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\$5

Late News

MMC to lay off 750 in restructuring

Marsh & McLennan Cos. Inc. has announced a \$225 million cost-cutting plan, which includes elimination of 750 positions, as a means to enhance operational efficiencies and improve profitability. New York-based MMC said that while the initiative calls for layoffs affecting less than 2% of its 55,000-member workforce, most of the savings will come from other steps, including establishing global centers for service, infrastructure and network operations; consolidating data centers and servers; and disposing of excess space. The plan is expected to yield annualized savings of approximately \$350 million by the end of 2008. MMC will incur about \$225 million in charges for the plan, taken over three years.

Csiszar to resign as PCI top exec

Ernst Csiszar will resign as president and chief executive officer of the Property Casualty Insurers Assn. of America on Sept. 30, the association said. Gerald Whitburn, chairman of PCI

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Inside



MANDATES FAIL

Benefits mandates vetoed in California, Chicago.

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ACE ARCHITECT

Brian Duperreault reflects on his work at the insurer.

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Reservists face challenges returning to work

EAPs, outreach can help vets ease transition

By JUDY GREENWALD

Reservists returning to their civilian jobs following U.S. military service in Iraq or Afghanistan often face difficulties adjusting to their previous lives, and experts say employers must be alert to potential problems.

Returning reservists face issues ranging from relatively minor problems, such as readjusting to the slower pace of everyday life vs. service in a combat zone, to post-traumatic stress disorder with symptoms that can include anger, depression, nightmares, extreme reactions to noise, oversensitivity to criticism, difficulty concentrating, drug and alcohol abuse, and marital problems.

Reincorporating returning workers will be a challenge many employers face. According to the U.S. Department of Defense, 110,500 National Guard and reserve person-



PHOTO: AP WIDE WORLD

California National Guard units arrive at a U.S. Air Force base after serving in Iraq. Some soldiers experience difficulties in adjusting to their return.

nel were mobilized as of August.

While many returning soldiers are just fine, the National Center for Post-Traumatic Stress Disorder,

which is part of the Department of Veterans Affairs, cites a 2004 study that estimates the risk of post-traumatic stress disorder is 18% from

service in the war in Iraq and 11% from Afghanistan.

However, observers say these estimates may be low. Denise Curran, a clinical therapist for Chicago-based CompPsych Corp., an employee assistance program provider, estimates that 30% of returning soldiers will have PTSD, increasing up to 70% for those returning from second tours of duty.

There are steps that employers can take to address the situation (see story, page 27) even though they generally do not have specific programs aimed at reservists and usually address such needs through their regular EAPs, observers say.

Employers also should encourage reservists to contact the federal Department of Veterans Affairs, which can provide returning soldiers with support groups that include their peers, said Ms. Curran. "They're so much better at being able to provide this for the soldiers," she said.

Spouses and families members can encounter problems as well, say observers. When a woman, for in-

See **PTSD** / page 26

Health insurers embrace CDHP for own employees

Some replace all traditional plans

By GLORIA GONZALEZ

For health insurers, the quest to spread consumerism begins at the office.

Insurers are encouraging their own employees to become better health care consumers by offering consumer-driven health plans and information tools and providing financial incentives for good health care decisions.

But health insurers have different ideas about how to promote consumerism within their own ranks, with some demonstrating their commitment to consumerism by completely replacing traditional health insurance plans with con-

sumer-driven plans, while others prefer to encourage, rather than mandate, their employees' participation in these plans.

Minnetonka, Minn.-based UnitedHealth Group Inc. last year became the first major U.S. insurer to replace its traditional plans with CDHPs, followed this year by CIGNA Corp. Both companies offer their employees two health reimbursement arrangements and a health savings account linked to a high-deductible health plan.

Prior to 2005, UnitedHealth offered an HRA plan as an option, but the insurer replaced its traditional plans with consumer-driven health plan options effective Jan. 1, 2005, in "a fairly dramatic commitment to consumerism," said Meredith Baratz, vp-market solutions, for

See **CONSUMERISM** / page 6

Corporate spying raises questions on D&O coverage

By DAVE LENCKUS

Despite potential criminal charges and damage claims that corporate espionage cases—like the one in which Hewlett-Packard Co. is embroiled—can generate, the executive masterminds behind such spying may not be left out in the cold without insurance, according to experts.

But directors and officers liability insurance may not cover all of the costs those

executives could face, said an insurer attorney and two brokers.

All three experts spoke in general terms about the D&O liability insurance issues that could arise in internal or external company espionage capers that are exposed—not specifically about the Hewlett-Packard situation.

California's attorney general's office said it likely will file criminal charges against

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BENEFITS MANAGEMENT

BENEFIT FINANCING STRATEGIES

Pension reform law eases surplus transfers; hybrid health plans aim to produce savings for small and midsize firms; employers seek to boost HSA participation.

How can you reduce medical costs in workers' compensation?

Ask Aon.

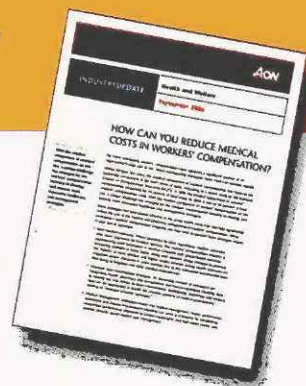


With the medical component of workers' compensation soaring, many organizations see no end in sight. However, there are strategies that have proven effective in the group health arena that could also

have a dramatic effect on the medical and pharmacy components of workers' comp. Visit www.aon.com/ask to learn more about cost-containment strategies that can help your workers' comp program.

— Heidi Mader, assistant vice president in Aon Consulting's health and welfare practice

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at www.aon.com/ask



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Inside

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State clarifies which employers will be subject to health care charge. **Page 4**

Optional federal charter bill to be introduced

Rep. Edward R. Royce's bill would allow life and P/C companies to avoid state regulation. **Page 4**

New law will strengthen defined benefit pensions

An editorial says the new pension law is not encouraging companies to quit the defined benefit system. **Page 8**

Canadian employers struggle with privacy law

Federal law establishes rules for how organizations collect and use personal information. **Page 21**

Online poll [9/11-9/15]

Did the the events of Sept. 11, 2001, significantly alter your organization's approach to risk management?



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

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Reporting on corporate risk and employee benefit management news

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Midsize firms to see sharp rise in health care rates

By JOANNE WOJCIK

Health plan premium increases for small and midsize employers may leap back into the double-digits next year following an 8.6% jump this year, according to a national survey conducted by United Benefit Advisors L.L.C.

"There is little confidence the premium increases will continue to decline, with anticipated increases next year running at 11.6%, and consumer-driven plans expected to increase slightly less at 11.1%," reports the survey, released last week, of 9,603 mostly small and midsize U.S. employers who collectively provide coverage to approximately 3.65 million lives.

The survey was conducted in the second quarter of 2006, making it necessary for many of the participating employers to project rates of

increase rather than report their actual renewal premiums, said David J. LoCascio, co-founder of Indianapolis-based UBA, a consortium of more than 140 benefit advisory firms located across the country.

The survey paints a grim picture for small and midsize employers than that of another survey of mostly large employers released last week by Mercer Health & Benefits L.L.C. Mercer survey respondents projected increases averaging just 5.6% in 2007—one of the smallest increases in years. However, the lower increases in the Mercer survey were attributed to plan design changes, such as raising deductibles. Otherwise, costs for large employers would increase by about 9% in 2007, the survey found.

The UBA survey found the average annual health plan cost per employee in 2006 was \$6,629, with an

average employee contribution of \$2,031 and average employer cost of \$4,592. Health maintenance organizations and consumer-driven health plans had 10% lower costs per employee than the average of all plans, while point of service and indemnity plans has nearly 9% and 21% higher annual costs, respectively, per employee than the average plan.

PPOs continue to dominate the employer-sponsored health plan market, with 61% of employers offering them and 63.3% of employees enrolled in them, the UBA survey reported. By contrast, traditional indemnity plans have nearly disappeared, with only 0.9% of employers offering them and only 1.4% of employees enrolled in them, according to the survey.

The newest entrant to the market, the consumer-driven health plan,

appears to be gaining a foothold, UBA reports. Such plans, usually offered in conjunction with either an employer-funded health reimbursement arrangement or a health savings account—which can be funded by either employers, employees or both—are now offered by 5.9% of employers vs. 2.6% last year, with 3.4% of all covered employees enrolled in such plans, also up from 1.9% last year.

The survey found that the average employer contribution to an HRA was \$1,033 for single coverage and \$1,965 for family coverage. The average employer contribution to an HSA was \$938 for single coverage and \$1,533 for family coverage.

Copies of the complete survey report are available for \$900 for UBA members and \$1,800 for nonmembers. For more information, visit www.benefits.com.

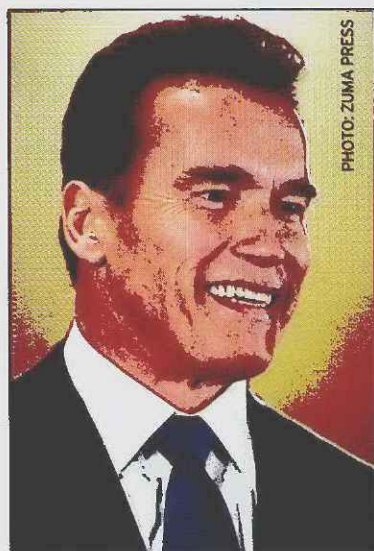


PHOTO: ZUMA PRESS

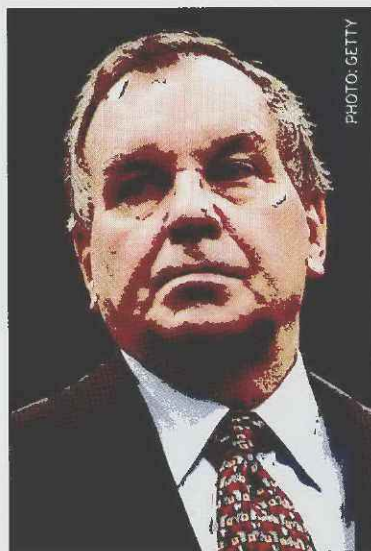


PHOTO: GETTY

California Gov. Arnold Schwarzenegger, left, and Chicago Mayor Richard J. Daley both recently vetoed bills that would have mandated spending levels on benefits.

Benefits mandates nixed by vetoes

Schwarzenegger, Daley refuse to sign measures

By JERRY GEISEL

The drive to mandate that big employers provide a certain level of benefits continues to be hit with setbacks.

In separate developments last week, two mandate measures went down to defeat.

In California, Gov. Arnold Schwarzenegger vetoed so-called "Fair Share" legislation that would have required employers with at least 10,000 employees in the state to spend an amount equal to at least 8% of payroll on health care benefits or pay the difference into a state fund providing coverage to the uninsured.

In his veto message, Gov.

Schwarzenegger said the bill, introduced by state Sen. Carole Migden, D-San Francisco, would neither reduce costs nor expand coverage.

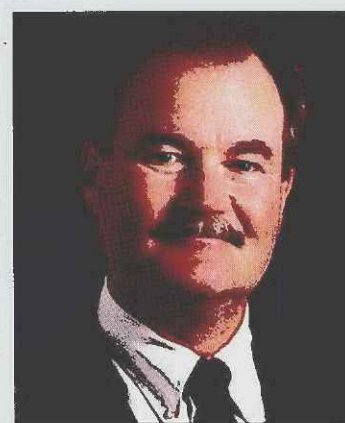
"Singling out large employers and requiring them to spend an arbitrary amount on health care does nothing to lower costs or guarantee that even one more person has health care coverage," he said in his veto message.

Gov. Schwarzenegger also noted that the bill, S.B. 1414, if enacted, would have led to expensive legal challenges. He referred to a federal court ruling in July that found a nearly identical bill approved by Maryland legislators ran afoul of the Employee Retirement Income Security Act, which pre-empts state and local rules and laws that relate to employee benefit plans.

California was the only state to pass Fair Share-style legislation since the July court ruling that

Transforming ACE into a global player

HAMILTON, Bermuda—ACE Ltd. has evolved from a special-purpose insurer to one of the largest global insurance organizations in the world over the past 20 years. The main architect of its expansion and diversification, Brian Duperreault, stepped down in June after 12 years with ACE to become nonexecutive chairman. Mr. Duperreault spoke recently with *Business Insurance* Editor Regis Coccia about ACE's past and future.



Brian Duperreault

Q: What are the secrets of ACE's success and growth as a global insurer?

A: These things are never easy to put in simple words. I was blessed, first of all, with a board that recognized what we needed to do. We needed to diversify; we needed to expand our capabilities. In fact, they hired me for that purpose. To start with, I had great support from the board. The company itself, when I arrived, had a great culture, great people, a solid balance sheet. It was the perfect ve-

hicle. I didn't have to fix anything when I got here. And there were very, very good people. The focuses were narrow, but what they were doing, they were doing very, very well. So I had a platform and the opportunities were there. It was a good time for ACE to reach out.

We were very disciplined in who we hired. We dealt in quality, not necessarily quantity. And we were as disciplined in who we acquired. I always said they had to make us better, we couldn't make them better. We didn't have enough people to acquire a company and have to go in there and fix things. We needed them more than they needed us, in a sense. By keeping to that, we were able to build up a momentum of capabilities. Every acquisition was a compounding process, it wasn't just additive. One step at a time, one place at a time. We didn't rush into it. It was more of a marathon. Simply put, it was the people in the company, whether they came through the companies we acquired or one at a time, who made it happen.

Q: ACE's record for successful acquisitions is remarkable, and purchasing CIGNA's property/casualty business was a special circumstance. What would ACE look like today if that opportunity hadn't come along?

A: We looked ourselves in the eye when we were doing this acquisition, saying the same thing, "What if we don't get it?"

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Evidence-based medical payment system proposed

By JOANNE WOJCIK

WASHINGTON—A payment model based entirely on evidence-based medical guidelines is nearly ready to be tested.

Even so, some doubt it will ever become the health care standard in the United States.

Designed to distribute clinical and insurance risk in a way its proponents claim is more fair, Prometheus Payment Inc. would pay health care providers based on what it costs to deliver only the care that medical science has proven to be appropriate for specified conditions. This differs from traditional fee-for-service payments, which can en-

courage a high volume of service, and capitation, which can induce providers to restrict services.

Washington-based Prometheus, which was unveiled last week, was developed by a team of experts in health care economics, law, policy, health plan operations and performance measurement that has been working quietly behind the scenes for the past two years (see list, page 25).

The group, which includes Francois de Brantes, national coordinator for the Washington-based Bridges to Excellence, an employer-spearheaded pay-for-performance initiative, is now looking for pilot demonstration sites to test, refine

and implement the model.

Some of the sites being considered are Chicago; Cincinnati; Detroit; Memphis, Tenn.; Philadelphia; San Francisco; Seattle; and Worcester, Mass. These locations are being targeted because they can provide the critical mass necessary to make participation attractive to providers while also creating a valid sample for research purposes, Mr. de Brantes said.

They also have local business coalitions that are members of the National Business Coalition on Health, whose president, Andrew Webber, has been involved in developing Prometheus.

"Employers have welcomed pay-

for-performance initiatives because they encourage transparency and performance measurement," Mr. Webber said. "Prometheus is the next generation. It is a fundamentally different health care reimbursement methodology that aligns payment with evidence-based care and ultimately that's what we need to control health care costs and bring quality care to our employees."

In the pilots, 12 so-called Evidence-Based Case Rates, or ECRs, will be applied in five specific clinical areas: cancer care, beginning with lung and colon cancers; chronic care, starting with diabetes, depression, hypertension and hyperlipidemia; interventional cardiol-

gy; orthopedic care, in particular joint replacements; and routine and preventive care. Hyperlipidemia is an elevation of lipids, which include cholesterol and triglycerides, in the bloodstream.

These conditions were selected because they are among those for which the various medical societies have agreed on treatment guidelines and protocols. A white paper introducing Prometheus posted on the organization's Web site poses a challenge to the medical profession to develop additional clinical practice guidelines that can form the basis for developing case rates for most

See PROMETHEUS / page 25

Massachusetts finalizes health assessment rule

State hopes to expand coverage

By JERRY GEISEL

BOSTON—Massachusetts regulators are moving ahead to implement the state's landmark health care reform law, finalizing a key rule that determines whether employers will be subject to a special assessment mandated by the law.

Under a provision in the law, companies with at least 11 full-time employees in the state are subject to an annual assessment of up to \$295 per employee if they do not provide a "fair and reasonable" health insurance premium contribution. Revenues raised by the assessment will be directed into a fund used to subsidize health insurance premiums for lower-income individuals and thus expand the number of state residents with coverage.

The final regulations, issued earlier this month by the state's Division of Health Care Finance and Policy, closely track rules the division proposed in late June. The final rules, like those proposed earlier, stipulate that if employers pass either one of two tests, they will have been considered to have made a fair and reasonable contribution and thus be exempt from the \$295 assessment.

Under the primary test, if at

Key points

How Massachusetts' fair and reasonable health insurance premium contribution rule would work.

A Massachusetts employer will be exempt from a \$295 annual fee if, under new final regulations, if:

- At least 25% of its full-time employees are enrolled in the company's group health plan; or
- The employer offers to pay at least 33% of the premium for employees' coverage

Final regulations also make clear that employees who decline coverage because of religious objections don't have to be counted in the coverage test.

least 25% of an employer's full-time employees are enrolled in its group health insurance plans, that employer would pass the fair and reasonable test.

If the 25% enrollment test is not met, employers that offer to pay at least 33% of the premium for individual coverage would

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Execs propose public/private terrorism coverage plan

By MEG FLETCHER

ST. LOUIS—A group of property/casualty insurer executives is offering a proposal for addressing terrorism insurance issues by balancing increased federal financial responsibility for losses from nuclear and other deadly exposures with increased industry responsibility for all other losses.

Industry representatives and regulators say the 17-member Property and Casualty CEO Roundtable's one-page "framework" for commercial lines coverages is a significant consensus-building accomplishment at a time when several trade associations are crafting individual proposals. The American Insurance Assn., for example, last month unveiled its own proposal (BI, Aug. 21).

The CEO Roundtable's objectives are to:

- Promote stability of financial markets and economic recovery
- Focus the federal role in providing terrorism coverage on what private markets cannot do
- Maximize private capacity by facilitating entry of new capital
- Encourage underwriting discipline and sound financial management

Yet some observers are concerned that the roundtable proposal may not go far enough with a Congress that wants less federal

involvement in providing a backstop for the industry's terrorism exposure, not more.

Paul Matterna, senior vp-government affairs for Boston-based Liberty Mutual Group Inc., presented the roundtable's proposal last week to the National Assn. of Insurance Commissioners' Terrorism Insurance Implementation Working Group during the NAIC's quarterly meeting in St. Louis. The working group is developing a position on the issue of terrorism insurance coverage for the NAIC.

The roundtable, like the AIA, proposes creating a two-part structure, in which the federal government would assume responsibility on a reinsurance basis for chemical, nuclear, biological and radiological exposures for risks such as

See ROUNDTABLE / page 25

Optional federal charter bill planned

House measure would apply to P/C, life insurers

By MARK A. HOFMANN

WASHINGTON—A prominent lawmaker plans to introduce a bill in the House of Representatives later this month that would allow life and property/casualty insurers to seek national rather than state charters.

Rep. Edward R. Royce, R-Calif., told the annual conference of the American Bankers Insurance Assn. in Washington last week that his bill would resemble the National Insurance Act introduced in the Senate earlier this year by Sens. John Sununu, R-N.H., and Tim Johnson, D-S.D. That bill would give life and property/casualty insurers—but not health insurers—the right to choose to be regulated by federal rather than state authorities. Under current law, most insurance regulation is reserved by the states.

Rep. Royce, who serves on the

House Financial Services Committee, noted that some advocates of optional federal charters believe the effort should begin only with life insurers. While limiting the optional federal charter to life insurers might be politically "easier," Rep. Royce said a "broad OFC bill" that would include property/casualty insurers as well is the better approach.

Such legislation would benefit consumers by providing a wider variety of insurance products and "we need as many people on our team as possible," Rep. Royce said.

He noted that Financial Services Committee recently approved a targeted bill that would streamline regulation of excess surplus insurers and reinsurers. He said that while he supports the goal of the Nonadmitted and Reinsurance Reform Act, he does not believe that it will be signed into law because the "base of industry support is

too small."

Rep. Royce said his experience as a state legislator helped make him "a strong proponent of providing an optional federal charter." He noted that he served in the California Assembly with California's current insurance commissioner, John Garamendi, with whom Rep. Royce disagrees on virtually every aspect of insurance regulation.

California imposes what the congressman called "an overly intrusive regulatory regime." But in the absence of optional federal charter, large states such as California and New York act as de facto national regulators, he said.

"Congress has the authority to create a national insurance marketplace," said Rep. Royce.

The ABIA is a Washington-based affiliate of the American Bankers Assn. that develops policy and provides advocacy for banks concerning insurance issues.

Errors & Omissions

• Due to incorrect information supplied to *Business Insurance*, a Products & Services item in the Aug. 28 issue contained incorrect limits offered under Hartford Financial Services Group Inc.'s Priority Protection Plus directors and officers Side A coverage. The limits offered are

up to \$25 million.

• A chart accompanying a story in the Sept. 4 issue, "Insurers Post Good Results on Low Losses, Strong Prices," contained incorrect information for CNA Financial Corp. results. A corrected chart appears on page 24.

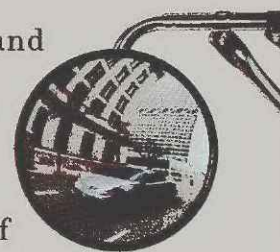
OBJECTS IN MIRROR ARE A LOT CLOSER THAN THEY APPEAR.



WAUSAU COMMERCIAL AUTO AT WORK.

While looking at the claim history of a food distributor we insure, we noticed a number of issues with its fleet safety. During the previous two years there had been 15 accidents, including a few sideswipes, that accounted for almost \$62,000 (nearly 50% of total costs). Part of the problem was poor visibility, especially when changing lanes. This was easily remedied by installing fender-mounted **PRICE ≠ COST.** elliptical mirrors on all of the trucks. Another problem was finding the right drivers. Working together, we established new hiring methods

(including background checks and road testing) and formalized the driver selection process. As a result, even with a significant increase in annual mileage, the number of accidents dropped 30% and dollar losses dropped 60%. And thanks to fewer accidents, the delivery schedule ran smoother as well. It's all part of Wausau TotalValueSM and our commitment to lowering your total cost of risk. And it's backed by the financial strength of the Liberty Mutual Group. To learn more, visit wausau.com or contact your Wausau representative.



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Consumerism: Health insurers offering CDHPs embrace plans for own employees

Continued from page 1

Definity Health, a unit of UnitedHealth. "We sought to preserve the element of choice for our employees."

Among UnitedHealth's employees, 34,321 enrolled in HRAs. Some 2,226 enrolled in HSAs—an HSA enrollment rate that's slightly less than what the company has seen across its book of business, Ms. Baratz said.

Before replacing its traditional plans, 42% of CIGNA's employees had enrolled in consumer-driven options, with the majority choosing HRAs.

"The HRA has been very popular with the employees," said Marilyn Paluba, benefits consultant for CIGNA in Philadelphia. "Employees find the fund very attractive with the HRA. I think the HSA is a different design than what they're used to."

Committing to consumerism, though, does not require replacing traditional plans with CDHPs, others say.

WellPoint Inc., for example, will add an HSA plan to its benefit program next year alongside two HRA and several health maintenance organization plans. The Indianapolis-based insurer offered an HRA plan for the first time last year, with 17% of its employees enrolling in the plan. The company anticipates enrollment in the range of 34% to 44% in its CDHPs in 2007, said Christine Miller, vp-human resources.

Many employees will choose to stay in WellPoint's "efficient" HMO plans, with which the company is comfortable, she said. "I'm certainly not of the persuasion that we

need to have all our associates in our CDHP products," Ms. Miller said. "I do not want to remove choice for our associates."

Insurers generally have a harder time fully replacing their traditional health plans with consumer-driven options than other employers because of insurers' traditionally rich benefit packages, said Tom Hricik, national director, HSA product distribution for ACS/Mellon HSA Solutions based in Pittsburgh. "The employees are such strong believers in HMOs," he said. "They're your most difficult customers, for sure. They expect more. They're more critical."

But insurers, like other large employers, have to manage rising health care costs, Mr. Hricik said. "We do expect over time for insurance companies to adopt (consumer-driven health plans) more," he said. "Given the nature of their traditionally rich benefits, it's going to be a little longer."

As a result of employing a full replacement approach, UnitedHealth has had a positive cost experience with overall health care cost trends that were both lower than expected and below previous years, Ms. Baratz said.

Signs that consumerism is being adopted are evident even for insurers that still offer traditional health plans. For example, employees of The Regence Group, which offers CDHP options alongside traditional products, used to complain about copayments and deductibles, said Denise Johnson, the Portland, Ore.-based director of the employee service center for Regence, a group of Blue Cross Blue Shield Assn. plans in Idaho, Oregon, Washington and

Utah. Now employees complain about transparency issues, such as not knowing what providers will charge, she said.

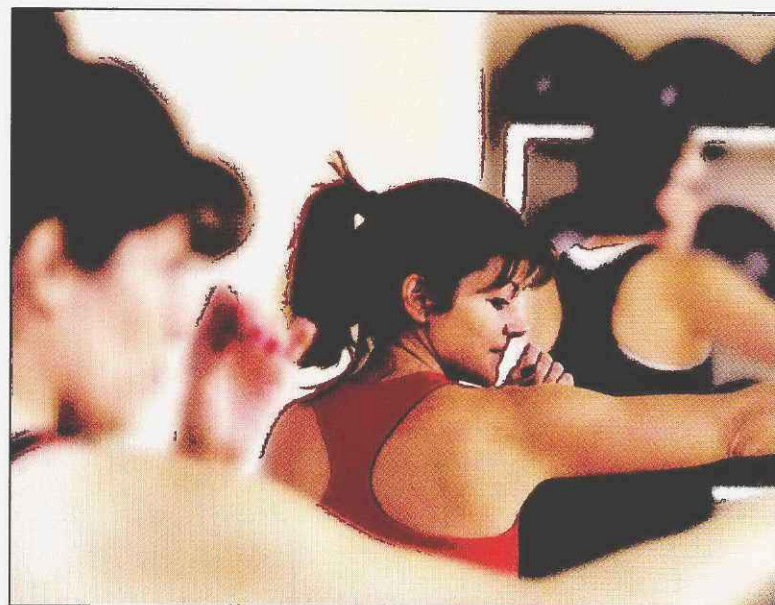
"What we were encouraging our employees to do was see the importance of holding themselves accountable for their health care," Ms. Johnson said. "It's changing the culture. It's changing the way our employees look at their behavior."

A lack of information is a deterrent to people enrolling in CDHPs or becoming better health care consumers, Ms. Johnson said. "The more we can do in that regard, the more success we'll have," she said. "Once they learn more information, they're more inclined to move in the direction of those kinds of programs."

All insurers agree on the need to provide the right tools to help employees make the right health care decisions. While many insurers offer tools to their employees and individual and group members, some limit the use of certain tools strictly to their employees.

Regence has an employee Web site called Building a Healthy Future that provides a wide range of information, including healthy food recipes, advice on how to begin a fitness program and schedules for onsite fitness center classes such as yoga, kickboxing and pilates.

The company also provides a medical plan cost estimator in which employees can enter costs and estimate out-of-pocket expenses under each of the company's health plans—a very popular tool, Ms. Johnson said. About 15% of the company's 6,200 employees are enrolled in CDHPs.



Employers offering consumer-driven health plans often encourage employees to live healthier lifestyles, for example, by offering advice on fitness programs.

Health care companies also try to encourage good health care decisions by offering financial incentives—or disincentives in some situations.

The Anthem Rewards program, for example, allows WellPoint employees performing physical activities to earn points that they can redeem for prizes. About 40% of the company's employees participate in the program.

Regence has a similar program that gives employees points for activities such as participating in a smoking cessation program or an onsite Weight Watchers program. Regence also provides a 35% discount on healthy foods at its cafeteria to encourage employees to make healthy eating decisions. "It's a way to keep employees engaged," Ms. Johnson said.

Several insurers provide financial incentives to employees to take health risk assessments.

UnitedHealth, for example, gives credits worth about \$100 to its employees who complete a health assessment in a program that is integrated with a health coach to help manage existing or potential health problems, Ms. Baratz said.

Insurers, like other employers, also are taking steps to address the

issue of smokers in the workforce and the impact they have on health care costs.

CIGNA has instituted a premium differential for smokers and non-smokers while implementing an I Can Quit smoking cessation program, for which 1,100 people have signed up, Ms. Paluba said.

As a company, WellPoint plans to go tobacco-free on Nov. 16, meaning employees no longer will be able to smoke on company property, but they will be provided free nicotine replacement therapy to help them quit.

While the company would not fire anyone who fails to abide by its anti-smoking rules, managers will have individual conversations with employees to stress the importance of quitting for their own health and the company's overall promotion of better employee health. "If individuals don't choose to abide by that, maybe we're not the best place for you to be working," Ms. Miller said.

However, unlike other employers, WellPoint has not implemented tobacco surcharges to encourage employees to quit. "I have caution around becoming too punitive in terms of actions," she said. "We don't want to be in a police role."

Regulations: Mass. finalizes health care levy rules

Continued from page 4

pass the fair and reasonable test.

The availability of the secondary test, state regulators said earlier, was due to a recognition that many employers offer premium assistance to their employees, but the employees turn down the coverage and instead enroll in a spouse's or government health program.

Either test would not be difficult to meet for any large or midsize employer now offering coverage.

"It would be hard not to pass either test," said J.D. Piro, an attorney in the Norwalk, Conn., office of Hewitt Associates Inc.

Group health plan participation is typically much higher than the 25% minimum set by the final regulations. A 2005 survey by Mercer Health & Benefits L.L.C. found that, on average, about 80% of eligible employees enroll in health care plans offered by their employers.

The same survey also found that employers, on average, pay more than 75% of the premium for single coverage and about two-thirds of the premium for family coverage.

The final regulations, which answer questions employers and others raised, also provide more clarification.

For example, in determining

whether an employer has at least 11 employees and therefore may be liable for the \$295 fee, the final regulations make clear that all employees who work at locations in Massachusetts are to be included in em-

"We have heard about some of the burdens.... and have gone back to the drawing board."

Amy Lischko
Mass. Division of Health Care
Finance and Policy

ployee counts, regardless of their state of residence. That was an important issue for those Massachusetts employers that have a high percentage of employees living in neighboring states.

Additionally, in running the 25% enrollment test, employers will be allowed to exclude those employees who have declined coverage because of "sincerely held" religious beliefs. In such cases, the employer would have to maintain documentation to verify that the employee claimed such an exemption.

The state division, though, did temporarily withdraw a proposed

rule that would have required employers in Massachusetts to file an employee health status report annually. For each employee, the employer, among other things, would have had to report whether health insurance coverage was offered; whether the employee accepted or declined coverage; and, if coverage was accepted, whether family or individual coverage was chosen.

In the case of employers with at least 50 employees, an updated report would have to be filed quarterly, reporting any new employees and whether those individuals accepted or declined coverage.

That rule was withdrawn as the Division of Health Care Finance and Policy consults with other state agencies about ways of obtaining the information that would eliminate the risk of identity theft and duplication of data collection, said Amy Lischko, the division's commissioner.

"We have heard about some of the (reporting) burdens....and have gone back to the drawing board," Ms. Lischko said.

Hewitt's Mr. Piro said perhaps the easiest way for the state to obtain the insurance information is to add a few coverage-related questions on state income tax returns.

Mandates: Calif., Chicago bills on health care coverage vetoed

Continued from page 3

struck down Maryland's law.

Most of the other roughly two dozen measures—dubbed Fair Share by prime backer, the AFL-CIO—that were introduced this year in state legislatures died without moving out of committee. A handful still are pending, but are not expected to win approval. Benefit observers say effective business lobbying and concerns—fueled by the challenge to the Maryland law that the approach violates ERISA—was responsible for the bills falling out of favor with state lawmakers.

In Chicago, a somewhat similar approach failed to win final approval. In July, the city council approved the so-called "big box" bill

to require retailers with at least \$1 billion in annual sales and stores with 90,000 square feet in a single location to pay their employees at least \$10 an hour and provide another \$3 an hour in benefits by July 1, 2010. The measure would have been phased in over three years, starting July 1, 2007.

But last week, Mayor Richard M. Daley vetoed the measure, saying that the bill would drive jobs and businesses from the city and penalize neighborhoods most in need of additional economic activity.

An attempt to override Mayor Daley's veto failed on a 31-18 vote. Supporters needed 34 votes—a two-thirds majority of the 50-member city council—to override the veto.

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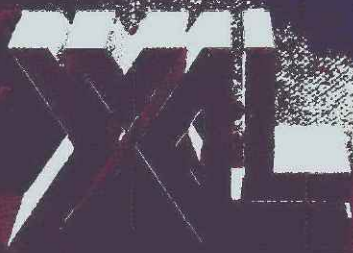
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FUNDAMENTAL STRENGTH - CAPITAL AND PEOPLE

Editorial

Tougher pension rules will strengthen the system

IS THE NEW PENSION funding reform law accelerating the demise of defined benefit plans?

One could come—erroneously, in our view—to that conclusion from recent events. Since Congress passed the legislation last month, about half a dozen companies, including Alliant Techsystems Inc., a big defense contractor, and Tenneco Inc., a large auto parts manufacturer, have announced that they are phasing out their defined benefit pension plans.

That those freezes came at the time the legislation was passed was coincidental. Corporations typically reach decisions regarding the funding, design and future of their pension plans only after months—in some cases, years—of analysis.

There is no question, however, that some companies, looking at some basic requirements of the new law—benefit promises will have to be funded faster and the ability to use certain gimmicks to put off funding is curbed—will decide to phase out their plans.

We don't find that especially startling or disturbing. Indeed, under the old loophole-ridden system—where employers could legally amass huge liabilities in their pension plans and not come close to funding what they promised—hundreds, if not thousands, of employers decided to freeze their plans.

Those corporate decisions, be they right or wrong, have not been based on whether funding rules are tough or weak. Rather, almost without exception, companies have said they no longer want to be exposed to the financial risk and volatility that is part and

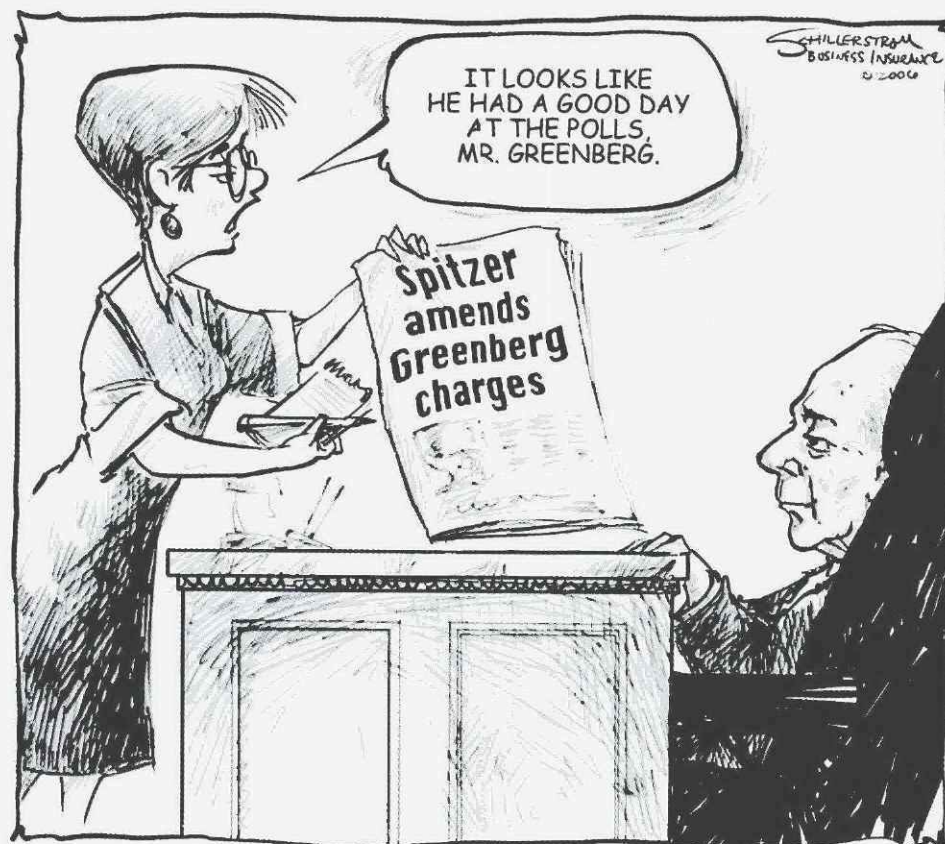
parcel of sponsoring a defined benefit plan. How much companies have to contribute to those plans is a function of investment results and changes in interest rates and there is little predictability on those two variables.

Increasingly, risk-averse companies prefer the cost predictability of a defined contribution plan and changes in defined benefit plan funding rules will have little impact on that mindset. While the defined benefit plan system will continue to decline, we still believe the new, tougher rules will strengthen, not weaken, that system.

By requiring employers to fully fund their plans, the likelihood that a plan will have sufficient assets to pay promised benefits is greater. That is important not just to employees but also to employers with a defined benefit plan. The latter care because failed pension plans are taken over by the Pension Benefit Guaranty Corp., and it is employers, through premiums they pay the PBGC, that foot the bill for companies that promise more than they can afford. With tougher funding rules should come smaller PBGC losses and perhaps stability in PBGC premium rates, defusing one reason why employers are phasing out their pension plans.

It also should not be forgotten that the new law protects new cash balance plans from age discrimination suits. Employers by the hundreds flocked to those plans before legal uncertainties forced them to back off. With those uncertainties eliminated, thanks to Congress, the cash balance design once again will be an option for employers who want to continue to offer defined benefit plans.

Schillerstrom



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Optional federal charter bill may stimulate action

NO ONE EXPECTS Congress to achieve much in the way of risk management and insurance-related legislation during the few remaining days before it adjourns for the November elections. Nevertheless, we still welcome the decision of a member of the House Financial Services Committee to introduce a bill that would allow insurers to choose a new federal charter in place of today's state charters.

As we report on page 4, Rep. Edward R. Royce, R-Calif., used an address to the American Bankers Insurance Assn. to announce his

plan to introduce an optional federal charter bill later this month. Although he didn't give details of the bill, he said it would resemble an optional federal charter measure introduced earlier this year by Sens. John Sununu, R-N.H., and Tim Johnson, D-S.D. The senators' National Insurance Act would allow both life and property/casualty insurers to seek a federal charter.

Federal charter advocates recognized when the Senate bill was introduced that getting a bill enacted into law would be a long process.

Yet it's one that's certainly worth pursuing. The current patchwork system of state-based regulation results in both inefficiency and unnecessary costs, both of which are ultimately borne by the buyer. The current system can also put U.S. insurers at a competitive disadvantage with their foreign counterparts, who deal with single regulators.

It's worth stressing that federal charters would be optional. No insurer that wanted to remain subject to state regulation would be forced to accept a federal regulator. But we

firmly believe that those insurers that prefer federal regulation should be given the right to choose that course.

Rep. Royce's introduction of an optional federal charter bill, even this late in the session, will help keep this issue before Congress. Given the legislative calendar, introducing a bill is a symbolic gesture. But symbolic gestures have their virtues, too. Having a bill before Congress in its waning days may help prod the next Congress to approach the issue sooner rather than later when it convenes next year.

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By Christopher E. Mandel

Perspectives

Ask A Risk Manager

Communicate simply and clearly

Q: In pursuing a broader approach to managing risk, how do risk language, terminology and communications play into the success of such an initiative?

A: Like in just about every aspect of life, clarity of communications is critical to effectively understanding and meeting objectives. One need only recall the controversy over insurance coverage for the Sept. 11, 2001, World Trade Center catastrophe to realize the magnitude of problems that can result from a failure to communicate accurately and in a timely fashion. In fact, most coverage disputes that end up in court are battles over "understandings."

Just as in the insurance world, clearly understood terminology is critical to achieving a meeting of the minds, so clear communications are equally if not more important in the broader realm of managing all risks to an enterprise. Most serious players agree that a common risk language is the starting point for any consensus reachable around a risk framework. Such frameworks are central to codifying and getting consensus around the risk strategy and tactics to achieve agreed-upon objectives. As such, objectives are well understood only when they consist of a language

that is consistent and easily interpretable by all stakeholders. Thus, risk frameworks should include a section that sets forth the definition of the most common terms used to communicate about risk in the entity.

Another common characteristic sought after in these initiatives is applying simple labels to what are often technically complex concepts. You've heard the complaint many times from senior management: "Just keep it simple," or "Can't you make it plain?" It's as if the capability of management for linguistic complexity is limited by their intellect, but in fact, it is limited only by their capacity for volume. In other words, most senior teams these days have much on their plates, so crowding conversations with technical complexity only causes frustration and impatience. There is often little patience in today's senior suite for those who can't get their messages across quickly and simply, no matter the complexity of the subject.

In the midst of this subject, the issue of standards arises. Many risk-related organizations across the globe have attempted, and some actually succeeded, in establishing standards for the practice of risk management. Examples include: AS/NZ 4360 Standard on Risk Management; ISO/IEC Guide 73 IRM/AIRMIC/ALARM 2002; JIS Q 2001, Japanese Industrial Standards Committee; Canadian BIP 2012,

Most senior teams these days have much on their plates, so crowding conversations with technical complexity only causes frustration and impatience.

CAN/CSA Q850-07. You can see in the naming of these standards a level of confusing jargon that isn't helpful. Of course, with a standard typically comes a vernacular that, by default, establishes a risk language that may or may not fit the culture of your company. And often, because these standards arise from specific parts of the globe, they often are germane only to that region, leaving many who attempt to use them at risk of communication confusion.

This is not to say that risk standards aren't valuable. But because they are often fashioned and marketed by supporters with very narrow or specific views of the world, they will often not work for the broadest of users, let alone those who recognize the value of creating a consistent risk language that first and foremost fits the needs of their company and only secondarily, others. While this fit must be the priority, all should recognize that this will make benchmarking a greater challenge for those that require third-party benchmarks to validate their strategies, tactics and results. Standards will help ensure

risks are addressed with consistency and so all good standards are focused around process, structure, objectives and terminology.

A starting point for many is the very definition of risk. You might not consider this important in the scheme of your strategy and plan, but there are enough different ways to view risk that it would be wise to get an early consensus on what "risk" is within any entity. In an informal survey conducted at the 2006 Risk & Insurance Management Society Inc. conference in Honolulu, the following results were collected in answer to the question, "What is your definition of risk?" Ten percent of those questioned said it was "likelihood times impact"; 20% said it was "chance of loss or gain"; 50% said it was "uncertainty"; 10% said it was "an adverse event"; and 10% said it was a "variation from what was expected." Each one is an important nuance in understanding what risk is to the user and his or her company. The variations are often perceived as minor, but where they are more significant, they revolve around whether a company's focus is on

the downside, the upside, or both. Regardless of your focus, getting this definition understood up front will be critical to your ultimate success in implementing an effective framework.

Since effective communications are centered on the words used to communicate, it is critical to the success of any risk management effort that the terminology is clear, unambiguous and well understood. Without such clarity, management will be frustrated and confused and your plans will falter on the hotbed of technical jargon. So, define the terminology early in your efforts. Get agreement on what terms make the most sense. Codify your language. Communicate often, simply, clearly and with impact.

Ask A Risk Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.

This month's column on the language of risk is written by Christopher E. Mandel, assistant vp, enterprise risk management at USAA Group in San Antonio; 2004 Risk Manager of the Year; and past president of the Risk & Insurance Management Society Inc.

Address your questions to ASK, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

COMINGS & GOINGS - INDUSTRY



Mr. Widing



Mr. LaGrassa



Mr. Dallafior



Ms. Wendt

Brokers:

Atlanta-based Beecher Carlson has named **Michael Suter** as senior vp to manage the California Medical Group Insurance Co., Risk Retention Group in Los Angeles. Before joining Beecher Carlson, he was a vp in Aon Corp.'s national health care practice.

William Gallagher Associates has added **Bradway G. Widing** to its Boston office as senior vp in the property/casualty group. Previously, he was an account executive with Willis Group Holdings Ltd.

Chicago-based Aon Corp. has named **Carlos A. Oliveras** as a managing director of its U.S. mergers and acquisitions group. Before joining Aon, he was president and chief executive officer of CAO Advisors.

Insurers:

Waterbury, Conn.-based Webster Insurance, a subsidiary of Webster Financial Corp., has appointed **Peter B. Matthews** senior vp and business finance officer. Previously, he was a financial officer with CIGNA Corp.

Praetorian Financial Group has named **Jason G. Holmes** as senior vp and property practice leader in New York. Before joining Praetorian, he was a senior vp at GEP II, an affiliate of Global Excess Partners, where he was responsible for underwriting all lines of property business.

Schaumburg, Ill.-based Zurich North America has promoted **John LaGrassa** to senior vp and director of ceded reinsurance for North America. Previously, he was vp of reinsurance.

New York-based American International Group Inc. has named **Anastasia D. Kelly** executive vp, general counsel and senior regulatory and compliance officer. Most recently, she was executive vp and general counsel of MCI/WorldCom.

ACE Ltd. has named **Lori Samson** chief administration officer for Bermuda-based operations. She assumes the administrative responsibilities of Keith White, executive officer of the Bermuda companies, who will retire at the end of the year. Previously, she was executive services director.

Joseph Morrello has joined Beazley Group P.L.C.'s U.S. mid-market commercial property team as eastern region underwriting manager in

Farmington, Conn. He joined Beazley from FM Global/Affiliated FM Insurance Co., where he held the role of operations vp.

Reinsurance:

Cooper Gay Intermediaries L.L.C., the U.S. treaty reinsurance broking arm of Cooper Gay (Holdings) Ltd., has named **Michael S. Joyce** as executive vp in the Minneapolis office. He joins the company from John B. Collins Associates, where he was a director.

Managed care:

Blue Cross Blue Shield of Michigan has named **Ken Dallafior**, president and CEO of LifeSecure, the company's long-term care subsidiary, to a new position as senior vp, group sales, for the managed care company. Succeeding Mr. Dallafior at LifeSecure as president and CEO is **E. Lisa Wendt**, who previously was a vp.

Other providers:

The Tillinghast unit of Towers Perrin has named **Steve Taylor-Gooby** as managing director for its Tilling-

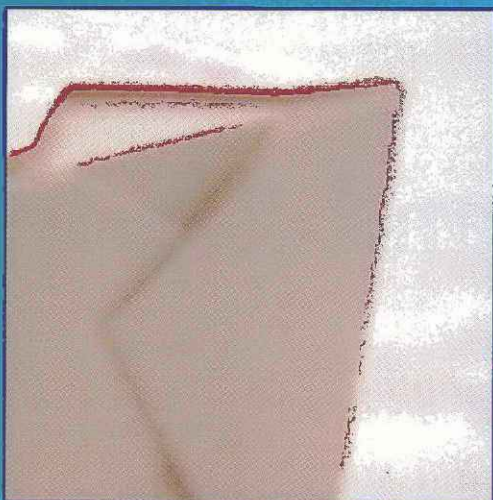
hast business. In his new role, he will assume responsibility for establishing overall strategic direction, key investment priorities and positioning for Tillinghast's global organization. Previously, he was the global business director.

Wil Gaitan has been named Buck Consultants' regional manager for Latin America. He will continue to lead New York-based Buck Consultants' global consulting practice in the Midwest region, and will remain in the Chicago office.

Memphis, Tenn.-based Sedgwick Claims Management Services Inc. has appointed **William A. Houlihan** as chief financial officer. Previously, he was CFO of Metris Cos. Inc.

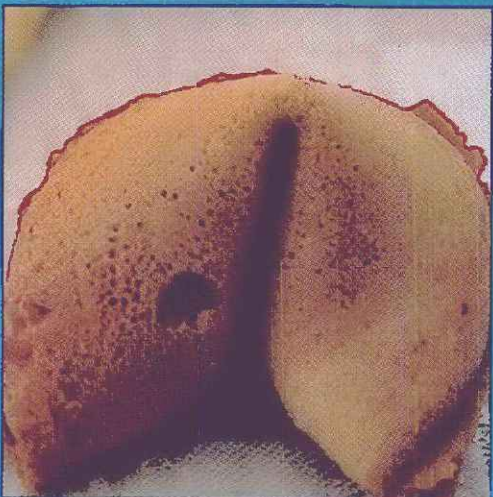
Business Insurance would like to report on senior-level changes at commercial insurance companies and service providers. Please send news of recently promoted, hired or appointed senior-level executives to: Joe Walker, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; jwalker@businessinsurance.com.

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BENEFITS MANAGEMENT

BENEFIT FINANCING STRATEGIES

A new federal pension funding law could help employers pay for retiree health benefits / 18

Employers turn to hybrid plans to rein in rising health care costs

By JOANNE WOJCIC

Hybrid health plans that blend self-funding with fully insured coverage are being heavily marketed to small and midsize employers struggling with escalating health care costs.

Some brokers and insurers have dubbed the practice as "under wraps" or "gap insurance" because these hybrid arrangements use a single employer-controlled account to self-fund claims between a high-deductible health plan purchased by the employer and lower deductibles assumed by individual employees.

In promoting the programs, brokers explain that such self-insured layers are permitted under Section 105 of the Internal Revenue Code—the same section of U.S. tax law

that the originators of the consumer-driven health plan concept used to develop health reimbursement arrangements.

As with HRAs, any funds remaining in the Section 105 accounts at year-end can be carried over to pay for subsequent years' medical expenses. Unlike HRAs, the balance in the Section 105 account is not allocated to individual employees; rather, the employer retains ownership and control of the account, which also can be funded on a pay-as-you-go basis.

While many small and midsize employers that have adopted hybrid plans have reaped considerable savings, some insurers have begun restricting the plans they will permit brokers to use in conjunction with a hybrid.

San Francisco-based Blue Shield of Califor-

nia, for example, in June 2003 sent a letter to producers advising them to only "offer the Shield Spectrum PPO Savings Plan in conjunction with an employer wraparound fund."

Blue Cross of California, a Thousand Oaks, Calif.-based division of Indianapolis-based WellPoint Inc., permits this type of arrangement "only under our existing EPO (exclusive provider organization) plan, as it is priced to accommodate this practice."

Neither insurer returned calls seeking comment.

Meanwhile, Anthem Blue Cross Blue Shield of Ohio canceled one broker's contract allegedly because it was promoting this

See HYBRIDS / page 16

Public employers face up to funding issue

Accounting rule mandates retiree benefits liabilities disclosure

By ROBERTO CENICEROS

As a deadline approaches for public employers to disclose their outstanding liabilities for nonpension retiree benefits including health care, some are taking steps to begin funding or reducing those liabilities.

Until recently, many governmental entities didn't even tabulate their accrued obligation for the nonpension benefits they have promised their workforces over the years. They funded post-employment health care benefits through a pay-as-you-go accounting approach and did not report the expense on

their books until after employees retire.

But to comply with Governmental Accounting Standards Board Statement No. 45, public entities as soon as Dec. 15 must account for their current retiree health plan expenses along with the actuarially accrued cost of unfunded retiree benefits promised to current employees.

Substantial impact

The impact on state and local government financial statements will be substantial, experts say.

To comply with GASB 45, public employers need only reveal the extent of their obligations to retirees. However, failure to establish a funding mechanism and reduce their obligations could damage public entities' bond and credit ratings.

That has driven many state and local governments to hire actuaries to evaluate their previously unknown liabilities. That process will guarantee their compliance and is a first step in developing strategies for paying down their liabilities, observers say.

See RETIREES / page 14

Plan design, deductibles, cost limit HSA enrollment

By GLORIA GONZALEZ

While the introduction of high-deductible health plans linked to health savings accounts has sparked substantial interest among employers, participation in these plans for employers that have implemented them has often been disappointing.

But employers can take several steps to boost HSA plan enrollment, such as funding these accounts and setting the price of these plans at levels that are favorable vs. other health plans they offer.

A substantial increase in enrollment, though, could be driven by regulatory

changes that would make these accounts more attractive to employees, including broadening the definition of preventive drugs to exempt more medications from the requirement that they apply toward the deductible.

Enrollment in HSA plans among large employers is generally low, hovering in the single digits for many companies. Tom Hricik, national director, HSA product distribution for ACS/Mellon HSA Solutions based in Pittsburgh, said he is seeing enrollment rates generally in the range of 1.5% to 3.5% for large employers.

Several factors influence enrollment rates

for employers that offer HSA plans as an option alongside other health plans.

A major cause of low enrollment rates relates to the plan design, specifically the deductible levels and how they compare with employee contributions to health care expenses featured in traditional health plans. A key part of this equation is the regulatory requirement that employees pay the retail cost of prescription drugs until they reach the deductible, consultants say.

"We suspect the major reason for low enrollment is people aren't comfortable with that design yet," said Scott Keyes, a Stamford, Conn.-based senior health care consultant for

Watson Wyatt Worldwide. "They're not comfortable with the high deductible and they're probably not comfortable with the way the prescription drug plan works."

The price differential between HSA plans and other health plan options also impacts enrollment because the differential must be significant enough to move people away from traditional health plans into the consumer-directed health plans, consultants say. "That pricing is paramount," Mr. Hricik said.

Employer contributions are another key factor because employees seem to be more at-

See HSAs / next page

HSAs: Employers look to spur enrollment rates by making plan adjustments

Continued from previous page

tracted to plans with money already in the account rather than those that they must fund entirely themselves. "I think without a funded HSA, the high deductible tends to scare people away," Mr. Keyes said.

Of the 60% of UnitedHealth Group Inc. employer clients funding the accounts at some level, about 90% of eligible employees open an account and two-thirds of these employees contribute to the account, said Meredith Baratz, vp, market solutions, for Definity Health Corp., a unit of the Minnetonka, Minn.-based insurer. For employers that do not fund the

HSA, fewer than 30% of employees open the account, she noted.

About 35% of ACS/Mellon employer clients either contribute to accounts or pay account fees, Mr. Hricik said. Of those contributing, the typical amount is about \$400 for individuals and \$800 for families. "Typically, the higher the deductible, the more money you're going to want to see coming from the employer," Mr. Hricik said. "I think we're going to see higher employer contributions as the deductibles go up."

One way to spur enrollment would be to have employers contribute a matching percentage

"We suspect the major reason for low enrollment is people aren't comfortable with that design yet."

Scott Keyes
Watson Wyatt Worldwide

based on salary levels rather than fixed dollar amounts, making the plans more of a viable option for low-income employees, said Jay Coldwell, the Wausau, Wis.-based director of product management at Fiserv Health Inc., a Minneapolis-based unit of information management services company Fiserv Inc.

After reaching higher income levels, the contribution can be phased out, he said.

"The ideal, in my mind, would be a match that's scaled by income," Mr. Coldwell said. "You're changing the whole benefit plan paradigm, but doing it in a way that makes it more affordable."

Employees' reluctance to transition from health plans with which they are familiar and comfortable to plans that may bear more risk for them is a barrier that needs to be overcome through an effective communications campaign, consultants say.

"People are accustomed to what they have," Mr. Hricik said. "They like their HMOs, their traditional PPOs. It's hard to get people to change. It takes a very concerted effort to get that change to occur."

Watson Wyatt encountered this issue when it told employees it was moving from a preferred provider organization plan to a high-deductible health plan linked to an HSA, receiving a mixed reaction from its employees, Mr. Keyes said.

The firm started an education campaign three months ago, informing its employees of the change and the business rationale for the transition. "Watson Wyatt isn't any different from any other employer," Mr. Keyes said. "Our health care costs are growing and we have to manage them like our clients."

One of ACS/Mellon's clients with about 25,000 employees got more than 60% of them to sign up for its high-deductible health plan because it tackled all these factors, Mr. Hricik said. For example, the company priced the plan aggressively compared with its other plans and spent well into the six figures to communicate the plan, discussing the preventive services covered and sending customized compact discs with information about the plan to its employees.

Regulatory changes

Several regulatory changes would spur increased enrollment in high-deductible health plans linked to HSAs, experts say.

While recognizing that the HSA guidelines developed by the government were "thoughtful and sensitive to the issues raised by the business community," there is still an opportunity to improve some of the technical issues, Ms. Baratz said. For example, announcing the annual adjustment of deductible amounts, out-of-pocket expense limits and contribution limits early enough to give employers sufficient time to determine their plan offerings for the following year would be beneficial. America's Health Insurance Plans, a Washington-based trade association, suggests these figures be announced by June 1.

Another change promoted by AHIP is to allow individuals to establish an HSA even if their spouse has a flexible spending account.

The key regulatory change that would impact enrollment would be a more expansive definition of preventive drugs or perhaps exempting prescription drugs from the deductible altogether. The current guidelines are confusing because prescription drugs can be considered either preventive or treatment-related, consultants say.

"From a logical perspective, most drugs are being taken to prevent

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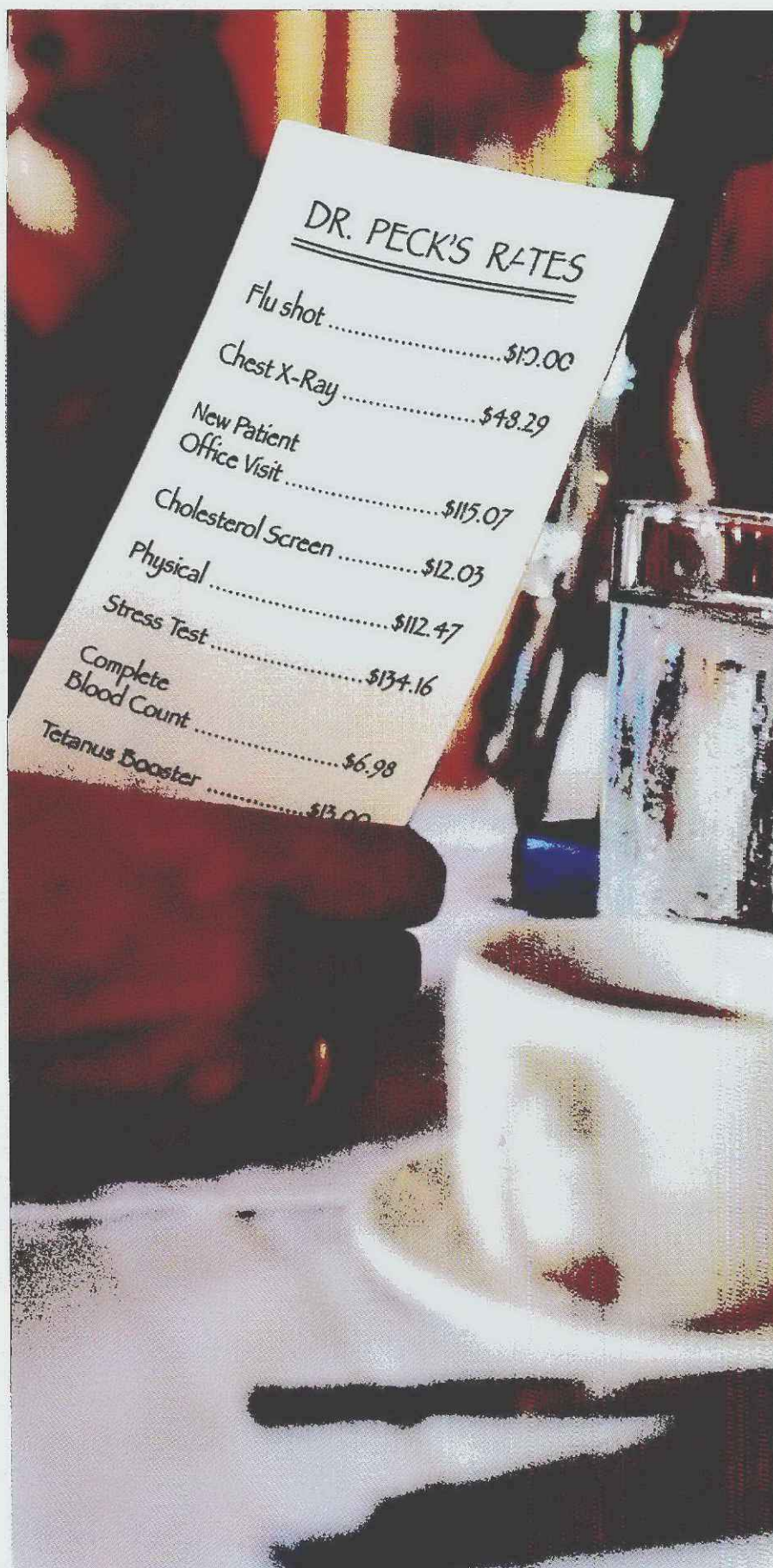
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HSAs: Ideas to boost enrollment

Continued from page 12

something," Mr. Keyes said. "They may not be preventive in the way the IRS considers them to be preventive."

Watson Wyatt is using a list of preventive drugs developed by its pharmacy benefit manager and helping its employees find ways to let the company know if their doctors think their drugs are preventive, Mr. Keyes said. Not having clear guidance, though, puts employers in the uncomfortable position of having to interpret regulations, he said. Some employers, rather than having the discussion, will simply allow all drugs to apply toward the deductible, Mr. Keyes said.

Wendy's International Inc. will integrate a preventive drug plan into its HSA offerings in 2007 because the benefit to employees is more important than any potential fallout from incorporating a plan not yet sanctioned by the government, said Jeff Cava, executive vp, human resources and administration for the Dublin, Ohio-based company.

"Typically, the higher the deductible, the more money you're going to want to see coming from the employer."

Tom Hricik
ACS/Mellon HSA Solutions

"We are in good company and we are acting in good faith," Mr. Cava said. "If we have to address that for a contrary decision at a later date, we can do that with a clear conscience."

Another potential change would be to give people an opportunity to increase their savings in their accounts to the out-of-pocket maximum rather than the deductible, employers say. For employees who have the ability to increase their savings, it would allow them to plan ahead for future health care expenses, Mr. Cava said.

Increasing the amount people can save, though, would not stimulate more enrollment because the people who can afford to enroll in the plans have already enrolled, Mr. Coldwell said.

A legislative change that would make HSAs more attractive would be to allow FSAs to pay for the deductible so employees could use the HSA for future expenses, capitalizing on the HSA's advantage of being a vehicle to accumulate assets that allows people to save money for health care expenses in retirement, he said. "That would make a big difference," Mr. Coldwell said.

Another policy recommendation made by AHIP is to allow employers to assist employees or their family

members who suffer from chronic conditions by permitting increased HSA contributions for individuals who are enrolled in disease management or care coordination programs.

Alleviating comparability requirements to allow employers to make higher contributions for chronically ill employees would enable them to get the coverage they need, Mr. Cava said.

While this type of change could be beneficial, it could also bring a lot of administrative complexity, such as ensuring that excess funding does not occur, Mr. Coldwell said.

Continued from page 11

Potential strategies include reducing benefit offerings or increasing employee contributions, issuing bonds, setting up trust funds and educating employees about Medicare options rather than relying on their employer's post-retirement plan.

Many public entities, however, do not yet have a plan in place to address their outstanding liabilities, say consultants, public entity benefit managers and government finance experts.

"There are some who are very much aware and, like us, have begun to do something about the lia-

bility in terms of contributions or strategies to mitigate the liability over the long haul," said Paul Hackleman, benefits manager for San Mateo County, Calif. "And there are some that it's not even on their radar screen."

Deadline set by revenue

After Dec. 15, the United States largest public employers—those with annual revenue of \$100 million or more—must begin complying with GASB 45, with the deadline depending on the start of their fiscal year. For entities such as San Mateo County, that means a com-

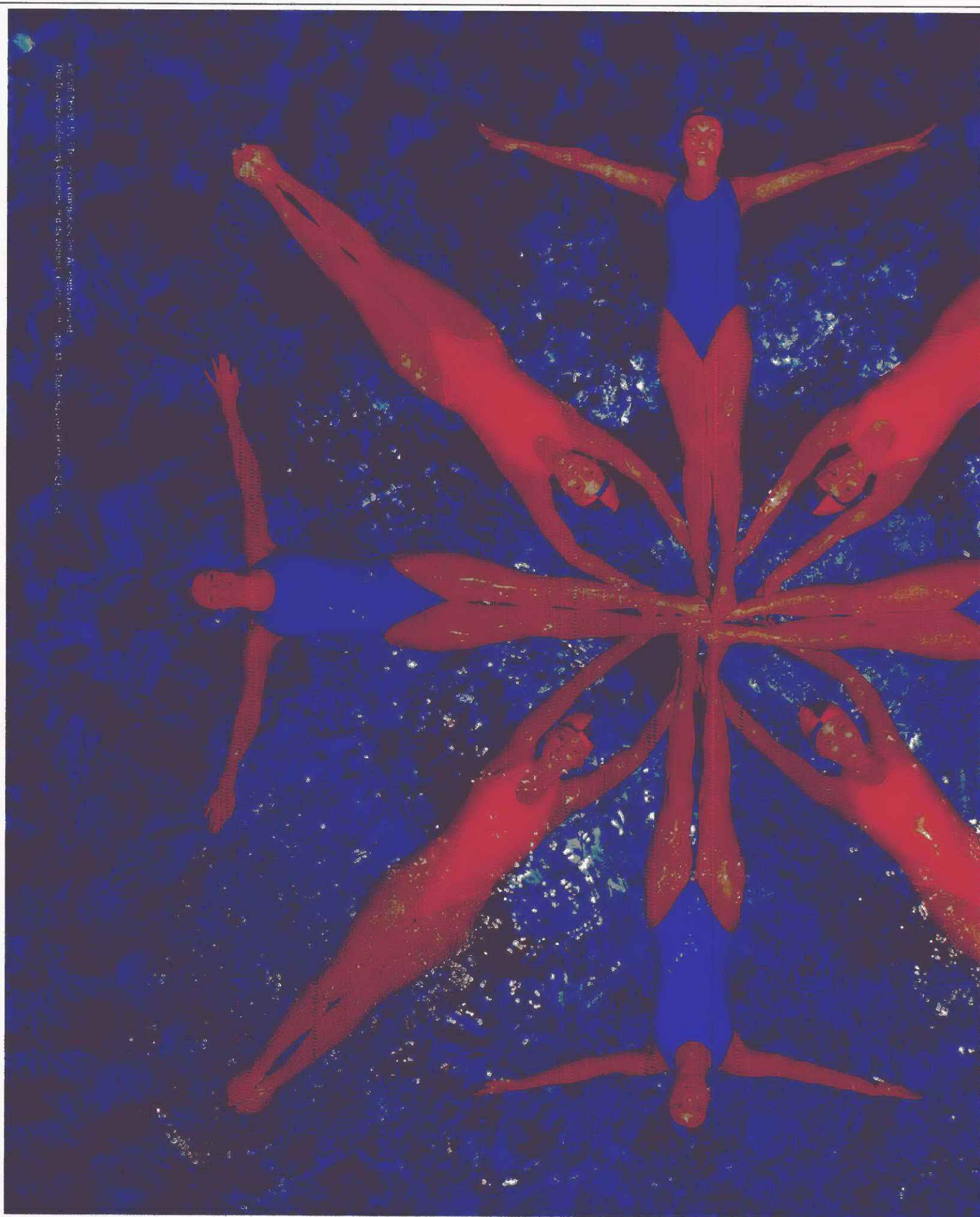
pliance deadline of July 1, 2007.

For governments with \$10 million to \$100 million in annual revenue, GASB 45 is effective after Dec. 15, 2007. For governments with less than \$10 million in annual revenue, the effective date is after Dec. 15, 2008.

Michael Merlob, a Boca Raton, Fla.-based health care consulting actuary specializing in public entities for Apex Management Group, a unit of Gallagher Benefit Services, agrees that some entities have been slow to value their liabilities.

"The deadline is rapidly ap-

Continued on next page



Continued from previous page

proaching and we haven't seen as many valuations get done as I would have expected," Mr. Merlob said.

Easier for some

Some public entities that have completed the valuation, however, have found that funding post-employment benefits is not an issue, Mr. Merlob said. Municipalities with a young workforce far from retirement might fit that category. Or they could be entities that recently experienced a rapid growth in tax collections that allowed them to accumulate assets in anticipation GASB 45.

Still others may already require

substantial worker contributions to their benefit plans. Doing so reduces a government entity's liability in two ways. First, it reduces the amount a public body must put away for each employee. Second, requiring contributions reduces the number of employees that participate in a plan, so a public entity can actuarially assume it will need to fund such benefits for fewer retired workers, Mr. Merlob said.

Older cities with older workforces that historically have contributed the full cost of retiree health benefits, however, could be looking at a potential cost of \$100,000 per currently active employee, Mr. Merlob said.

Norwalk, Conn., completed its valuation in July 2005, said Thomas

"The bond issue is going to end up being a strategy that a lot of governmental entities take advantage of. Some will keep going with pay-as-you-go."

**Robert Friedman
Holland & Knight L.L.P.**

S. Hamilton, the city's director of finance. It also has held workshops so elected officials, budget planners and employee groups understand how moving from a pay-as-you-go to a funded system will impact them and the city.

Mr. Hamilton has recommended that Norwalk establish a trust fund and gradually phase into fully funding the city's nonpension liabilities. It could do so by increasing the amount of money that currently flows from its operating budget to retiree benefits.

That way, the current benefits under the pay-as-you-go system would continue to receive funding while the additional money from the operating budget could build up in the trust fund for future liabilities.

"The magnitude of the numbers we are looking at, I don't think it's feasible in one fell swoop to go from pay-as-you-go financing to advance funding the liability without some transition period," Mr. Hamilton said.

How Norwalk will oversee the fund and invest its assets are among issues that must still be determined, Mr. Hamilton said. Norwalk currently has a defined benefit pension plan with \$450 million in assets. The pension fund's board of trustees could oversee a nonpension benefit trust, Mr. Hamilton said.

Potential benefits cuts

Several public entity benefit managers said they are looking at options to reduce retiree benefits. However, the benefit managers, citing fear of backlash, declined to discuss such ideas publicly until they address the issue with unions in which workers participate.

Mr. Hackleman said he opted for an early calculation of San Mateo County's retiree benefits obligations to be ready to address future union negotiation requests for increased retiree benefits.

The county is in "comparatively good shape" because it already incorporates a defined contribution approach to retiree health, Mr. Hackleman said. Any unused sick time that accumulates during an employee's career can be used to offset the worker's health plan contribution upon retirement.

Mr. Hackleman also has recommended that the county set up a retiree health savings account that would not become a GASB liability. Such accounts would have time to grow to fund benefits for employees with retirement dates that are still a long way off.

Meanwhile, contributions the county has already made to retiree health would pay for those closer to retirement. The structure of such arrangements has yet to be worked out, Mr. Hackleman said.

Still another approach some public entities are weighing would rely on educating employees about Medicare Advantage plans, Mr. Merlob said.

Under Medicare Advantage arrangements the federal government pays health insurers to manage an enrollee's health care rather than paying claims directly. If an employer requires a contribution from a retiree, it could be more advantageous for a retiree to enroll instead in a Medicare Advantage plan, Mr. Merlob said.

"Some Medicare Advantage plans provide excellent coverage including prescription drugs and there is no (additional) premium," Mr. Merlob said. "So it actually can be advantageous for retirees."

Out of concern about how a substantial liability would look on their balance sheets, some entities also are exploring issuing bonds to raise funding, said Robert Friedman, a partner whose specialty includes employee benefits, at Holland & Knight L.L.P. in Miami.

"The bond issue is going to end up being a strategy that a lot of governmental entities take advantage of," Mr. Friedman said. "Some will keep going with pay-as-you-go."

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Hybrids: Alternative plan touted as significant cost cutting tool for employers

Continued from page 11

practice (see related story, page 16).

"Since day one this has been a constant gadfly," said David Cowles, co-founder and principal Medfield, Mass.-based Benemax, which began selling hybrid health plans in 1985 and now offers them exclusively.

"We've disrupted their distribution channel," said Tom Quigley, president of Total Benefits Consulting L.L.C., a Loveland, Ohio-based consulting firm that was spun off from broker Total Benefits Planning Agency Inc.

Mr. Quigley said he sold his brokerage business in July after losing his contract last year with Anthem Blue Cross and Blue Shield of Ohio and has developed a software program called Benefits Coach to help employers structure hybrid health plans on their own.

No other brokers offering the plans that were contacted by *Business Insurance* returned calls seeking comment.

Benemax, however, currently has 225 clients using the approach and, so far, "every client has been making money on it," Mr. Cowles said.

For example, after struggling to keep year-to-year health insurance premium increases below 10%, Salem, Mass.-based supermarket chain Crosby's Markets Inc. expects a 1% to 2% premium reduction going into its November renewals, said Bob Vello, general manager.

"It seems to be working very well," Mr. Vello said.

Under Crosby's hybrid health plan, the employer assumes a \$5,000

annual per-person deductible, providing first-dollar coverage up to \$1,000 to its 110 employee plan members, 75% coverage between \$1,000 and \$5,000 and 100% coverage after that. Employees, who contribute \$25 per month for individual coverage and \$75 per month for family coverage, also make \$25 copayments for office visits and have a three-tiered drug plan with \$10, \$20 and \$35 copayments per prescription. The plan also provides dental coverage.

The program is virtually invisible to employees, whose health claims are submitted first to Blue Cross Blue Shield, with those that fall within the \$5,000 deductible being handed over to Benemax, which pays the claims from Crosby's Section 105 account.

In some ways, it's like being fully self-insured with stop-loss coverage attaching at \$5,000, Mr. Vello said.

Another Benemax client, a 500-group life employer in Philadelphia that Mr. Cowles declined to name, reduced its annual health care premiums from \$3.5 million to \$2.4 million by switching to a PPO with a \$2,000 deductible from a point of service plan with first-dollar coverage. After paying \$575,000 in claims and administrative fees, the employer saved \$525,000, he said.

"If we can't save an employer at least \$1,000 per employee, we'll do another approach," Mr. Cowles said.

After cutting health care premiums by 55% in the first year, the University of Nevada School of Medicine Multi-Specialty Group

Practice South in Las Vegas saw premiums go up between \$1 and \$2 per covered employee in its second year of having a hybrid health plan with a \$7,500 deductible above employees' \$250 deductible, said Craig Seiden, fiscal officer. The medical group's plan is administered by Investment Insurance Services Inc., a benefits broker in Las Vegas.

"The additional claims expense hasn't made any appreciable difference," he said. "The plan has paid off amazingly. Our reserves have built up to the point that even if we had a significant claims exposure in any given year we'd be able to weather that."

The medical group, which pays 100% of the premium for employee-only coverage used a portion of its first- and second-year savings to add fully paid vision coverage, expand its dental coverage and begin subsidizing dependent care coverage, for which employees had been paying 100%. Now, employees pay two-thirds of the cost of dependent coverage, Mr. Seiden said.

Benemax's Mr. Cowles said that while hybrid health plans work best for employers with 100 to 500 plan participants, he has structured successful programs for employers with as few as 10 covered lives.

"It's a powerful tool for employers that aren't experience-rated," he said. "Groups under 100 generally aren't experience-rated, and groups with 100 to 500 lives have an element of experience rating and community rating. Once you get over 1,000 lives, they're all experience-rated."

Though Mr. Cowles said he has met with some initial resistance from insurers to the hybrid health plan concept, he usually wins their support after showing them how the programs can be beneficial to insurers as well. One argument insurers generally present is that employees are likely to be more conservative when they spend their own health care dollars.

"Even if the employer is the principal claims cost sharer, there's usually positive claims experience," he said. This is because "when an em-

ployer takes on claims risk, they tell their employees. Employees realize that their benefit costs will be affected by claims, so there's 'social pressure' not to smoke two packs a day or to get fit."

Moreover, "once an employer is as skin in the game, they're much more receptive to doing something that affects their risk pool," such as implementing wellness and disease management programs, which is often anathema to small employers because of the added cost, Mr. Cowles said.

Broker fights insurer over plan structure

Hybrid health cover spurs suit

By JOANNE WOJCIK

LOVELAND, Ohio—Total Benefits Planning Agency Inc.'s decision to use a more than 50-year-old federal tax law to help small and midsize employers save money on health insurance nearly put it out of business.

Under the Loveland Ohio-based company's program, employers would essentially "refinance" health care costs by raising deductibles on existing group insurance policies and administering benefits through a medical expense reimbursement plan created under Section 105 of the Internal Revenue Code.

While other health insurance brokers also employed the strategy in other states to help their similarly situated clients save money, the Total Benefits Strategy went a step further. It also provided an option to exclude from the group policy certain high-risk employees, spouses and dependents and instead cover them with individual health insurance policies.

The Total Benefits Strategy is explained in detail in a book published last year and co-written by Total Benefits' founder Thomas J. Quigley and his attorney, Edward A. Lyon, titled "How to Beat the High Cost of Health Care."

"It takes Section 105 to its fullest, using individual health insurance, which is less expensive than group" in many cases, Mr. Quigley said. "The strategy works with any carrier that offers high-deductible plans."

Total Benefits claims its strategy has helped employers in Ohio, Kentucky and Indiana save 20% or more on their health insurance costs without cutting benefits. But his brokerage was forced to temporarily suspend use of the strategy when the insurer underwriting the high-deductible umbrella coverage canceled its contract as of July 2005.

"They said they would cancel our contract if we continued to sell individual policies," Mr. Quigley said.

So on Aug. 4, 2005, Mr. Quigley sued the insurer, Anthem Blue Cross and Blue Shield of Ohio; several of its affiliated companies; and a competing broker, Cincinnati-based Cornerstone Broker Insurance Services Agency Inc.—accusing all defendants of conspiring to restrict Total Benefits from selling its money-saving product.

The suit, filed in U.S. District Court for the Southern District of Ohio in Cincinnati, claimed the defendants violated federal antitrust law, defamed and libeled the Total Benefits Strategy to third parties as "unethical" and "illegal," and blacklisted other agents seeking to use the Total Benefits Strategy.

The insurer responded by filing a motion for dismissal, claiming exemption to federal antitrust law under the McCarran Ferguson Act, among other arguments.

On Sept. 8, the court ruled against Anthem's motion to dismiss the complaint.

Anthem is in the process of fully reviewing the opinion and considering its options, a spokeswoman said. A spokeswoman from Cornerstone declined to comment on the litigation.

In the meantime, Mr. Quigley has filed formal complaints against the carrier and the other broker with insurance regulators in neighboring states, including Indiana and Kentucky. He also sold Total Benefits' health insurance brokerage business and is now concentrating on providing benefits consulting services to other agents, brokers and employers.

Moreover, he's continuing to advocate the Total Benefits Strategy and has developed a software program called Benefits Coach that employers can use to set up their own Section 105 plans.

Total Benefits Planning Agency Inc., et al., vs. Anthem Blue Cross and Blue Shield, et al. Case No. 1:05CV519. U.S. District Court for the Southern District of Ohio Western Division.

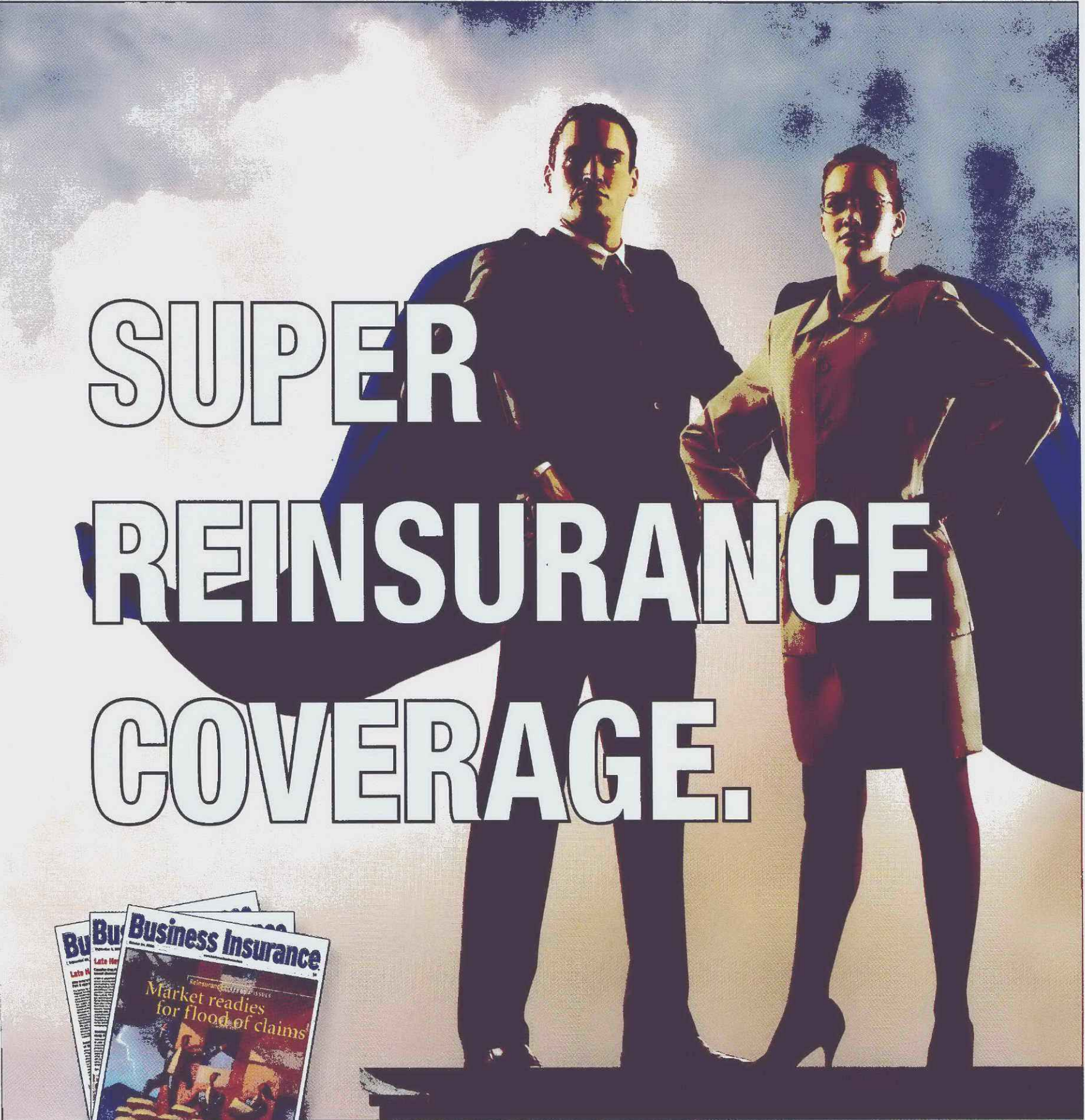
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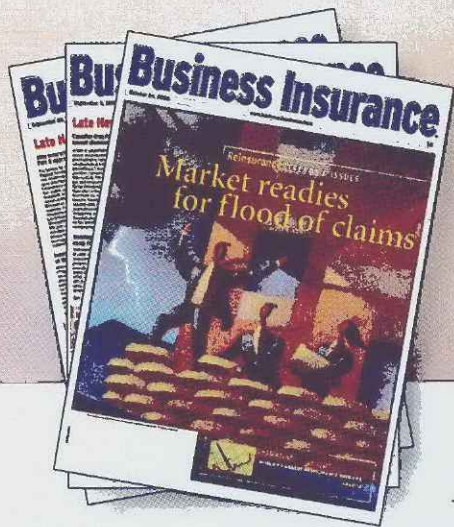
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Pension reform law could ease retiree health care funding

By JERRY GEISEL

A new federal law intended to improve pension plan funding also makes it easier for employers to fund retiree health care liabilities using surplus pension assets.

Employers have had such an option for years, but with pension plan funding levels taking a nosedive due to lackluster investment returns and declining interest rates, few plans, until recently, had surplus assets that could be transferred.

But with pension plan funding levels rebounding due to improved

investment returns and higher interest rates, more employers once again could be eligible to take advantage of this transfer mechanism.

And Congress, as part of the more than 900-page pension funding reform legislation, has lowered the barriers to use the transfer option through several changes. Those changes include:

- **Eligibility.** Under prior law, employers could transfer surplus pension plan assets to pay for retiree health care benefits if the pension plan remained at least 125% funded after the transfer.

Under the new law, surplus assets can be transferred if the plan is at least 120% funded after the transfer.

- **Transfer period.** Under the old rules, only current year retiree health costs could be paid with the transferred surplus pension plan assets. If the transferred amounts were not used to pay for retiree health costs, the money had to be returned to the pension plan and the employer was slapped with a 20% excise tax on the returned funds.

By contrast, the new pension law allows transferred assets to be used

to pay for retiree health care expenses incurred for up to 10 years, decreasing the likelihood that the transferred amount would not be used up.

Additionally, another change in the pension law makes it easier for employers to overfund their pension plans and have surplus assets. Under the new law, employers are allowed to make annual tax-deductible contributions to their pension plans until their plans are 150% funded. By contrast, under prior law, employers generally could not take a tax deduction for pension plan contributions after

their plans were 100% funded.

Benefit experts say all these factors increase the likelihood that more companies—as a financial strategy—will make the maximum contributions possible to their pension plans as a way of building up sufficient surplus assets, which they then can use to fund retiree health care expenses.

“When companies focus on this, they will see an opportunity,” said Jerry Mingione, a principal in the Philadelphia office of benefit consultant Towers Perrin.

“Congress has given companies a great opportunity to prefund” retiree health care benefits, said Bill Sweetnam, a principal with the Groom Law Group in Washington and who lobbied for the changes on behalf of client Prudential Financial Inc., which has a significantly overfunded pension plan. Prudential is currently analyzing whether it will use the transfer approach, said a spokesman for the Newark, N.J.-based financial services giant.

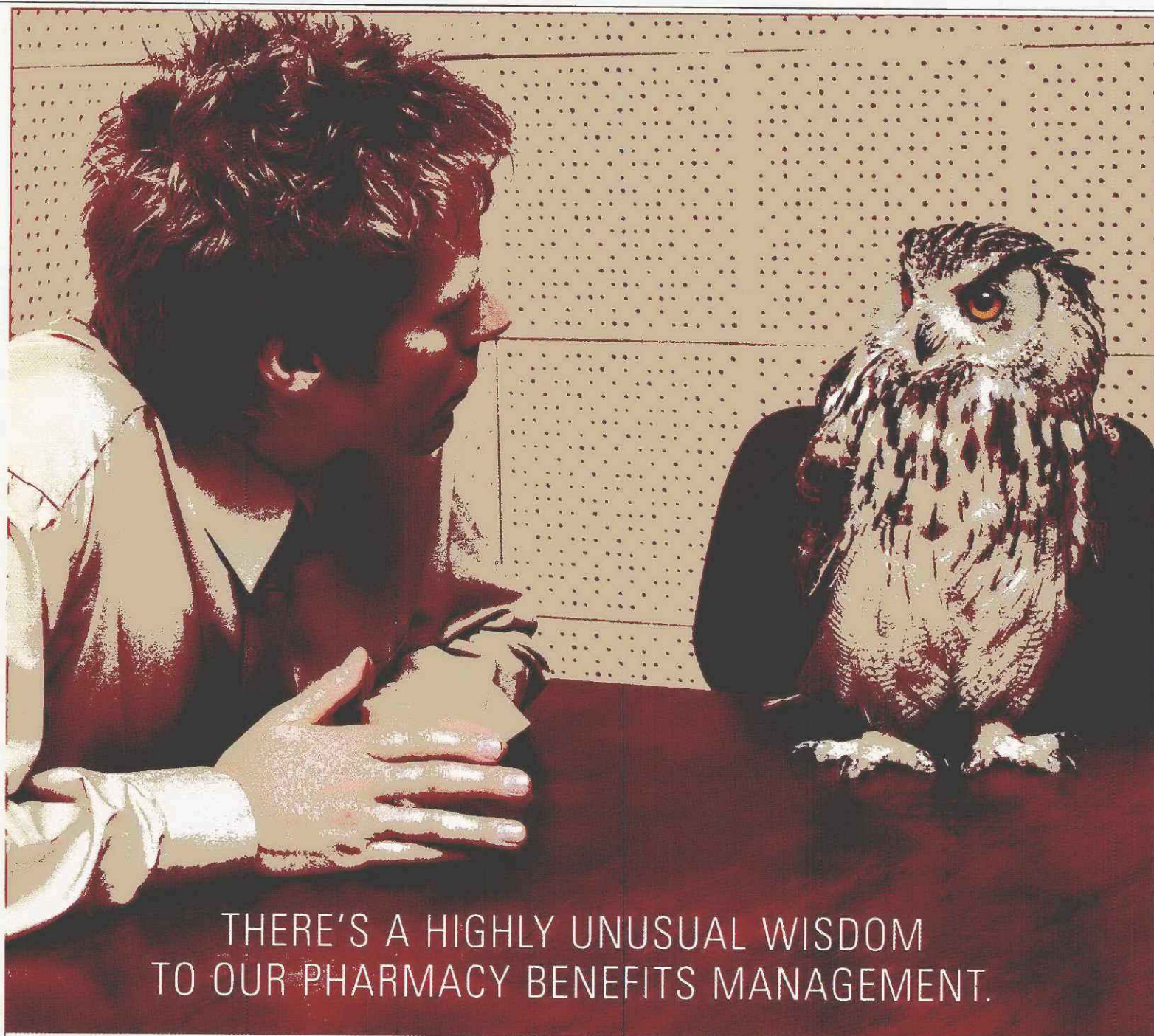
Under the new law, surplus pension plan assets can be transferred if the plan is at least 120% funded after the transfer.

By deliberately overfunding their pension plans, employers have a tax-effective way to prefund retiree health care expenses, experts note. In such an arrangement, the employer receives an immediate tax deduction for pension plan contributions, while the assets earn tax-free investment income, regardless of whether the assets are used to pay for pension or retiree health care expenses.

By contrast, employers now have few tax-effective vehicles to prefund retiree health care liabilities. For example, while employers that offer retiree health care benefits through collective bargaining agreements can prefund future obligations through contributions to tax-free trusts known as voluntary employee beneficiary associations, VEBAs are not a practical option to prefund retiree health care obligations for salaried employees. Under a 1984 federal law, investment income earned on VEBA assets held to pay for retired salaried employees' health care obligations would be considered unrelated income and subject to federal taxes.

Even before the changes in the pension law, employers had incentives to transfer surplus pension assets to prefund retiree health care expenses.

By so doing, companies could tap an unused asset—the surpluses in their pension plans—and conserve corporate cash.



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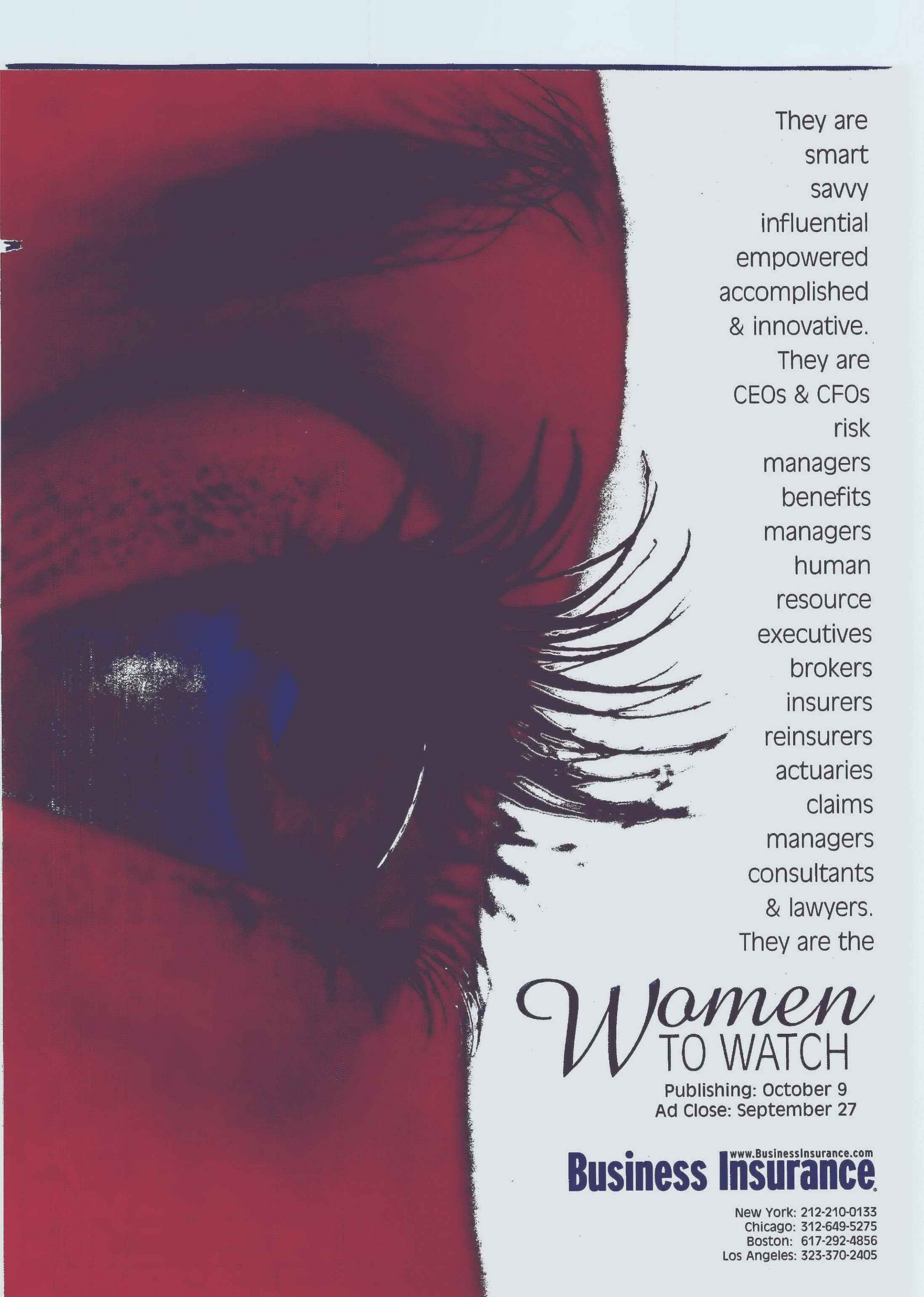
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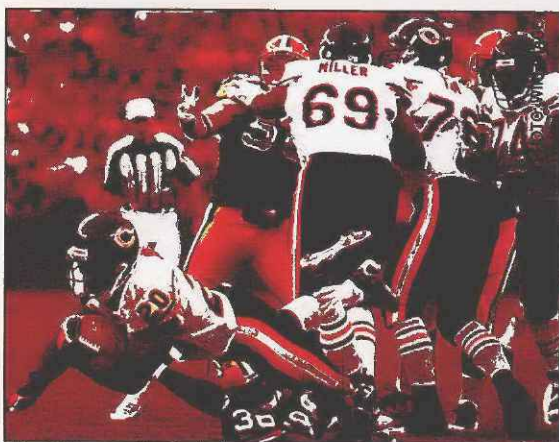
Compiled by Joanne Wojcik

A \$275,000 shutout

The Green Bay Packers' defense may have failed to protect the NFL team from a 26-0 shutout by the Chicago Bears, but a defensive move by a store owner near Plano, Ill., succeeded in blocking a \$275,000 casualty to his business.

Randy Gonigam, owner of World Furniture Mall, had offered a Labor Day weekend special to shoppers: free furniture up to \$10,000 if the Bears shut out longtime rival Green Bay in their season opener.

To the delight of shoppers, the Bears blanked the Packers in their



The Chicago Bears' Thomas Jones, stopped here by the Green Bay Packers, led all rushers in the 26-0 shutout of Green Bay.

Sept. 10 meeting—the first time in 233 games that Green Bay was held scoreless and the first shutout of quarterback Brett Favre's 16-year career.

Fortunately for World Furniture Mall, the business had coverage for the promotion from OddsOn Promotions, a

Reno, Nev.-based company that specializes in prize reimbursement for such events as hole-in-one contests at golf outings.

While even the store owner thought it was a long shot that the Bears would end the Packers' streak of putting at least something on the scoreboard, such insurance claims are fairly common, according to a spokeswoman for OddsOn Promotions.

She added that football-themed conditional rebate promotions are just one of the many products OddsOn Promotions sells to help businesses gain publicity and, hopefully, enhance sales.

Inmates create hostile work environment

Penal institutions are not immune from maintaining a hostility-free work environment despite prisoners' inherent propensity toward inappropriate and socially deviant behavior, a federal appeals court has ruled.

The decision, which was handed down Sept. 13 by the 9th U.S. Circuit Court of Appeals in San Francisco, stemmed from a 2000 lawsuit filed by a former female prison guard at Pelican Bay State Prison in Crescent City, Calif., who claimed she was fired for complaining about being subjected to repeated acts of exhibitionism by inmates.

After the guard prevailed at trial and was granted a jury award of \$600,000, the California Department of Corrections and Rehabilitation appealed, claiming it was exempt from such laws as Title VII of the 1964 Civil Rights Act because its "distinctive character and problems" created an "inherently hostile work environment." Moreover, the department argued, the guard essentially welcomed such sexually abusive conduct by merely accepting the job.

The 9th Circuit, however, ruled that nothing in federal law suggests that prison officials can look the other way when inmates' actions violate the rights of employees or other prisoners.

Spitzer takes step toward governor's mansion

Insurance industry adversary Eliot Spitzer could become an even bigger force to reckon with after winning the Democratic nomination to run for New York's governor in the November elections.

As the state attorney general, Mr. Spitzer for the past two years led probes into insurance industry business practices, impacting several major brokers and insurers in the industry.

After winning last week's primary, he now goes on to face Republican candidate John Faso in the Nov. 7 general election.



Mr. Spitzer

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

Pension: Law could help fund retiree health care

Continued from page 18

"There are some good cash flow reasons to do this," said Scott Macey, a senior vp with Aon Consulting in Somerset, N.J.

On the other hand, there are several conditions, aside from keeping their pension plans at least 120% funded, that could chill employer interest in the surplus asset transfer approach.

For example, under both the old and the new law, employers transferring surplus assets to pay for retiree health care expenses are required to vest all pension plan participants' accrued benefits.

While the cost of vesting, especially at mature companies where

most employees already are vested, may be relatively small, some companies may not want to incur the additional administrative burden—such as sending out benefit reports to participants—for what are very small benefits, Towers Perrin's Mr. Mingione said.

"The vesting requirement could hold up some companies," said Bill Miner, a senior consulting actuary with Watson Wyatt Worldwide in Chicago.

Additionally, the new law requires, in a so-called "maintenance of cost" provision, that employers not reduce retiree health care costs during the transfer period and four years after that period.

With health care costs continuing to rise, the likelihood of not meeting that requirement typically would be very low. Still, some employers that want to cut back on how much they want to pay for retiree health care expenses might not want to be locked into such a commitment, experts say.

At the same time, companies also might not want to be obligated to keep their pension plans 120% funded during the transfer period. "That could be troublesome for some companies," said Barbara Bald, a principal with the human resources unit of PricewaterhouseCoopers L.L.P. in New York.

Employer health care plan costs expected to rise by 5.6% in 2007

By JERRY GEISEL

Employers are predicting that their health care plan costs will increase by an average of 5.6% in 2007, according to a survey released last week by Mercer Health & Benefits L.L.C.

That increase, which would be one of the lowest in years, comes as employers continue to aggressively shift costs to employees and offer new health plan designs, such as high-deductible plans linked to health savings accounts and health reimbursement arrangements, that give employees strong financial incentives to use services in more cost-efficient ways.

"As in the past few years, employers are working to lower cost increases by raising deductibles

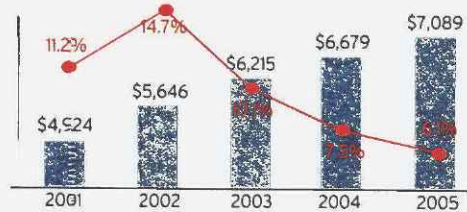
and other employee cost-sharing provisions," said Blaine Bos, a Mercer consultant in Minneapolis, in a statement.

"But this year, we're also seeing a lot of change in health plan offerings—specifically, employers implementing HSA and HRA-based consumer-directed health plans," Mr. Bos added.

If employers maintained their existing group plans without making changes, costs in 2007 would increase by about 9%, according to the survey. But just more than 60% of the nearly

Costs at a glance

Annual increases in average total health care plan costs per employee.



Source: Mercer Health & Benefits L.L.C.

1,700 employers responding to the Mercer survey said they are taking steps, such as boosting deductibles or adopting new plan designs, to reduce cost increases.

Last year, group health care costs increased by an average of 6.1%.

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Starr to open Lloyd's syndicate

LONDON—C.V. Starr & Co. Inc., a New York-based insurance group, is to open a Lloyd's of London aviation, marine and energy syndicate.

Starr has received approval from Lloyd's to establish syndicate 1919, although Lloyd's Franchise Performance Directorate was still finalizing the approval of syndicate 1919's business plan, a spokeswoman for Lloyd's said Tuesday.

The syndicate is to be capitalized and funded 25% by C.V. Starr and 75% by Starr International Investments Ltd., C.V. Starr's investment company.

The company expects syndicate 1919 to be underwriting by Oct. 1 with a capacity of £50 million (\$93.2 million) in 2007. Chris Hancock, who was previously at Faraday Group, the London-market subsidiary of Berkshire Hathaway Inc., will be the active underwriter for the syndicate.

Syndicate 1919 will be managed by Marlborough Underwriting Agency Ltd., the London-based Lloyd's managing agent owned by Berkshire Hathaway.

—By Stuart Collins

Canada reviews federal privacy law

Employers' efforts at compliance yield mixed results

By GLORIA GONZALEZ

Canadian employers are still struggling to comply with the requirements of federal privacy legislation that came into full effect more than two years ago.

And a mandatory review of the legislation slated to begin this fall has raised concerns that the obligations of employers to protect the privacy of the personal information of their employees and customers will become more complicated under a modified privacy law.

The Personal Information Protection and Electronic Documents Act establishes the ground rules for how organizations collect, use and disclose the personal information of both customers and employees (see story, page 23).

Employers' efforts to comply with the requirements of PIPEDA have yielded mixed results, according to an annual report on PIPEDA conducted by the office of the Privacy Commissioner of Canada.

In investigating alleged violations, Privacy Commissioner Jennifer Stoddart concluded that organizations had complied with PIPEDA requirements in only 19% of these cases. While the number of cases in which the commissioner determined that an organization failed to respect a provision of PIPEDA was about 10%, the report noted that this does not mean that more organizations failed to comply with PIPEDA. Rather, the number is a reflection of the fact that many cases were resolved by means other than a full investigation by the commissioner's office, such as a finding that the office does not have jurisdiction or that the complaint had been settled, according to the report.

In general, employers have expressed a

Privacy violations

Industries most frequently accused of violating federal privacy law and the number of complaints filed in Canada in 2005:



Source: 2005 Annual Report on the Personal Information Protection and Electronic Documents Act, Office of the Privacy Commissioner of Canada

"surprising" lack of concern about privacy compliance in the workplace, said Avner Levin, co-author of a recent report titled "Under the Radar? The Employer Perspective on Workplace Privacy." None of the employers interviewed for the report identified workplace privacy as a current issue of concern.

"There's a real disconnect between what employees are worried about, what the privacy commissioner and provincial privacy commissioners are worried about, and what employers are doing," said Mr. Levin, a law professor in the business department at Toronto-based Ryerson University.

Employers attempting to comply with Canadian privacy legislation have encountered numerous challenges—the first obstacle being the application of different federal and provincial standards to protect personal information. "I think what employers really want across the board is uniform standards," Mr. Levin said. "That would make their lives easier and that would make compliance easier."

Alberta, British Columbia and Quebec have privacy legislation that has been determined to be substantially similar to the federal legislation, meaning that the provincial law supersedes PIPEDA in certain situations. Privacy law, for example, does not apply in the same manner to the personal information of employees if their employers are provincially regulated, said Andrea York, a Toronto-based partner in the labor and employment practice of Blake, Cassels & Graydon L.L.P., who advises employers on privacy issues.

While a federally regulated organization such as a bank must comply with PIPEDA requirements in protecting the personal information of its employees, a provincially regulated company such as a law firm must comply with a mix of federal and provincial privacy standards, she said.

"What we recommend to our clients is that they address the most stringent requirements

See **PRIVACY** / next page

Hiscox seeks to boost profits by redomesticating to Bermuda

By RUPAL PAREKH and STUART COLLINS

LONDON—Lloyd's of London insurer Hiscox P.L.C. plans to shift its domicile from the United Kingdom to Bermuda in an effort to boost business, the company said in a regulatory filing last week.

"A move of our domicile to Bermuda should increase the earnings and add to our international status," Robert Hiscox, chairman of Hiscox, said in a statement.

The domicile change is subject to regulatory approvals, but the company's board has already approved a corporate reorganization to create a new Bermuda-domiciled holding company, to be called Hiscox Ltd. If approved by regulators, shareholders would receive an equal number of shares in the new company to replace their existing shares in Hiscox P.L.C.

Hiscox Ltd. is to be listed on the London

Stock Exchange in place of Hiscox P.L.C. and is expected to replace Hiscox P.L.C. as a member of the FTSE 250 Index, Hiscox noted in its statement that accompanied the company's first-half earnings report.

Hiscox posted profits of £63 million (\$116.0 million) for the first half of 2006, down from £88.1 million (\$156.0 million) in the prior-year period.

According to a spokeswoman for the company, Hiscox will benefit from Bermuda's "favorable tax regime" and less corporate regulation.

The proposed move to Bermuda follows a "strong



start" to Hiscox's operations in Bermuda, which opened last year, and Hiscox USA, which opened in March. Hiscox Bermuda is on track to underwrite its target of \$325 million this year and Hiscox USA has increased its forecast premium volume to \$25 million from \$15 million.

Overall, Hiscox reported a 43% increase in gross premiums to £625.1 million (\$1.15 billion) in the first half of this year compared with the same period of 2005. The increase was due to growth in its Bermudian and U.S. operations as well as a surge in U.K. commercial and personal lines business following a recent U.K. advertising cam-

paign. The volume of European business was static but profitable, Hiscox said.

Hiscox's first-half 2006 pretax profits were down 30% to £61.3 million (\$112.9 million) while the combined ratio was almost 10 percentage points higher at 93.2%.

Commenting on market conditions, Mr. Hiscox said that rates were strong for any risks exposed to catastrophes but competition is growing fiercer for other risks. In the U.K. market he said: "We are reaching the stage in the cycle when chief executives state in public that their company will not reduce rates, while demanding more income from their troops."

Commenting on the redomestication, a spokesperson for Lloyd's of London said: "Hiscox has made it clear for some time that they are doing this for operational reasons, and that it in no way reduces their commitment to writing a significant element of their business through Lloyd's."

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Privacy: Employee consent the main focus of a review of Canada's PIPEDA law

Continued from previous page

just because you have different requirements in different provinces," said Robert Parker, a Toronto-based retired partner of Deloitte & Touche L.L.P.'s enterprise risk practice, who still consults with employers on privacy law compliance.

Companies often cite the cost of compliance as a key issue, but what they fail to realize is that the cost of taking security measures is minimal compared with the potentially significant consequences of security breaches involving personal information, said Mark Hayes, a partner in Blake, Cassels and Graydon's Toronto office who also consults on privacy issues. "What I think a lot of companies forget is that there are a lot of things that can be done that are not expensive or don't have any

costs at all," he said.

The lack of clarity on specific issues is another concern, privacy experts say. In the most high-profile case involving a PIPEDA complaint, both the privacy commissioner and a federal court rejected the contention by employees of Vancouver, British Columbia-based TELUS Communications Inc. that the company breached PIPEDA by implementing a speech recognition security program and requiring employees to provide a voice print.

While finding that the collection of this information by TELUS was reasonable, both the privacy commissioner and the court had trouble reconciling the language of PIPEDA's consent requirement with the case, which did not clearly fall within the consent exceptions es-

tablished in the federal legislation, Ms. York said. This demonstrates the difficulty of applying PIPEDA,

"In an employment relationship, consent is meaningless. It makes no sense to create an obligation like that to begin with."

Avner Levin
Ryerson University

which focused more on protecting consumers' information even though it also governs employee information, she said. "The excep-

tions don't neatly fit into the employment relationship," she said.

The consent-based structure of the federal statute is one of the key issues that will be considered during the upcoming review. Generally, PIPEDA requires the knowledge and consent of the individual for the collection, use and disclosure of personal information, which has raised several concerns. PIPEDA, for example, protects the personal information of employees, but they may not feel that they can withhold their consent for fear of termination. "In an employment relationship, consent is meaningless," Mr. Levin said. "It makes no sense to create an obligation like that to begin with."

A more appropriate approach may be to model federal law after

standards created by Alberta and British Columbia laws that allow employers to collect personal information about their employees without their consent under certain conditions as long as it is being collected for a reasonable purpose. The PIPEDA review will address whether this test is an appropriate alternative.

Another key issue to be considered involves the privacy commissioner's lack of enforcement power. Currently, the privacy commissioner has the authority to investigate complaints, make findings and issue non-binding recommendations, but has a limited ability to initiate a complaint, conduct an audit or publicly disclose information relat-

See PRIVACY / next page

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	Revised Payment Percentages	Substantive Closure Payment Percentages
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14 September 2006

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Scheme Administrators
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Privacy: Canadian employers worry about possible rule changes

Continued from previous page

ing to the protection practices of an organization. "On a practical level, employers don't have to comply with them," Mr. Levin said. "It's not a court order."

Some privacy experts want PIPEDA to authorize enforcement powers similar to those in the legislation in Alberta and British Columbia. "The employers are cringing when they hear that," Mr. Levin said.

Employers that have taken steps to comply with privacy legislation are also concerned that they have spent significant amounts of time on privacy issues and that the upcoming review will force them to comply with a different set of rules, he said.

Employers should take basic risk management steps to protect personal information such as limiting the number of employees that have access to information and ensuring that business discussions of matters that refer to personal information do not take place in open workspaces, privacy experts say.

Ensuring employees are properly trained to recognize potential security breaches and address them is a major factor in avoiding or mitigating the impact of breaches, Mr. Parker said, adding that several of his clients had good privacy policies and procedures of which their em-

ployees were unaware.

Employers also need to develop separate policies covering consumer and employee personal information. Many companies attempt to use the privacy policies they develop for their customers for their employees, which may not be an effective approach because they do not address the specific dynamics of the workplace, Mr. Levin said. "I think we will see more policies out there that target what happens specifically with respect to employees, but we're not there yet," he said.

Privacy law takes effect in phases

Canada's Personal Information Protection and Electronic Documents Act sets standards for the collection, use and disclosure of personal information in the course of commercial activities. It aims to balance an individual's right to privacy with an organization's need for personal information for legitimate business purposes.

PIPEDA has been coming into effect in stages. Since Jan. 1, 2001, the act has applied to personal in-



formation collected about customers and employees in federally regulated industries such as banking, telecommunication and transportation. It has also applied to information transported across

provincial and territorial boundaries.

Since Jan. 1, 2004, PIPEDA applied to all personal information collected, used or disclosed in the course of commercial activities by all private sector organizations except in provinces that have enacted legislation deemed to be substantially similar to the federal law. Alberta, British Columbia and Quebec all have legislation deemed similar to PIPEDA.

—By Gloria Gonzalez

Cash Balance Pension Plans: Back on the Table

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- Moderator: Jerry Geisel**, Editor-at-Large, Washington, DC

QUESTIONS TO BE ADDRESSED:

- Do cash balance plans have a brighter future in the wake of the Pension Protection Act and recent appeals court ruling upholding IBM's plan?
- Does it make sense for employers to set up new cash balance plans or continue existing plans in the wake of the new pension reform law?
- What plan designs will work and which ones will not pass muster?
- Is a hybrid plan approach, like cash balance, more attractive for employers and employees than a defined contribution plan only approach?

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Duperreault: The best legacy is for ACE to succeed 'regardless of who's running it'

Continued from page 3

So we decided to raise the price. It's very hard to speculate. We would've had great people, we would've been energetic and we would've done something. But that was such a unique opportunity to be global instantaneously that we probably would not have the capabilities that we have today. We would try to acquire them, and it would have been much more difficult. It would be many more steps, and when you take that many more steps, the chances of missteps increase. I don't know where we would've been, but it would've been a much more difficult path. I think the goal would've been the same, but it would've been much harder to do.

Q: Where do you see business opportunities for ACE in the next one to two years? Will ACE continue to make acquisitions?

A: We acquired at a time when we had no capabilities in certain areas. Either you grow them inside the company or you acquire them. It was much easier to acquire. Then, post-9/11, there was this wonderful time of organic growth where we absolutely increased our capabilities, but we were able to do it by acquiring talent one at a time, let's say. And the marketplace was giving us the opportunity to grow organically. So it was more the method fits the time. Will we acquire again? Absolutely. I don't think there's any question that we will acquire, but we'll also grow organically and everything in between.

The place for greatest opportunities? They're everywhere. I'm an optimist. If you look at the world, you'd have to first say Asia. It's such a dramatic opportunity for everybody, not just ACE. And everybody

knows the story: There's a growing middle class, technological advances, open markets, all these things are there. So China, South-east Asia, India, all are growth opportunities where you can grow much faster than GDP. But we're doing great in Latin America, particularly in the accident and health business. Our U.S. operations are continuing to grow. We are nowhere near our maximum spread within the United States. Our regional expansion has been pretty good in the past five years, but it continues. The U.S. is just as much an opportunity for us as the emerging markets.

Q: What are the keys to successful underwriting? What are some of the things you've tried to instill at ACE?

A: Underwriting is not like any other kind of discipline. The closest thing you can compare it to is gambling, in a sense. We take risks. There are odds. Even the worst gamblers know you don't play every hand. In instilling the proper approach to underwriting, the first thing you have to tell your underwriters is do the right thing. If the right thing is grow, then you should grow. If the right thing is to decline the business, decline the business. You can't buck a trend. If the market is soft and the opportunities are few, and you're growing, there's something wrong. All too often in our business, companies think that they can grow in spite of that. You can't.

There's always some opportunity, but by and large you have to keep faith with your underwriters. You can't tell them, "I want you to be disciplined, select the right risks and if you can't get the price don't write the business," and then in the next breath say, "What's your production like? Are you making your

budget?" They're not stupid. If you tell them one thing, then say you're short of your budget, they know you're really telling them: grow. Underwriters all want to do the right thing. And they absolutely want to grow. You don't have to push them to grow. What you have to do is reassure them that doing the right thing by not growing is supported by management. I used to tell them all the time, "Don't worry about growth. I'll worry about growth. You worry about profit."

In the last soft market, we acquired companies. And we had a great growth track record but we never gave in on our underwriting. If you look from the day we went public, I think our combined ratio is the best around for the kind of company we are, which is global and diversified. But I think we probably have the best track record, and it boils down to the underwriter believing management will support them if they have a decline in production.

You can't get these numbers right. You can't tell precisely what the profitability is in a particular year. But you know whether it's good or bad. It doesn't require that kind of fine-tuning to make the right decision. When it's good, you should write as much business as you can. When it's bad, you better be cutting back. Underwriters can always make money no matter what the market is. Maybe they have to cut their production in half to do so, but they can make money. Our simple approach to business is we just like to make money every year, but we don't necessarily want to have percentage increases in production every year. You grow book value and the rest takes care of itself.

Q: You joined ACE as CEO in 1994 and led it during a

period of stellar growth. In 2004, you turned over the CEO post to Evan Greenberg and remained executive chairman until your retirement June 1. Why step out of an executive role now?

A: I stepped away from an executive position because I really believe there is a certain timeframe for everybody to run a company as a CEO. You should always step down when you're doing a good job. You don't want somebody tapping you on the shoulder saying, "I think it's time for you to go." By definition, people should be saying "Why are you stepping down? You're doing a great job." That's one of the requirements to have a successful turnover, that the guy who's leaving the job has been doing a good job. ACE is my baby. I feel very much like an owner, one of the architects. What I would like to see as a legacy is a company that succeeds period, regardless of who's running it. I don't define myself as a CEO and I don't define the success of ACE as "it works because I'm running it."

When I had all those thoughts in mind, I didn't want to stay too long. It is good to change management. People get stale, not just the guy in the CEO's office. Everybody gets stale, you figure Brian likes things done this way, so you don't do it a different way. And maybe Brian doesn't even know what way that is, but there's this feeling that that's the way it is. Things start to settle down and calcify. You don't want that. There needs to be a breakup of patterns and change. And that only occurs with a new person coming in with a fresh set of eyes, and also the people expecting that there's going to be change. You have to have the right guy. Evan was with me and he was clearly the right guy. The market

was right. You don't want to step down when the market is bad because everybody thinks there's something else wrong. So my timing had to be just right, and the time was there.

Q: How did you get into the insurance business? Everyone wants to be successful, but did you foresee this for yourself?

A: Not at all. I didn't want to be a businessman. I was going to be a scientist, a mathematician. The purest of the sciences. Then I got drafted, got married and figured I needed a job. For a math major there weren't a lot of job opportunities in 1973. But I found one in the insurance business. So it's just circumstance, happenstance that I ended up in the insurance business. I went to work for AIG. Great company, great training ground. I learned so much there. So if I planned it, I don't think I could've planned it any better. But I can tell you, there was no plan.

It's like making acquisitions. You can't make this list and say I'm going to do this one next. Never happens. Somebody calls one day and presents an opportunity. Your planning has to be more in terms of your ability to execute. I didn't have a plan, but I recognized an opportunity when I saw one at AIG.

Q: What's next for you? What's the next chapter?

A: I'm still the chairman of ACE. I have other outside interests. "Retired" is a funny word. I'll be working on other things, and that's fun, too. I play golf. My family thinks it's an obsession, but I do like it. I did buy a ranch in Texas, so I'm a rancher now, too. It has a whole different rhythm to it. That's my outlet and it's really a lot of fun.

Corrected property/casualty insurers' 2006 first-half results

Ranked by net income. All amounts are in thousands of dollars.

	Net income	Corporate Percent increase (decrease) 2005-2006	Consolidated revenues 2006	Combined ratio 2006 ¹	Combined ratio 2005 ¹	Property/casualty operations Net premiums written 2006	Percent increase (decrease) 2005-2006	Policyholder surplus 2006	Percent increase (decrease) 2005-2006
American International Group Inc.	\$6,385,000	(23.0)%	\$54,002,000	87.8%	92.7%	\$22,889,000	6.8%	N/A	N/A
The St. Paul Travelers Cos. Inc.	1,976,000	54.3	12,305,000	89.4	89.1	10,429,000	4.3	19,037,000	18.0%
Chubb Corp.	1,270,000	31.6	6,951,000	84.0	88.9	6,006,000	(2.6)	10,000,000	16.3
Hartford Financial Services Group Inc.	1,204,000	(5.0)	11,514,000	89.0	87.8	5,336,000 ²	0.7	7,400,000	5.7
ACE Ltd.	1,062,000	17.5	6,470,000	89.3	89.5	6,376,000	1.6	12,466,000	18.7
Cincinnati Financial Corp.	684,473	126.5	2,588,640	93.3	88.2	1,643,009	3.5	4,701,755	12.5
Liberty Mutual Insurance Co.	615,000	(31.4)	11,498,000	102.9 ²	101.3 ²	7,661,000 ²	10.7	10,157,000	2.9
CNA Financial Corp.	468,000	(1.5)	4,913,000	96.0	99.4	3,546,000	1.5	7,374,000	-
SAFECO Corp.	407,900	2.2	3,097,500	86.8	88.8	2,877,900	(2.0)	3,790,700	2.5
Old Republic International Corp.	244,078	(14.8)	1,891,849	89.6 ²	91.4 ²	951,974 ²	6.2	2,209,842	4.3
American Financial Group Inc.	224,400	55.3	1,991,100	88.1	91.0	1,295,900	7.1	2,431,800	3.2
Ohio Casualty Corp.	87,500	9.6	835,500	97.0	95.5	726,900 ²	(2.2)	1,007,000	0.2
RLI Corp.	48,578	(23.7)	293,449	90.9 ²	77.4 ²	281,841 ²	14.2	672,344	(3.0)
Argonaut Group Inc.	43,900	(11.7)	453,300	95.0	95.2	378,200	8.2	742,900	12.9
Cumulative	\$14,720,829	(4.4)%	\$118,804,338	90.3%	92.0%	\$70,398,724	2.2%	\$81,990,341	10.5%

¹ Includes dividends. ² Statutory.

Source: BI survey

Roundtable: Public/private terrorism cover

Continued from page 4

workers compensation, which insurers are now required to cover without exclusions for terrorism or the CNBR risks. The proposal also requires the federal government to assume responsibility on a "follow form" basis for losses, such as property, that currently exclude CNBR-related losses.

In addition, non-CNBR risks would be handled by insurers with the help of a facility similar to the current federal backstop program under the Terrorism Risk Insurance Extension Act. Insurers, however, would increase their financial responsibility for these losses by "gradually increasing insurer deductibles," for example, at the rate of 1 point per year for 10 years or subject to a Treasury Department determination of available capacity.

"This is a difficult issue politically, in that (the roundtable's plan) could be said to be less than responsive to what we hear the Congress saying to us: 'Come to us with something which reduces our responsibility, doesn't increase it,'" Mr. Mattera said.

Yet, given the proposal for increasing insurer deductibles, "there is some...economic and political tradeoff. Whether that is in sufficient balance, only the Hill will tell us, but we have to that conversation," Mr. Mattera told regulators.

The roundtable also proposed creating a special-purpose vehicle that would "facilitate development of new private reinsurance capacity

and sale of industry loss warranty contracts to help fund deductibles," according to the proposal. ILWs are financial instruments that pay out

"Currently, I do not think there is an appetite in Congress to have any further responsibility related to the insurance industry."

Maria L. Berthoud
B&D Consulting L.L.C.

when industry losses for an event reach a certain amount. Insurer participation in that program would be voluntary.

New York Insurance Department Superintendent Howard D. Mills initially responded with some frustration to the proposal. "We expected, frankly, more" than this "thin outline," Mr. Mills, the working group chair, said at the meeting.

Five months ago, Edmund Kelly, chairman, president and chief executive officer of Liberty Mutual, presented a basic roundtable proposal at a working group hearing and promised to have a formal proposal finalized by July at the latest.

"I am concerned," Mr. Mills said. "This does not bode well for the process going forward."

Mr. Mattera responded that "it has not been an easy process for the industry. This is a difficult industry

to gain consensus around anything."

Rey Becker, vp-commercial lines and claims with the Des Plaines, Ill.-based Property Casualty Insurers Assn. of America, said in an interview after the meeting: "I can understand the regulators' frustration, but it is more important that the solution be right rather than fast."

Representatives of trade associations expressed support for the roundtable proposal.

David Snyder, vp and assistant general counsel for the Washington-based AIA, said: "For the first time...the industry put forth a near-consensus framework and direction for what would be the long-term structure for financing the economic costs of terrorist attacks."

During the meeting, Mr. Snyder said that "there is not a word that Paul Mattera said that we would disagree with."

Joel Wood, senior vp-government affairs for the Washington-based Council of Insurance Agents & Brokers, said the roundtable has "contributed valuably to the discourse."

However, Maria L. Berthoud, senior vp with Washington-based B&D Consulting L.L.C., said: "Currently, I do not think there is an appetite in Congress to have any further responsibility related to the insurance industry." Ms. Berthoud formerly was a senior vp with the Independent Insurance Agents & Brokers of America Inc., where she led that group's efforts to lobby for the original Terrorism Risk Insurance Act.

Spying: D&O questions raised

Continued from page 1

some executives at Palo Alto, Calif.-based HP for their alleged roles in illegally collecting personal phone records of company board members and several reporters. The vendors that HP retained to collect the records through a process known as pretexting—which involves duping phone companies into assuming they are releasing personal records to their customers—also could face charges, according to the attorney general's office.

Leaks of confidential corporate information to the press triggered HP's internal investigation of its board, according to the company.

As the company's boardroom drama unfolded last week, Chairman Patricia Dunn issued a statement in which she apologized to the board and announced that she would resign as chairman in January but would continue as a director.

But in her statement, posted Sept. 12 on the company's Web site, Ms. Dunn also defended the company's investigation of its board—an investigation that she said spun out of control.

"These leaks had the potential to affect not only the stock price of HP but also that of other publicly traded companies. Unfortunately, the investigation, which was conducted with third parties, included certain inappropriate techniques. These went beyond what we understood them to be, and I apologize that they were employed." Ms. Dunn said in the statement.

Companies that engage in similar

subterfuge against either competitors or their own management could face various lawsuits and criminal investigations if their actions are exposed, the experts noted.

But unless a derailed corporate espionage mission hurts the culprit's financial performance and leads to a significant and sustained drop in the company's share price, a shareholder class action lawsuit would be unlikely, the experts agreed.

Even so, an organization's espionage escapades may prompt a shareholder derivative action lawsuit designed to recover any losses the company sustains as a result of wrongdoing by its management, the experts agreed. Those losses could include the company's defense costs in a criminal case, any fines and penalties it is ordered to pay, any diminution in the value of the company's reputation, and the value of any acquisitions or contracts the company lost because of such a scandal, the experts said.

Coverage questions

Whether the defendants could tap their D&O policies to cover the damages related to fines and penalties the company paid is questionable, said broker Nicholas Conca, a managing principle with Integro Ltd. of New York.

Mr. Conca said "there may be an argument" that those fines and penalties amount to damage and economic loss to the company and

See SPYING / next page

Prometheus: Evidence-based medical payment system nearly ready for testing

Continued from page 4

other medical conditions and procedures.

The Prometheus case rates will include adjustments for illness severity, whether patients have other conditions that might complicate their care as well as regional cost variations, Mr. de Brantes said.

Providers that produce high-quality outcomes can make more than 100% of the ECR, while poor performers will make less. Providers will be responsible for additional costs that arise as a result of their own medical errors.

To ensure that providers don't skimp on care to capture a greater payment—something often alleged to have occurred under managed care because of capitation—the Prometheus system will collect data on the quality of care that is delivered, such as outcomes, patient experience and cost efficiency, and generate a comprehensive scorecard on participating providers.

"It's all about the scorecard," Mr. de Brantes said. "Capitation never had good scorecards, and it passed on insurance risk. That's not to say someone won't try to skimp, but history and economics show that cheaters are a minority that is actually easy to spot."

The Prometheus "engine," the software system that would be used to administer the new payment system, is in development and is to be ready to roll out in two to three months, according to Mr. de Brantes. To ensure ease of transition, it is being designed to link to health plans' existing payment systems, he said. The Prometheus engine will also be designed to accommodate payments to a wide range of providers that participate in the

treatment of each patient—from doctor to hospital to rehabilitation facility, Mr. de Brantes said.

Fighting waste

Helen Darling, president of the National Business Group on Health, a Washington-based organization of large employers that has been working on initiatives aimed at reducing costly medical errors, is supportive of the group's effort to redesign the medical payment system.

"They certainly are attacking a serious problem—a fatally flawed payment system—that pays for redundant tests and services, yet pays next to nothing for physicians to spend time counseling and talking with patients on their most critical health issues," she said.

"We need to learn what methods of payment are effective and encourage and reward the right behaviors. Private and public payers need to change the way they pay for care and this very creative initiative will teach us a lot about what works and what we should be doing in the near future. We are wasting many billions now on the wrong care because of our distorted payment system," Ms. Darling said.

New York-based independent benefit consultant Joe Martingale, who was formerly with Watson Wyatt Worldwide, also commended the group.

"It's a big boost to reforming the health care market. It attempts to get the financial incentives right and introduces new information both for payers and consumers," Mr. Martingale said. Moreover, "it's throwing down a challenge, explicitly to the medical profession

Prometheus team

A team of experts in health care economics, law, policy, health plan operations and performance measurement have banded together to develop PROMETHEUS, a new payment model based on evidence-based medical guidelines. Team members are:

James Bentley, senior vp, strategic policy planning, American Hospital Assn., Chicago
Francois de Brantes, national coordinator, Bridges To Excellence, Washington

Douglas Emery, vp reimbursement policy, eHealth Initiative, Washington

Alice G. Gosfield, principal, Alice G. Gosfield and Associates P.C., Philadelphia

Dr. Jeffrey Levin-Scherz, chief medical officer, Partners Community Health Care, Boston.

Elizabeth McGlynn, associate director, RAND Health, Santa Monica, Calif.

Toni Mills, managing director, Blue Cross & Blue Shield Assn., Chicago.

Dr. Michael Pine, principal, Michael Pine and Associates, Chicago.

Daniel Roble, partner, Ropes & Gray L.L.P., Boston.

Meredith Rosenthal, associate professor, Harvard School of Public Health, Boston

Craig Schneider, project officer, Centers for Medicare and Medicaid Services regional office, Boston.

Michael Taylor, principal, managed care delivery systems, Towers Perrin, Boston.

through their medical societies, to assist in making this work well by telling the world what the best evidence-based treatments are for all of the various conditions that they are responsible for."

However, Ray Brusca, vp of benefits at Black & Decker Corp. in Towson, Md., was skeptical that the approach would ever gain a foothold nationwide regardless of how well the pilots work.

"I just don't see any change in the payment system possible unless two things happen. First, as goes Medicare and Medicaid, so goes the rest of the system. So unless they change their medical reimbursement system, you're not going to see it widely adopted," he said. "There have been some limited experiments that have worked, but as far as on a widespread basis where it trickles down to everybody else, unless Medicare and Medicaid change the way they reimburse the medical community, the medical community is not going to go along with it."

The other part of the equation that is not being addressed is the patient and their families who, when it comes to their health or their loved one's health, think they should have access to unlimited resources, he said.

"So unless you get a change in the way the larger medical community accepts payment—and that's through Medicare and Medicaid—as well as get patients to understand that only certain approaches to medical care will be reimbursed, I don't think anything has a chance of flying broad-based. The tail doesn't wag the dog, and Medicare and Medicaid as well as the population as a whole is the dog," Mr. Brusca said.

Ways to aid veterans' return to workplace

While employees who show signs of post-traumatic stress disorder should be referred to their company's employee assistance programs, there are steps employers can take on their own to make life easier for troubled workers, experts say.

Observers say PTSD symptoms can include anger, depression, nightmares, extreme reactions to noise, oversensitivity to criticism, difficulty concentrating, drug and alcohol abuse, and marital problems.

To help returning soldiers who have difficulty concentrating, employers can reduce the work environment's distractions, said Mary Vasquez, president and chief executive officer of Gurnee, Ill.-based VMC Behavioral Healthcare Services, an employee assistance program provider. "They can provide enclosures or private space for the person to work in," she said.

Employers also can divide larger assignments into smaller units, she said.

If often helps also to give employees their assignments in writing, including e-mail, as well as orally because a PTSD sufferer "may easily forget or be confused by the directions that are given them," said Ms. Vasquez.

"Provide day-to-day guidance and feedback," she said. "Be very clear in the expectations and the

consequences of not meeting the expectations that have been placed on that person."

Returning workers who "demonstrate overreactions to the smallest stimuli" may need longer or more frequent work breaks, she said.

If a worker does have a panic attack, allow him or her to take a break "and go to a place where they feel comfortable," or allow the worker to contact a support person, said Ms. Vasquez.

In interacting with co-workers, "the supervisor can encourage the worker to walk away from frustrating situations and confrontations," she said, "and allow the employee to work from home part of the time."

Because PTSD often involves sleep disruption, "it would help if the employer can allow the employee to work on a consistent schedule, have flexible starting times and perhaps provide a place for the employee to sleep during breaks," Ms. Vasquez said.

Rich Paul, vp of health and performance solutions at Norfolk, Va.-based ValueOptions Inc., an EAP provider, also suggested employers "set up a buddy system of sorts, where (reservists) can have a buddy who's had similar experiences at one point or another in their lives."

—By Judy Greenwald

PTSD: Reservists at risk of post-war problems

Continued from page 1

stance, is left to take care of all the family chores herself, "there's probably some anger, she's feeling deserted, she's feeling abandoned. She's feeling like all the work's falling on her" while her husband is "getting some glory for what he's doing," said Ann D. Clark, chief executive officer of San Diego-based ACI Specialty Benefits Corp.

Generally, family members of employees are also covered under EAPs.

"It's sort of a very individual response," said Kristine Brennan, executive director of Continuum Employee Assistance, Training, Consulting, a Lincoln, Neb.-based EAP provider.

At Lakeland, Fla.-based Publix Super Markets Inc., referrals are made through the chain's internal EAP program, said a spokeswoman. For issues such as depression, "there are a lot of different options, with a lot of different possibilities. Our EAP assists them to try to find the right person" to address their needs, said the spokeswoman.

Employers overall are concerned about the issue, said Rich Paul, vp of health and performance solutions at Norfolk, Va.-based ValueOptions Inc., an EAP provider. Employers recognize "the importance of playing a role in the successful adjustment of someone returning from military service," he said.

But problems nonetheless may emerge, experts say. "I think the biggest problem there is, is the rapid shift from one culture to another," said Ms. Clark.

After coming from a highly emotional environment, where they

feel "very bonded to the people around them," veterans "may feel isolated, may feel disoriented, may feel like they're not part of their own families anymore. They proba-

"I think the biggest problem there is, is the rapid shift from one culture to another."

Ann D. Clark
ACI Specialty Benefits Corp

bly feel like people don't understand," said Ms. Clark.

Whereas overseas they may have felt they had a "real purpose" and a structured existence, they may come home and find their work boring or unimportant, said Teresa Zahren, a clinical social worker with Continuum. Their job just "doesn't seem like a big deal in the scheme of life," said Ms. Zahren.

The swiftness of change from military to civilian life may be a factor. Somebody can be in a war zone one day and be back in their own bed at home less than 24 hours later, said Richard Seidel, director of clinical programs at Roanoke, Va.-based Carilion Behavioral Health, which operates Carilion EAP.

That leaves little time to decompress, said Mr. Seidel. "It takes time for the nervous system to recalibrate itself," but some people have

trouble doing so. "It's like your nervous system gets stuck on high alert," he said.

Returning reservists "may have difficulty concentrating or remembering the tasks they have to complete, or in making decisions," said Mr. Paul. "We also see some anxiety. Certainly, there may be feelings of anger or irritability, where someone becomes very sensitive to comments and perhaps more explosive than normal."

Reservists also may self-medicate with alcohol or drugs, said Isabelle Duguay, a counselor with Bensinger, DuPont & Associates in Chicago. "Those are very common dual diagnoses you would encounter" with PTSD sufferers, she said.

If an employee shows PTSD symptoms, "Do not be alarmed," said Ms. Duguay. "Understand that everybody adjusts in a different time frame, and sometimes just patience is enough and they'll go back to being normal."

Observers, warn also, however, that problems may not be immediately apparent. Soldiers are "taught to suck it up, so to speak, and to be strong," said Pat Gilligan, ACI's clinical director and himself a veteran of combat in Vietnam.

Furthermore, PTSD "sometimes doesn't show up for years" and then "it will hit them," said Mr. Gilligan.

While it is normal to relive the trauma of, for instance, seeing someone killed, this should eventually fade away, said Ms. Duguay. But people with PTSD may start reliving the situation six months

Continued on next page

Spying: Corporate espionage could trigger lawsuits covered by D&O insurance

Continued from previous page

therefore should be covered as part of the damages sought in a derivative action lawsuit.

"If I'm sued as a director because I failed to oversee the company, I'm being sued for economic damages—I'm not being fined by the shareholders," Mr. Conca said.

But, Mr. Conca also noted that "the definition of loss generally excludes fines and penalties," and garnering coverage for them would be difficult "under any circumstances."

That issue may be moot, however, according to insurer attorney Dan A. Bailey, a partner with Bailey Cavalieri L.L.C. of Columbus, Ohio. Mr. Bailey said the economic damage to a company tripped up while spying on its own management may not be "a large enough number to attract a plaintiffs attorney."

Broker Ann Longmore was not so certain. "In today's world, it's hard to imagine this situation not leading to a shareholder suit," said Ms. Longmore, a New York-based executive vp and the D&O product leader for the Willis Executive Risks practice in North America at Willis Group Holdings Ltd.

A more likely lawsuit would be an invasion-of-privacy case filed by directors who were targets of a probe, Mr. Bailey said.

But if a director were to sue fellow board members for invasion of privacy, the defendants could not tap their traditional D&O policy for coverage since D&O policies exclude coverage when one insured individual sues another insured, Mr. Bailey noted.

Side A policies

If the company had purchased a separate Side A-only difference-in-conditions policy, however, the defendants might be able to tap it, the experts said. While those policies typically include a company vs. insured individual exclusion, many do not contain an insured vs. insured exclusion, they noted.

Most D&O policies still would be in play, however, if corporate espionage exposes the perpetrators to criminal charges, the experts noted.

The policies would cover the defendants' legal costs, the experts agreed.

But any fines or penalties would be left to the defendants to cover personally, Mr. Bailey said.

Even a guilty verdict would not necessarily require the defendants to return their defense coverage, Mr. Bailey noted.

"In today's world, it's hard to imagine this situation not leading to a shareholder suit."

Ann Longmore
Willis Executive Risks

For example, while policies typically exclude coverage for deliberate fraudulent acts, Mr. Bailey said he doubted that a conviction on charges related to corporate espionage could be characterized as fraud.

Of course, coverage under traditional D&O policies would depend on an organization first agreeing to indemnify its directors and officers for their legal costs and then seeking recovery from its D&O insurers. As allowable under state law, organizations generally agree to indemnify their executives—even those

convicted in a criminal case—as long as the defendants maintain they did not believe they were violating any laws and were acting in their organization's best interests, the experts said.

As support for their claims that they did not intentionally commit any wrongdoing, defendants could argue they relied on outside data-gathering companies and the advice of the company's general counsel.

But Ms. Longmore questioned whether that defense could succeed if the only way to obtain certain intelligence would be through illegal measures, even if operatives were not authorized to collect the information through any means. "Can I play ostrich? Is that enough of a defense?" Ms. Longmore asked.

Another coverage problem for defendants could arise if, to avoid a public relations backlash, a company's board refuses to cover the defendants' defense costs even when the company's governance rules would allow it, Mr. Bailey said.

Even in that scenario, the defendants still may have coverage—if the company purchased a separate Side A-only policy, Mr. Bailey said.

Side A policies may even cover the six- or seven-figure corporate

deductible that the company would have had to assume if it indemnified the defendants and then sought a recovery from its traditional D&O insurers, Mr. Bailey said.

But, in that situation, the Side A insurer would have the right to seek reimbursement of the deductible from the company, which already had decided against covering its executives, Mr. Bailey noted. "That could be an interesting show."

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later. This means employers must remain alert for PTSD symptoms "even though you have an employee coming back who seems to be functioning normally," she said.

"I think probably the best thing that an employer can do is plan and prepare for the transition of the individual back into the workplace," said Mr. Paul.

"They need to hear from us, 'Welcome home.' They need to hear, 'Thank-you for your service to your country,' not, 'You've been gone for six months, your work's piled up and, yeah, welcome back,'" said Jodi Aronson Prohowsky, senior vp of operations for Eden Prairie, Minn.-based CIGNA Behavioral Health, which plans to start a dedicated support line for returning veterans in November.

"It's important for employers to communicate clearly with their returning soldiers what the expectations are around their job," Mr. Paul said. "Let them know kind of clearly what is happening with respect to office procedures, department dynamics, how has the work changed and what are the work expectations, and sort of make sure they recognize there may be some training that's required to bring the person up to speed," he said.

Employers "can help the employee adjust by recognizing that everyone kind of adjusts or reintegrates back into the workplace differently," he said. There is no "right way or a wrong way with respect to how quickly someone is able to assimilate back into the workplace," Mr. Paul said.

If problems do emerge, employ-

Helping returning reservists deal with post-traumatic stress

The National Center for Post-Traumatic Stress Disorder, a part of the Department of Veterans Affairs, estimates the risk of post-traumatic stress disorder is 18% from service in Iraq and 11% for soldiers returning from Afghanistan. However, for soldiers who have completed multiple tours, up to 70% will have PTSD, ComPsych Corp. estimates.

How employers can help:

- Encourage returning reservists to use employee assistance programs and remind them that their families are covered as well. Counseling for spouses can be especially beneficial.
- Work-life services can ease the transition with help on financial and legal questions.
- Meet with reservists' managers to discuss reintegrating reservists back into the workplace and consider reduced workload/responsibilities or reduced work schedule to ease reservists back into their jobs.
- Educate managers about what to expect of returning reservists, including symptoms of PTSD—such as withdrawal, irritability and absenteeism—and what steps to take if employees are having trouble.

- Educate managers about being sensitive to reservists' need for or aversion to talking. Some will want to discuss their experience at length while others will prefer not to discuss it at all, so managers should not pry.

Source: ComPsych Corp.

ers should refer employees to their EAPs and not try to solve his personal issues themselves, Mr. Gilligan stressed.

Focus on "what's required of them at work" and "don't give them any sort of special treatment,"

he said. "Hold them accountable."

An EAP is "critical at this time," Ms. Clark said. It can provide easy access to counselors as well as a variety of guidelines to managers "to help ease the transition" for veterans, she said.

Late News

Continued from page 1
board of governors, said the organization will begin a national search for a new CEO immediately. June Holmes, PCI's current chief operating officer, will serve as the interim CEO of the insurer trade group. In a statement, Mr. Csiszar, who gave no reason for his resignation, said he plans "to continue to work within the financial and insurance industries." A spokesman for PCI did not elaborate on the reasons for Mr. Csiszar's resignation.

Runoff specialist gets Quanta top job

Quanta Capital Holdings Ltd. has named Peter D. Johnson as its president and chief executive officer. Mr. Johnson, who previously led the runoff of The Home Insurance Co., replaces interim CEO Robert Lippincott. Mr. Lippincott, who took over from Tobey J. Russ last November, will continue as deputy chairman. Hamilton, Bermuda-based Quanta in May placed most of its business in runoff following a ratings downgrade out of the A range due to the 2005 hurricanes.

WCIRB suggests 6.3% rate decrease

The Workers' Compensation Insurance Rating Bureau has recommended a 6.3% pure premium rate decrease for California policies incepting Jan. 1. The proposal, however, is based on an expectation that Gov. Arnold Schwarzenegger will veto S.B. 815. The legislation is currently on the governor's desk and seeks to double permanent disability benefits over three years. If the governor does not veto the bill, a 1.8% pure premium rate increase would be appropriate, the WCIRB said.

Treasury Department names benefits counsel

W. Thomas Reeder, a veteran employee benefits attorney, has been appointed benefits counsel at the Treasury Department. Mr. Reeder had been Treasury's acting benefits counsel since early last year following the resignation of Bill Sweetnam, who left to become a principal in the Washington office of the Groom Law Group. Before joining the Treasury Department, Mr. Reeder was a partner with the law firm Paul, Hastings, Janofsky & Walker L.L.P.

Kiln to increase capacity in 2007

Lloyd's of London insurer Kiln P.L.C. said it plans to increase its capacity in 2007 to take advantage of "excellent opportunities" in property, reinsurance and personal accident lines. The company, which manages four Lloyd's syndicates, intends to increase the capacity it manages at Lloyd's from the current £803 million (\$1.50 billion) to £1 billion (\$1.86 billion) in 2007. The increase, to be funded by Kiln's existing resources, would put the London-based company among Lloyd's largest managing agents.

Comp rate increases advised in Mich., N.C.

The Compensation Advisory Organization of Michigan, the state's workers compensation rating bureau, has announced an average 4.7% pure premium rate increase, while the North Carolina Rate Bureau has asked for a 9.8% increase. The Michigan organization's pure premium increase announcement, effective Jan. 1, is advisory in nature. Michigan workers comp insurers are free to independently set their own rates. Meanwhile, the North Carolina Rate Bureau has asked the state's Commissioner of Insurance for the 9.8% rate increase for the workers comp residual market to be effective April 1, 2007. Generally, however, North Carolina's rating bureau does not get the rate increases it requests, a spokeswoman for the commissioner's office said.

Sedgwick CMS appoints CFO

William A. Houlihan has been named chief financial officer of Sedgwick Claims Management Services Inc. Mr. Houlihan, who most recently served as CFO of credit card firm Metris Cos. Inc., succeeds Donald W. Burkett, who is retiring as CFO at the end of 2006. According to a spokesman, Mr. Burkett will continue working on "a variety of special assignments" until his retirement.

W.R. Berkley unit forms specialty division

Berkley Specialty Underwriting Managers L.L.C. has formed a division offering specialty insurance products for environmental contractors, consultants and site-specific facility risks. Robert J. Patterson, who joined the W.R. Berkley Corp. unit from Zurich Insurance Group, has been named vp of the Atlanta-based division.

BI Stock Index [9/11 - 9/15]

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

Percentage change of BI Stock Index vs. key indicators

BI Stock Index

3083.95



2.30

Dow Jones

11560.77



1.48

S&P 500

1319.87



1.61

Largest gains

Tower Group Inc.	13.11%
Fairfax Financial	11.14%
United Fire & Casualty	9.28%
Odyssey Re	7.91%
Humana Inc.	7.48%

Largest losses

Gainsco Inc.	-2.00%
Health Net Inc.	-1.54%
SCOR S.A.	-0.83%

Weekly change by market segment

Brokers	2.92%
Insurers/Reinsurers	2.69%
Managed Care Organizations	2.68%

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

Leadership in Specialty

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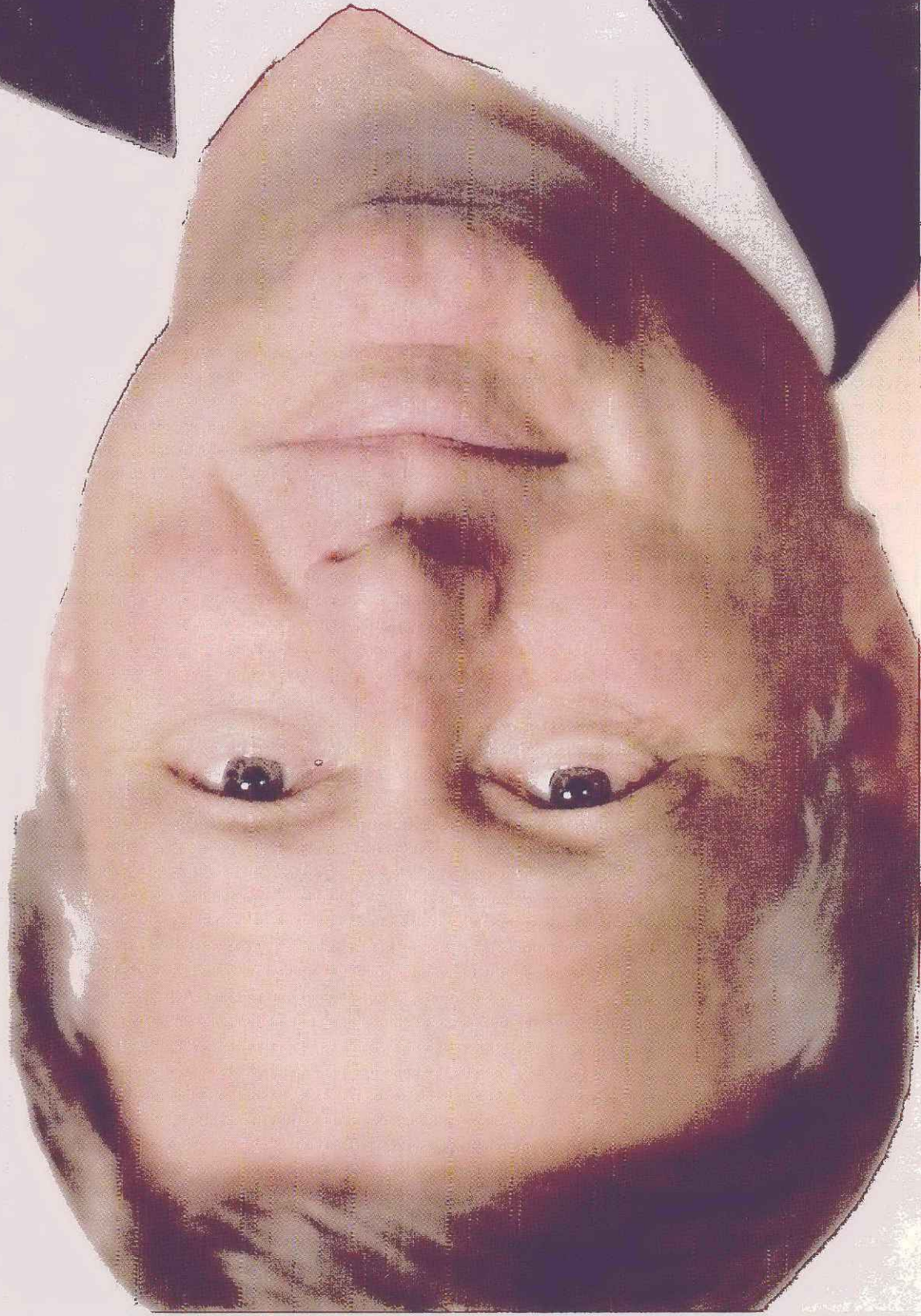
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New Online Poll: Do you think the property market will become more competitive next year?

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