, Becker & Green in Washington, agreed. "Basically, what they were trying to do is find some means of making doctors and genetic counselors liable" for performing their work sloppily "but did not want to do so by creating the principle that there's such a thing as wrongful life."

Schirmer et al., appellants and cross-appellees, vs. Mt. Auburn Obstetrics & Gynecological Associates Inc., et al., appellees and cross-appellants; Ohio Supreme Court, No. 2004-0296, March 3, 2006.



Substance.

Business Insurance delivers all the news and information on trends and developments corporate executives responsible for employee benefits need – in print each week, online at BusinessInsurance.com and in *BI's* Daily News Alert and Benefits Management News Alert e-mail products.



Wisdom.

More than 121,000* readers depend on *BI's* editorial products as their most important resource for the most timely, accurate and thorough coverage of employee benefits management issues. *BI's* authoritative editorial leadership sets the agenda for our industry.



And the tools you need to devour your competition.

BI's targeted **Benefits Management Sections** make it possible for our advertisers to get their message directly to the prospects they need to reach most – top-level corporate decision-makers responsible for purchasing employee benefits products and services.

BUSINESS INSURANCE BENEFITS MANAGEMENT SECTIONS

Many of *BI's* monthly **Benefits Management Sections** also include statistical charts and exclusive rankings of benefit service providers, ensuring that they will be relied on all year long. Plus bonus distribution* of specific issues at key meetings and conferences such as ECFC, NBGH, NMHCC, CEBE, SHRM, BMFE, ISCEBS, Canadian RIMS and Baden Baden assures your message will definitely not be hungry for extra exposure.

Take advantage of this opportunity while it's hot. Contact Ken Luker, Advertising Director, at 212-210-0133 or e-mail kluker@BusinessInsurance.com.

*Includes pass-along readership.

2006 ISSUE LIST

Jan 23:	Retiree Benefits: Health Care
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:	Benefit Consulting & Outsourcing

AD CLOSE

Jan 11
Feb 15
Mar 1
Apr 5
May 17
Jun 7
Jun 28
Aug 2
Sep 6
Oct 4
Nov 15
Nov 29

* Bonus Distribution

NEW YORK: 212-210-0133
CHICAGO: 312-649-5275

IRVINE: 949-255-5355
BOSTON: 617-292-4856

www.businessinsurance.com
Business Insurance

Uninsured: States cut workers' benefits

Continued from page 1

private employers to help shore up their overtaxed Medicaid systems, observers say. Strapped for cash, many states are reducing their own employees' access to health benefits by relegating them to part-time or temporary status, or increasing their contributions to a point where they sometimes become unaffordable.

Ohio last July increased state employee health plan contributions to 15% of premiums from 10%, because "the state, like many other states, had significant concerns about the state budget," according to Nan Neff, benefits administrator, in Columbus. With the increase, the employee contribution for single coverage is now \$47.30 a month and \$128.91 for family coverage, she said.

While Ohio offers health benefits to part-time employees, their contributions are based on the number of hours worked, so those part-time employees who work fewer hours pay more for their health care, said Ms. Neff.

About 5,000 of the state's 60,000 workers are not eligible for coverage because they are either seasonal or temporary workers—a growing phenomenon in the public sector, experts say.

"Perma-temps—people without health insurance—are almost as big a problem in the public sector as the private sector," said David West, executive director of the Center for a Changing Workforce, a nonprofit research organization in Seattle that focuses on issues affecting low-wage and nonstandard workers. "In the last 10 years, the public sector strategy has been to reduce the number of employees eligible for insurance."

He said that the center's analysis of 2004 Medicaid enrollment found that as many as 10% of Washington state's 160,000 employees were receiving government health assistance.

"I'm sure every state and local government has people on Medicaid," Mr. West said.

Because many government budgets provide for a specific number of full-time positions, public entities often hire temporary, seasonal, part-time or other types of contract workers who usually are not eligible to participate in benefit plans, according to Rick Johnson, senior vp and national public sector health practice leader for the Segal Co. in Washington.

Dennis DiMarzio, chief operating officer for the city of Boston, attributed that city's appearance on the Massachusetts list to part-timers, "school crossing guards and things like that."

Because, in his opinion, the city's benefit package is reasonably priced—\$45.12 a month for individual coverage and \$121.32 a month for family coverage, Mr. DiMarzio said that any eligible employee who isn't enrolled is "irresponsible."

"Even if you're making \$30,000 a year—that's \$600 a week—to not spend essentially \$10 a week to get yourself coverage, outstanding cov-

erage, to me is individual irresponsibility," he said.

He acknowledged, however, that it might be difficult to afford family coverage on that income.

According to the Massachusetts list, 1,110 city of Boston employees were receiving public health assistance. The city has 17,000 active employees and about 12,000 retired employees enrolled in its health plan, according to Mr. DiMarzio.

"I'm not surprised there are folks

health care," said Darrell E. Wells, director of risk management for the city of Odessa, Texas, and chairman of the board of trustees of the Family Health Benefits Pool that provides coverage to city employees.

"Eventually, the pain level rises to the point where even government has to act," he said.

While the city of Odessa is still offering benefits to employees at almost no cost—individual coverage is free and employees with two or

State government vs. retail industry

	Government	Retail
Average salary:	\$38,411	\$31,951
Employer offers incentive to waive coverage:	19%	5%
Percentage of employees waiving coverage:	9%	30%
Percentage of employees electing dependent coverage:	56%	44%
Benefit cost as percent of payroll:	15.6%	9.9%

Source: 2005 Mercer Human Resource Consulting National Survey of Employer-Sponsored Health Plans

who can't make it on public salaries," because "there's always a tug of war between pay raises and benefits," said Segal's Mr. Johnson. "There's only so much tax money. They can't raise prices like private employers—that would be called raising taxes."

In general, public-sector employees "are probably over-benefited and underpaid and some of that reflects the thinking of our members. They really value their benefits," said Steve Kreisberg, head of collective bargaining at American Federation of State, County and Municipal Employees in Washington, which represents about half of the nation's public employees.

"So when we negotiate, the members say in a very clear voice, 'Look, if I have to sacrifice wages, I will, but hold onto my health benefits,'" he said. "But we're not increasing their standards of living as much as we should because health benefits are eating up an increasing share of their income."

For example, New York employees earn an average of just \$28,000, which would make any kind of contribution difficult, according to Mr. Kreisberg.

"That's about rent if you're going to live in a lot of neighborhoods in New York City," he quipped.

Subsidized workers

While AFSCME doesn't track the number of public employees without health care coverage, it is looking into the uninsured program among a growing number of employees, such as home health and child care workers, who are not on public payrolls but whose wages are financed by government programs.

These individuals are "paid with Medicaid money, but they have no health benefits," Mr. Kreisberg said. "There are also childcare workers who are getting subsidies from public programs. In the '80s there might have been a state agency created to employ them and provide benefits. But not today."

"The fact is, I don't know of a single government that is so rich and fat and happy that it can keep up with the increased cost in employee

more dependents pay just \$27.85 a month—other Texas communities aren't," Mr. Wells said.

As an example, he described the recent experience of a police officer who left Odessa to take a job as the police chief in another town.

"He called me on my cell phone after he was offered the job to say he had gotten his health insurance information and that something was terribly wrong," Mr. Wells recounted.

While the town offered to pay 100% of the cost of his individual coverage, he would be required to pay more than \$370 a pay period for employee-plus-family coverage.

"It was almost \$10,000 for the same thing he was getting for a little over \$300 a year here," Mr. Wells said. "He asked me, 'They pay pretty good around here in this little town. But they've got garbage truck drivers and low-level people, how can they afford to spend \$10,000 a year to insure their families?' I said, 'That's the point. This city is sending a message. The message is, 'We'll insure our employees. But we don't want your spouses and children.'"

"The fact is, we're starting to see government reject the idea that we have to provide the best benefits in town," Mr. Wells said.

When Kip Wall, former chief executive officer of the Office of Benefits for the state of Louisiana, discovered that about 9% of the state's workers could not afford to participate in the government's health plan, he tried to create a low-cost plan that would have provided at least basic benefits.

"We have a material percentage of state employees making under \$25,000 a year," said Mr. Wall, who now practices law in Baton Rouge.

Unfortunately, "we never could put together a plan of sufficient value to the employees to make it worth their while to invest in the product, and so it never did get off the ground," Mr. Wall said.

"There are still some public employer plans out there to die for...but comparable to what they were five years ago, not they're not common any more. The very rich plans are the exception," he said.



General Motors Corp. Chairman and Chief Executive Officer Rick Wagoner announces benefits changes as part of wider cost-cutting measures.

Pensions: GM changes benefits

Continued from page 1

hired before Jan. 1, 2001, and who are now covered under a traditional plan based on final-average pay will earn future benefits under a defined benefit plan based on career-average pay. That formula will result in reduced retirement benefits compared with those accrued in the final-average-pay plan.

- GM will restore its matching contributions to the 401(k) plan for all salaried employees. GM will match 50% of employees' salary deferrals up to the first 4% of pay. That match had earlier been suspended. At the time the match was suspended, GM had matched 20% of employees' deferrals on the first 6% of pay.

- The 401(k) program—both GM's automatic contributions and its matching contributions—will be the sole retirement income plan for salaried employees hired on or after Jan. 1, 2007.

GM, which last year lost \$8.55 billion, said it was taking its action to save money and reduce risk. "These changes will reduce financial risks and future costs for GM," said Rick Wagoner, chairman and chief executive officer of the Detroit-based automaker.

GM estimates that the changes to its retirement plans will reduce its pension obligation by \$1.6 billion this year.

Benefit experts say that, given GM's crucial need to further reduce benefit costs to restore profitability, the next likely action for GM and its competitors will be to propose phase-outs of the defined benefit plans for their union employees.

"In a troubled industry, the next step is for companies to say to their unions, 'We have bitten the bullet with salaried employees. Now we need help from you. Let's talk,'" said Sheldon Gamzon, a principal with PricewaterhouseCoopers L.L.P. HR Services unit in New York.

Others concur with that assessment. "Any employer that has taken that step with its salaried employees will try to make it a topic of negotiation with its union employees," said Andy Anderson, of counsel with the law firm of Morgan, Lewis & Bockius L.L.P. in Chicago. "Employers are certainly going to try that," concurred Michael Johnston, a consultant with Hewitt Associates Inc. in Lincolnshire, Ill.

Meanwhile, benefit experts say, the phasing out of defined benefit

plans by big employers shows no sign of slowing down. Indeed, as more big nationally known employers freeze their plans, it may be a catalyst for others to do the same.

"There is a bit of a copy-cat phenomenon," said Alan Glickstein, a senior consultant with Watson Wyatt Worldwide in Dallas.

In the past year or so, Hewlett-Packard Co., IBM Corp., Lockheed-Martin Corp., Motorola Inc. and Sears Holding Corp. have announced phase outs of their defined benefit pension plans.

The decisions that federal lawmakers make in the coming weeks in hammering out a final pension plan funding reform measure could determine if a lot more employers will be joining those that already are exiting the defined benefit plan system.

One key factor, pension consultants say, will be the extent of protection from age discrimination lawsuits legislators give to employers with cash balance plans and what strings, if any, legislators will attach to that protection.

Mr. Glickstein, for example, said he has several major clients with traditional plans that want to convert them to cash balance plans but have been waiting to do so until Congress clarifies the legal status of the plans. But if Congress does not give "iron-clad" certainty with "no unreasonable conditions attached," those and other employers may phase out those plans and offer only 401(k) plans, he said.

Resolving the legal status of cash balance plans is essential if legislators want to keep employers in the defined benefit plan system, Mr. Glickstein said.

ADVERTISER

INDEX

Issue of March 13

ADVERTISER	PAGE #
Aetna Corporate	11
AIG	24
Alliance for Affinity Security	15
Aon Corporation	2
Benefit Software, Inc.	12
Burnham Systems	16
Dempsey, Myers & Co., LLP	6
Flexible Benefit Service Corp.	9A/B
Liberty International Underwriters	13
Milliman	7
WLT	14
XL Insurance	5

Silverstein: Seeking double WTC limit

Continued from page 1

Silverstein argued that the destruction of each tower by a separate aircraft was a separate event entitling it to two policy limits. Before trial, though, a federal judge ruled that the definition of "occurrence" in the Willis policy form used in the placement process aggregated similar losses and would treat the Sept. 11 attack as a single event.

The question for jurors, then, was whether each insurer bound coverage under the Willis form or—as Silverstein argued—under various other forms, including a form Willis was negotiating with Travelers Indemnity Co., another participant in the program.

In the first phase of the trial, a jury found that 10 insurers—representing \$1.94 billion of the program's \$3.55 billion limit—bound on the Willis form. They included Swiss Reinsurance Co., Lloyd's of London underwriters and other London market insurers.

Nine insurers—representing \$1.13 billion of the limit—bound coverage under a variety of other forms, and a jury in the second phase concluded that they were all liable for two occurrences.

Before the trial, three insurers won summary judgments that they bound on the Willis form, while two others settled with Silverstein on a one-occurrence basis. They represented the remainder of the program limit.

In its appeal of the Phase I verdict, Silverstein argues that it is en-

titled to a judgment that Swiss Re did not bind itself to the Willis form because Willis had sent the insurer a revised binding slip in July 2001 attaching the Travelers form. That form did not define "occurrence" and would treat the Sept. 11 attack as two events, Silverstein contends.

Similarly, the London insurers never intended to be bound to the Willis form, signing slips that included the phrase "agreement of wording waived," Silverstein argues.

If the appeals panel does not reverse the jury verdict, the WTC leaseholder argues that it is entitled to a new trial against all of the Phase I insurers because of a variety of alleged errors by the trial judge in admitting evidence and charging the jury.

The jury was initially unable to reach a verdict on Swiss Re's participation, for example, and resumed deliberations after being ordered to do so by Judge Michael B. Mukasey. Judge Mukasey, though, improperly refused to give jurors a supplemental charge proposed by Silverstein on the law governing changes to the WTC policy form, Silverstein alleges.

Judge Mukasey also wrongly excluded evidence, such as testimony that would corroborate a Willis broker's claim that he orally notified a Swiss Re underwriter that the Willis form was no longer being used for the placement, Silverstein contends.

The nine insurers found liable for two occurrences in Phase II of the trial, meanwhile, are appealing that jury's verdict on a range of grounds.

The Phase II insurers argue that they are entitled to a judgment that they also bound coverage on the Willis form. One of the nine, for example, Royal Indemnity Co., notes that another Royal unit separately participated on the program and was found before trial to have bound on the Willis form; Royal Indemnity contends that two units of the same company could not have intended to bind coverage on different forms.

Judge Mukasey also improperly allowed testimony by expert witnesses for Silverstein, the insurers charge. One such expert testified that the insurance industry customarily treats each direct physical loss as a separate occurrence, supporting Silverstein's two-occurrence argument.

Another witness, a Travelers claims official, described a case in which a California arsonist set fire to four courthouses, three in a single day and two only 200 yards apart. Travelers treated the losses as four occurrences under a policy that, like the one it issued to Silverstein, contained no occurrence definition, the witness testified.

If the appeals panel does not reverse the jury's findings, the Phase II insurers—like Silverstein in its Phase I appeal—are seeking a new trial.

Late News

Continued from page 1

November 2005 estimate of 1,400. The brokerage earlier this year said it expects the initiatives to result in \$262 million in cumulative pretax charges through 2007, with targeted annualized savings of about \$180 million by 2008.

House names conferees for pension reform bill

U.S. House of Representatives leaders have named members to a congressional conference committee formed to work out a compromise pension funding reform bill. Named to the conference committee were 11 representatives—seven Republicans and four Democrats—including House Majority Leader John Boehner, R-Ohio, who played a key role in winning passage of funding reform in the House. The Senate earlier this month named its members of the conference committee.

Wisconsin lawmakers OK med mal award cap

The Wisconsin state Senate has approved a bill that would cap noneconomic damage awards in medical malpractice cases at \$750,000. The Senate sent the bill—A.B. 1073—to Democratic Gov. Jim Doyle for his signature last Wednesday. Both the state Senate and Assembly passed the measure by veto-proof majorities. A spokesman for Gov. Doyle said the governor is reviewing the bill.

Hannover Re forms U.S. specialty unit

Germany's Hannover Re Group is launching a new U.S. unit, Praetorian Financial Group Inc., to which it has transferred all specialty business. The New York-based operation is headed by Chief Executive Officer Rodman Fox, former CEO of reinsurance intermediary Benfield Inc., who joined Hannover Re U.S. unit Clarendon Insurance Group Inc. earlier this year. New York-based Clarendon, which had previously been responsible for the specialty business, will concentrate on the management of terminated programs and existing commodity business that falls outside of Praetorian's focus.

Berkshire seeking cat cover rate hikes

Berkshire Hathaway Inc. officials have concluded that its reinsurance units should now write "mega-cat policies only at prices far higher than prevailed last year," Berkshire Chairman Warren Buffett wrote in his annual letter to shareholders. And such business should be written "only with an aggregate exposure that would not cause us distress if shifts in some important variable produce far more costly storms in the near future," he wrote. Because of \$2.5 billion in hurricane losses from Katrina, Rita and Wilma, Berkshire Hathaway Reinsurance Group reported a \$1.07 billion pretax underwriting loss for 2005 vs. a \$417 million gain in 2004.

Catlin Group names head of new U.S. unit

Catlin Group Ltd. has named Rich Banas as president and chief executive officer of its planned U.S. operation, Catlin Insurance Co. Inc., for which it expects to gain regulatory approval to begin underwriting shortly. Mr. Banas previously was chief underwriting officer for XL Professional Lines, a division of XL Capital Ltd. Catlin said it would raise \$150 million of subordinated debt in the first half of 2006 to support its underwriting. Meanwhile, Bermuda-based Catlin posted net income of \$19.7 million for 2005, down from \$154.1 million in 2004, and raised £38 million (\$66.0 million) through a share issue last week. Catlin attributed the profit drop largely to hurricane losses.

NAIC to mull changes to collateral rules

The National Assn. of Insurance Commissioners at its spring meeting in Orlando, Fla., charged its reinsurance task force with developing "alternatives to the current regulatory framework, including the use of collateral within the U.S. and abroad." Unauthorized reinsurers—which are mainly non-U.S. companies—have been seeking relief from a U.S. requirement that they post 100% collateral for risks written in the United States. Many U.S. ceding companies and guaranty funds oppose change, fearing that it may diminish their security.

Briefly noted

Olin L. Wethington, former special envoy on China for the U.S. Department of the Treasury, has joined American International Group Inc. as chairman of AIG Cos. in China. In his newly created position, Mr. Wethington will oversee AIG's expansion of business in China....The United Kingdom's Pension Protection Fund, a guaranty fund modeled loosely on the Pension Benefit Guaranty Corp., said that Myra Kinghorn, its chief executive, will step down "in the spring." Ms. Kinghorn said in a statement that, after having been involved with setting up and running the rescue fund for two years, she wished to return to "my former part-time, nonexecutive career."...The property/casualty insurance market continued to soften in February, with composite rates for all lines down an average of 5% from the same month a year earlier, according to Dallas-based MarketScout.com, an online distribution channel.

At BusinessInsurance.com

New Online Poll: When will Congress approve legislation creating an optional federal charter for insurers?

Items in the Late News column originally appeared in *BI's Daily News* feature on www.businessinsurance.com. Visit the *BI* Web site to sign up to receive *BI's Daily News* by e-mail.

Products: Criminal sanctions proposal criticized

Continued from page 4

might be "well intentioned," it could end up criminalizing "subjective" judgments about a product's safety. "Are we seeking to hold the manufacturers criminally liable for a one-in-a-million event?" Mr. Engler asked.

Victor E. Schwartz, general counsel of the American Tort Reform Assn. who appeared before the hearing on behalf of both ATRA and the

U.S. Chamber Institute for Legal Reform, noted that defining "defect" is extremely difficult.

Dr. Barry J. Maron, director of the Cardiomyopathy Center at the Minneapolis Heart Institute, endorsed adding criminal sanctions to product liability law, citing problems with particular heart defibrillators—problems he said the manufacturer knew of but did not disclose.

"To make it criminal to knowing-

ly sell defective defibrillators would have the desired effect on the willingness of companies to make full disclosure. However, such a bill would have to be drawn narrowly so as to not have a potentially disastrous, chilling effect on law-abiding companies whose products may have occasional random defects," Dr. Maron said.

Sen. Specter gave no indication of when he might introduce a bill.

BI Stock Index [3/6 - 3/10]

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	
2953.70	0.86
Dow Jones	
11076.34	0.50
S&P 500	
1281.58	-0.44

Largest gains

SCPIE Holdings	10.61%
Markel Corp.	5.17%
EMC Insurance Group	3.60%
Ambac Financial	3.41%
AIG	3.31%

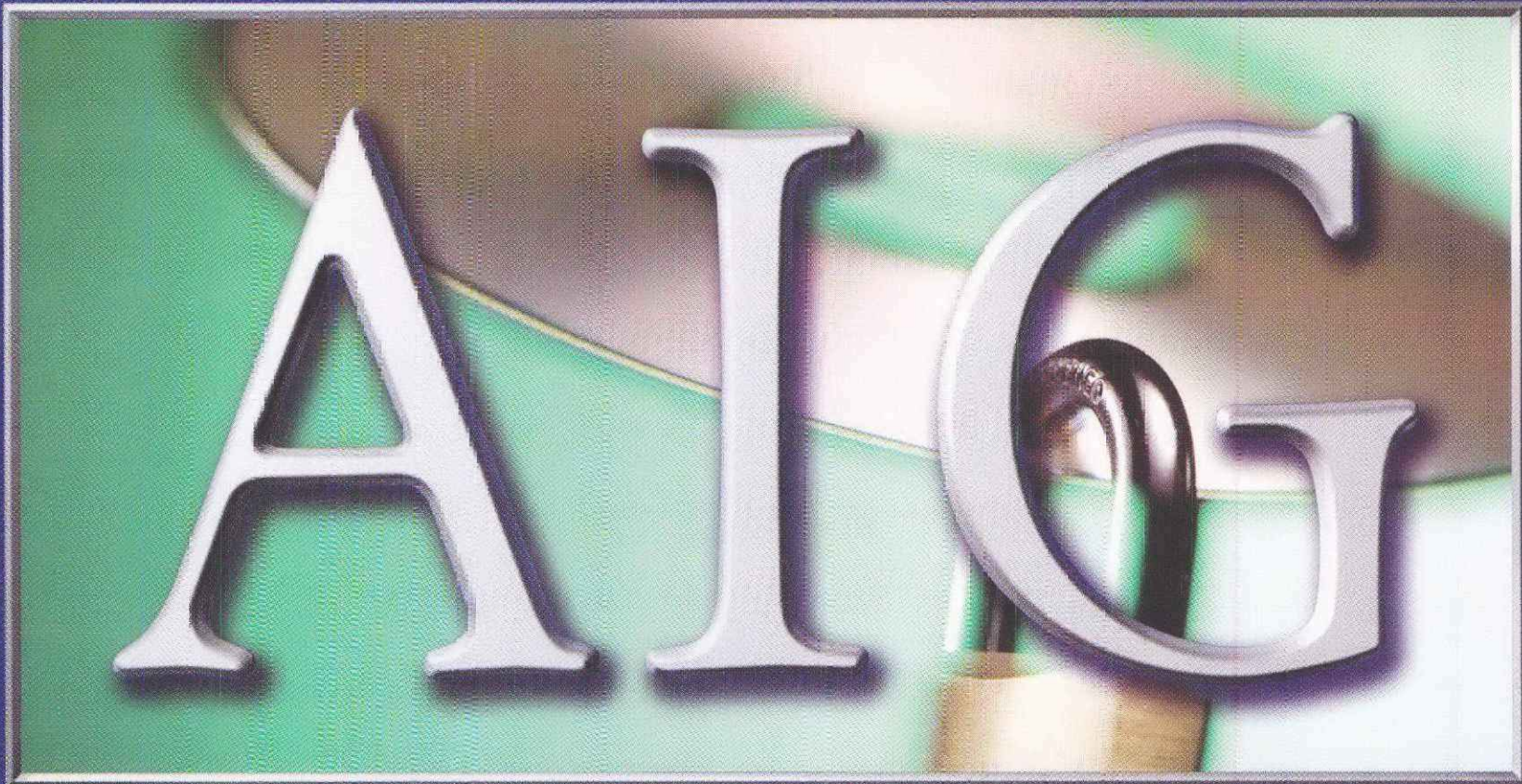
Largest losses

Vesta Insurance	-20.93%
Hub International	-6.97%
United Fire & Casualty	-6.35%
Argonaut Group	-3.75%
Willis Group Holdings	-3.30%

Weekly change by market segment

Brokers	-1.95%
Insurers/reinsurers	-0.18%
Managed care organizations	0.52%

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



**THE SECRET IS OUT.
CONSUMER INFORMATION IS HIGH RISK.**

Your clients can face significant legal liability when security breaches put private or confidential data at risk. Until now, insurance solutions weren't available to address this exposure. That's all changed with Security & Privacy Insurance from National Union, a new coverage that protects companies in all industries when personal data or confidential corporate information is unintentionally disclosed. Available alone or as part of our multifaceted network infrastructure, cyber-risk and professional liability insurance solutions, Security & Privacy Insurance will help your clients avoid the high cost of secrets told.

Join us for a FREE webcast on network
security & privacy Tuesday, April 25th at 2PM EST.
To receive an invitation or to learn more about
Security & Privacy Insurance, e-mail
professionalliability@aig.com.



WE KNOW RISK.®

National Union refers to National Union Fire Insurance Company of Pittsburgh Pa, a member company of American International Group, Inc (AIG). Insurance underwritten by member companies of American International Group, Inc. The description herein is a summary only. It does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for complete details of coverages and exclusions. Coverage depends on the actual facts of each case and the specific terms, conditions and exclusions of the applicable policy. Coverage may not be available in all jurisdictions. Issuance of coverage is subject to underwriting approval.