

CAR WORKERS RATIFY CONTRACT SHIFTING RETIREE BENEFITS INTO VEBA / PAGE 3

NEW ISO POLICY LANGUAGE NOT ENOUGH TO BAR COVERAGE IN MOLD SUIT, SAYS COURT / PAGE 3

SUPREME COURT CONSIDERS CLOSING CASE ON INSURANCE / PAGE 3

In Brief

3Q cat losses total \$1.13B

Property/casualty insured catastrophe losses totaled \$1.13 billion in the third-quarter, according to the Insurance Services Office Inc.'s Property Claim Services unit. For the comparable period in 2006, insurers paid \$1.25 billion in cat losses. For the first nine months of 2007, insured losses totaled approximately \$4.7 billion.

House panel OKs mental parity bill

The House Energy and Commerce Health Subcommittee last week approved mental health care benefits parity legislation and sent the bill to the full committee. The legislation mirrors bills cleared earlier by the House committees on Education and Labor as well as Ways and Means. Under the bill,

See **IN BRIEF** page 30

BENEFITS MANAGEMENT

Modeling tool could increase uptake of value-based plan designs; software shows it can pay employers to keep workers healthy; program helps assess outside vendors' performance; Web-based tools still don't meet expectations of employers with consumer-driven health plans. **Page 11**



Connecticut Attorney General Richard Blumenthal last week announced charges against reinsurance brokerage Guy Carpenter & Co. L.L.C. for alleged anticompetitive practices that went on as long as 50 years.

Marsh unit faces conspiracy suit

Reinsurance business targeted in latest probe

By SALLY ROBERTS

HARTFORD, Conn.—Another Marsh & McLennan Cos. Inc. unit—this time its reinsurance brokerage—came under fire last week when Connecticut Attorney General Richard Blumenthal filed antitrust and unfair trade charges against the unit.

The suit against Guy Carpenter & Co. L.L.C. marks a new twist in investigations into insurance industry practices, which until now have focused on brokers and insurers.

However, it is uncertain whether the suit—reminiscent of former New York Attorney General Eliot Spitzer's 2004 blockbuster fraud and antitrust suit filed against MMC and its Marsh Inc. brokerage unit—will have the same industrywide impact, sources say.

Several experts last week raised questions about the strength of the suit, and Guy Carpenter vowed to

defend itself saying the complaint has "no merit."

The suit, filed Oct. 4 in Superior Court in Hartford, Conn., alleges that the New York-based reinsurance brokerage conspired with reinsurers to fix prices—at levels above where they would be set in a competitive market—and stifled competition through its use of its own reinsurance facilities (see story, page 29).

As a result of the alleged schemes, insurance buyers have paid up to 40% more for coverage as cedents passed on the higher reinsurance costs, Mr. Blumenthal alleges (see story, page 29).

Rather than seeking competitive quotes on behalf of its cedents, Mr. Blumenthal alleges that Guy Carpenter funneled lucrative business to the facilities, with which it retained binding authority until 2004, in exchange for excessive fees

See **CARPENTER** page 29

Schwarzenegger fuels focus on convergence & consolidation

Latest proposal targets income workers and tax credits for employees earning up to 350% of the federal poverty level.

By JOANNE W.

SACRAMENTO, Calif.—Although numerous lawmakers, health plans and even a coalition of large, national employers are praising California Gov. Arnold Schwarzenegger's latest health reform efforts, they stopped short of endorsing his newly unveiled proposal.

Meanwhile, a package of competing bills also introduced last week by the Senate Republican Caucus is likely to fall by the wayside as lawmakers instead focus on the governor's 222-page plan.

The governor's proposal, which was introduced in bill form last week, largely resembles the plan he unveiled in January, with a few exceptions.

It still contains both an individual and an employer mandate, but it also calls for leasing out the state's lucrative lottery operations to a private vendor to raise money for health insurance premium subsidies

See **CALIFORNIA** page 29

Captives to battle IRS over key tax deduction

Rule would delay credit for loss reserves

By JERRY GEISEL

WASHINGTON—The captive insurance industry is gearing up to fight proposed Internal Revenue Service rules that would strip a key tax break now enjoyed by hundreds of captives.

In a move late last month that caught the industry by surprise, the IRS proposed removing a favorable tax rule for sponsors that use their captives to fund risks of various corporate affiliates and that file a consolidated tax return covering the affiliates and the captive.

Under current tax rules, such captives can take an immediate tax deduction for reserves established to pay for future losses of affiliated companies, the same treatment accorded commercial insurers. But

under the IRS proposal, a tax deduction—with only a narrow and largely irrelevant exception—could be taken only at the time a loss is actually paid.

Specifically, in situations where at least 5% of a captive's business was generated by related companies in which a consolidated tax return is filed, the IRS would treat such "intercompany transactions" as if they were self-insurance for which tax deductions cannot be taken when reserves are made—only when claims are paid.

"They would take away from captives what insurance companies have been permitted to do for a long time," said Anthony DiGilio, a partner with PricewaterhouseCoop-

See **CAPTIVES** page 28

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Union approves historic contract with GM

By JERRY GEISEL

DETROIT—Members of the United Auto Workers last week ratified a historic contract with General Motors Corp. that will end GM's obligation to provide retiree health care benefits to UAW members and also establish a cash balance pension plan for certain new employees.

In its announcement of the agreement, which was approved by about two-thirds of UAW members, the UAW disclosed additional details about the centerpiece of the contract: the creation of a voluntary employees' beneficiary association to fund retiree health care coverage.

Meanwhile, the UAW and Chrysler Group last week tentatively agreed to a new contract, which also calls for a retiree health care VEBA that Chrysler would fund in exchange for the automaker no longer being liable for providing benefits. Additional details were not available late last week.

Under its pact with the UAW, GM will continue to provide retiree health care coverage—at an estimated cost of \$5.4 billion—through Jan. 1, 2010, at which point its obligation

to provide coverage to current and future retirees will end. GM now has roughly \$50 billion in unfunded retiree health care obligations promised to current and future UAW retirees and their dependents.

On Jan. 1 2008, GM will make a cash contribution of \$24.1 billion to a retiree health care VEBA, which the UAW will administer. GM also is liable for up to 20 additional annual VEBA payments of \$165 million. These payments would be triggered at any time the VEBA's funding level is projected to be insufficient to provide current benefit levels for at least 25 years from the date of the required payment.

GM also is contributing a convertible note to the VEBA with a face value of \$4.37 billion. This note, which will pay interest, can be converted into GM stock by VEBA trustees and then can be sold by the trustees.

Additionally, retirees and surviving spouses currently receiving pension benefits will receive an additional special monthly pension benefit of \$66.70, offset by a \$51.67 monthly VEBA contribution. The size of the special pension benefit



REUTERS

Following the deal between the United Auto Workers union and General Motors, the Chrysler Group last week tentatively agreed to a new contract with the UAW, which calls for the creation of a health care VEBA.

and the VEBA contribution are fixed.

Additionally, new "non-core" entry-level employees will receive pension coverage through a cash balance plan. Under the plan design, employees will receive credits of 6.4% of pay, with employees' account balances credited with interest tied to the interest rate on the 30-year U.S. Treasury bond.

GM is the fourth major employer to announce adoption of a cash bal-

ance plan since Congress last year gave new plans protection from age discrimination suits. Other employers that have moved to cash balance plans over the last year include MeadWestvaco Corp., SunTrust Banks Inc. and, most recently, Dow Chemical Co.

Package delivery giant FedEx Corp. expanded an existing cash balance plan to cover many more employees.

Bar on 'known losses' doesn't halt mold claim

Court ruling tests new policy wording

By DOUGLAS McLEOD

WEST PALM BEACH, Fla.—An early judicial test of language added to general liability policies to limit claims for "known losses" has not gone as insurers might have hoped.

A federal court in Florida this month found that the so-called Montrose endorsement, developed by the Insurance Services Office Inc. in 1999, does not automatically bar coverage of claims arising from mold damage to a property, even though the liability policyholder—a roofing contractor—knew of water leaks at the property before its policies' inception.

ISO developed the endorsement in response to the California Supreme Court's landmark 1995 ruling in *Montrose Chemical Co. vs. Admiral Insurance Co.* The California court ruled, among other things, that policy provisions barring coverage of known losses do not necessarily apply—even when a policyholder knows of an event giving rise to losses—if the scope of the loss or the policyholder's ultimate liability have not been determined when coverage incepts.

ISO's Montrose endorsement, added to its comprehensive general liability forms to limit the *Montrose* ruling's impact, bars bodily injury or property damage coverage if a policyholder knows or any of its authorized employees know of the injury or damage "in whole or in

part" before the policy period.

In the Florida case, Transportation Insurance Co., a unit of Chicago-based CNA Financial Corp., sued Regency Roofing Cos. Inc. of Macedonia, Ohio, for a declaratory judgment on grounds that it had no liability for a mold claim under a trio of policies in force between 1999 and 2002.

The claim arose from Regency's replacement of a Florida homeowner's roof in 1999. The homeowner called Regency workers back several times over the next 17 months to fix leaks, and in 2002 sued the roofer for mold-related injuries allegedly caused by Regency's defective work.

In the coverage case filed by Transportation Insurance in U.S. District Court in West Palm Beach, Fla., earlier this year, the insurer contends that the Montrose endorsement bars coverage under two of the three policies, incepting in 2000 and 2001, because Regency knew by then about the homeowner's repeated complaints of roof leaks.

U.S. District Judge Donald M. Middlebrooks refused to grant the insurer summary judgment on the issue, though, distinguishing between Regency's knowledge of the leaks and its knowledge of mold damage.

Transportation "has provided no evidence establishing that Regency had any knowledge of the existence

High court ruling may increase E&O losses

Securities fraud case spotlights third parties

By DAVE LENCKUS

WASHINGTON—As the U.S. Supreme Court contemplates how far to cast the liability net in securities fraud cases, insurance experts dispute what effect even the most plaintiff-friendly ruling might have on executive management and professional liability insurance markets.

In a closely watched case, the high court last week heard arguments over whether securities law and an earlier Supreme Court decision allow investors to sue a company's suppliers for their role in the company's securities fraud scheme.

A ruling that upholds the so-called scheme liability theory would allow defrauded investors to try to recover their losses from not only companies that committed fraud but also accountants, lawyers, bankers and other third parties.

A defense victory would mean that only the U.S. Securities and Exchange Commission and the U.S. Justice Department could pursue those third parties.

Besides the case before the court, which involves a large cable TV and Internet provider, the ruling also could resurrect a suit that Enron Corp. investors brought against a group of investment banks. A federal appeals court in March ruled that securities law and the Supreme Court's earlier decision bar the investors from recovering \$33 billion from the banks for allegedly helping Enron deceive investors before the company's 2001 col-

lapse. Legal experts say scheme liability theory originated with the Enron case.

In the current Supreme Court case, *Stoneridge Investment Partners L.L.C. vs. Scientific-Atlanta Inc.; Motorola Inc.*, investors of St. Louis-based Charter Communications Inc. are suing two of Charter's business partners that allegedly helped it conceal its disappointing financial results in 2000.

To meet stock analysts' revenue expectations, Charter engaged in accounting chicanery that depended on Scientific-Atlanta's and Motorola's willing participation, according to the suit.

Under the plan, Charter paid the two companies \$17 million more than contracted for cable TV boxes they produced for Charter. The companies then paid Charter \$17 million as advertising fees.

Charter inflated its revenues by spreading the overpayment over time but immediately booking the advertising fees as new revenues, the investors allege.

Scientific-Atlanta and Motorola said the transaction was necessary to cover higher-than-expected production costs, but the two companies did not impose similar cost increases on other buyers, the investors allege.

The defendants said they never recognized the overpayment as revenue and did not expect Charter would account for the advertising

See **MONTROSE** page 28

See **LIABILITY** page 28

Business Insurance.

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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New Orleans capacity still squeezed despite improvements

Rebuilding could slow or stop absent greater backing by insurers

By GLORIA GONZALEZ

NEW YORK—Despite dramatic improvements in New Orleans' hurricane protection system that have reduced the risk of flooding, property insurance capacity for risks in the city remains constrained, threatening the post-Hurricane Katrina rebuilding process, observers say.

High premiums and sizeable deductibles are complicating risk managers' efforts to secure adequate insurance coverage, particularly builders risk insurance, a critical element in rebuilding the city.

Although New Orleans still faces

a significant risk of flooding, the exposure has been vastly reduced due to efforts to strengthen the hurricane protection system, said Lewis Link, senior research engineer in the department of civil and environmental engineering at the University of Maryland in College Park. Mr. Link spoke at a seminar sponsored by the Inland Marine Underwriters Assn. in New York last week.

The U.S. Army Corps of Engineers is raising the height of New Orleans' levees and floodwalls and enhancing the protection system's ability to withstand environmental factors such as erosion that can weaken protection. That "gives latitude to deal with the effects of Mother Nature that were not built into the previous system," said Mr. Link, director of the Interagency Performance Evaluation Task Force, a

team of experts from various public and private organizations.

IPET was established by the Corps of Engineers in October 2005 to evaluate the performance of the hurricane protection system in responding to Hurricane Katrina and to analyze the risk and reliability of the system following repairs. The group developed a risk assessment model that factors in potential hazards from 152 storms of varying sizes and degrees of intensity, the performance of the levees, floodwalls, pumps and gates that comprise the hurricane protection system, and the projected life and property losses based on the reliability of the system.

The critical hazard for New Orleans and the surrounding area is

See **NEW ORLEANS** page 28



LANDOV

Since the post-Katrina levee failure along New Orleans' 17th Street Canal, the Army Corps of Engineers installed pumps to control the canal's water level.



Potential playground injuries are one of many hazards for which school risk managers must plan.

School risk manager designation expanding

Program that began in Texas adding two sites in California

By KRISTIN GUNDERSON HUNT

AUSTIN, Texas—In response to the growing need for strategic risk management at educational facilities, a program geared toward helping school risk managers mitigate operational risks is expanding at the end of this month.

The Certified School Risk Managers Program, a designation for risk management education specialists that originated in Texas in 2005, will now be offered in San Francisco and Pasadena, Calif. The program, created by the Austin, Texas-based National Alliance for Insurance Education & Research, delivers continuing education for insurance and risk management professionals.

"Risk management has certainly escalated in its importance and value in the public and private industries," said Priscilla Oehlert, vp of advanced program development at the National Alliance. Ms. Oehlert is also based in Austin. "The school risk management sector has mirrored that rise in value as well."

The growing importance of risk

management at schools stems from the exposures unique to educational institutions as well as typical exposures most organizations or businesses face, Ms. Oehlert said.

Some of the exposures include school violence, school buses, cafeterias, playgrounds and extracurricular activities.

"Exposures exist from the time doors open for business," Ms. Oehlert said.

Those risks, and a need for industry-specific professional training, spurred the National Alliance to develop the program, said Carolyn Smith, the group's vp of marketing. She said a group of Texas school risk managers came to the organization in 2005 and requested a forum for networking and for education on risk management issues.

"There has been a big demand for professional training," Ms. Smith said. "They want to have something that is state of the art and something that is consistent from state to state and school to school."

The curriculum is made up of five courses covering topics such as identifying exposures, the risk management process, implementing and monitoring risk management programs, examining loss funding

See **DESIGNATION** page 27

Surplus lines industry fears growth of government-backed insurance

Federal, state vehicles impinge on areas served by E&S market

By ROBERTO CENICEROS

NEW ORLEANS—Additional involvement by government in the insurance industry—from catastrophe coverage to health care—would do more harm than good, a panel of industry leaders told the National Assn. of Professional Surplus Lines Offices Ltd.

In particular, several concerns have arisen from Florida's expansion of the state's Citizens Property Insurance Corp., a state-backed insurer of last resort, insurers and

wholesalers said at NAPSLO's 2007 Annual Convention Oct. 3-6 in New Orleans.

In January, Florida lawmakers directed Citizens to write commercial policies beyond high-risk coastal areas. They also froze Citizens' rates for this year and added \$17 billion to a state catastrophe fund to help insurers purchase reinsurance at below-market rates.

Then in April, Citizens announced it would begin offering a multiperil policy throughout the state. The policy would cover the first \$2.5 million in limits for structures valued at \$20 million or less, but how the coverage will be managed and how claims will be paid remains unknown, the speakers told NAPSLO.

But if Citizens proves successful, the federal government could decide to expand the model from Massachusetts to Texas, said M. Steven DeCarlo, president and chief executive officer of Charlotte, N.C.-based AmWINS Group Inc.

"The federal government is in crop (insurance); they are in TRIA," Mr. DeCarlo said. "My biggest fear is the federal government sees this (Citizens' program) as a model."

Surplus lines companies wrote nearly \$4.6 billion in property premiums in Florida during 2006, according to industry data.

Citizens' expansion would cover the midsize risks and small commercial properties that are a surplus

See **SURPLUS LINES** page 27

Nonadmitted premium volume falls as prices soften across most lines

More options open to insurance buyers as capacity increases

By ROBERTO CENICEROS

NEW ORLEANS—Rapidly falling property catastrophe insurance rates, further easing in casualty rates and weakness in the housing sector are combining to shrink premium volume in the surplus lines sector.

And that trend is likely to continue absent a major natural catastrophe loss, said insurers and wholesale brokers attending the National Assn. of Professional Surplus Lines Offices Ltd.'s annual convention in

New Orleans earlier this month.

Property cat rates today are softer than they have been since the hurricanes of 2005.

"There is general surprise at how quickly the (property) market got really soft," said Christopher M. Treanor, president and chief executive officer for Mercator Risk Services Inc., a wholesale brokerage in New York. "Short of a major windstorm or quake, this market is not going to change soon."

Declines as much as 50%

Rates for earthquake-exposed property have seen particularly sharp declines, said Ronda Whaley, a property broker for Brown & Riding Insurance Services Inc. in Los Angeles. At the end of the summer,

renewal rates for quake-exposed property were about 25% to 30% lower, and now some accounts are seeing 50% reductions, she said.

At the same time, capacity is increasing, Ms. Whaley said. Some accounts that required four or five insurers last year to fill out their necessary limits now can obtain the same limits from one market, she said.

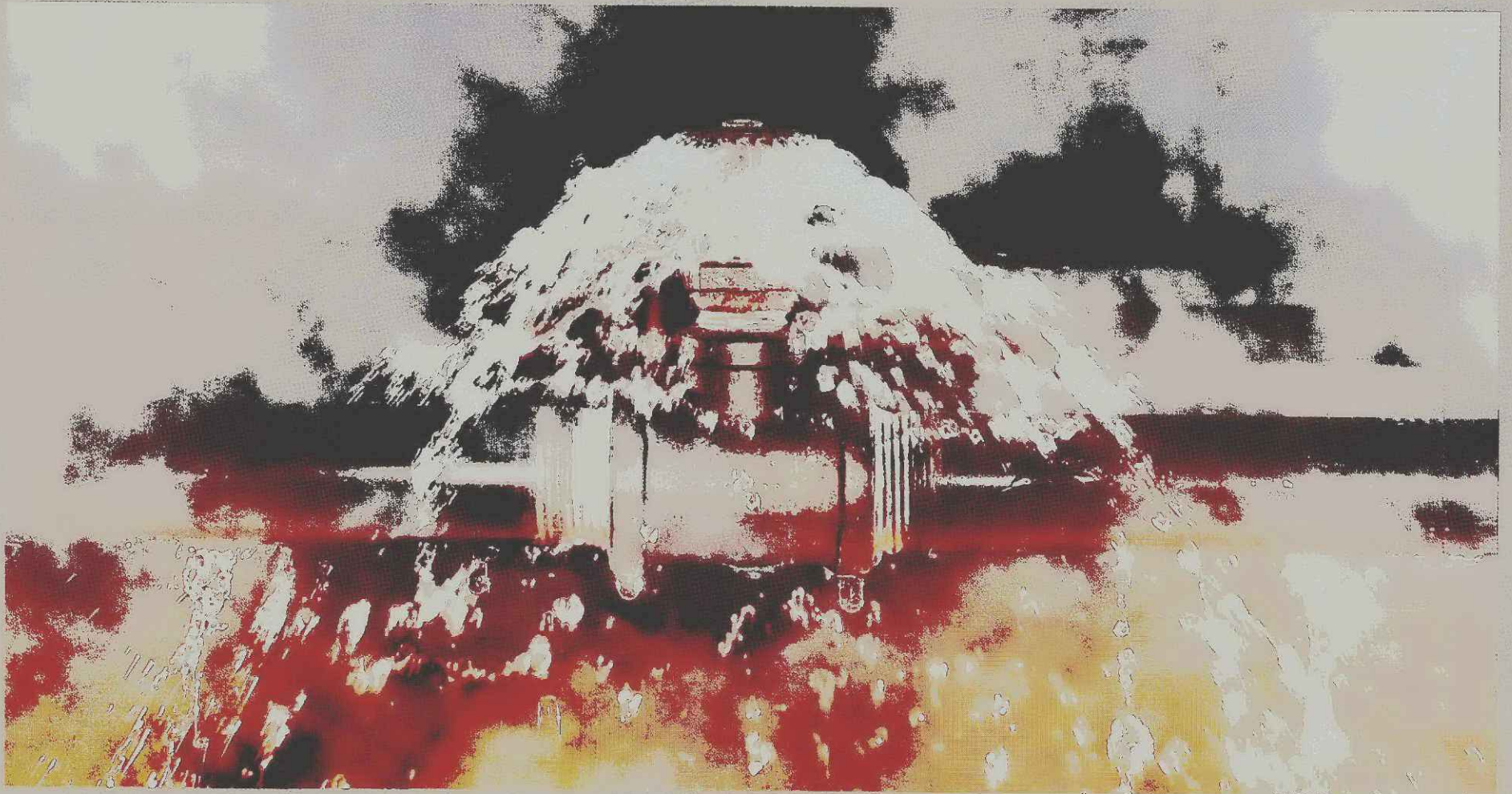
On certain large, layered property programs, Boston-based Lexington Insurance Co. is providing higher limits than it did a year ago for catastrophe-exposed risks, said Matthew F. Power, president of Risk Specialists Companies Inc., a network of broker units for Lexington.

See **PRICING** page 27

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that appealed to both the company and its landlord. The existing system was replaced with one designed for high-pile storage and the building was outfitted with new heaters to prevent the pipes from freezing. In addition to protecting its inventory, the company saved almost \$30,000 a year in premiums. It's all part of Wausau TotalValueSM and our commitment to lowering our customers' total cost of risk. A commitment backed by the financial strength of the Liberty Mutual Group. To learn **PRICE ≠ COST.** more, visit wausau.com or contact your Wausau representative.

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Commentary

Manufacturers cannot outsource responsibility

When you consider the risks associated with toys, safety seems like it would be at or near the top.

Designing and manufacturing safe toys is crucial because, unlike adults, children cannot be expected to make informed judgments about potential hazards and risks.

So it was shocking to see tens of millions of toys made in China being recalled recently for potential health hazards from lead paint and loose magnets—both hazards to the health of children, especially infants who tend to put any and everything in their mouths.

Mattel Inc. in August recalled about 20 million toys—including Sesame Street characters, Dora the Explorer figures and Barbie doll accessories—after learning that the paint used on them by Chinese subcontractors contained lead. It also recalled millions of toys with magnets that could potentially fall off, creating a choking hazard.

When these recalls were first announced in August, the initial reaction of many was to blame China, where regulatory supervision has not kept pace with the growth of manufacturing outsourced to low-cost suppliers there. In the wake of recalls earlier this year of tainted pet food and toothpaste made in China, that reaction was understandable. Following the toy recalls, two baby crib manufacturers issued a recall for 1 million cribs made in China.

I know of one mother who has pledged not to buy anything made in China, and she no doubt is far from alone in fearing that the safety of goods made there are suspect. Some U.S. politicians have called for trade restrictions on Chinese exports following the recalls.

China does need to improve its product safety oversight, but the ultimate responsibility for product quality remains with the manufacturers who design the products and import them. It is their name on the product, their profit from employing cheap overseas labor, their brand and reputation at stake and their risk management programs that must identify and eliminate safety lapses.

A Chinese-American insurance executive said to me last week of companies now scrambling to re-examine the risks of outsourcing manufacturing to China, "What the @#&?! did they expect?" Just because a product can be made in China for 30 cents vs. \$1 in America, he said, does not mean a manufacturer does not remain responsible for the quality of its product.

Mattel apparently agrees. In September, the world's largest toy maker took the unusual step of sending an executive to China to publicly apologize to Chinese safety officials, saying that flaws in Mattel's design were to blame for



PAUL WINSTON

Associate Publisher
and Editorial Director
Paul Winston's commentary
appears monthly. E-mail:
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the "vast majority of those products that were recalled."

Mattel pledged an overhaul of its product safety procedures, including certification of Chinese suppliers and more inspections of overseas manufacturing facilities and processes.

Whether Mattel's profits and reputation take a hit as consumers, especially in the upcoming holiday season, steer clear of Chinese-

'What the @#&?! did they expect?'

made toys remains to be seen.

In this era of global outsourcing and enterprise risk management, there are several lessons to be learned. Foremost among them is that any analysis of the benefits of using cheap labor in China and elsewhere must be weighed against added investment in product quality and safety controls. Consider also the potentially enormous cost of damage to reputation when outsourced production without oversight leads to a safety disaster, resulting in reduced market demand. For a toy maker, the implied promise of providing safe toys for children is paramount, and no insurance policy can make up the financial losses when that brand equity is damaged.

Toy makers are hardly alone in relying in low-cost labor in China to boost profits at home in America and elsewhere. In the wake of the toy recall fiasco, all companies should be on notice that risk management of outsourcing needs to be strengthened and maintained. After all, when consumers and shareholders sue for negligence and lost profits following safety problems and lower revenues, it won't be the subcontractor in China who is the main defendant.

To companies that ignore these lessons, one can only say: "What the @#&?! did they expect?"

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Business Insurance OPINIONS

Connecticut AG's suit has a familiar ring

OCTOBER HAS BECOME a terrible month for Marsh & McLennan Cos. Inc. On Oct. 4, Connecticut's attorney general sued MMC unit Guy Carpenter & Co. L.L.C., nearly three years to the day that Eliot Spitzer filed his landmark lawsuit against Marsh.

Charges of anticompetitive behavior, conspiracy to inflate prices and failure to disclose business relationships to clients sound eerily familiar. Yet those are among the allegations in the suit by Connecticut Attorney General Richard Blumenthal.

Guy Carpenter quickly condemned the suit, saying it reflects a "fundamental misunderstanding" of its clients' reinsurance needs and that the intermediary will defend itself vigorously.

At the heart of the suit are several facilities Guy Carpenter created and, the suit alleges, in which the broker had a financial interest and acted as underwriter. If true, that certainly smacks of a conflict of interest. Creating capacity and markets for insurers on facultative and treaty business is what good reinsurance brokers should do. But all brokers also have a duty to represent their clients' best interests, not play off both buyers and sellers.

The notion that ceding insurers were systematically overcharged for decades because Guy Carpenter didn't seek competitive bids defies belief, and it's something Mr. Blumenthal will have to prove. His suit notes that reinsurance historically has been little understood by those outside the industry, yet he seeks a jury trial of the charges.

Guy Carpenter should have its say, but it seems it will have a lot of explaining to do to clear its name.

All brokers have a duty to represent their clients' best interests, not play off both buyers and sellers.

Federal 401(k) match encouraging, troubling

"AMBIVALENCE" BEST DESCRIBES our attitude regarding a proposal by Sen. Hillary Clinton for the federal government to match lower and middle income employees' 401(k) plan contributions.

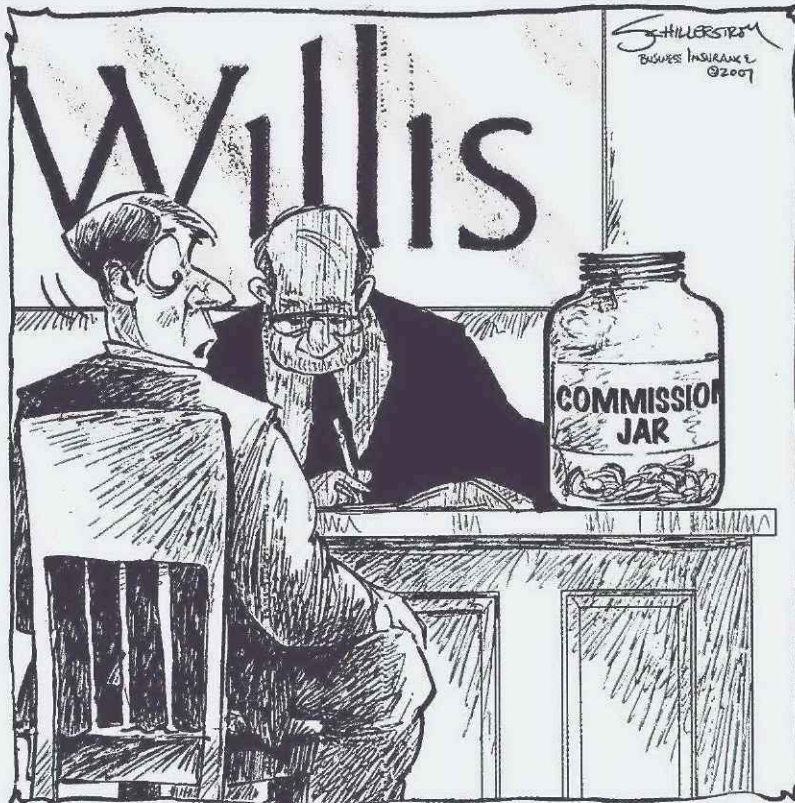
Under the proposal, which Sen. Clinton, D-N.Y., outlined last week on the campaign trail, the government would fully match the first \$1,000 contributed to a 401(k) plan by an employee earning up to \$60,000 a year, while matching 50% of the first \$1,000 contributed by those earning between \$60,000 and \$100,000.

These matching contributions would come in the form of a tax credit, which then would be deposited into employees' 401(k) accounts.

It would be difficult to oppose anything that encourages employees to save for retirement, especially given the nation's low savings rate. And we like that Sen. Clinton, currently the front-runner to win the Democratic presidential nomination, wants to give a boost to employer-sponsored savings plans.

On the other hand, there are troubling aspects to the proposal. Many, if not most, employers now match employees' salary deferrals to some extent. If employers are already matching employees' contributions, is there a need for a second match? In such cases, is that the best use of federal tax revenues?

That said, we very much like the fact that Sen. Clinton is focusing attention on retirement savings plans, something we hope the other presidential candidates start to do as well.



BI beat list

In an effort to ensure continuing timely coverage of risk management, insurance and benefit-related news, Business Insurance has formalized a list of its reporters' assigned beats. This list is not intended to be exclusive but rather to represent core subject areas of importance to BI readers. BI welcomes ideas and tips from readers on these and other areas. Following is a list of the beats and the principal reporters for each:

Agents/brokers: Sally Roberts.	legislation-risk management: Mark A. Hofmann.	Regulation of Insurance: Meg Fletcher.
Benefits-health care and ancillary benefits: Joanne Wojcik.	Health care industry operations: Gloria Gonzalez.	Reinsurance: Judy Greenwald.
Benefits-retirement savings/pensions: Jerry Geisel.	Industry Focus: Rodd Zolkos, Meg Fletcher.	Risk management profession: Dave Lenckus.
Canada-risk management and benefits: Gloria Gonzalez.	Insurance coverage litigation: Douglas McLeod.	Runoffs/receiverships: Douglas McLeod.
Employment practices: Judy Greenwald.	Insurance fraud: Douglas McLeod.	Safety/ergonomics: Meg Fletcher.
Environmental risk management: Sally Roberts.	Latin American markets: Roberto Cenicerros.	Surplus lines/wholesalers: Roberto Cenicerros.
Federal regulation/legislation-benefits: Jerry Geisel.	Property/casualty industry operations: Judy Greenwald.	Tort reform: Mark A. Hofmann.
Federal regulation/	Professional liability: Dave Lenckus.	Work/life benefits and EAPs: Sally Roberts.
	Property loss control/cat risks: Mark A. Hofmann.	Workers compensation: Roberto Cenicerros.

Online Poll at www.businessinsurance.com

Following the UAW/GM deal, how many more unions will take on responsibility for managing their members' retiree health care arrangements?



NEXT WEEK'S POLL: Is the proposed partial match of lower- and middle-income workers' 401(k) contributions by the federal government good retirement policy?

BI Online Poll tool sponsored by Wausau Insurance Cos.

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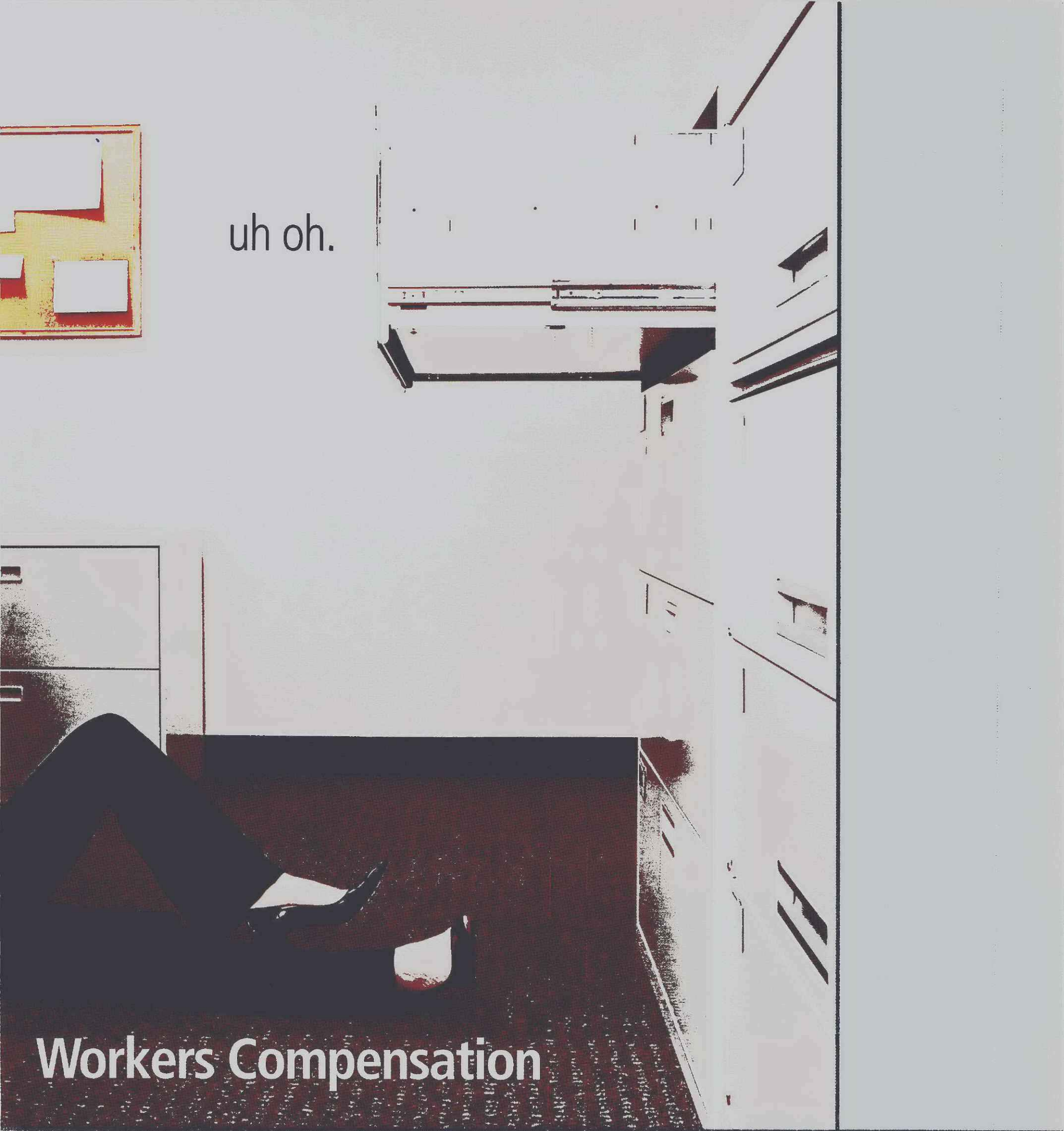
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In Brief

ING unit settles
kickback charge

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

UnitedHealth loses
bid to block probe

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

See **IN BRIEF** page 30

Benefits Management Technology & Online Solutions

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

IRS rules create problems for firms launching HSAs

By JERRY GEISEL

WASHINGTON—Employees who start health savings accounts next year could be shortchanged if their employers offer flexible spending accounts with grace periods.

In such situations, the maximum tax-free contribution made to an employee's HSA could be cut by as much as 25% during the first year of HSA enrollment, reducing funds available to pay for current year's health care expenses.

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

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

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

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

IRS rules, though, say that,

See **HSAs** page 6

Drug pricing system nixed by pact

Class settlement may
lead to reduced
prescription costs

By JOANNE WOJCIK

A proposed settlement of a class action lawsuit against the nation's No. 1 provider of average wholesale prices for pharmaceuticals likely will result in pharmacy benefit managers attempting to renegotiate their contracts to preserve their profit margins, experts say.

Employers, organizations and other PBM users should not pin their hopes on lowering their drug



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Page 20

BENEFITS MANAGEMENT



EXAMINING THE BENEFITS OF TECHNOLOGY

Value-based designs boost prescription usage up to 15%

Research focus shifting to examine how reducing copayments improves compliance and the bottom line

By JOANNE WOJCIK

A new modeling tool that measures the financial impact of value-based health plan designs may persuade more employers to implement them, its creators hope.

The tool, which was developed by researchers at Harvard Medical School and the University of Michigan using several large, national employers as test subjects, initially was used to determine the medical efficacy of implementing value-based health plan designs, which emphasize high-value medication and services by lowering or eliminating copayments to encourage plan members to use them.

But Lincolnshire, Ill.-based consultant Hewitt Associates Inc. has found a way to adapt the tool to help employers make implementation of a value-based health plan cost-neutral by projecting the additional plan costs if members avail themselves of the newly dis-

counted drugs and services so that employers can, in turn, raise the copayments for other less-valued drugs and services.

Although the value-based insurance design concept is nearly a decade old, the early adopters—such as Stamford, Conn.-based Pitney Bowes Corp.; Washington-based Marriott International Inc.; and Juno Beach, Fla.-based utility company FPL Group Inc.—pretty much did so based on “faith” rather than science, benefit experts acknowledge.

Although these companies publicly encouraged more employers to follow their lead, “the later adopters are more skeptical and hesitant,” said Craig Dolezal, a senior health care consultant for Hewitt in Atlanta.

“The universal question that employers ask is if there always is an increased cost,” he said. “This model takes prescription drug cost and utilization data at the most detailed level, calculates and organizes the data to show compliance...then imports the data into a clinical

actuarial model” that employers can use “to calculate the cost and utilization impact on their plan and how to spread those costs.”

For example, “if an employer wants to add incentives for diabetes and heart medications, but it doesn’t have additional money to spend, the tool will help determine how much to increase costs for other therapeutic classes and non-chronic condition-treating drugs to offset the additional cost,” Mr. Dolezal said.

“Value-based designs are attractive because they are designed in a way that removes financial barriers to care and encourages employees to seek and receive the essential care they need to manage their health,” said Melissa Miller, director of employee benefits and services at FPL, which was among the employers involved in the development of the Hewitt tool.

“But the biggest question for many employers is how to design these programs in the

most cost-effective way,” she said in an August statement announcing Hewitt’s release of the tool.

Before now, most studies have measured the negative impact on utilization of raising drug copayments, but little research has examined lowering copayments, said Clive Riddle, president and founder of Managed Care On-Line Inc., an online medical and health benefit technology vendor based in Modesto, Calif., who was not involved in the development of the Hewitt tool.

Since “cost shifting to the patient has been the big mantra this decade,” Mr. Riddle said, “usually studies look at the opposite: If they raise copayments, what impact will it have on utilization?”

Mr. Riddle cited a study of two employer-sponsored drug plans published in 2003 that found a significant number of employees

See **VALUE** page 14

Value: Change in focus examines the benefits of reducing copays

CONTINUED FROM PAGE 11

stopped taking certain medications—rather than switching to generics—when their employers moved to a prescription drug plan that charged significantly more for brand-name drugs (BI, Dec. 15, 2003).

Moreover, any estimates of potential savings of implementing value-based insurance designs “have historically been not research- or tool-based,” he said. “It’s been more quick-and-dirty, comparing projected expenses against actual.”

“They look at the prior year’s drug spend and try to project, but

they’re always off,” Hewitt’s Mr. Dolezal agreed. “Quantifying of the investment is a really big step for employers.”

“For a number of employers, this type of tool would give them a much better comfort level. These kind of tools are required to get the next layer of employers to move” into value-based health plan design, MCOL’s Mr. Riddle said.

Using a tool to reallocate health care expenses also “allows companies to meet cost targets without sacrificing the quality of care their workers receive,” said Michael Chernew, professor of health care policy at Harvard Medical School in

Boston, a collaborator on the tool’s development.

“The other question is to figure out how much savings would be produced by reducing adverse events that might occur if a person suffering from a chronic condition does not take their drugs,” he said.

“Value-based design initiatives recognize that it is imperative that as employers continue to control health care costs, they also have the responsibility, and the vested interest, in doing so in a manner that does not jeopardize employee health. The principles behind value-based insurance design, and the tool developed by Hewitt Associ-

ates, enable employers to meet these two important goals,” Professor Chernew said in an August statement announcing the new tool.

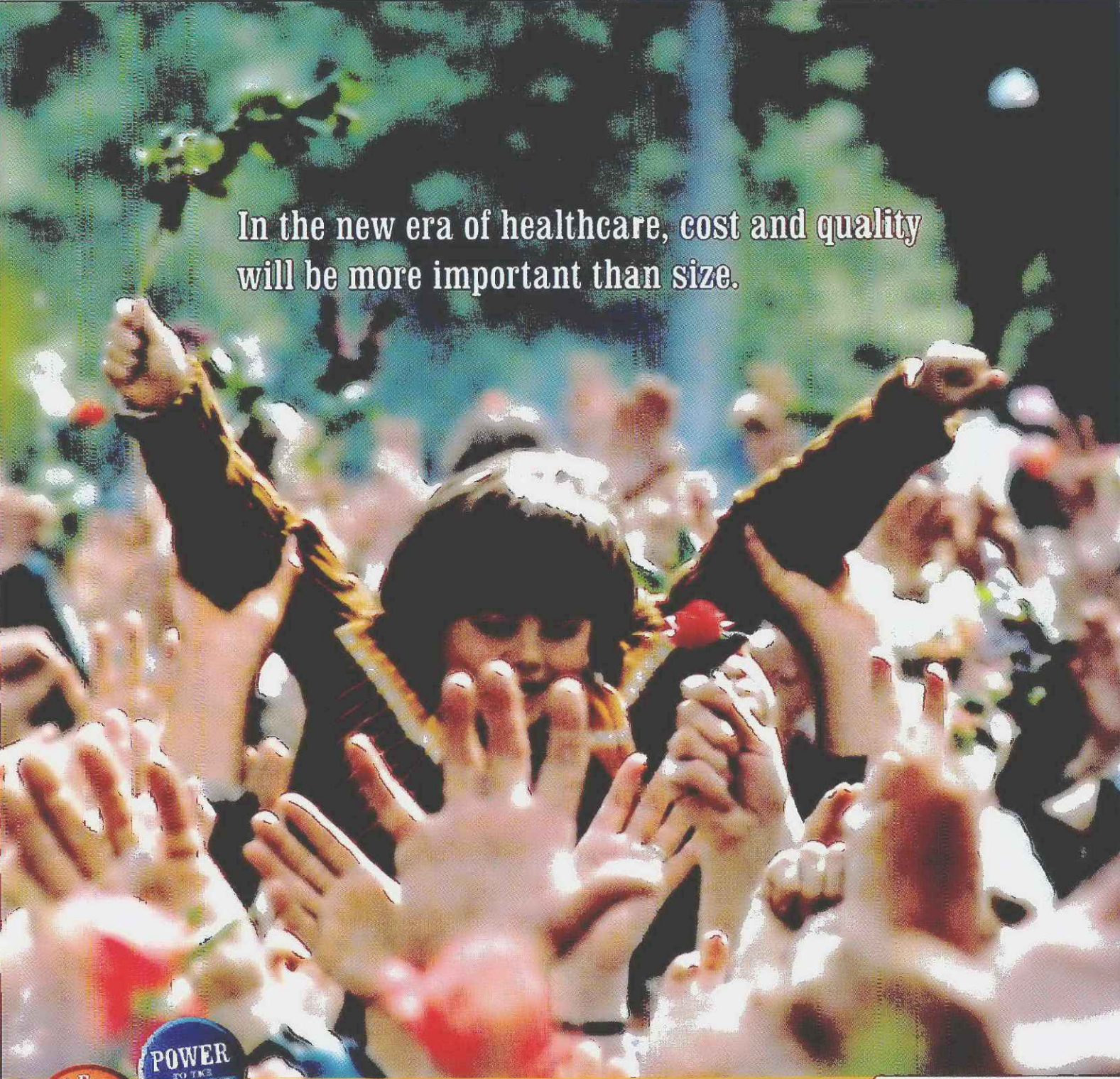
“What the tool is designed to do is to allow a firm to meet whatever financial target they want to meet in a way that incorporates value-based insurance design as opposed to across-the-board clinically insensitive ways,” Professor Chernew said in an interview.

“Before value-based design, they would just raise copays across the board to meet a financial target. But this doesn’t recognize the differences in value for different services,” he said.

Professor Chernew and Dr. A. Mark Fendrick, director of the Ann Arbor, Mich.-based Center for Value-Based Insurance Design at the University of Michigan, published the conceptual framework for value-based plan design nearly a decade ago, and founded the center, which was created to promote, implement and evaluate value-based designs.

New York-based ActiveHealth Management has been using a similar tool, also developed in conjunction with Professor Chernew and Dr. Fendrick, in a three-year pilot program involving Marriott, said Dr. Steve Rosenberg, senior vp of outcomes research at the disease management and clinical decision support firm. ActiveHealth also has technology that identifies patients in particular need of interventions who are not getting them for one reason or another, he said.

“We use it in two ways: If a company or a health insurer is interested in implementing the value-based insurance design and they want to know the estimate of the cost or savings, we can run this model on



In the new era of healthcare, cost and quality will be more important than size.

‘There’s a 10% to 15% improvement in long-term compliance when copay is reduced or eliminated.’

Dr. Steve Rosenberg,
ActiveHealth Management

their data to produce an estimate,” Dr. Rosenberg said. “For customers we already have, we use the model to report to them every six months on the savings their program is achieving.”

While not divulging individually identifiable health information, the tool “measures how many people receive notices” telling them about the program and “how many comply after getting the notice,” he said. “We also measure the people already taking the drugs to see how many continue taking them.”

In general, “we find there’s a 10% to 15% improvement in long-term compliance when copay is reduced or eliminated,” Dr. Rosenberg said.

In addition, “what we find routinely is that the cost for medication for the employer always increases, the non-drug costs for the employer are reduced by the same amount or a little more, so it’s basically a wash,” he added.

In the Marriott study, which was reported at the March annual meeting of the Washington-based National Business Group on Health, generic copays were eliminated and brand-name drug copayments were halved for the types of medication used to treat diabetes, asthma and heart disease.

Researchers are still studying the experiment’s outcomes, but “as we implement this technology, we are finding these strategies are creating a positive difference in trend,” said Jill Berger, Marriott’s vp of health and welfare at last spring’s NBBG meeting last spring.



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Calculator estimates cost of employee health problems

Online tool uses company-specific data that can show employers true worth of wellness programs

By LOUISE ESOLA

Many of today's corporate executives want more than promises that wellness and preventive health care programs will lower medical insurance premiums and other costs related to workplace illnesses. C-suite executives want hard data, say corporate health experts touting a new tool that helps make clearer the connection between wellness and savings.

The more information, the better, is the thought behind Blueprint for

Health, a free online tool now being used among companies small and large to estimate how illnesses among workers affect medical costs, employee absences and productivity.

Developed by several organizations, the tool—essentially an online calculator—takes into account an array of information specific to a company, including the gender, age, geographic location, salary and marital status, to calculate estimates on the number of absences per employee, per-employ-

ee doctor visits and prescription costs, and percentage of employees who will be impaired during the workday.

According to John Riedel, president of the Denver-based Riedel & Associates Consultants Inc., who also helped build the Blueprint for Health, the estimates are based on more than 1 million data points from several large employers.

"We loaded input variables, looking at absence data, (employee) impairment data and...we created estimators on these large company

data points," he said. "In essence, we created algorithms in that database to gather estimates, creating a very robust tool for estimates."

In addition to work by Riedel & Associates, a health and productivity management consulting firm, other organizations involved in building the tool include the Health as Human Capital Foundation, the American College of Occupational and Environmental Medicine and the National Business Coalition on Health. In addition, Bridgewater, N.J.-based pharmaceutical maker

Sanofi-Aventis U.S. L.L.C. supported the effort with a grant and a national advisory committee of corporate medical directors and benefits experts also helped steer the project.

Mr. Riedel said the tool is an easy way for employers to learn about their employees and the costs related to keeping a healthy workforce.

Quantifying costs

Once an employer fills in the online questionnaire, reports are generated providing estimates of costs for all employees, including those likely to have chronic conditions such as diabetes, high blood pressure, high cholesterol, hypertension, insomnia as well as obesity and heart-related conditions among others. A summary, charts and bar graphs provide employers with total estimates.

So far, Mr. Riedel said more than 700 companies have used the free estimator since its inception in early 2006.

"The tool is pretty good if you are going to be using it for estimates specific to your organization," said Laurel Pickering, New York-based executive director of the New York Business Group on Health. "When (statistics) say, 'Diabetes costs the workplace X amount of dollars a year' it's really not specific to one organization. (Companies) really need the specifics for their organization and the Blueprint for Health allows them to do that."

Ms. Pickering, whose organization provides guidance for companies in the arena of health and welfare, said some employers have used the tool to justify their wellness programs, including everything from smoking cessation programs to exercise incentives.

For example, Peoria, Ill.-based Caterpillar Inc. used Blueprint for Health to help executive officers better understand the need for a wellness program now in development, said Dr. Steve Goldman, Caterpillar's medical director who also served on the Blueprint for Health's advisory committee.

"This tool helps us see the cost of medical care and realize why employees' health is a lot more affordable when you take care of them before they get sick," he said.

Dr. Goldman said the Blueprint for Health is the first tool he's seen that looks at productivity when related to sickness. "We see that (the costs for) medical care is only the tip of the iceberg. A lot of (the productivity) costs are hidden and difficult to get to."

The Blueprint for Health is available at blueprint.hhcfoundation.org and features five applications: How to estimate total health-related costs including absences and presenteeism; understanding the skewed distribution of health care cost, absence, and presenteeism; estimating the cost of various health conditions; understanding salary level and salary equivalence on productivity loss; and understanding the dynamics of the migration of employees from year to year between the various cost levels.



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CDHP communication tools fall short of employers' needs

Health insurers working to create new online information resources and drive use of existing offerings

By KAREN PALLARITO

Black & Decker Corp. began offering a consumer-driven health plan to its employees this fall but expects only a small percentage will sign up for the CDHP, said Ray Brusca, vp of benefits at the Towson, Md.-based power tool maker.

That's because explaining new health plans to workers remains a challenge, he said, especially since none of the existing Web-based tools, in his view, do a good job of formatting and displaying informa-

tion in a way that consumers can easily digest. In response, some employers are taking matters into their own hands by enhancing plan offerings (see related story, page 22).

The big insurers and consulting firms all offer CDHP tools, "and they all have problems in terms of really trying to allow employees to easily and accurately compare one plan to another," he said.

And Mr. Brusca is not alone in his criticism of the tools. Most employers are disappointed with Web-based tools, a recent survey by Watson

Wyatt Worldwide and RAND Corp. revealed. For example, only 11% of employers rated physician quality comparison tools as good or excellent, and 13% gave favorable marks to tools that compare physician costs.

Employers were slightly more impressed with hospital cost and quality comparisons; even so, fewer than half rated that information as good or excellent in any category. By contrast, most employers responding to the Watson Wyatt/RAND survey, "The CDHP Implementation

Experience With Large Employers," gave prescription drug cost and quality information a favorable rating.

"If you went out there and said, 'I want to find the cost for Prozac,' you could go out there right now and find the cost for Prozac at Walgreen's down the street from you," said Cathy Tripp, national leader for consumerism in Watson Wyatt's Minneapolis office. "That's what I think consumers want on the health care side, but we're a long way from that."

The lag is partly due to the way information historically has been captured and stored, said Kyle Rolfing, a co-founder of CDHP pioneer Definity Health and now chief executive officer of RedBrick Health, a Minneapolis-based company that offers CDHP tools.

Insurers constructed databases to serve groups—not individuals, Mr. Rolfing said, "so start with that as a huge problem out there."

It can be difficult and expensive to retrieve relevant data from large information systems, he added.

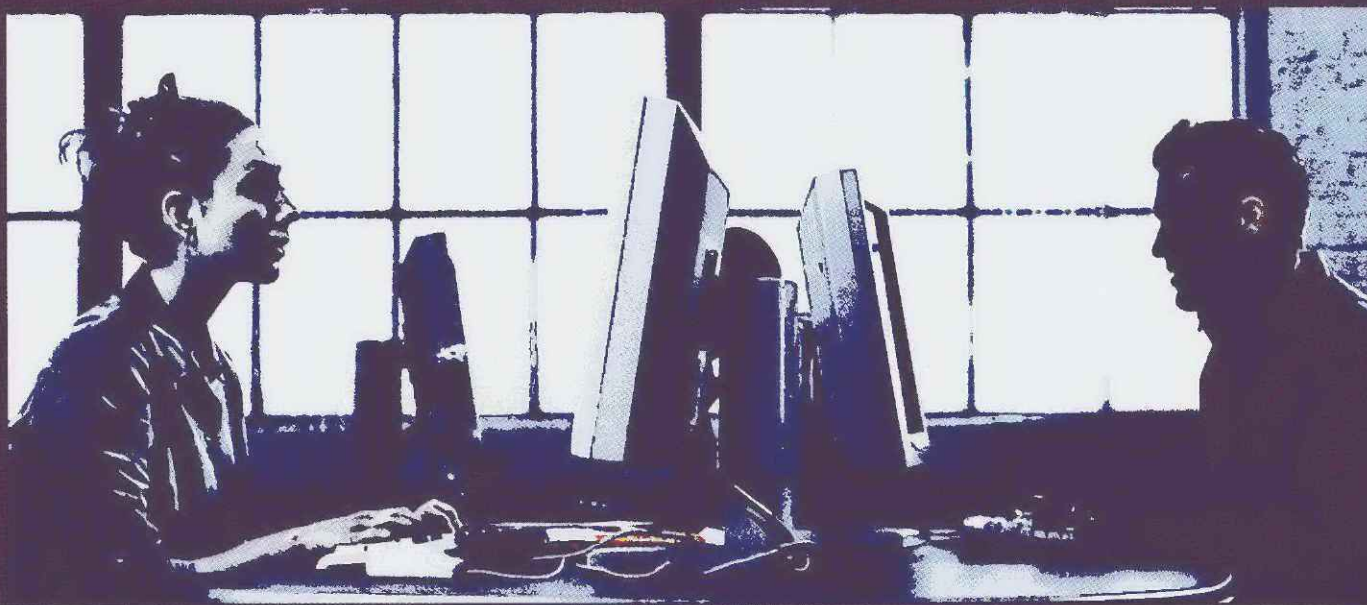
What's more, many early CDHP adopters bombarded employees with "stacks of information" but failed to tie it together in a relevant way, said Shawn Jenkins, president, CEO and founder of Benefitfocus.com Inc., a health care software and services provider in Charleston, S.C. "It was...approached less from a marketing communications standpoint and more from...a legal and cover-all-the-bases" strategy, he said.

There's another problem, too: Much of the information needed for decision-making tools—for example, what a particular provider charges for a specific service under an individual's benefit plan—is not readily available. Insurers, for the most part, remain reluctant to publish unit pricing information, industry experts said.

But health plans don't need to disclose individually contracted rates, said Ted von Glahn, director of consumer engagement and performance information at the Pacific Business Group of Health in San Francisco. "If I'm living in Nebraska and the prevailing contract rate for (an) MRI is \$1,000, that's what I need to know. I

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- What choices do employers have for protecting their workforces from terrorist attacks?
- Should employers avoid concentrations of workers in urban areas?
- What coverages are available to respond to catastrophic workers comp risk?
- How should employers communicate risk mitigation plans to their workers?
- What role should government play in addressing catastrophic workers comp risks?

WHO SHOULD ATTEND:

- Risk Managers & Risk Financing Executives
- Senior Corporate & Financial Management
- Employers
- Benefits & HR Executives
- Insurers, Brokers, & Consultants

SAVE THE DATE: Wednesday, November 14, 2007

TIME: 11:00 a.m. Eastern / 8:00 a.m. Pacific

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"make you smarter the next time the services are out for bid," he said.

2007 Benefit Manager OF THE YEAR[®]



Jerry Geisel, *Business Insurance* Editor-at-Large, (left), Regis Coccia, *Business Insurance* Editor, Linda M. Kuklinski, Benefit Manager of the Year[®] honoree, and Paul Winston, *Business Insurance* Associate Publisher/Editorial Director.



Dawn Tabat, COO, Generac Power Systems, Inc.



Regis Coccia, Editor, *Business Insurance*, highlights Linda Kuklinski's accomplishments before presenting her award.



Stephanie Borowski, VP, Human Resources, Generac Power Systems, Inc.



Diane McKenzie, Account Manager (left) and Michele Anzivino, Operations Manager, from Multiplan.



William Treffert, CEO, Generac Power Systems, Inc. (right), Paul Winston, *Business Insurance* Associate Publisher/Editorial Director (center), Dale Toma, Executive VP, HRH (left), along with friends, colleagues and coworkers listen as Linda Kuklinski accepts her award.



Benefit Manager of the Year[®] honoree Linda M. Kuklinski greets friends and colleagues at a special luncheon in Milwaukee, WI.



Stephanie Borowski, VP, Human Resources (right), William Treffert, CEO (center), and Dawn Tabat, COO (left), from Generac Power Systems, Inc., toast Linda at the reception in her honor.



Regis Coccia, Editor (left) and Jerry Geisel, Editor-at-Large (center), from *Business Insurance*, propose a toast in honor of Linda Kuklinski.



Margaret Dallmann, Account Manager, Serve You Prescription Manager (right), Liz Schuster, Account Manager, HRH (center right), Alisa Zablen, Account Manager, Sun Life (center left) and Linda Kuklinski (left).



Linda Kuklinski hugs co-worker Kerri LaDu, Sr. HR Generalist, as co-workers Mary Mix, Benefits Specialist (right) and Stephanie Borowski, VP, Human Resources (left) look on.



Linda Kuklinski (right), Crystal Portz, LPN (center) and Wendy Lasota, Office Manager (left) for Community Nursing Center.



Linda Kuklinski (right), Susan Quantrell, Employee Relations, ProHealth (center) and Vicki Dalmann-Pepke, Director, Corporate Health Services (left).

On September 26th, at Bacchus - Lakeview Private Dining, in Milwaukee, WI, *Business Insurance* presented its prestigious Benefit Manager of the Year[®] award, which recognizes excellence and innovation in employee benefits management. This year's honoree, Linda M. Kuklinski, Employee Benefits & Risk Manager, Generac Power Systems, Inc., was chosen by an independent panel of judges representing previous honorees, leading employee benefit consulting firms, brokerage firms, health insurance/managed care organizations and benefits industry vendors.

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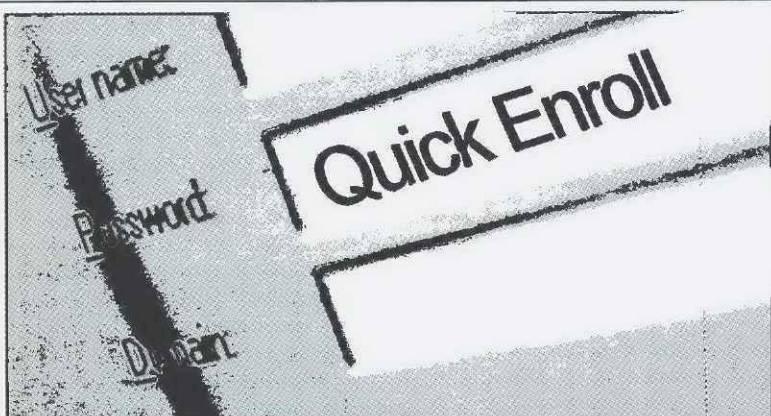
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Some employers enhance CDHP programs as many online tools lag plan development

Web-based tools for consumer-driven health plans are still a work in progress, but some employers are trying compensate for that by beefing up their plan offerings.

Sperian Protection Americas Inc., a protective equipment maker, designed its consumer-driven health plan in a way that takes some of the guesswork out of the equation. Once an employee hits his or her deductible for the year, Sperian pays 100% of all services.

The company also enhanced customer support through its third-party administrator to help workers navigate the system.

"We recognized there was not going to be as much good information for them to make a decision as they normally would want...so we designed our HSA plan that, (even), in the worse case scenario, it wasn't going to cost the employee any more than in the PPO plan," said Michael Vittoria, director of human resources at the Smithfield, R.I.-based manufacturer.

When Charleston, S.C.-based Blackbaud Inc. first rolled out its CDHPs, "we did not have the

'My hope is one day...it'll be like going to a fast-food restaurant, and the prices are posted and you can look and see the quality that goes along with that.'

Shannon Edwards, Blackbaud Inc.

tools we needed to have," said Shannon Edwards, compensation and benefits manager for the software and services company, who joined the company later that year. "We jumped on the high-deductible bandwagon immediately" on Jan. 1, 2005, "and those tools were just not developed yet."

Even so, the high-deductible health plan proved extremely popular, achieving 80% partici-

pation in the first year among Blackbaud's young workforce in which the average age is about 29. The premium was set at zero for employee-only coverage, "so that makes a big difference," Ms. Edwards said.

In January of this year, the company hired a new administrator—HealthSCOPE Benefits Inc. of Little Rock, Ark.—and replaced its previous health plan. Employees now can choose between a high-deductible health plan linked to a health savings account or a plan linked to a health reimbursement arrangement, and HealthSCOPE's plan comparison tool helps employees decide which one will cost them less.

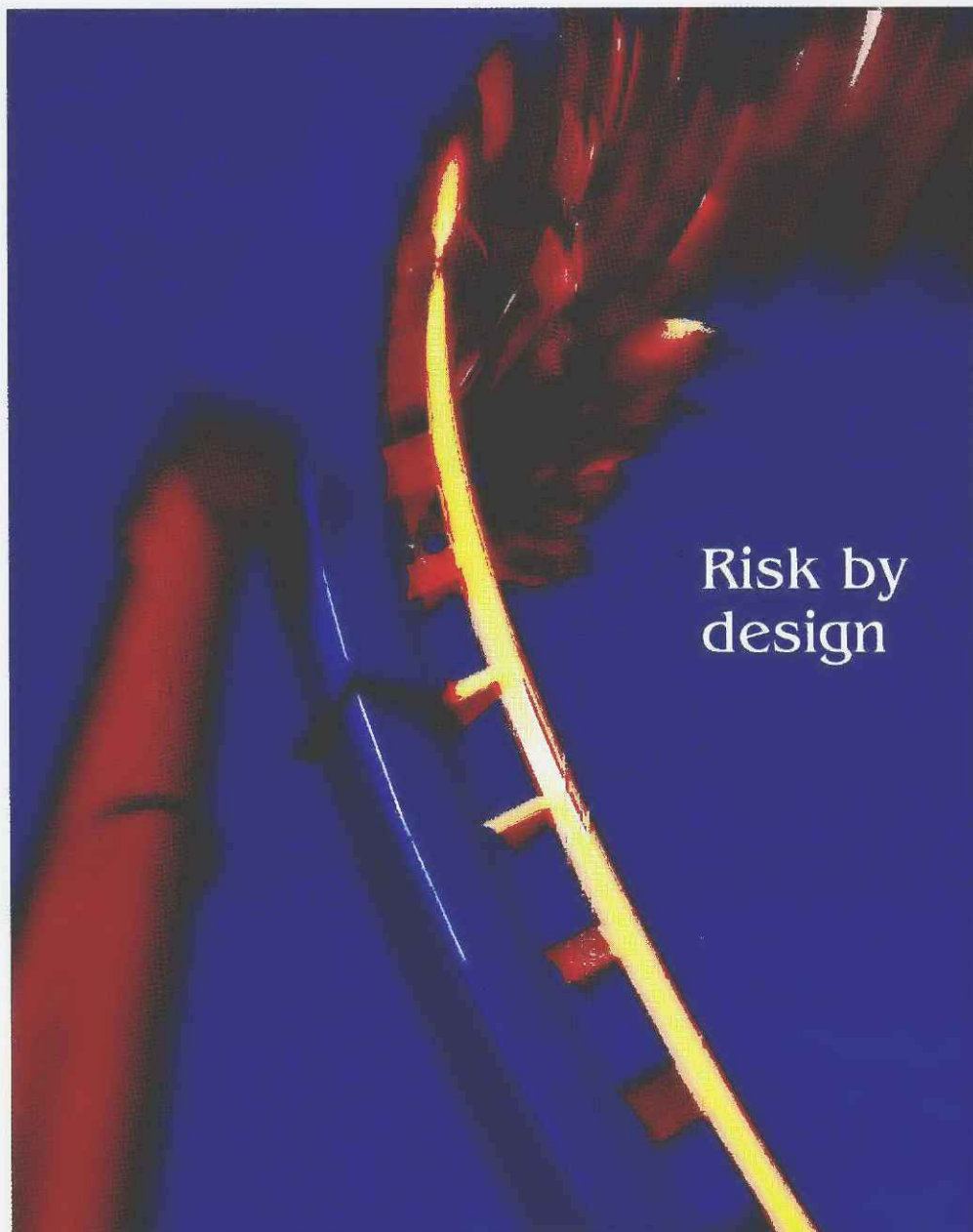
"My hope is one day...it'll be like going to a fast-food restaurant," Ms. Edwards said, "and the prices are posted and you can look and see the quality that goes along with that, and employees are not blindsided by the time they get the explanation of benefits."

—By Karen Pallarito



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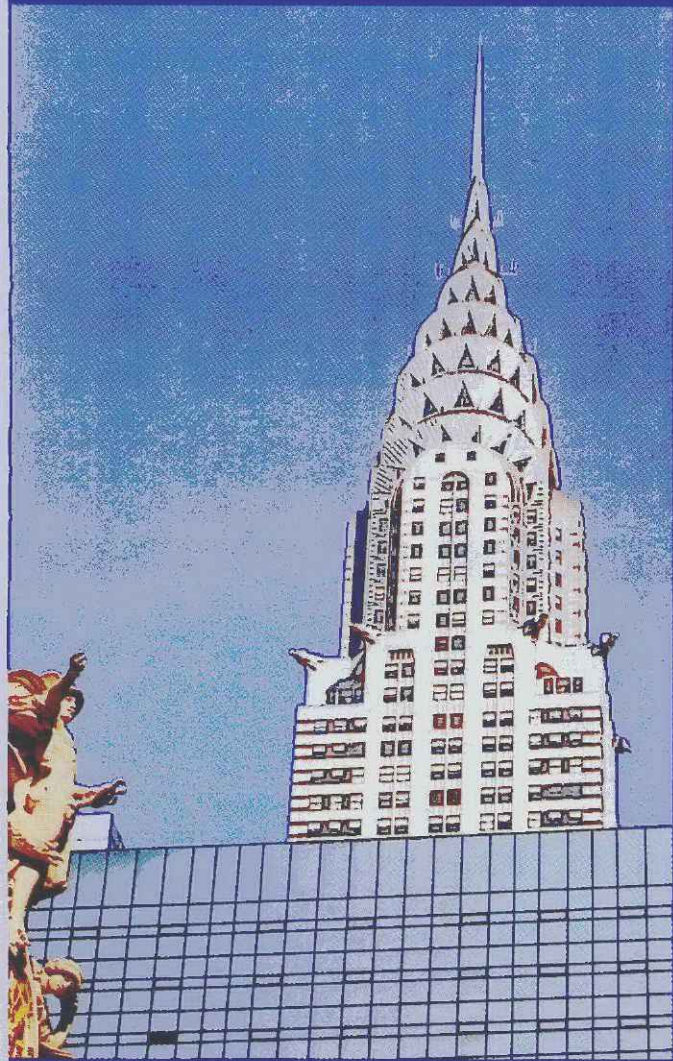


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Tools: Insurers aim to improve online health care information

CONTINUED FROM PAGE 20

don't need to know that it's \$1,050 at 5th and Main and \$1010 at 9th and Gulliver," he explained.

Insurers have been working to create online tools that provide more useful and meaningful information and drive use of existing tools.

Working with employer groups, WellPoint Inc. developed Anthem Care Comparison, a tool that bundles all costs associated with a procedure, from lab tests and physician services to anesthesia and recovery room charges. Launched in a September 2006 pilot with General Motors Corp. in Dayton, Ohio, the comparison tool is being rolled out

in additional markets.

"Simply giving the cost of a procedure...may not capture all of these additional costs," said Jason Gorevic, New York-based senior vp and chief marketing and product officer for WellPoint.

CIGNA Behavioral Health recently introduced an online tool that provides a photograph and biographical information for its nearly 10,000 network providers. The Eden Prairie, Minn.-based insurer says it is the first managed behavioral health organization to offer online provider-profile pages with photographs.

CIGNA sees this as a way to help members "get acquainted with their

'Simply giving the cost of a procedure...may not capture all of these additional costs.'

Jason Gorevic, WellPoint Inc.

therapists online" before making an appointment, thereby increasing member comfort in their decision and reducing the likelihood of trying several providers before selecting one.

UnitedHealth Group Inc. has developed United with Me, a program designed to help members make the most of their health benefits and better use of available Web-based tools. Through the program, employers can personalize messages to encourage employees to establish a health savings account or manage a chronic condition, for example. In a pilot of the program with six national employers, UnitedHealth found that 46% of employees were not optimally using their health care benefits.

Aetna Inc., widely viewed as a leader in the "transparency" movement, introduced a tool earlier this month that will allow members to

compare cost ranges for more than 30 common procedures at hospitals and other free-standing facilities. And it has replicated a pilot program in several markets through which it discloses the rates it pays doctors for office visits, diagnostic tests and other minor procedures.

Robin Downey, vp and head of product development at Aetna in Hartford, Conn., said the insurer is "progressing along very well with our transparency tools" but acknowledged that they aren't yet perfect. "Are they where we want them to be? No," she said. "But it's like any other industry, if something is new, they continue to evolve."

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UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK
IN RE PETITION OF ROLF ABJÖRNSSON,
AS OFFICIAL RECEIVER OF
ATERFORSÄKRING AB LUAP,
DEBTOR IN A FOREIGN PROCEEDING
CASE NO. 03-10945 (PCB)

NOTICE IS HEREBY GIVEN THAT ON SEPTEMBER 27, 2007, THE BANKRUPTCY COURT ENTERED AN ORDER (THE "ORDER") CONTINUING THE PRELIMINARY INJUNCTION ORDER PURSUANT TO 11 U.S.C. §304 ORIGINALLY ENTERED IN THIS CASE ON FEBRUARY 19, 2003. THE ORDER SHALL REMAIN IN EFFECT PENDING A HEARING SCHEDULED TO BE HELD ON MARCH 6, 2008 AT 11:00 A.M. (THE "RETURN DATE") BEFORE THE HONORABLE PRUDENCE CARTER BEATTY, UNITED STATES BANKRUPTCY JUDGE, IN THE UNITED STATES BANKRUPTCY COURT LOCATED AT ONE BOWLING GREEN, NEW YORK, NEW YORK. ALL PAPERS SUBMITTED FOR THE PURPOSE OF OPPOSING THE CONTINUATION OF THE ORDER AFTER THE RETURN DATE SHALL BE FILED WITH THE COURT, WITH A COPY TO THE CHAMBERS OF THE HONORABLE PRUDENCE CARTER BEATTY AND SERVED ON COUNSEL FOR THE OFFICIAL RECEIVER LISTED BELOW, SO AS TO BE RECEIVED AT LEAST FOURTEEN (14) DAYS PRIOR TO THE RETURN DATE. ANY PERSON WISHING TO OBTAIN A COPY OF THE ORDER SHOULD CONTACT COUNSEL TO THE OFFICIAL RECEIVER.

CHADBOURNE & PARKE LLP
ATTORNEYS FOR THE OFFICIAL RECEIVER
30 ROCKEFELLER PLAZA
NEW YORK, NEW YORK 10112
(212) 408-5100
ATTN: HOWARD SEIFE, ESQ.
FRANCISCO VAZQUEZ, ESQ.

LEGAL NOTICE

LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT • SOUTHERN DISTRICT OF NEW YORK

In re: Petition of CLIVE PAUL THOMAS, as foreign representative of
COMPAGNIE EUROPÉENNE D'ASSURANCES INDUSTRIELLES S.A.,
Debtor in a Foreign Proceeding.

In a Case Under Chapter 15
of the Bankruptcy Code
Case No. 07-B-12009 (MG)

NOTICE OF ORDER GRANTING RECOGNITION OF FOREIGN PROCEEDING, PERMANENT INJUNCTION AND RELATED RELIEF

NOTICE IS HEREBY GIVEN THAT, in connection with the petition (the "Petition") filed on June 28, 2007 by Clive Paul Thomas (the "Petitioner"), in his capacity as the duly authorized foreign representative, as defined in section 101(24) of title 11 of the United States Code (the "Bankruptcy Code"), of Compagnie Européenne d'Assurances Industrielles S.A. (the "Company"), the United States Bankruptcy Court for the Southern District of New York (the "Bankruptcy Court") has issued an Order Granting Recognition of Foreign Proceeding, Permanent Injunction and Related Relief (the "Order"), among other things:

1. Providing that the proceeding respecting the Arrangement (as defined in the Order) under the Companies Act 1985 of England and Wales (the "Companies Act") pending before the High Court of Justice of England and Wales (the "High Court") and the Arrangement are granted recognition pursuant to section 1517(a) of the Bankruptcy Code;
2. Providing that the proceeding respecting the Arrangement under the Companies Act pending before the High Court and the Arrangement are granted recognition as foreign nonmain proceedings pursuant to section 1517(b)(2) of the Bankruptcy Code;
3. Providing that all relief equivalent to that afforded foreign main proceedings pursuant to section 1520 of the Bankruptcy Code is granted as additional relief for a foreign nonmain proceeding, under section 1521 of the Bankruptcy Code;
4. Providing that the Arrangement shall be given full force and effect in the United States, and shall be binding on and enforceable against any person or entity that is a Creditor (as defined in the Order), including against such person or entity, in its capacity as a debtor of the Company;
5. Providing that the Arrangement shall be final and binding on the Company and such Creditor, including against such Creditor, in its capacity as a debtor of the Company;
6. Permanently enjoining all Creditors from taking any action in contravention of, or inconsistent with, the Arrangement;
7. Permanently enjoining all Creditors from seizing, repossessing, transferring, relinquishing or disposing of any property of the Company in contravention of, or inconsistent with, the Arrangement;
8. Permanently enjoining all Creditors from: (a) commencing or continuing any action or legal proceeding in connection with Arrangement Liabilities, the Weavers Business, the Non-Weavers Business, or any Claims (including, without limitation, arbitration, mediation or any judicial, quasi-judicial, administrative action, proceeding or process whatsoever), including by way of counterclaim, against the Company, or any property in the United States, or any proceeds thereof, and seeking discovery of any nature against the Company; (b) enforcing any judicial, quasi-judicial, administrative judgment, assessment or order, or arbitration award obtained in connection with any Arrangement Liabilities, the Weavers Business, the Non-Weavers Business, or Claims, or commencing or continuing any act or action or legal proceeding in connection with any Arrangement Liabilities, the Weavers Business, the Non-Weavers Business, or Claims (including, without limitation, arbitration, mediation or any judicial, quasi-judicial, administrative action, proceeding or process whatsoever) or any counterclaim to create, perfect or enforce any lien, attachment, garnishment, self-off or other claim arising out of Arrangement Liabilities, the Weavers Business, the Non-Weavers Business, or any Claims against the Company or any of its property in the United States, 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 action, proceedings or process whatsoever) in connection with Arrangement Liabilities, the Weavers Business, the Non-Weavers Business, or Claims and such statute, rule or requirement will be rendered null and void for proceedings; provided, however, that nothing in the Order in any respect (i) affects any Security in existence at the Effective Date (as defined in the Order) or the replacements for such security or (ii) enjoin any police or regulatory act of a governmental unit, including a criminal action or proceeding, in accordance with section 1521(d) of the Bankruptcy Code; (d) drawing down any letter of credit established by, on behalf of or at the request of the Company, that relates to Arrangement Liabilities, the Weavers Business, the Non-Weavers Business, or Claims 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 that relates to Arrangement Liabilities, the Weavers Business, the Non-Weavers Business, or Claims in which the Company has an interest in excess of amounts expressly authorized by the terms of the contract and 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 Petitioner or the Company or permitted by further Order of the Court;
9. Requiring that all 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 that relates to Arrangement Liabilities, the Weavers Business, or the Non-Weavers Business, to: (a) provide notice to the Petitioner's United States counsel of any drawdown on any such letter of credit established by, on behalf of or at the request of the Company, or any withdrawal from, self-off 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 Company to assess the propriety of such drawdown, withdrawal, self-off or other application, including, without limitation, the date and amount of such drawdown, withdrawal, self-off or other application and a copy of any contract, related trust or other agreement pursuant to which any such drawdown, withdrawal, self-off, or other application was made, and provide such notice and other information contemporaneously therewith; and (b) turn over and account to the Company for all funds resulting from such drawdown, withdrawal, self-off, 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 Creditor has a bona fide defense to this obligation to turn over;
10. Providing that nothing in the Order shall in any respect prevent the commencement or continuation of proceedings against any person or entity other than the Company; provided, however, that if any third party shall reach a settlement with, or obtain a judgment against, any person or entity other than the Company, such settlement or judgment shall not be binding on or enforceable against the Company;
11. Providing that except with respect to the matters over which the Court has expressly retained jurisdiction, the Chapter 15 case is closed, subject to it being reopened pursuant to section 350(b) of the Bankruptcy Code;

Copies of the Order, the Arrangement and the Petition are available upon request to the undersigned counsel.

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

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International NEWS

Portugal turns to fire prevention

Risk is so high that insurers are reluctant to offer coverage

By RODRIGO AMARAL

PORTO, Portugal—Along with tourists and gorgeous beaches, forest fires are a hallmark of the summer season in Portugal; the country ranks among the worst affected by the problem in Europe.

The risk is seen as so high that insurance companies are reluctant to offer coverage for forest fires in the country, observers say.

"We do not have insurance policies for forest fires in Portugal," said José Manuel Dias da Fonseca, the president of Associação Portuguesa de Gestão de Riscos e Seguros, the association of risk managers in Porto.

"We want to reduce risk levels so the market can start offering insurance products," said Rosário Alves, director of Porto-based forestry association Forestis.

Statistics gathered by the Lisbon-based Direcção Geral de Recursos Florestais, the Portuguese forest authority, show that 2007 has been a particularly good year in terms of the number of forest fires.

At the end of August, 986 forest fires had been reported in the country. With the critical season almost over, it seems certain that the total for the year will stay well below the levels of 2006, when there were 2,894 fires, and 2005, when there were 6,757. The total area affected by the fires has reached more than 30,000 acres, a far cry from the more than 934,000 acres that burned in 2003, the worst of recent years.

But Ms. Alves warns the good news must not lead to complacency.

Economic activities related to forests account for 4% of the country's gross domestic product and 5% of all jobs. So Ms. Alves' organization is one among many entities working actively to reduce the risks from forest fires.



REUTERS

Public and private institutions in Portugal are rolling out programs to help battle the problem of forest fires in the country.

She said that the approach to the problem in Portugal so far has been concentrated on fighting fires.

Joaquim Carvalho, a captain at the Carnaxide-based Autoridade Nacional de Protecção Civil, the Portuguese civil protection agency, said that Portugal is already efficient in putting out fires. "We have reached reaction and intervention times that are very difficult to be improved upon," he said. "So it became obvious to us that we needed to work more with prevention."

Several initiatives are being deployed to tackle the problem. "Actions that have been implemented lately make us believe that risk levels will be lower in forthcoming years," Ms. Alves said, "but we still have a lot of things to do."

According to Ms. Alves, some structural changes are required to reduce the risk of fires. For instance, it would help if Portugal's rural areas would grow more than one sort of crop, so that it can be divided into smaller areas. The adoption of forest management techniques to create natural barriers to the spreading of

fire is critical as well.

Ms. Alves said that many forest fires are started by small farmers. She indicated that, "sometimes, ranchers burn fields to renovate pastures. Farmers also often burn excessive production, but they can lose control of the fire."

Forestis is working with local governments to help small farmers control the fires, she said.

Some big Portuguese companies are taking their own actions to mitigate the danger as well.

For example, Portucel Soporcel Group, a pulp and paper company in Figueira da Foz, has earmarked €2 million (\$2.8 million) for fire prevention measures in 2007. Many of these measures are undertaken by Afocelca, a joint venture involving several companies that hires professional firefighters.

The group is set to invest €4 million (\$5.7 million) until the end of the year to fight forest fires. The funding covers such costs as the deployment of three helicopters, more than 50 firefighting vehicles and 400 people.



AP PHOTOS

Typhoon Krosa dumped heavy rain and caused widespread damage in Taiwan and China. Up to 60 inches of rain fell in some areas of eastern China.

Typhoon Krosa damage could reach \$600 million

By JEFF CASALE

Insured losses in Taiwan and China from Typhoon Krosa could total as much as \$600 million, a catastrophe modeling firm estimates.

AIR Worldwide Corp. last week said that wind and flood-related losses from the storm, which made landfall in China on Oct. 7 with sustained winds of 73 mph, will likely be between \$200 million and \$600 million. Before hitting China, Krosa had lingered over the Taiwan Strait, dumping massive amounts of rain and forcing evacuations, AIR said in a statement.

Peter Sousounis, senior research scientist at Boston-based AIR, said

in the statement that the storm destroyed 3,500 homes, caused extensive flooding of cropland and fish farms, and disrupted transport and air travel in areas of east China, including Shanghai.

Chinese government officials estimated that the total economic damage from the typhoon exceeds \$1 billion.

Mr. Sousounis said that despite Krosa being a "weak-wind" typhoon, it produced near-record amounts of rain—up to 60 inches—in some parts of eastern China. AIR said it expects flooding from Krosa to result in significant insured losses to several of the region's low-rise industrial buildings.

U.K. nonlife runoff market contracts for first time since 2001

By BEN NORRIS

The nonlife insurance runoff market in the United Kingdom contracted by more than 14% in 2006, research shows.

A recent survey found that total liabilities in the U.K. nonlife run-off market were an estimated £32.7 billion (\$63.99 billion) in 2006, down £5.5 billion (\$9.44 billion) compared with 2005 figures.

The research was commissioned by the Stowmarket, England-based Assn. of Run-off Companies Ltd. and conducted by the London unit of New York-based KPMG LLP.

The decrease is the first time that a "significant contraction in the size of the U.K. nonlife runoff market" has been identified since the survey was first produced in 2001, said Mike Walker, head of

restructuring insurance solutions practice at the London branch of KPMG.

The main reasons for the decrease are proactive management of existing runoff portfolios, absence of new runoffs and a weaker U.S. dollar, the survey concluded.

Runoff represented 18% of total liabilities in the United Kingdom nonlife market as a whole in 2006. This compares with 19% in 2005,

according to ARC.

Total capital tied up in solvent U.K. nonlife companies in runoff increased, however, to £4.9 billion (\$9.60 billion), up 2% compared with 2005 figures.

The use of so-called solvent schemes or arrangement increased dramatically in 2006, the survey of 480 insurance companies reported.

"With more than £418 million

(\$818.0 million) liabilities of nonlife insurance business subject to solvent schemes of arrangement to the end of 2006, we have witnessed a threefold increase on the previous year, demonstrating the continued support for this exit mechanism," Mr. Walker said.

The survey is available at www.arcrunoff.com/thearckpmguknonliferunoffsurvey2007.php.

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Comings & Goings

BROKERS:

Crawford Advisors L.L.C. has named John Cellucci managing director of the Philadelphia office. Previously, he was senior vp of sales and marketing for Wachovia Insurance Services.



Mr. Cellucci

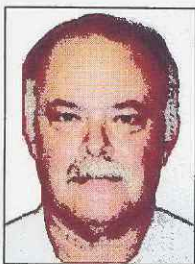
Regions Insurance Group Inc. has named Natalie McCulley senior vp in the Memphis, Tenn., office. Previously, she was multiline and casualty practice leader with Marsh USA Inc.

Brenda Shelly has been named director of client advocacy for Willis North America Inc. in New York. She will continue as executive vp.

Lockton Cos. L.L.C. has named Henry Jennings as a senior vp and global practice leader for its Private Equity and Corporate Acquisitions Practice in New York. Before joining Lockton, he was private equity practice leader at Integro Ltd.

Dallas-based U.S. Risk Insurance Group

Inc. has named Monte Stringer executive vp, national brokerage manager of U.S. Risk Brokers, the company's wholesale excess and surplus lines insurance brokerage operations.



Mr. Stringer

Previously, he was executive vp of marketing and manager of the Dallas office of U.S. Risk Brokers.

INSURERS:

The Injured Workers' Insurance Fund, a Maryland provider of workers compensation insurance, has named Paige Beck



Ms. Beck

executive vp and chief financial officer. Before her promotion at the Towson-based insurer, she was head of IWIF's internal audit department. Zurich North America has named William Blake as regional executive for its Southwest region. He will be based in Zurich North America Commercial's Glendale, Calif., office and will be responsible for Arizona, Southern California, Colorado, Southern Nevada, New Mexico and Wyoming. Previously, he was platform executive for Zurich's commercial markets business unit.

Max Specialty Insurance Co. in Richmond, Va., has named Michael Miller chief underwriting officer of its newly formed Marine Division. Previously, he was senior vp and chief underwriting officer of Fireman's Fund Insurance Co.'s specialty business unit.

New York Life Insurance Co. has named Steven Lash senior vp in the corporate finance department. Most recently, he was principal in the insurance and actuarial advisory services division of Ernst & Young L.L.P.

Branchville, N.J.-based Selective Insurance Co. of America has made several senior-level appointments:

- Richard Connell, senior executive vp and chief information officer, will assume the additional role of chief administrative officer.

- John Marchione, senior vp, personal lines and flood operations, will take on the additional duties of chief field operations officer.

- Chuck Musilli, senior vp, chief field operations and marketing officer, will head the newly created Selective Risk Solutions operation.

- Ed Pulkstenis, senior vp, chief commercial lines underwriting officer, will assume oversight for marketing and communications, the business services unit and accounts, the commercial lines service center and the strategic operations group.

MANAGED CARE:

Dennis Casey has been promoted to president and chief executive officer of Chicago-based UniCare, a subsidiary of Well-Point Inc. Previously, he was president and general manager of Anthem Blue Cross & Blue Shield in Indiana.

Sacramento, Calif.-based Health Net Federal Services L.L.C., the government operations division of Health Net Inc., has named Dr. Ted Christy chief medical officer. Before his promotion, he was vp and medical director.



Mr. Casey

REINSURANCE:

Guy Carpenter & Co. L.L.C. has appointed Paul Lumbis managing director of corporate finance, Europe. Mr. Lumbis, who will be based in London, previously was senior manager in the insurance sector team of Ernst & Young L.L.P.

REGULATORS:

The Pennsylvania Insurance Fraud Prevention Authority has named Ralph Burnham executive director, replacing Roy Miller

UP CLOSE Dr. Allen Woolf

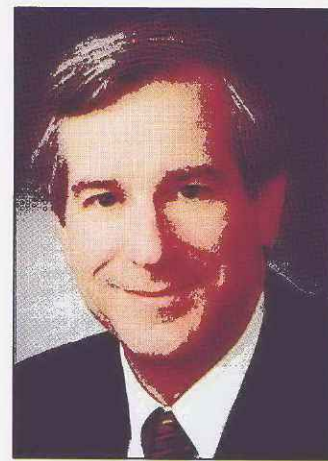
NEW JOB TITLE: Chief medical officer, CIGNA Group Insurance in Philadelphia.

START DATE: Sept. 4

OLD JOB TITLE AND COMPANY: In my previous role as medical officer for CIGNA Behavioral Health/CareAllies, I provided clinical leadership for CIGNA's managed behavioral health and population health improvement programs.

GOALS FOR NEW POSITION: I have several things that I would like to accomplish in this position. First, I will assure that all work done by CIGNA Group Insurance in our disability, life and accident insurance programs continues to be of the highest quality and clinical integrity. Second, I look to enhance existing programs—and establish new ones—that continually minimize the negative impact of health risks, injury and illness on workplace productivity. Finally, by meeting these goals I look to create an environment that continues to attract and retain the best clinical professionals in the industry.

REASON FOR THE SWITCH: I saw this new role as an exciting opportunity to design programs that put CIGNA at the forefront of integrated health and productivity management, with a focus on prevention and wellness. With tight linkages across our medical, disability, leave management and behavioral health programs, we work to keep people well and on the job, and to return them to productive work quickly if they become injured or ill. As a result, our employer customers will experience industry-leading



outcomes in managing medical and lost productivity costs. To be a part of this effort is very rewarding.

VITAL STATISTICS: Pomona College, B.A., 1977; Harvard University School of Medicine, M.D., 1981; Children's Hospital of Seattle/University of Washington, pediatric residency. I have held several medical leadership positions during my 23-year career with CIGNA. My most recent appointments included: medical officer for CareAllies; medical officer, health care operations for CIGNA and Intracorp; and medical officer for Intracorp.

FIRST TIME IN THE JOB MARKET: My first job was in high school working at a Kentucky Fried Chicken. My first job in medicine was practicing pediatrics in a large group practice.

TOP ADVICE: The biggest risk you can take is to not take a risk. Be prudent, but don't wait until everything is all buttoned up to take a stance and begin to act.

OUTSIDE THE INDUSTRY, A DREAM JOB: My dream job would be leading an organization that focused on advocacy for child health and welfare issues.

effective in December. Previously, Mr. Burnham was chief of the Antifraud Compliance Division of the Pennsylvania Insurance Department.

OTHER PROVIDERS:

Thomas Chuba has joined Buck Consultants L.L.C. as a principal in the health and productivity practice in Pittsburgh. Previously, he was regional sales vp of the government and labor division of Aetna Inc.

Also at Buck, Todd Hanson has been named principal and market leader for the Minneapolis office. Previously, he was principal and advisory practice leader for Mercer L.L.C.

And Rob Goren has joined Buck as a director in its Atlanta office. Previously, he was vp and actuary at CompBenefits Corp.

Hugh McCormick has joined the LeBoeuf Lamb Greene & MacRae L.L.P. in New York as of counsel. Previously, he was executive vp of corporate development at Scottish Re Group Ltd.

The New York Liquidation Bureau in New York has made four senior-level appointments:

- Susan J. Pogoda has been named first assistant special deputy superintendent and chief of staff, and is in charge of managing the day-to-day operations of the Liquidation Bureau's 400-person staff. Before joining the agency, she was bureau chief of the claims bureau for the New

York attorney general.

- Andrew Lorin has been named assistant special deputy superintendent and general counsel. Previously, he was enforcement section chief of the New York attorney general's Investment Protection Bureau.

- Joseph J. Liberatore is the new assistant special deputy superintendent and chief financial officer. Previously, he was vp, finance and controls, for Citigroup Alternative Investments.

- Dennis J. Hayes is now an assistant special deputy superintendent for reinsurance and estate management. Before his promotion, he was executive director for receivership operations.

TO SUBMIT ITEMS

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

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Designation: School risk managers see more training opportunities

CONTINUED FROM PAGE 4

techniques and measuring school risks.

"The objective...is to provide practical education—education where the participant can walk back into their environment and apply what they learned," Ms. Oehlert said.

Thirty-six people, including school risk managers and insurance agents and brokers, have received the designation thus far.

Larry Helgesen, director of risk management and nonexempt services for the Galena Park Independent School District in Houston, is one of six charter designees. He has since become part of the faculty teaching the curriculum in addition to his position with the Houston school district.

Mr. Helgesen said he decided to obtain the designation because he was new to the school risk management arena, and he wanted to learn as much as he could about the different risks that schools or public entities face.

"The risk management industry is becoming more complex, and school districts need to have someone who is looking out for the land mines and avoiding those land mines when it comes to risk," Mr. Helgesen said.

Often, school risk managers have an education background as opposed to a risk management background. Because of their administrative background, principals, assistant principals and coaches are likely school risk management candidates, so risk management training is welcome, said

Steve Levering, associate director of risk management programs for the National Alliance.

Mr. Helgesen said the education has been invaluable. It has given him a foundation for what risk management is and the processes it involves.

"I can apply all the lessons to do my job better, and then I can explain it better to my school board or to upper management," Mr. Helgesen said. "It allows us to make informed decisions instead of shooting in the dark."

In addition to the specific education, obtaining the Certified School Risk Manager designation provides a networking venue for school risk managers, Ms. Oehlert said.

"They discuss common solutions and issues," she said. "Oftentimes, school risk managers feel isolated

because they're the only ones in their district. If they have this network, they can use each other as resources."

While the program courses are currently offered in Texas and California, the designation is recognized in every state, Ms. Smith said, and six states have approved three to four of the courses for continuing education credits. All five courses have been approved in Texas. Ms. Smith said she is not anticipating problems getting more courses approved in more states.

The National Alliance is looking to add course offerings in several states in 2008, but Ms. Smith said the states have not yet been determined. She also said the organization is considering offering its courses online.

Mr. Helgesen said the designation can benefit schools and the insurance industry as a whole because school risk managers can learn the insurance business and learn the right questions to ask insurers. At the same time, the insurance industry can make sure it's giving schools the appropriate products and information.

Trained school risk managers will be in demand, Mr. Helgesen said.

"As risk management becomes more prevalent in school districts, people are going to say they want someone who has a basic understanding and has even gone beyond getting the basic understanding" of school risk management, Mr. Helgesen said. "We need to be good custodians of our tax dollars and assets. We need to know what we can do to mitigate risk."

Surplus lines: Industry weighs government's role

CONTINUED FROM PAGE 4

Federal position

Creating a natural catastrophe fund, meanwhile, has been proposed at the federal level in Washington, said Richard M. Bouhan, NAPSLO's executive director.

"I'm not real in favor of it," said J. Neal Abernathy, president and CEO of Swett & Crawford Group in Atlanta. It could work, though, if it were structured as a backstop for insurers, similar to the terrorism backstop, he said.

"But if the federal government starts looking at becoming an insurer, where several hundred thousand insureds are trying to go to the government to have their claims settled, there is no way that is going to work," Mr. Abernathy said.

Thomas F. Mulligan, executive vp of Franklin Lakes, N.J.-based Western World Insurance Group, said he wonders whether a federal natural catastrophe fund would encourage more states to establish funds.

That, in turn, could eliminate private capital and reduce loss control incentives, Mr. Mulligan said.

Perhaps there is an underlying "feeling that people have, that our government takes care of us on certain fundamental things," said Marshall P. Kath, CEO of Dallas-based Colemont Brokerage Group Inc.

"I don't necessarily embrace that philosophy, but I think that is a macro trend out there that we cannot ignore," Mr. Kath said.

That will play out in health care coverage and it's not a matter of if, but when, Mr. Kath predicted.

Private insurance industry solutions may not be adequate for all events, said Dennis Crosby, president and CEO of ACE Westchester in Atlanta. Mr. Crosby said he likes the proposed federal Terrorism Risk Insurance and Extension Act of 2007.

"From our perspective, it's something we feel is very important because we don't feel that we can price (terrorism coverage) appropriately," Mr. Crosby said.

E&S industry up despite soft market

NEW ORLEANS—The U.S. surplus lines industry posted a combined ratio of 79.6% during 2006, according to a report released at the 2007 Annual Convention of the National Assn. of Professional Surplus Lines Offices Ltd.

The industry also tallied \$38.7 billion in direct written premiums for 2006, which amounts to more than 14% of the nation's property/casualty market, according to the 14th annual report prepared by Oldwick, N.J.-based A.M. Best Co. Inc.

Direct written premiums have grown about 173% over the past five years for surplus lines insurers. In contrast, the total U.S. property/casualty market grew only 40%, Best reported.

Best also said it expects "continued positive underwriting returns," driven by adequate rates, disciplined underwriting and favorable loss reserving. But it also noted that the cost of commercial insurance continued falling through the second quarter of 2007 and surplus lines business is 80% commercial coverage.

About 3,200 people attended the Oct. 3-6 convention held in New Orleans. Next year's convention will be held Sept. 10-13, 2008, in San Diego.

For more information contact Kansas City, Mo.-based NAPSLO at 816-741-3910 or go to www.napslo.org.

—By Roberto Cenicerros

Pricing: Premium volume shrinks as rates decline

CONTINUED FROM PAGE 4

But Mr. Power stressed that increasing coverage limits is not a blanket strategy for combating soft market conditions at Lexington, a unit of American International Group Inc. Property insurers still face significant exposure from the ongoing Atlantic storm season, he said.

"The industry is still very exposed, even in the wake of a couple of benign (storm) years we have behind us," Mr. Power said.

Casualty lines, meanwhile, continue to slide, said several sources who attended NAPSLO's convention.

Earlier, Swiss Reinsurance Co.'s specialty practice managed to maintain its premium volume because of the breadth of coverages it offered, said Robin P. Sterneck, Swiss Re's managing director, Americas property & casualty in Overland Park, Kan.

"But we are feeling it now," Ms. Sterneck said. "Probably in the last six months we are feeling it more."

To counteract the softening market, Swiss Re's specialty practice, like other E&S entities, has expanded its product offerings. For example, it now offers casualty coverage to oil and gas equipment manufacturers and excess transportation risks.

With the market softening, many insurers and brokers are content if their premium volume is down only slightly on previous years, said Alan J. Kaufman, chairman, president, and CEO of Farmington Hills, Mich.-based Burns & Wilcox Ltd.

Insurers also say they are happy just to hold prices flat, especially if they can write additional accounts.

Fireman's Fund Insurance Co. is seeing slight decreases or flat renewals for its lead umbrella coverage, said Brian S. Specht, vp of specialty insurance in New York for the Novato, Calif.-based insurer.

But "we are giving back a little" on pricing for "high excess" coverage layers, he said. His specialty unit

has written \$20 million in new excess layer business over the past year, Mr. Specht said.

Several surplus lines insurers say they are drawing a line on how far they will lower pricing as more standard markets enter their territory. But brokers say they haven't yet seen that line.

"Everybody is saying, 'We have got to draw the line in the sand,'" said Glenn Hargrove, president and CEO of Dallas-based Crump Insurance Services Inc. But "try to figure out where that line is they are going to draw."

Buyers should expect more reductions before market conditions change, said Tap Johnson III, president of TAPCO Underwriters Inc., a Burlington, N.C., E&S managing general agent.

"I don't have a lot of faith in our industry to hold the line," Mr. Johnson said. "There are still weak players who think the way you deal with the problem is to lower the price or pay more commission, and both erode the margin."

Nationwide economic conditions also are pressuring premium volume, several sources said. Providing coverage for residential construction had been a mainstay of the excess and surplus lines industry, they say, but a decline in building has meant less need for E&S products.

NAPSLO conference attendees differed on whether a slowdown in manufacturing orders reported by the U.S. Commerce Department on Oct. 4 would have a similar impact.

Manufacturing operations, unlike housing construction projects, generally do not come to a complete standstill because of economic conditions, said Crump's Mr. Hargrove.

But a manufacturing slowdown has a trickle-down effect on the surplus lines market, said Mr. Kaufman of Burns & Wilcox. For example, fewer engineers and architects will need professional liability coverage if they are not designing and building manufacturing facilities, he said.

'The whole risk-sharing mechanism of reinsurance and insurance has been taken out of the fray.'

David E. Leonard, RSUI Group Inc.

admitted side."

If a large catastrophe should strike somewhere in the state, Florida taxpayers might have to pay claims or a policyholder assessment could become necessary, the panelists said.

"The whole risk-sharing mechanism of reinsurance and insurance has been taken out of the fray," said David E. Leonard, executive vp for RSUI Group Inc. in Atlanta.

An analysis of operations in Florida would show that over time, insurers have not earned a "big cash bonus" from providing catastrophe coverage, said Dale H. Pilkington, president of San Antonio-based Argonaut Group Inc.'s excess and surplus lines segment.

"So I think the private industry has responded properly and effectively" to recent catastrophes, Mr. Pilkington said. "But that short-term extraordinary event drives this perception that everything is wrong, everything is broken."

Captives: IRS tax credit plan 'a big deal'

CONTINUED FROM PAGE 1

ers L.L.P. in Washington.

In the proposed rules, the IRS gives no policy reason for the change. Instead, it says favorable tax treatment for captive sponsors filing a consolidated tax return covering corporate entities may be costing the government too much money. "The IRS and the Treasury Department have become aware of the increasing prevalence of captive insurance arrangements within consolidated groups," the IRS said in the proposal published in the Sept. 28 Federal Register.

As a result, "The separate entity treatment...may now have a greater effect on consolidated taxable income than was anticipated when the current regulations were issued," the IRS said.

"It is very much of a revenue issue," said Gary Bowers, a tax partner in the Raleigh, N.C., office of Johnson Lambert & Co. L.L.P.

It isn't known exactly how many captive sponsors would be affected, but the number is thought to be several hundred.

Len Crouse, Vermont's deputy commissioner of insurance, says the IRS rules, if finalized, would have a significant, negative impact on many of the state's captives. Vermont is the No. 1 U.S. domicile, with 558 captives.

Hawaii Deputy Insurance Commissioner Craig Watanabe estimates that a majority of Hawaii's 165 captives could be affected. Hawaii is the nation's second-largest captive domicile.

"Hundreds of captives could fit the category in which there are numerous corporate affiliates with

one consolidated tax return being filed," said Robert H. Myers Jr., a partner with Morris, Manning & Martin L.L.P. in Washington.

How great the impact would be on any individual captive and affiliated companies to which it provides coverage would vary. The greatest impact would be on captives writing long-tail business, such as product liability, where losses might not be paid for years after reserves are set up.

"You lose the tax benefit of getting a deduction today for something that might not be paid for five years from now," said Charles Lavelle, a member of the tax and finance group at the law firm Greenebaum, Doll & McDonald P.L.L.C. in Louisville, Ky.

"This is a big deal," Mr. Lavelle added.

Lobbying begins

But the captive industry isn't sitting still.

For example, South Carolina Director of Insurance Scott Richardson has written to the state's representatives in Congress, alerting them to the IRS proposal and warning of adverse economic consequences.

"If these rules are implemented, the effect would create additional economic burdens," Mr. Richardson wrote. Among other things, such rules could drive some captives out of business or into economically "unviable" contracts. "It is in the best interest of South Carolina, and of the insurance industry, that these rules not be implemented," he wrote.

South Carolina is the third-largest domestic domicile, with 163 cap-

tives.

In Hawaii, Insurance Commissioner J.P. Schmidt is discussing with Gov. Linda Lingle a possible response strategy, while the Captive Insurance Cos. Assn., which represents captive owners and service providers, has set up a task force to prepare a response to the IRS, said CICA President Dennis Harwick in St. Petersburg, Fla.

"There is going to be tremendous pushback from the industry," Mr. Lavelle said.

Experts note that many captives were set up after the IRS, through a series of rulings, effectively blessed a variety of captive arrangements as bona fide insurance.

For example, in a 2002 Revenue Ruling, a captive that provided coverage to 12 subsidiaries owned by a domestic holding company was recognized as a valid insurance arrangement by the IRS. In that situation, all the subsidiaries had at least 5% but not more than 15% of the risk insured by the captive.

Additionally, federal appeals courts have ruled that if a captive has a significant percent of outside business—generally at least 25%—its coverage is not self-insurance and its tax treatment should be comparable to a commercial insurer.

Through the proposed rules, the IRS is attempting to override judicial decisions as well as its own prior rulings, said Tom Jones, a partner with McDermott, Will & Emery L.L.P. in Chicago.

Observers say it is too soon to say whether the IRS will stick to the proposal.

"Many things can happen before this is done and over with," said Vermont's Mr. Crouse.

Liability: Securities fraud case spotlights third parties

CONTINUED FROM PAGE 3

fees as revenue.

Those deals and others forced Charter to restate its results from 2000 through 2002 to reduce revenue by about \$292 million, triggering a dramatic drop in its share price.

The Securities Exchange Act of 1934 bars any direct or indirect manipulative or deceptive acts "in connection with the purchase or sale of any security" that violate SEC rules and regulations.

SEC rule 10b5 prohibits "any act, practice, or course of business, which operates or would operate as a fraud or deceit upon any person in connection with the purchase or sale of any security."

In 1994, the Supreme Court interpreted the law to mean that investors cannot sue those that only aid a fraud.

In its ruling, however, the court noted: "Any person or entity, including a lawyer, accountant, or bank, who employs a manipulative device or makes a material misstatement (or omission) on which a purchaser or seller of securities relies may be liable as a primary violator."

Under pointed questioning by Supreme Court justices in the case last week, the attorney for Charter's investors argued against assertions that the investors want to expand liability in securities fraud cases to include "aiders and abettors." Some justices also noted that the defendants did not issue any public statements on which Charter's investors relied.

But the defense attorney in the case also fielded a barrage of questions from the justices over the breadth of the defendants' theory of liability in securities fraud cases. Several justices attempted to sort out whether the high court could bar investors from suing Scientific-Atlantic and Motorola but in other cases allow investors to recover from accountants and lawyers who knowingly allowed organizations to commit fraud.

In particular, Justice Ruth Bader Ginsburg questioned whether there should be three classifications of securities fraud defendants: primary violators of securities law, aiders and abettors who cannot be sued,

and a new category of third parties who can be sued because their deceptive actions permitted securities fraud to occur.

Regarding that potential third category, Arthur Washington, a partner at Mendes & Mount L.L.P. in New York, said, "Conceivably, that's what this case could do."

Insurer groups claim that a pro-plaintiff ruling would drive up directors and officers liability insurance losses and, as a result, D&O rates. In addition, because D&O insurers collect financial information as part of their underwriting process, they might be sued if the policyholder later is accused of securities fraud, insurers say.

But an insurance attorney and two brokers disagree.

From a rating standpoint, "It's not all that important to directors and officers," said Dan A. Bailey, a partner with Bailey Cavaliere L.L.C. of Columbus, Ohio. Even a pro-plaintiff ruling would not affect litigation against alleged prima-

ry violators of securities law, he said. Mr. Bailey also predicted that investors in third parties sued for their roles in other companies' securities fraud scheme likely would not file derivative-action claims.

The more likely insurance market problem is that errors and omissions insurance losses would spike if the Stoneridge investors succeed and investors are allowed to sue professional service firms, he said.

Steve Shappell, managing director of the legal and claims practice for Aon Financial Services Group in Denver, agreed that E&O losses likely would swell if the Stoneridge plaintiffs succeed. He said that few D&O policies could be interpreted to cover claims by another organization's shareholders.

But broker Damian Brew doubted whether even E&O losses would increase materially if the Stoneridge investors succeed. Many E&O policies do not respond to securities fraud claims, and financial institutions often do not purchase that expanded coverage when it is available because of its cost, said Mr. Brew, national claims advisory practice leader for the FINPRO unit of Marsh Inc. of New York.



Justice Ginsburg

New Orleans: Building cover constricted

CONTINUED FROM PAGE 4

the size of hurricane surges and waves rather than the intensity of hurricanes as measured by the Saffir-Simpson scale, Mr. Link said. Hurricane Katrina, for example, was a Category 3 storm when it hit the Mississippi and Louisiana coast with a 28-foot storm surge. By contrast, Hurricane Camille in 1969 was a Category 5 hurricane that hit the Mississippi coast with a 19- to 20-foot storm surge.

The hurricane protection system has undergone dramatic improvements that would protect parts of New Orleans that were devastated by Hurricane Katrina, Mr. Link said. In the Lower 9th Ward, for example, enhancements have been made to the system that would reduce the average depth of flood water caused by a potential 100-year storm by 2.5 feet, decrease estimated fatalities by 18% and property damage by 4%. Completion of further improvements to the system in the Lower 9th Ward would achieve an additional 9.5 foot decrease in the depth of flooding, a 95% decrease in estimated fatalities and an 82% decrease in property losses from pre-Katrina levels.

Although the repairs and enhancements have reduced hurricane risk overall, some areas remain vulnerable, including the area around the Inner Harbor Navigation Canal and Lock, located within city limits, Mr. Link said. The goal of the Corps of Engineers is to repair and enhance the entire 350-mile hurricane protection system by 2011, he said.

Risk managers still have difficulty securing adequate insurance coverage for rebuilding projects in the region due to misperceptions about potential exposures, said Warren C. Perkins Jr., vp, risk manager at Boh Bros. Construction Co. L.L.C.

At the Ernest N. Morial Convention Center in New Orleans, for example, most of the Hurricane Katrina damage was related to the presence of the evacuees rather than flooding, he said. In fact, there was no flood damage in the convention center and little significant wind damage, Mr. Perkins said. Despite the lack of weather-related damage to the convention center, four out of six insurers would not renew the terms of Boh Bros.' builders risk policy for an expansion project, he said. "We just didn't understand the logic," Mr. Perkins said.

Two years after Hurricane Katrina, only six markets are willing to write builders risk policies in southern Louisiana, while a few others are available on a small percentage quota-share basis, said Michael Tubbs, account executive/producer with Willis of Louisiana Inc. in New Orleans. Rates remain 50% to 100% higher than they were before Katrina for commercial construction, although prices have moderated slightly this year, he said. In addition, coastal deductibles for named windstorms are at 5% with a \$250,000 minimum, Mr. Tubbs said. With many construction jobs valued at \$300 million or higher, "how do contractors finance that portion of the risk to protect their balance sheets?" he asked.

Insurers should consider several factors in determining whether to write property coverage in the region, including a greatly improved regulatory climate in Louisiana, state-funded incentives to write property insurance and vastly improved building codes, Mr. Tubbs said.

"Without insurance, recovery and rebuilding efforts will slow down and in some cases, will never happen," he said.

Montrose: Mold claims

CONTINUED FROM PAGE 3

of any mold damage...allegedly caused by Regency's defective roof repairs at any time prior to August of 2001," after the policies' effective dates, the judge ruled.

The decision is believed to be the first interpreting the Montrose endorsement, and it undercuts the endorsement's intent of broadening the "known loss" exclusion, said

Randy J. Maniloff, a lawyer with White & Williams L.L.P. in Philadelphia who represents insurers in coverage disputes.

"This is just one case, but it's not the start the (insurance) industry wanted to see," Mr. Maniloff said.

Transportation Insurance Co. vs. The Regency Roofing Cos. Inc.; U.S. District Court, Southern District of Florida; No. 05-80830.

Carpenter: Promises vigorous defense of deceit charges

CONTINUED FROM PAGE 1

and other benefits that were not disclosed to cedents.

Mr. Blumenthal alleges that Guy Carpenter misled its cedents regarding its "duplicious role." It also alleges that, despite relinquishing underwriting authority in 2004, cedents were unaware that Guy Carpenter continues to set ceding commissions. Ceding commissions are paid by reinsurers to cedents.

In addition, Guy Carpenter set up an unlawful tying arrangement by insisting that cedents that used the facultative facilities also buy treaty coverage through the brokerage, the suit charges.

"My antitrust investigation has revealed an industry plagued by pervasive anticompetitive and anti-consumer practices," Mr. Blumenthal said in a statement. "Guy Carpenter's schemes were enabled by a shifting coterie of more than 20 co-conspirators—reinsurers willing to play Guy Carpenter's game of deceit, and damage consumers."

The suit also names Philadelphia-based Excess Reinsurance Co., a reinsurer in which Guy Carpenter has a 9.5% ownership interest and a management role. Mr. Blumenthal alleges Guy Carpenter funneled business to Excess Re, which is 90% owned by its policyholders, without clients' knowledge of its ownership and management interest. Excess Re ceased underwriting in 2003.

The suit, which alleges violations of the Connecticut Antitrust Act and Connecticut Unfair Trade Practices Act, seeks damages, restitution, disgorgement and civil penalties.

In a statement, Guy Carpenter blasted the lawsuit. It "is based on a fundamental misunderstanding of reinsurance facilities that have been in operations for the benefit of small and midsize clients for a long as 50 years. As many of our clients have confirmed during this investigation, these facilities result in improved availability and terms of reinsurance and ultimately benefit insurance buyers," the reinsurance brokerage said.

In a statement, Excess Re said it is "confident" that the allegations are "without merit" and that it will defend itself "aggressively."

Although not charged in the suit, Mr. Blumenthal lists as "current co-conspirators:" Arch Reinsurance Co., Aspen Insurance U.K. Ltd., Employers Mutual Casualty Co., Farmers Mutual Hail Insurance Co. of Iowa, Farm Mutual Reinsurance Plan, Swiss Reinsurance America Corp., Hartford Steam Boiler Inspection and Insurance Co., Toa Reinsurance Co. of America and QBE Reinsurance Corp.

An HSB spokesman said the company is "disappointed" that it was named in the suit and it "is confident that it has done nothing wrong and has been cooperating with the attorney general's office in its investigation."

"Swiss Re is not named as a defendant in the complaint. We have cooperated with the AG's investigation and have fully complied with the AG's subpoena for documents and information," a Swiss Re spokeswoman said.

Other reinsurers either declined to or were unavailable for comment.

Market impact uncertain

Attorneys and other industry experts had various reactions to the lawsuit and its potential effect on the reinsurance market.

"What's especially interesting here is he is specifically going after the reinsurance market, which has always been known as a murky, insulated business," said Anthony Sabino, a law professor at the Peter J. Tobin business school at St. John's University in New York. "Clearly Blumenthal is taking the tack that the way it works is in a very dirty fashion."

It's too early to say whether the suit will have the same effect on the industry as Mr. Spitzer's did, Mr. Sabino said. But "he's definitely

going to pull a Spitzer" in issuing subpoenas and investigating other players in the reinsurance market.

Mr. Blumenthal said further action is anticipated.

James W. Carbin, a partner with Duane Morris L.L.P. in New York, said Guy Carpenter's reinsurance facilities detailed in the complaint are not "particularly uncommon" in the reinsurance market. "What it does potentially highlight, though, is the conflict arising when a company wears two hats—that of intermediary and that of binding authority for the very risks they're placing and the proper use of that authority and the disclosure of those roles."

"I don't think the case raises any particularly novel antitrust issues," said James M. Burns, a partner with Williams Mullen in Washington. "The complaint seems to ask whether it is appropriate for several reinsurers to work together to satisfy certain capacity requirements and that presents a rather common joint venture-type question."

"To the extent that any of the other conduct alleged in the complaint is the basis for the state's antitrust claim, well that might be novel, but I don't think that is the case, nor do I think that it would support such a claim if it is," Mr. Burns said.

Robert P. Hartwig, president of the New York-based Insurance Information Institute, for one, said he thinks the complaint falls short.

"It makes no mention of the fact that this is a very competitive market, and from an economic perspective it's difficult to believe that these organizations were systematically being overcharged for decades and didn't go off with another (reinsurance) broker," he said.

According to the complaint, New

London County Mutual Insurance Co. and Patrons Mutual Insurance Co. had to substantially increase their primary umbrella insurance rates in 2002 to comply with terms of purchasing reinsurance through Guy Carpenter's umbrella facility.

Mr. Carbin questioned, however, whether the ceding companies, given their relatively small size, "could have gotten the same reinsurance protection had they gone into the open market as opposed to what they were able to secure by these facilities."

Overcharges alleged

Insurance buyers have paid up to 40% more for coverage over the years as a result of anticompetitive practices by Guy Carpenter & Co. L.L.C., Connecticut Attorney General Richard Blumenthal has alleged.

In the lines the facilities wrote, the decades-long price fixing orchestrated by Guy Carpenter resulted in 40% higher profits than the industry averages for that business, Mr. Blumenthal charged in his antitrust suit filed Oct. 4 against the New York-based reinsurance brokerage.

As a result of the schemes, reinsurers unlawfully took in more than \$1 billion in premiums and inflated insurance premiums for consumers by as much as 10% to 40%, Mr. Blumenthal said.

Guy Carpenter, however, said there is no basis for the lawsuit and it intends to aggressively defend itself.

According to court papers, Guy Carpenter received more than \$80 million in fees, plus millions more in undisclosed contingent commissions as a result of the alleged conspiracies.

In all, Guy Carpenter exploited a group of approximately 170 insurer clients by withholding critical information and leading them to believe that the brokerage was acting in their best interests when in fact it was at all times working to enhance and maintain the profitability of the reinsurers and itself, according to the lawsuit.

"Because of the unregulated nature of the reinsurance industry, Guy Carpenter's dominant position in the market and the inertia inherent in the industry, Guy Carpenter maintained these conspiracies virtually undetected for almost 50 years," according to the statement from Mr. Blumenthal's office.

—By Sally Roberts

California: Health plan progressing

CONTINUED FROM PAGE 1

The two Democratic lawmakers whose successful reform measure Gov. Schwarzenegger has threatened to veto praised him for putting his proposal into bill form so that it can be considered by the legislature. The governor opposed the bill primarily because it did not contain an individual mandate (BI, Sept. 17).

"I am pleased the governor will be putting his health care proposal into a bill that can be properly studied and evaluated," Assembly Speaker Fabian Nunez, D-Los Angeles, said in a statement.

"The governor's wise in putting his proposal in legislation," said Sen. Don Perata, D-Oakland, also in a statement. "It allows interested parties to make comparisons on the facts and merits. Central to the discussion is how to pay for it. We look forward to working on the details as they become public."

'We're still concerned that the governor's proposal' doesn't 'reduce the cost of the health care system.'

California Manufacturers Assn.

However, the California Labor Federation criticized the plan for maintaining an individual mandate.

The California Teachers Assn. did not comment regarding the part of the proposal that would lease out the lottery. Currently, proceeds from the California lottery are earmarked for education. The lottery provides schools with an estimated \$1.1 billion per year in funding.

Groups representing small businesses and manufacturers also remained skeptical.

"We're still concerned that the governor's proposal—or any of the proposal—doesn't do enough or show it will do enough to reduce the cost of the health care system," said a spokesman for the California Manufacturers Assn.

A spokesman in the Sacramento office of the National Federation of Independent Business said, "We continue to have concerns about the mandate on employers to provide coverage."

However, the governor remains confident that his proposal will prevail.

"We're optimistic that there is a groundswell of support that will help us carry this as we continue in the special session," the governor's spokeswoman said.

The new measure "demonstrates the feedback that stakeholders have given us," adding that the governor's office has been working close-

'Unique' facilities decades old

Connecticut Attorney General Richard Blumenthal's 107-page complaint centers on a number of facultative and treaty facilities created by Guy Carpenter & Co. L.L.C.

Guy Carpenter and one of its predecessor companies, Balis & Co., created the facilities with several participating reinsurers, in some cases more than 50 years ago, to provide primary insurers that were too small to obtain reinsurance on their own with a place to cede their risks.

While various reinsurance pools and other joint underwriting arrangements have existed for many years within the reinsurance market, Guy Carpenter's reinsurance facilities are different, court papers say.

Under traditional reinsurance pools, reinsurers will agree to act as a single entity in the market and share risk on a joint and several basis, often reinsuring high-risk, unusual or specialized lines of business, according to court papers that cite the aviation market as an example.

Other times, primary insurers

that would otherwise have a difficult time finding reinsurance individually agree with other insurers of similar size or type to provide reinsurance for each other and share the premiums and losses on risks written by all participants in the pool.

The complaint says Guy Carpenter's facilities consist of "Main Street" risks and the reinsurers are responsible only for their share of the risks; they do not act as a single entity nor do they share risk on a joint and several basis.

The biggest difference, the complaint says, is that the facilities are organized and administered "by a large broker with significant market share."

Not only are the facilities different, they also are unique to the New York-based reinsurance broker, according to Mr. Blumenthal. Guy Carpenter's competitors that specialize in the market for small to midsize insurers do not utilize such facilities and, instead, seek competition on rates and terms through the open market.

—By Sally Roberts

ADVERTISER

INDEX

Issue of October 15

ADVERTISER	PAGE #
Ace	7
Aetna Corporate	13
Aon Corporation	22
Ariel Holdings	2
Brownyard Programs	24
Burnham System	24
Business Insurance	6, 9, 10, 17, 20, 21, 23, 30
Florida State University	24
Healthlink	20R
IBM	19
Information Products, Inc.	22
Marsh Inc.	32
National Alliance	6A
Travelers	16
TriZetto Group	14
Wausau Insurance Companies	5
Wellpoint	17R
Wells Fargo	18
XL Insurance	15

See CALIFORNIA next page

News In Brief

CONTINUED FROM PAGE 1

group health care plans would have to provide the same coverage for mental health care disorders as they do for other medical conditions. Group health care plans would have to cover all mental health care services that are listed in the most recent edition of a diagnostic treatment manual published by the American Psychiatric Assn.

Judge bars regulation on worker documents

Employers for now will not have to comply with a new federal regulation designed to control illegal immigration by requiring companies to clear up discrepancies in workers' Social Security information or risk prosecution for employing

unauthorized workers. A federal judge last week issued a preliminary injunction against the regulation on several grounds, including that the U.S. Department of Homeland Security was not authorized to promulgate the rule and that DHS failed to consider how it would affect small businesses.

Sen. Clinton proposes 401(k) tax breaks

Employees enrolled in 401(k) and similar defined contribution plans would be eligible for new tax breaks under a proposal unveiled last week by Democratic presidential candidate Sen. Hillary Rodham Clinton, D-N.Y. Under the plan, the government would provide a matching tax credit—dollar for dollar—for the first \$1,000 contributed by an individual to a 401(k) plan by those earning up to \$60,000 a year. A 50% tax credit would be provided on the first \$1,000 for higher-wage earners. Individuals not covered by 401(k) plans would be eligible for these same tax credits if they set up so-called American Retirement Accounts, which would

allow a pretax contribution of up to \$5,000 a year.

AK Steel to set up VEBA to settle retiree suit

AK Steel Holding Corp. will contribute \$663 million to a voluntary employees' beneficiary association to pay for retiree health care benefits to settle a lawsuit. Under the settlement, which covers about 4,600 retirees who worked at a mill in Middletown, Ohio, AK Steel will have no further obligation to provide benefits to the retirees. AK Steel has about \$2.1 billion in retiree health care obligations, about half of which is related to the retirees involved in the settlement.

Munich Re America to be restructured

Munich Reinsurance Co. last week unveiled a strategy to increase direct and broker-placed reinsurance as well as primary insurance in the U.S. property/casualty market. Munich Re plans to develop closer broker relationships and build a presence in niche primary insurance segments,

executives said during in a teleconference. Starting in January, Munich Re America will have new structure and management aligned by client type to support its strategy, the company said. Anthony J. Kuczinski, who will succeed John Phelan as chief executive officer of Munich Re America in January, said the structure will better serve clients and create partnership-oriented business development.

Noted

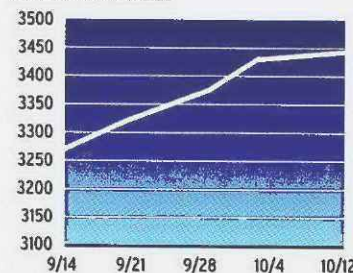
Nebraska Insurance Director **Tim Wagner** died last Tuesday after suffering a stroke Oct. 3. Mr. Wagner, 65, served as the state's top insurance regulator since he was appointed in January 1999. Insurance Department Deputy Director Ann Frohman is serving as acting director....North Dakota Gov. John Hoeven on Tuesday appointed attorney **Adam Hamm** to the post of insurance commissioner. Mr. Hamm is filling the unexpired portion of a term vacated by Jim Poolman, who resigned Sept. 1 to begin an insurance consulting business.

Stock Index

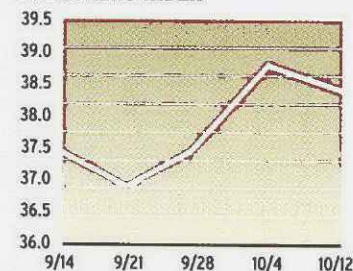
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Up-to-the-minute data for all 82 companies that comprise the BI Stock Index can be found at www.BusinessInsurance.com.

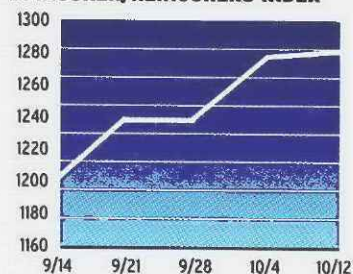
BI STOCK INDEX



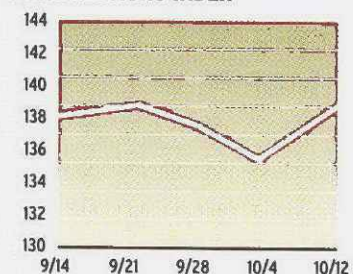
BI BROKERS INDEX



BI INSURER/REINSURERS INDEX



BI MANAGED CARE ORGANIZATIONS INDEX



Percentage change of BI Stock Index vs. key indicators

Indicator	Value	Change
BI/STOCK INDEX	3448.24	0.44%
DOW JONES	14093.08	0.19%
S&P 500	1561.80	0.27%

LARGEST GAINS

SCPIE Holdings Inc.	7.54%
EMC Insurance Group Inc.	6.42%
Berkshire Hathaway	4.95%
Philadelphia Consolidated	4.67%
Axis Capital Holdings Ltd.	4.58%

LARGEST LOSSES

Odyssey Re Holdings Corp.	-5.42%
Aspen Insurance Holdings	-4.63%
Tower Group Inc.	-4.01%
Selective Insurance Group	-3.54%
IPC Holdings Ltd.	-3.22%

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

California: Latest proposal keeps employer mandate

CONTINUED FROM PREVIOUS PAGE

ly with hospitals, health plans and employers in devising the legislation.

While the California Chamber of Commerce remains opposed to the employer mandate, the Los Angeles

Chamber of Commerce has come out in support of the governor's previous proposal, a spokeswoman confirmed. However, she said the business group has not yet taken a position on the formal bill because it is still being reviewed.

Although a spokeswoman for the

Republican reform bills use tax incentives, not mandates

SACRAMENTO, Calif.—The California Senate's Republican Caucus, which had criticized the governor's plan for mandating that employers provide coverage, last week introduced a competing set of health reform bills that use tax incentives rather than mandates to make coverage more accessible and affordable for residents.

The GOP plan also hopes to reduce demand for expensive emergency room services by expanding low-cost clinics with an emphasis on preventive and primary care medicine, and using funds from Proposition 10, which levied a \$1.10 per pack tobacco tax. That measure was intended to raise funds to help needy children under the age of 5.

Although many of the elements of the plan are the same as those that were introduced as CalCare last March, the "CalCare Plus" package includes four new bills. Among the new proposals is to use low-interest California health facilities financing revenue bonds to raise money to expand private neighborhood clinics that would provide

access to both the insured and uninsured and take some of the pressure off hospital emergency rooms.

Another one of the new bills would provide financial incentives to doctors and nurses during their first 10 years in practice, while yet another would provide incentives for doctors and nurses to work in underserved areas.

While a spokeswoman for the Assembly's leading Democrat slammed the measure, a spokesman for Gov. Arnold Schwarzenegger said his proposal contains many of the same elements, including raising reimbursement rates under the state's Medicaid program and expanding access to clinics.

"The new Republican proposal is never going to see the light of day because there's no Democratic support, the governor doesn't support it, and nobody in the Assembly (supports it), so it's going to go nowhere fast," said a spokeswoman for Assembly Speaker Fabian Nunez, D-Los Angeles.

—By Joanne Wojcik

CALIFORNIA PLAN

The Health Care Security and Cost Reduction Act would:

- Require that all employers offer a minimum level of health care coverage or pay a tax up to 4% of payroll.
- Mandate that every Californian buy a minimum level of health care coverage and provide subsidies and tax incentives to individuals.
- Establish a sliding scale for premium contributions by small employers.
- Require insurers to spend at least 85% of premiums on care.
- Require employers to establish Section 125 plans.
- Allow tax deductions for health savings accounts.
- Significantly increase Medi-Cal reimbursements.
- Require that all health providers have the capacity to e-prescribe by 2010.
- Mandate that health plans promote wellness and disease management.
- Create diabetes, obesity and smoking cessation initiatives.
- Promote greater use of retail clinics as an alternative to hospital emergency rooms.

Coalition to Advance Healthcare Reform—a group of more than 50 large national employers, health insurers and drug companies—said CAHR supports the governor's efforts in general, it is not yet endorsing his bill.

"We believe universal coverage is what the country needs, and the way to do that is through individual mandates and market-based reforms," said a spokeswoman for the Washington-based organization that was formed in May to promote health reform at the state level.

While stopping short of endorsing the concept of an employer mandate, the spokeswoman said

CAHR takes "seriously the concept of shared responsibility," adding that the group has been working closely with the governor's office to ensure that any measure that is eventually enacted is not pre-empted by the Employee Retirement Income Security Act. ERISA precludes states from dictating the content of employee benefit plans.

Indeed, careful consideration was given to the ERISA pre-emption possibility, according to Gov. Schwarzenegger's spokeswoman.

"We have been working with attorneys as we craft the proposal," she said. "We've been mindful of ERISA as we've crafted this legislation, and we're optimistic that the governor's plan will meet ERISA standards," she said.

In particular, "we don't dictate what benefits employers must have," she said. She explained that by delegating the establishment of a minimum benefit package to a regulatory body, the governor's office hopes to pass an ERISA pre-emption test.

"We chose that approach because if you do something in statute, it's too rigid and you have to change it again by statute, but by doing it through the regulatory process, we can keep in mind all of the various considerations that need to be taken while crafting regulation," the spokeswoman said.

However, J.D. Piro, an attorney at Hewitt Associates Inc. in Norwalk, Conn., disagreed. "You can't just get around preemption by letting a state department, a state agency, regulate them rather than put it into the legislation," he said. "That's the same thing. ERISA was intended to stop that."

The chances of some components of the legislation passing are good, said a spokesman for the state senate Republican caucus. If Gov. Schwarzenegger has the backing of the Democrats, he will have enough votes to get it passed, he said.

Contributing: Jeff Casale, Roberto Cenicerós,
Douglas McLeod, Joanne Wojcik

Business Insurance END PAGE

Doctors and nurses are
accused of violating former
E.R. star George
Clooney's privacy rights.

Real doctors in trouble over Clooney hospital stay

As many as 40 employees of a New Jersey hospital are being investigated for possibly violating federal privacy laws by leaking to the media details of injuries actor George Clooney sustained in a September motorcycle accident.

Mr. Clooney reportedly asked that Palisades Medical Center be lenient in its punishment of the group, but at least seven nurses and other health professionals have been suspended without pay.

In defense of its members, the Health Professionals and Allied Employees union is blaming the North Bergen, N.J., hospital for the infraction.

"The hospital had a responsibility to establish proper systems to protect patient privacy," said union President Ann Twomey in an Oct. 10 statement. She called for an examination into "what went wrong with the hospitals' security systems that would have allowed such a large breach of patient privacy."

The Health Insurance Privacy and Portability Act prohibits anyone except patients, providers and parties involved in the delivery and financing of health care services to have access to patients' private medical records.

Life imitates sitcom in fake lawyer scam

Brian Valery, a former paralegal at policyholder law firm Anderson Kill & Olick P.C., had an interesting idea for landing a good job—one seemingly borrowed from the imagination of George Costanza.

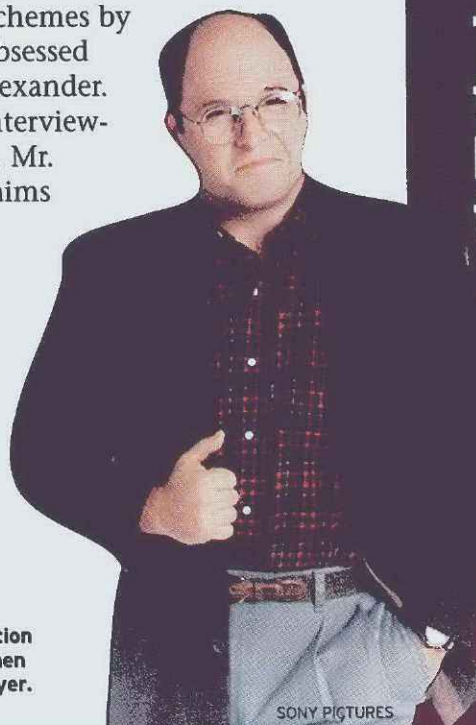
Mr. Valery wanted to become a practicing lawyer, but without the expense and drudgery of law school. So he told his bosses at Anderson Kill over a two-year period that he'd graduated from Fordham University School of Law, passed the bar exam and been admitted to practice in New York.

He then worked for the firm as a lawyer for two years, collecting \$200,000 in salary before his managers discovered that he'd made it all up.

The bold career plan evokes similar schemes by George Costanza, the conniving, self-obsessed "Seinfeld" character played by Jason Alexander. In one such plan, after the executive interviewing him for a job takes off on vacation, Mr. Costanza shows up at the company, claims he's been hired, moves into an empty office and reports to work every day (doing nothing).

But Mr. Valery's not laughing—he pleaded guilty last week to second-degree larceny for defrauding Anderson Kill. He faces five to 15 years in jail, though a New York state judge said he would sentence Mr. Valery to probation if he repays \$150,000 of his salary by his Jan. 30, 2008, sentencing.

A former paralegal may have taken his inspiration from "Seinfeld" character George Costanza when he made up qualifications to get a job as a lawyer.



SONY PICTURES

The 2005 Dodge Ram Pickup is the fifth most popular vehicle among car thieves.



HOTTEST WHEELS

Vehicles most often reported stolen in 2006

1. 1995 Honda Civic
2. 1991 Honda Accord
3. 1989 Toyota Camry
4. 1997 Ford F-150 Series Pickup
5. 2005 Dodge Ram Pickup

Source: National Crime Information Center

Thieves nab fewer cars but hold on to more

There's the movie, "Gone in Sixty Seconds" and then there's reality—gone in under 30 seconds.

Last week the Des Plaines, Ill.-based National Insurance Crime Bureau released its annual vehicle theft study, "Hot Wheels," which reported that every 26.4 seconds a vehicle is stolen in the United States. That said, the report also stated that the number of vehicles reported stolen is declining.

In 2006, 1,192,809 motor vehicles were stolen, which is 42,417 fewer than in 2005, according to NICB. Using the FBI's average valuation of \$6,649 per stolen vehicle, this amounts to over \$7.9 billion in losses in 2006. However, while overall thefts are down for the third consecutive year, results from the NICB study reported that only 59% of the stolen vehicles were recovered—the lowest recovery rate in over a decade.

For 2006, the hottest commodity was the 1995 Honda Civic, followed by the 1991 Honda Accord, according to NICB. Other mainstays on the list over the past few years have been the 1989 Toyota Camry and the 1990 Acura Integra. This year, the Camry was listed as the third most stolen car and the Integra tenth.

But with so many vehicles reported stolen and so few to be recovered, where do the outstanding vehicles go?

"Chop shops" and exports are two ways thieves like to get rid of stolen cars and trucks, NICB agents said in a statement. They add that it is "not unusual" for stolen vehicles to be shipped intact to other countries where prospective buyers can have them for a fraction of what they would legitimately cost with no questions asked."

For more information on the NICB study, visit www.nicb.org.

Club tries stripping dancer of workers comp benefit

Shangri-La is described as mystical place where perfection abounds and harmony reigns. But settling a workers compensation claim wasn't harmonious for an exotic dancer injured while performing at Shangri-La, a Fort Wayne, Ind., strip club.

Angela Hobson claimed she injured her neck and shoulder in December 2001, while performing a "pole trick," court records show. After several hospital visits and surgery to repair a herniated disc in her cervical spine, she filed a claim in 2003. In 2006, the Indiana Worker's Compensation Board awarded her temporary total disability payments and compensation for permanent impairment.

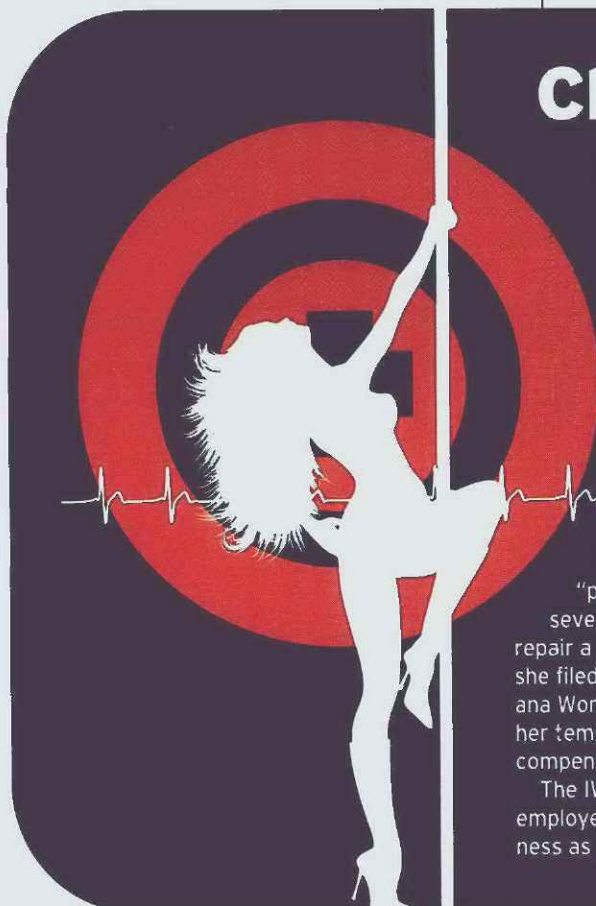
The IWCB also discovered that her employer, Wholesalers Inc., which does business as Shangri-La, did not have mandatory

workers comp insurance.

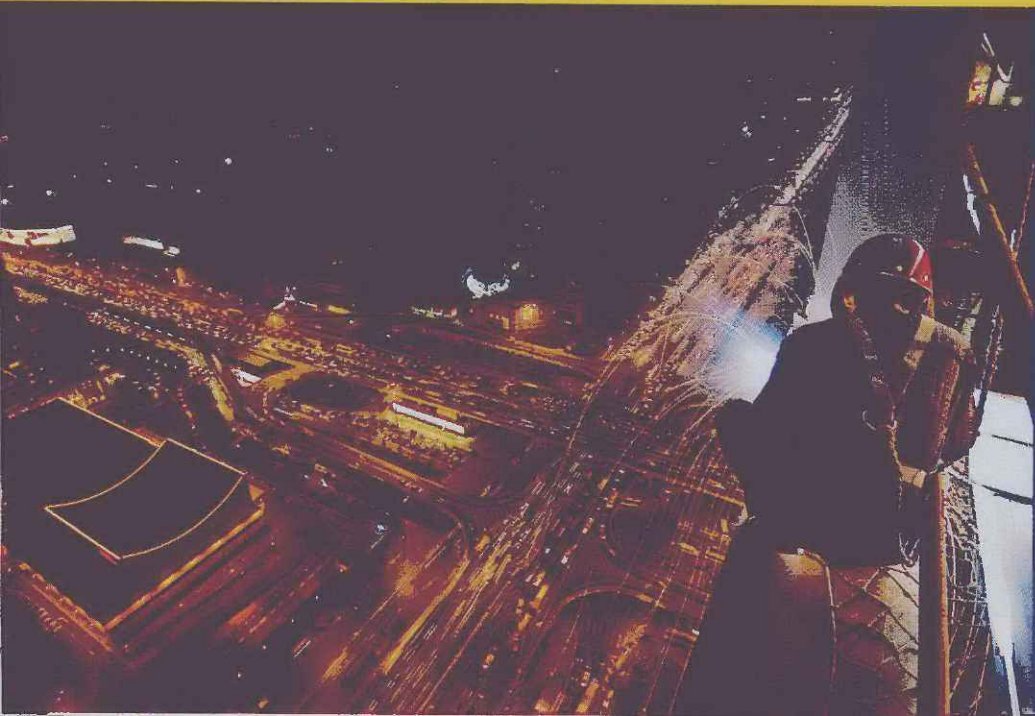
Shangri-La appealed the IWCB's decision and argued that it erroneously found Ms. Hobson more credible than Shangri-La's witnesses who disputed she was injured at work.

The Court of Appeals of Indiana affirmed the IWCB's decision favoring Ms. Hobson, but it struck down her request for appellate attorney fees and 10% increase in her award. However, the court added a 5% increase due to the passage of time and remanded the case to the IWCB to determine whether Ms. Hobson is entitled to double compensation due to the allegation Shangri-La violated state law by not having worker's comp insurance.

Court records indicate that had Shangri-La maintained adequate procedures for recording work injuries and purchased workers comp coverage, the claims settlement process could have been much quicker and, thus, more harmonious.



WORKERS COMP COSTS: WHAT'S YOUR UPSIDE?



As costs continue to soar and liabilities extend farther into the future, workers compensation demands heightened focus and strategic attention. Marsh can help you lower your total cost of risk and improve your claim outcomes with unrivalled diagnostic tools, deep benchmarking insights, and innovative workforce safety, return to work, and medical management strategies. The upside? A safer, more productive workplace. To learn more, visit findtheupside.com

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