HSAs help ease transition to consumer-directed care

Dramatic growth in health savings accounts expected now that guidance is available

By JUDY GREENWALD

There was some "kicking and screaming" when Neenah, Wis.-based Plexus Corp. began to move to consumer-driven health care programs two years ago, says corporate benefits manager Sarah Novak.

It demanded a "real shift in mindset for employees, and it's been a difficult one," says Ms. Novak, whose firm introduced a high deductible plan linked to a health savings account last month.

But now, employees at the contract manufacturing firm are coming to her with reports of where they can get lower-priced prescription drugs. They are "starting to be engaged, starting to look at the cost of health care, which I think is really key," said Ms. Novak.

That change in mindset is something that many other employers hope to see in their own employees as they also explore HSAs. Although relatively few firms have introduced HSAs so far, there is strong interest in them by employers, and many observers predict they will grow dramatically next year.

HSAs, which were authorized by a 2003 law, operate similarly to 401(k) plans or IRAs (see chart, page 14).

Most employers that offer HSAs, particularly large firms, offer the accounts as an option within their health care program, but smaller firms are more likely to offer them as a total replacement health plan. Employer funding of the HSA can vary from zero to full funding, with most falling somewhere in between, say observers.

Proponents anticipate that having to pay at least initial medical expenses out of their own HSAs, regardless of who initially funds them, will encourage employees to become more careful health care consumers.

But relatively few employers have introduced HSAs. Observers say that the slow uptake is likely because the bulk of needed government guidance on the accounts was not published until mid-2004, when many large employers had already locked in their benefit plans for the following year.

Furthermore, "they don't want to be the first ones on the block," said Rob Corrigan, director, product management, at Downers Grove, Ill.-based First Health Group Corp., a managed care company. "They want to see how this really works out and get some sense of the issues" and what the experience is going to be, he said.

A recent survey of 29 members of the Washington-based trade association America's Health Insurance Plans, found that 438,000 people were enrolled in HSA high-deductible plans as of September 2004.

"I would say that probably 75% of our clients have spent a considerable amount of time getting smart on HSAs," said Ray Herschman, Cleveland-based national practice leader for consumer health strategy at Mercer Human Resource Consulting. "Most are either going to them as a pilot, or are trying to develop a longer-term strategy so they are in a position to offer HSAs," he said.

Next year, there will be a 'high percentage of employers who are interested in some variation of consumer-directed health plans.'

Andy Anderson
Hewitt Associates Inc.

Next year, there will be a "high percentage of employers who are interested in some variation of consumer-directed health plans and a number of those will ultimately have HSAs linked to them," said Andy Anderson, a consulting attorney with Lincolnshire, Ill.-based Hewitt Associates Inc.

The accounts have the strong backing of President Bush, who has enrolled in the federal government's own high-deductible HSA plan and has made HSAs a "real centerpiece" of his domestic program, said Linda Bergthold, a senior consultant with Watson Wyatt Worldwide in Los Angeles.

Most observers say the majority of employers that offer the accounts are making at least some contributions to the plan. Out of the 25 to 30 employers that Palatine, Ill.-based Benefits Age, an HSA provider, has worked with, just one has made no contribution to the employees' accounts, said President Tim Elenz.

Employer contributions are particularly prevalent in large group plans, said Mr. Herschman.

Employers that do not fund the accounts are "not going to get anybody to pick that option," said Dan Perrin, president of the Washington-based HSA Coalition.

Chris Calvert, senior health consultant with The Segal Co. in New York, said, "I think a lot of employers will put some funding in, but be

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HRA-linked plans cut costs for some employers

Change in employee behavior 'at the heart' of controlling health care costs

By JERRY GEISEL

For Logan Aluminum Inc., health care cost increases had reached the breaking point in 2003.

Since 1999, its costs had been rising an average of 12% a year, including an eye-popping increase of 22% in 2002.

Over the long term, cost hikes of that magnitude were not sustainable, said Howard Leach, head of human resources for the Russellville, Ky.-based manufacturer of aluminum sheet products.

Rather than shift some of the cost increases to employees through such means as big premium hikes, Logan Aluminum took an entirely new approach to providing health care to its 950 employees and their dependents.

That year, Logan Aluminum, through its insurer, Hartford, Conn.-based Aetna Inc., moved to a consumer-driven health care plan that, for the first time, exposed employees to significant health care costs but also gave them a powerful financial incentive to use health care services prudently.

Under the arrangement, Logan established a high-deductible health insurance plan that, in the case of family coverage, provided full coverage after an employee incurred $2,000 of expenses.

But Logan Aluminum also set up accounts—known as health reimbursement arrangements—to which the company credited fixed amounts. In the case of family coverage, for example, Logan Aluminum credited accounts with $800. Employees could draw upon their accounts to pay for uncovered health care expenses, such as those that fell under the deductible. HRA balances that remained at the end of the year could be rolled over to pay for the next year's expenses.

The financial impact of the new plan was immediate and dramatic. Costs declined by about 6% in 2003, and preliminary indications are that they fell just over 1% in 2004. Those cost decreases are in contrast to the 10% to 15% annual cost increases that have been typical for group health care plans during the past two years, numerous surveys have found.

That reversal of health care cost trends was due to the change in plan design, which began, in turn, to change employee behavior, Mr. Leach said.

"Changing employee behavior is at the heart of controlling health care costs," he said.

Employees, for example, made greater use of an onsite medical facility at which certain services, such as X-rays and mammograms, are provided at no cost rather than go to more expensive outside facilities, while the number of visits to hospital emergency room visits declined.

"There is no evidence that employees are deferring care. They are just using services more wisely," Mr. Leach said.

Other favorable reports

While the decline in Logan Aluminum's costs associated with its HRA-based consumer-driven health care plan—coming at a time when double-digit annual cost increases have been the norm—has been dramatic, that company is far from the only employer with an HRA to report favorable results.

For example, John Reschke, vp-employee benefits at Aon Corp.—which in 2001 became one of the first employers to adopt an HRA-based consumer-driven plan—noted that annual cost increases at his company have been averaging about 4%, compared to increases of 10% to 12% in the other major health care plans the Chicago-based broker and benefit consultant offers employees.

The plan is "helping to control costs," Mr. Reschke said, noting, for example, an increase in the proportion of lower-cost generic drugs dispensed to plan enrollees and a decline in emergency room visits.

Similarly, Janice Pushaw, director of global benefits strategy at major

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HSA: Transition to consumer-directed care

Continued from page 20

conservative," because once the funds are deposited, they become the employees', even if they leave the firm. In light of that feature, most employers fund their employees' HSAs on a month-to-month basis, observers note.

Neptune, N.J.-based Meridian Health, a nonprofit health care organization, matches 50 cents for every dollar the employee contributes, up to $500 for a single employee and $1,000 for an employee with a family, according to John Sindoni, senior vp, human resources. Once the deductible, which is $1,500 for a single employee and $3,000 for a family, is satisfied, coverage is provided through a three-tiered preferred provider organization, according to Mr. Sindoni.

One employer that fully funds its HSAs is San Diego-based First Pacific Bank of California, which contributes $2,400 annually for individuals and $4,800 for families, plus half of the individual premium, for its approximately 50 employees, said Chairman Dr. James Knight. "We were afraid if we didn't give them the money, some wouldn't fund it," and would not have any funds available in the event of an emergency, said Dr. Knight.

At least for now, most employers are offering HSAs as an option along with other plans. Otherwise, employees will perceive it as a "take away," said Dan Plante, Chicago-based senior manager for PricewaterhouseCoopers L.L.P. Over time, though, depending in part on how well they perform, "there'll be a migration" into using HSAs on an exclusive basis, he predicted.

It is still unclear how popular HSAs will be with employees who have other options. At Aetna, 15% of its employees have enrolled in one of two HSA models introduced in January, which is "pretty good," said Robin Downey, head of product development in Middletown, Conn. Another 64% remain in one of two models of an HRA plan, which Aetna first introduced in January 2002, she said. The company also has an HMO.

Plexus had an initial 12% enrollment in its HSA plan, said Ms. Novak. The company, which has 2,800 U.S. employees, plans to promote the plan to increase future enrollment, she said.

Jay Savan, St. Louis-based group leader, health and welfare, for Towers Perrin, said, "I think there'll be any number of strategies to help people migrate from current coverage levels in HMOs or PPOs to the higher deduction options." Thoughtful employers will "make a valid economic proposition to people" and may give additional incentives, such as subsidized premiums or matching contributions, he said.

There may be "some creativity in the market over the next two years" as employers encourage their workers to sign onto HSAs, said Thomas Lerche, senior vp with Aon Consulting in Chicago. For instance, employers may only contribute funds in the first year to kick off the program or maybe tie their contributions to profit sharing.

At the same time, employers are still sorting out HSAs' essential role for their employees, which will help determine how the plans are communicated and structured. They are asking, "Do I want my employees to think of this as a spending account, or a savings account?'" said Meredith Earatz, New York-based vp, marketing and product design, for Uniprise, a UnitedHealth Group company. "I think as these discussions play out," answers to these questions will emerge, she said.

Meanwhile, a competing alternative to HSAs are health reimbursement arrangements, which is a comparable option where employers can limit distributions to the reimbursement of health care expenses, but no employee contributions are permitted. They are also not portable if the employee changes jobs. Aetna's Ms. Downey said that, for January 2005, among companies with 51 or more employees, 65 clients took on an HRA plan and 57 an HSA.

"I think employers are probably still leaning in the direction of the HRAs because they control the utilization of the funds," said Mr. Anderson.

Turnover is a factor, said First Health's Mr. Corrigan. "The higher the turnover in the company, the more likely they are to lean towards an HRAs" because of HSAs' portability, he said.

However, Mercer's Mr. Herschman said HSAs "are beginning to surpass HRAs" in popularity. "The amount of commitment to move forward with HSAs is well beyond what we saw for HRAs, and part of it is because HRAs really did help people get familiar with the concept of an account-based plan." Mr. Herschman said he has several clients who did not introduce HRAs, but when HSAs were developed, said, "'Let's go.'"

Diana Anderson, vp, corporate benefits, at Salt Lake City-based Zions Bancorporation, said the company decided to introduce two HSA plans in January rather than an HRA to its 8,000 eligible employees because "the HRA doesn't quite engage the employees as much in consumerism as they would with an HSA, because it's actually their money" which means "they'd think twice before spending it."

HSAs are particularly appealing to employers with 200 or fewer employees, said Mr. Lerche. "They don't have the resources to hire an actuary and do a lot of the plan design work required with an HRA." HSAs are also appealing to firms with a population nearing retirement age, because turnover is not an issue, he said.

Some employers are offering both. Decatur, Ga.-based DeKalb Medical Center, for instance, is offering two plans with an HRA option and one featuring an HSA. "They both have benefits to the employer and to the employee," said human resources Vp Tom Crawford.

HRAs: Financial impact can be immediate, dramatic

Continued from previous page

appliance manufacturer Whirlpool Corp. in Benton Harbor, Mich., noted that cost increases in Whirlpool's HRA-based consumer-driven plan have been about 15% lower than those in other plans it offers.

Phil Sutton, director of human resources at Atlantic Marine Inc., a ship repair company in Jacksonville, Fla., said costs for its six-month-old HRA are on track to rise about 6% in the plan's first full year, in contrast to double-digit annual increases experienced by its more traditional plans in recent years.

"So far, we are very pleased," Mr. Sutton said, adding that 70% of Atlantic Marine's eligible employees have signed up for the new plan, well over three times the number its consultant expected.

No one knows for certain, however, how successful HRA-based consumer-driven plans will be over the long term in holding down health care cost increases.

"It is a long road ahead. Still, I am a guarded optimist," said Nicki Gustin, employee benefits manager at Kansas City, Mo.-based Aquila Inc., an electricity and natural gas distributor that set up an HRA plan in January.

Indeed, experts say the long-term success of the plans will depend on the ability of plan promoters to obtain and present data on hospital and physician costs, quality and outcomes to plan enrollees to enable them to make better-informed decisions about which providers to choose.

'Employees are avoiding using emergency rooms and they are looking at medical bills more closely and catching mistakes.'

Phil Sutton
Atlantic Marine Inc.

"We need to improve on the information available for cost, quality and outcomes," said Roger Chizek, director of U.S. benefits at defibrillator manufacturer Medtronic Inc. in Minneapolis, which has had an HRA-based plan since 2001.

But obtaining that kind of information, which is already starting to become available in varying forms, in a widespread manner may not be that far off. "Large employers are taking steps" to ensure that provider information becomes more transparent, said Tom Beauregard, a consultant at Hewitt Associates Inc. in Norwalk, Conn.

"There is still not enough information out there on provider pricing, but that will come," concurred Barry Barnett, a principal in the HR unit of PricewaterhouseCoopers L.L.P. in New York.

Nonetheless, the early results of HRA-based plans, while by no means definitive, are encouraging, employers with the plans say. They say they have seen an immediate change in employees' health care purchasing decisions. That's because employees are directly exposed—through the high-deductible plan—to health costs for the first time, and they now have a financial incentive—building up their credited funds in the HRA—to use services cost effectively.

"We are seeing greater use of generic drugs, while employees are avoiding using emergency rooms and they are looking at medical bills more closely and catching mistakes," said Mr. Sutton.

"Employees know it is their money. They compare prices," said Deborah Sanders, senior director-human resources at Fujitsu America Inc. in Richardson, Texas. Fujitsu America adopted an HRA-based plan last year.

The adoption of HRA-based plans has almost always come in tandem with other design changes as well. Typically, for example, employers give financial incentives to encourage employees to fill out health risk appraisals—used to help spot health conditions—as well as to participate in programs to reduce the likelihood of health care conditions mushrooming into very serious and expensive-to-treat medical problems, noted Doug Kronenberg, chief strategy officer at Lumenos, an Alexandria, Va.-based HRA provider.

For example, at Fujitsu, $100 is credited to an employee's HRA account if he or she fills out an online health risk appraisal, while another $100 is credited if the individual enrolls in a program to help treat or manage certain conditions identified by the appraisal. Finally, another $100 is credited to the HRA when the employee successfully completes such a program.

"Managing health conditions means lower costs in the long run," said Fujitsu's Ms. Sanders.

HRA vs. HSA

For years, HRAs were the only way an employer could effectively link a savings account with a high-deductible health insurance plan. But since 2004, employers have had another option: health savings accounts. Most agree that HRAs and HSAs have their pros and cons (see chart, page 14).

Currently, corporate interest in the two arrangements is about even, noted Robin Downey, Aetna's head of product development in Middletown, Conn.

Others, though, say that large employers still are gravitating toward HRAs, principally because of greater design freedom and employer control over the accounts that they offer.

"Undoubtedly, HRAs are more common among large employers," said Joe Martingale, national health care strategy leader with Watson Wyatt Worldwide in New York.

"HRAs and HSAs are kind of like bagels and doughnuts. The shapes are similar on the outside, but they are very different. When a large employer bites in, they find they like the taste of the HRA much more," said Jay Savan, health and welfare group leader with Towers Perrin in St. Louis.

Still, interest in HSAs is likely to increase among larger employers, because allowing employees to contribute to their HSAs "may instill a greater sense of ownership with the individual," said George Metzger, vp-human resources and benefits in Providence, R.I., with Textron Inc., an earlier adopter of an HRA plan that recently added an HSA option.

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WorldCom securities settlement unravels / 3

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COMPENSATION CRISIS

MARSH SETTLES UP

Pact may be blueprint for other deals

By DOUGLAS McLEOD

NEW YORK—Marsh & McLennan Cos. Inc. and rival brokers are far from being out of the woods in the brokerage compensation scandal despite Marsh's $850 million settlement of fraud and price-fixing charges last week.

Marsh took a big step forward by agreeing with New York Attorney General Eliot Spitzer to establish a compensation fund for clients and to reform a number of its longstanding business practices.

The settlement with Mr. Spitzer, however, does not resolve investigations by attorneys general and insurance regulators in other states or several policyholder and shareholder class action lawsuits filed against Marsh and various other brokers in the wake of Mr. Spitzer's October 2004 complaint (see related story).

In addition, Mr. Spitzer himself is not finished: His investigation of the industry continues, and he said last week that there will additional charges will be filed "very shortly." So far, five insurer executives and one Marsh executive have pleaded guilty to criminal charges related to alleged schemes.

The specific targets of future civil or criminal charges remain to be seen, though Mr. Spitzer's probe has ranged from bid-rigging at Marsh to possible reinsurance tying arrangements by Aon Corp. and Willis Group Holdings Ltd. and to transactions in the lawyers malpractice and finite risk insurance markets.

If Mr. Spitzer ultimately brings civil charges against Aon, Willis or another broker, any settlement is likely to mirror Marsh's in its terms if not in its monetary scale, the attorney general's office and industry observers agree. Marsh consented, among other things, to prohibitions against contingent commissions, bid-rigging and reinsurance tying and agreed to disclosure standards.

"It really is essentially going to be a blueprint for anything else that comes down the road in

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COST OF A CRISIS

PAYOUT:
- $850 million client compensation fund set up to settle Eliot Spitzer's lawsuit

PHOTO: AP

PEOPLE:
- CEO Jeffrey W. Greenberg steps down
- 3,000 staff laid off to cut costs
- Senior brokers depart

PRACTICES:
- Contingent commissions abandoned
- Global Broking unit dissolved
- Greater disclosure pledged

POTENTIAL:
- More state/regulatory action
- Investor/client litigation
- Loss of business

INSIDE:

Battle ends, but other attacks loom

By JUDY GREENWALD

NEW YORK—The $850 million settlement reached by Marsh & McLennan Cos. Inc. with New York Attorney General Eliot Spitzer over alleged fraud and bid-rigging charges leaves many unresolved questions for the company.

Not only could future settlement payments still affect the brokerage's prospects but issues of client and key personnel retention against the background of a softening market are concerns as well, say observers.

The settlement announced last Monday will remove a cloud that has been hanging over MMC and its Marsh Inc. brokerage unit since Mr. Spitzer filed suit against them last October.

But other state attorneys general and civil litigants may still seek substantial settlements from MMC, observers say. And although the Spitzer settlement, will be affordable for New York-based MMC, it is unclear how much the broker will ultimately pay in settlements.

"Obviously, the settlement resolves the issues between the New York Attorney General Eliot Spitzer and the Department of Insurance in New York," said Patrick McDonough, a policyholder attorney with Howrey, Simon, Arnold & White in Los Angeles.

But "it does not resolve the issues with other state regulators, it does not resolve issues that have been raised in the U.K., and it doesn't necessarily resolve issues of civil litigation" from current and former Marsh clients, said Mr. McDonough.

Furthermore, "it doesn't resolve the impact on Marsh's reputation and what impact it had on their business, and that is something that is yet to be determined," said Mark Lane, a principal and research analyst with William Blair & Co. in New York. "It is something that is going to stick with them for quite a long time," he said.

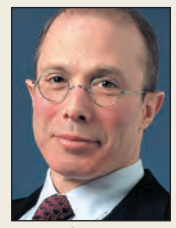
Analysts say the settlement itself is good for the brokerage. The fact that it will be paid over four years mitigates its impact, said Timothy J.

See SETTLEMENT/page 29

Late News

ACE plans to fight Connecticut suit

ACE Ltd. plans to file a motion to dismiss a lawsuit filed last month by Connecticut Attorney General Richard Blumenthal against an ACE unit and broker Marsh & McLennan Cos. Inc. The suit charges that ACE paid Marsh a secret commission to steer $80 million in Connecticut workers compensation business to the insurer. "We have investigated the complaint, and both we and our outside counsel believe it is without merit," ACE President and Chief Executive Officer Evan G. Greenberg said last week. Meanwhile, the insurer's net income for 2004 fell 20% to $1.14 billion, due in part to a reserve boost and catastrophe losses.



Evan G. Greenberg

PBGC takes over US Airways plans

The Pension Benefit Guaranty Corp. Tuesday took over financially ailing US Airways Group Inc.'s remaining three underfunded pension plans, saddling the federal agency with a $2.3 billion loss, one of its biggest ever. The plans are about 40% funded, with $1.7 billion in assets to cover $4.2 billion in liabilities. The PBGC does not guarantee all benefits, though. The action of the PBGC, which has a $23.3 billion deficit, came about three weeks after a U.S. Bankruptcy Court judge ruled that US Airways could not emerge from bankruptcy unless the plans were terminated.

John P. Woods, son join Towers Perrin Re

On the heels of Arthur J. Gallagher & Co.'s decision to combine its reinsurance brokerage operations, Towers Perrin Reinsurance has

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NEWSPAPER

Benefits Management

CONSUMER-DRIVEN HEALTH PLANS

Begins on page 10

Leading Consumer-Driven Health Plans

Ranking on page 16

Class action reform bill heads to Senate

By MARK A. HOFMANN

WASHINGTON—The Senate Judiciary Committee has cleared the way for the full Senate to begin consideration of class action reform legislation on Monday.

The Senate Judiciary Committee voted 13-5, with three Democrats joining the unanimous Republican majority, to approve the Class Action Fairness Act—S.5—last week. Among other things, the act would permit the removal of interstate class actions to federal courts from state courts under certain circumstances, subject noncash awards—such as coupons good for discounts on a defendant company's goods or services—to heightened judicial scrutiny; and forbid settlements in which class members suffer a net loss.

Meanwhile, a bipartisan group of lawmakers in the House have unveiled their own class action reform bill. The measure, HR 516, is also called the Class Action Fairness Act. The measure is similar, though not identical, to the Senate bill, most notably in that its provisions would apply retroactively to actions that had already been filed in state court. The House bill is identical to the bill that passed the House last year.

President Bush has repeatedly called for class action reform and other tort reforms, most recently in last week's State of the Union Address. "Justice is distorted and our economy is held back by irresponsible class actions and frivolous asbestos claims. And I urge Congress to pass legal reforms this year," he said.

But opponents of changes in class action law are not giving up without a fight, as was evident in the nearly two hours of often-contentious debate that preceded the Senate Judiciary Committee's vote. Judiciary Committee Chairman Arlen Specter, R-Pa., said that he would not support any amendments during the committee markup. Instead, amendments should be introduced on the Senate floor, he said.

Sen. Specter noted that the Senate leadership intended to begin consideration of the measure today. At that time, "there will be plenty of time for floor debate," he said.

That did not stop Sen. Russell Feingold, D-Wis., from introducing an amendment dealing with remand procedures that he ultimately withdrew. The committee's ranking Democrat, Sen. Patrick Leahy of Vermont, also introduced an amendment that would have raised federal judges' salaries, but that amendment was overwhelmingly defeated.

At one point, Sen. Joseph Biden, D-Del., began pounding the table in opposition to the bill as he praised what he called "bottom-feeders"—attorneys whose tenacity helps force corporations to clean up their operations. "This isn't the Class Action Fairness Act—this is the Class Action Moratorium Act," said Sen. Richard Durbin, D-Ill.

Although Sen. John Cornyn, R-Texas, said that he found some of the opponents' arguments "to be somewhat surreal." He added that

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WorldCom settlement unravels

Outside directors to face D&O coverage battle

By DAVE LENCKUS

NEW YORK—The disintegration of an unusual settlement between 10 former outside directors of WorldCom Inc. and company investors could leave the directors with substantially less insurance protection.

With the settlement dead, the former directors—who had agreed to contribute personal funds in the deal—will now face a jury trial in class-action securities litigation while fighting efforts by their directors and officers liability insurers to rescind their coverage.

The lead WorldCom plaintiff scuttled the settlement last week after a New York federal judge scrapped a provision designed to maximize the recovery that company shareholders and bondholders could obtain from WorldCom's bond underwriters and auditor in the jury trial set to begin Feb. 28.

The investors sued WorldCom's directors and officers, the company's 17 bond underwriters and its auditor, Arthur Andersen, after the telecommunications giant filed for the largest bankruptcy in U.S. history in 2002. Earlier that year, WorldCom revealed it had tampered with its financial reports for years to make the company look profitable.

Ashburn, Va.-based WorldCom emerged from bankruptcy last year as MCI Inc.

Under the settlement announced last month, the former directors would have contributed $18 million—or 20%—of their personal net worth in addition to the $36 million that their directors and officers liability insurers agreed to pay WorldCom investors (*BI*, Jan. 10).

The former directors were not accused of directly participating in any fraud, but the lead plaintiff in the case, the New York State Common Retirement Fund, insisted on the personal contribution because of the directors' alleged lack of oversight in the boardroom.

Merrill Lynch not liable for 401(k) losses page 31

In addition, a provision of the settlement was designed to ensure that the New York fund would be able to maximize its potential recovery against the nonsettling defendants at trial. Under that provision, any judgment against the remaining defendants would have been reduced by only the financial ability of the settling defendants to contribute to the plaintiffs' award if those defendants had not settled.

But the remaining defendants argued that the provision violated both the Private Securities Litigation Reform Act of 1995 and a 1994 U.S. Supreme Court ruling. They argued that both require that a defendant's judgment be reduced by an amount that reflects a settling defendant's percentage of liability.

If a jury were to find for the plaintiffs and then determine that the settling directors' percentage of liability amounts to a sum that exceeds their net worth, the settlement would have unfairly required the remaining defendants to pay the plaintiffs that difference, the defendants argued.

New York District Court Judge Denise Cote agreed and struck that provision from the settlement on Feb. 2.

In response to the ruling, the New York fund withdrew from the settlement. Without that provision, a jury

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St. Paul increases asbestos reserves

By JUDY GREENWALD

ST. PAUL, Minn.—There is no guarantee the $1.01 billion increase in asbestos and environmental liability reserves reported by St. Paul Travelers Cos. is the last major asbestos reserves increase for the insurer, although its current estimate is based on the best available data, say analysts.

The reserve increase, which resulted in a $673 million charge to fourth-quarter 2004 earnings, was made following a previously announced review of long-tail liability reserves by the St. Paul, Minn.-based insurer.

"The increase resulted primarily from changes in the asbestos landscape over the last two years and was largely driven by an increase in litigation costs and activity surrounding peripheral defendants," the insurer said in a statement.

The charge contributed to a 44% drop in St. Paul Travelers' net income in 2004, to $955 million, compared with the prior year. The insurer's net written premiums were $18.94 billion in 2004, up 43%.

In 2002, St. Paul reported a second quarter net loss after posting a $380 million aftertax charge for its settlement with one asbestos defendant.

"I think investors were expecting something in the billion dollar range, so I would call it in line with expectations," Cliff Gallant, an analyst with Keefe, Bruyette & Woods in New York, said of the reserve increase.

"There's been so many reserve additions in recent years for this company, that certainly there's some frustration on behalf of investors that the company seems to be having trouble resolving the balance sheet concerns, and I guess it's difficult to have confidence that we've seen the last one, when there's been so many," Mr. Gallant said.

Last year, St. Paul made a second-quarter $1.63 billion reserve

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Inside Business Insurance

Online

- The **Datebook** calendar lists upcoming industry seminars and meetings and allows you to add info about your own event.
- Searchable **directories** provide access to all the listings of industry vendors found in *BI*'s Market Sourcebook.
- New **Opinion Poll** for readers: Do you agree with New York Attorney General Eliot Spitzer's charge that the insurance industry is "rife" with corruption in every line of coverage?

Departments

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Ride Along Enclosed in Edition 01

Senator seeking quick action on asbestos reform plan

By MARK A. HOFMANN

WASHINGTON—Senate Judiciary Committee Chairman Arlen Specter, R-Pa., still intends to push ahead quickly with a measure that would replace the current litigation-based system for compensating victims of asbestos-related disease with a no-fault national trust fund, despite continuing disagreement over some key issues.

The senator's commitment to getting a bill to the Senate floor soon was evident on two occasions last week. Shortly before the committee began marking up the Class Action Fairness Act on Feb. 3, Sen. Specter said that his "interest in moving ahead" with asbestos reform legislation as soon as possible is that the arguments surrounding the issue would be complex.

He said that legislation, which still exists only in draft form, needs to reach the Senate floor by next month.

If any eventual legislation is passed, it likely would get a favorable reception from President Bush, who supports tort reform and has spoken out in favor of asbestos liability reform.

Only 24 hours before Sen. Specter's remarks, the committee held another hearing on unresolved asbestos issues. Most of the committee's time was taken up with consideration of ways to assure that asbestos claimants do not attempt to circumvent a trust fund remedy by seeking compensation for injuries allegedly caused by silica, mixed dust or other substances. The matter of asbestos and silica "is a challenging one," said Sen. Specter at the Feb. 2 hearing.

The depth of the challenge was evident during the hearing concerning the compensation of people who have suffered injury attributable to airborne dust, fiber or minerals. Critics charged during the hearing that a provision in the draft bill would require that plaintiffs pursuing a mixed dust or silica injury claim would have to prove that their injuries were not caused by asbestos exposure. Under the Specter

See ASBESTOS/page 6

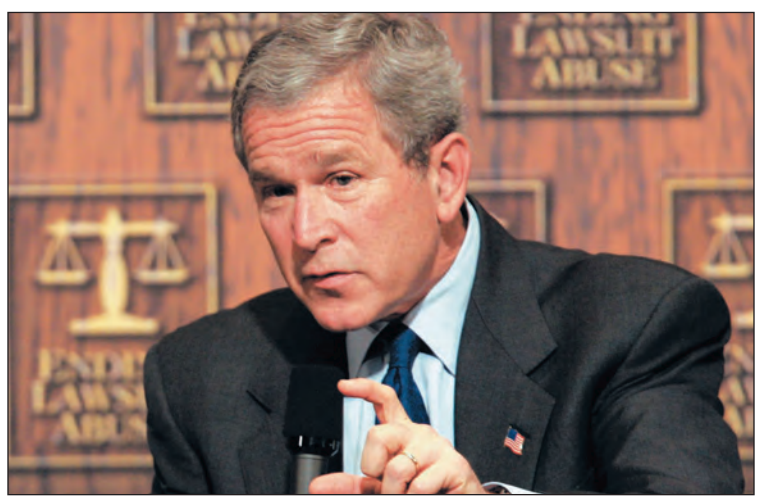

PHOTO: EPA

Speaking last month in Michigan, President Bush said he wants to make asbestos reform one of the accomplishments of his second term in office.

Equitas, others to pay $93 million

Cleanup settlement ends longtime feud

By ROBERTO CENICEROS

SACRAMENTO, Calif.—Insurers will pay $93 million to settle a decades-old legal battle over general liability coverage for the infamous Stringfellow Hazardous Waste Site in Glen Avon, Calif.

The insurance settlements cover only a portion of the hundreds of millions of dollars the state ultimately will pay to clean up and monitor the Superfund site, said California Attorney General Bill Lockyer.

But the settlement will ensure that California recoups some money to pay for the cleanup and allow it to focus its litigation efforts on nine other insurers who did not participate in the settlement, he added. A trial involving the state and those remaining insurers is scheduled in Riverside Superior Court in March, the attorney general said.

London market entities will pay more than half the settlement amount.

Equitas Ltd., the runoff reinsurer for the pre-1993 liabilities of Lloyd's of London, will pay about $40 million, said an Equitas spokesman, making it "by far" Equitas' largest remaining pollution liability exposure.

Other London market insurers will pay $9 million, according to sources familiar with the settlements.

Citing confidentiality agreements, the attorney general's office released only a partial list of insurers participating in settlements and would not disclose the amounts each insurer paid.

The settlement agreements are significant because they cap more than two decades of court battles involving a litany of lawsuits, said David L. Muliken, a partner in the San Diego office of Latham & Watkins who represented a company that disposed of waste at the site.

The Stringfellow site was used extensively as a hazardous waste site between 1956 and 1972. Over that period, entities from the d efense, aerospace, pesticide and other industries dumped nearly 35 million gallons of liquid hazardous wastes at the site.

The state took control of the 17-acre site in 1975 after the original owner abandoned it. In 1983, California and the U.S. government sued companies that disposed of waste at Stringfellow seeking to have them pay for the cleanup. But the companies won a counterclaim that the state was the de facto owner/operator of the site and was responsible for the former rock quarry's cleanup.

In 1993, California sued

See POLLUTION/page 6

Whole Foods executive advocates move to consumer-driven plans

By JERRY GEISEL

WASHINGTON—Employers should stop offering traditional health insurance plans to their employees, says the top executive of one of the nation's best-known food markets.

Unless employers have core competence in providing coverage, "they should get out," said John Mackey, chairman and chief executive officer of Austin, Texas-based Whole Foods Market Inc.

Speaking last week at the 2nd annual World Health Care Congress in Washington, Mr. Mackey said employers have revealed their "incompetence" in the health care arena, referring to their inability to keep health care costs under control.

Whole Foods itself, which Mr. Mackey and two other entrepreneurs launched in 1980 and through internal growth and acquisition has become a natural foods powerhouse with $3.7 billion in revenues, still provides health care coverage to employees.

But Whole Foods offers a consumer-driven health care plan in which a company-funded health reimbursement arrangement is linked to a high-deductible health insurance plan.

And Mr. Mackey is an enthusiastic proponent of the CDHP approach, whether it is based on an HRA or its cousin, a health savings account.

"We have to try different things. We have got to experiment. HSAs are an experiment that have not been tried," he said.

The Whole Foods executive contrasted the CDHP approach in which employees have a strong financial stake in using health care services, to other health care benefits delivery systems.

With a single-payer health care system, for example, government bureaucrats decide the cost of services which results in the rationing of care, he said. That approach "does not work anywhere," he

See CDHP/page 6

HUD expands rating agency options for mandatory LTC liability coverage

By MICHAEL BRADFORD

COLUMBUS, Ohio—Long-term care facilities will have a larger market of professional liability insurers to choose from after the Department of Housing and Urban Development's approval of a change in the way those underwriters can be rated.

HUD about a year ago began requiring nursing homes and other long-term care facilities that apply for mortgages or other real estate loans guaranteed under a HUD program to purchase a minimum of $1 million per occurrence and $3 million annual aggregate of professional liability insurance from insurers with at least a B++ rating from A.M. Best Co.

Long-term care facilities expressed concerns that the rule would close off coverage written by risk retention groups and captives, insurers that the facilities often rely on because of the difficulty in finding professional liability insurance in the commercial market (*BI*, March 29, 2004). Many such insurers are not rated by Best, which generally requires a financial track record before it assigns a rating.

NEW RATER ON THE BLOCK

Demotech Inc.'s Financial Stability Ratings reflect a percentage of insurers expected to have positive policyholder surplus for 18 months from the rating date.

- **A''** (A double-prime), "unsurpassed": 100% of insurers.
- **A'** (A prime), "unsurpassed": At least 99% of insurers.
- **A** "exceptional": At least 97% of insurers.
- **S** "substantial": At least 95% of insurers.
- **M** "moderate": At least 90% of insurers.

Source: Demotech Inc.

Although HUD's rule remains unchanged, on Jan. 31 it approved Demotech Inc. of Columbus, Ohio, as a rating service provider for professional liability insurance. That means long-term care facilities can purchase the coverage from insurers with a Demotech rating of A or better, which HUD considers equivalent to A.M. Best's B++ rating.

"We're looking at captives, risk retention groups, regional insurers" and risk-sharing facilities that can provide the coverage to long-term care facilities, said Joseph L. Petrelli, president of Demotech. Ratings can be issued in around 30 days, he said.

Demotech already provides HUD and other government agencies with ratings on insurers that write homeowners insurance, Mr. Petrelli said. "We tend to specialize in regional insurers," he added.

"Our process will involve onsite meetings," Mr. Petrelli said, and it will cover "all aspects of the opera-

See HUD/page 6

Koken presses for more transparency as NAIC head

By MEG FLETCHER

KANSAS CITY, Mo.—Amid a challenging time for the insurance industry, the new president of the National Assn. of Insurance Commissioners is working to increase the transparency of broker compensation, while not losing sight of the NAIC's push to modernize state regulation.

The NAIC has made some progress in its modernization efforts in recent years, including achieving greater uniformity in licensing and national standards for some life/health products. And continuing that work is a key goal for NAIC President Diane Koken, according to Ms. Koken, who took office at the Kansas City, Mo.-based organization last year.

Ms. Koken, who is commissioner of the Pennsylvania Insurance Department, was elected NAIC president without following the traditional path of first holding a lower-level office. She was elected first in September, after the NAIC's two top officers—Ernst Csiszar and Jim Poolman—resigned. She was then re-elected in December, during the NAIC's regular annual election.

Ms. Koken, who holds a law degree from Villanova University in Villanova, Pa., began her career as an insurance regulator in 1997, when former Gov. Tom Ridge, a Republican, named her insurance commissioner. Before that, she had served as general counsel, vp and corporate secretary for Provident Mutual Insurance Co. She was subsequently reappointed by Democrat Gov. Ed Rendell—the first Pennsylvania commissioner to survive such a party change, Ms. Koken noted in an interview.

Ms. Koken, who represents the state with the nation's fifth-largest premium volume, has held leadership posts for several NAIC groups, including those dealing with internal administration and Holocaust issues.

Responding to a scandal

Shortly after becoming NAIC president, Ms. Koken tackled the unfolding broker compensation scandal. She chaired the NAIC task force that promptly developed a three-part plan to address the allegations of bid rigging and self-dealing that New York Attorney General Eliot Spitzer raised in an October lawsuit against Marsh & McLennan Cos. Inc. That suit was settled last week (see stories, page 1).

As part of its efforts, the NAIC made good on its promise to adopt amendments to its Producer Licensing Model Act by the end of 2004. The amendments, which must be adopted by individual state legislatures, are designed to ensure that the insurance buyer receives essential information about how the producer is compensated to help identify potential conflicts of interest.

PHOTO: COMMONWEALTH MEDIA SERVICES

NAIC President Diane Koken cites transparency as a key goal.

"It was an amazing effort to develop language and be able to offer a model law in less than three months," so that it would be available for state legislatures to consider as they convened in 2005, Ms. Koken said.

Efforts to refine the model rules continue, though, particularly with regard to some controversial amendments (*BI*, Jan.10).

The NAIC also responded to the broker scandal by establishing an online fraud reporting system that allows for anonymous tips and by coordinating state insurance departments' queries of insurer and broker practices within their jurisdictions.

The scope of the broker compensation scandal and the fact that much of the investigation was done by attorneys general in New York and other states have raised questions about how well regulators were protecting the interests of corporate consumers (*BI*, Nov. 15, 2004).

Focus on individuals

While Ms. Koken contends that "the NAIC and state insurance regulators have been very concerned about all consumers," observers generally agree that the association's primary focus has been on individual consumers. Historically, corporate buyers asked only to be left alone and unregulated.

Meanwhile, NAIC critics say the failure of regulatory systems to prevent the practices uncovered in the broker compensation scandal may mean a rethinking of the proposed State Modernization and Regulatory Transparency Act. That federal proposal would make several regulatory changes, including some supported by the NAIC, such as enhancing the organization's role and using some model laws as the basis for national regulation (*BI*, Sept. 27, 2004).

State regulators have "fundamental concerns" about the draft proposal, Ms. Koken said. "While the SMART documents appear to rely heavily on the state regulatory system, regulators are extremely concerned by the sweeping pre-emptions of state law, the provisions that deregulate rates—for commercial and personal lines buyers—and the role of the federal government," she explained. The NAIC plans to discuss those issues with all interested parties.

The NAIC has not taken a formal position on another federal issue—whether risk retention groups should be allowed to write property as well as liability coverages. If property coverage remains available and affordable, such a change may not be necessary, Ms. Koken said.

Ms. Koken is married to John K. Herr III, who is treasurer of the United Way of Lancaster County, Pa. They have two daughters in college.

CDHP: Savings possible

Continued from page 4

maintained.

By contrast, in a consumer-driven approach, individuals decide the kind of health care services they want to purchase, just like they do for other goods and services, he said.

John Goodman, president of the National Center for Policy Analysis, a Dallas-based public policy research organization, who also spoke at the session, concurred that giving individuals incentives—through a high deductible health insurance plan linked to an account that covers only a portion of expenses—is the best way to control costs.

Referring to traditional plans, in which employees are shielded from most costs, he said "it means a lot of waste when it is someone else's money."

Mr. Goodman compared the high cost of two painkilling drugs—Vioxx and Celebrex—with ibuprofen. The monthly prescription costs for either of the two brand name drugs would be about $800 more than a supply of ibuprofen, which works comparably to Vioxx and Celebrex.

If individuals paid the full cost of the prescriptions, they would be much less likely to select the brand-name drugs, which recently have come under fire for potential side effects, Mr. Goodman said.

And he concurred with Mr. Mackey on the problems of single-payer health care systems. Such systems he said, tend to overprovide to the healthy and underprovide to the sick.

"It is easy to see a doctor, but if you are having a problem, it is harder to get treatment," he said.

Widespread adoption of consumer driven plans, Mr. Goodman says will likely spur cost consciousness among both providers and individuals.

To back that point up, Mr. Goodman cited the falling cost of cosmetic surgery, which unless needed to correct birth defects or deformities that are a result of an accident, typically is not covered in group health care plans.

The demand for such services is significant, but costs have fallen because doctors and hospitals know they can't charge such high prices when they know individuals—not employers—are paying for the services, he said.

"If you control the money, the system will work better for you," he said.

Another speaker, Henry Aaron, a senior fellow in economic studies at the Brookings Institution in Washington, acknowledged ambivalence about consumer-driven health care plans, especially HSA-based plans.

Potentially, the plans could cut premiums for employers, while some employees could be better off compared to other types of health care plans, he said.

But he questioned if exposing individuals to more health care costs will over the long run slow down cost increases. Providers, he said, will do the utmost to maintain their income levels, while advances in medical technology also will bring continuing higher costs, he said.

Asbestos: Senator pushing reform

Continued from page 4

bill, asbestos claims would be handled by the trust fund under most circumstances.

"Let me be clear, the biggest danger to enacting bipartisan asbestos legislation is overreaching by some interests for immunity from lawsuits brought by victims with legitimate injuries caused by silica or other substances," said Sen. Patrick Leahy, D-Vt.

But several witnesses told the Judiciary Committee that some plaintiffs are trying to seek double compensation by alleging both silica and mixed dust or asbestos injuries, even though few documented cases exist where a patient suffered from asbestosis and silicosis.

And Dr. David Weill, an associate professor at the University of Colorado Health Sciences Center in Denver, noted that while silicosis mortality has declined, silica injury claims have been rising. "Nearly all of the litigation diagnoses do not come from treating physicians but from screening companies that sell their diagnostic services to plaintiffs' law firms," he said.

He said that many of the "silicosis plaintiffs have also been diagnosed by plaintiffs experts, at one time or another, with" asbestos-related illnesses.

Dr. Weill said that the majority of silicosis claims he has seen are not valid; "they are simply recycled or duplicated asbestos claims."

Pollution: Longtime feud settled

Continued from page 4

Lloyd's syndicates along with four other insurers seeking coverage under general liability policies the state purchased, the attorney general said. In 2001, California added thirty additional insurers to the suit.

Because of acquisitions, however, the number of insurers involved in the suit decreased.

The settlement of coverage under Lloyd's policies is particularly significant because "Lloyds was one of the state's major insurers, and (its) attorneys had been leading the defense against the state's claims," the attorney general said.

A partial list of insurers participating in settlements includes Boston-based One Beacon Insurance, Princeton N.J.-based American Re. Corp., and a unit of Warren, N.J.-based Chubb Corp.

HUD: New system, more choices

Continued from page 4

tion of the company." HUD asked that Demotech also do a six-month follow-up with the companies it is rating to ensure that the insurers are holding to original rating standards.

Mr. Petrelli said last week that ratings have already been issued to a risk retention group and pooling facility with administrative offices in Michigan. Demotech had performed the analyses of the facilities in anticipation of the HUD approval.

Although the HUD move will allow more insurers to provide coverage to long-term care facilities, its original rule still contains a requirement that restricts insurers the facilities can use.

Under the rule, coverage can be purchased only from an insurer licensed in the state where the facility seeking HUD financing is located.

That is troublesome to risk retention groups because, under federal law, the groups, once they are licensed in one state, can then operate anywhere they have policyholders without having to meet licensing requirements outside their domiciles.

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Editorial

An opportunity for reform

MARSH & MCLENNAN COS. INC.'S $850 million settlement of New York Attorney General Eliot Spitzer's suit alleging fraud and bid rigging is the latest and perhaps the most important chapter in a scandal that has shaken the insurance industry.

The world's largest insurance brokerage's agreement to pay U.S. clients is hardly the end of this sordid affair. The real work is just beginning, and not just for Marsh. As we report in this issue, Mr. Spitzer last week said the industry is "rife" with corruption and that more guilty pleas are expected. The industry as a whole now must strive to regain its clients' trust.

Many questions remain unanswered. For starters, what other industry companies may face suits from Mr. Spitzer or other state attorneys general? Connecticut Attorney General Richard Blumenthal recently sued Marsh and an ACE Ltd. unit on similar charges. How will Marsh make the private litigation go away, after making a public apology and agreeing to a huge settlement that doesn't cover all plaintiffs, such as investors?

Let's not forget the initial victims in this case: Marsh clients undoubtedly paid more than they had to for insurance coverage so that Marsh could line its pockets with hundreds of millions of dollars in contingent compensation.

Also, we should not forget how the wrongdoing of perhaps a few has sullied the good name of the vast majority of honest, ethical insurance professionals and resulted in financial losses for thousands of Marsh workers and retirees.

Marsh has agreed to make changes, including dismantling the Global Broking Center model that facilitated the alleged bid rigging, but it's time for other insurance industry companies to embrace this opportunity for reform, find a new compensation system and again put the interest of clients first.

CDHPs cause for optimism

BY NOW, IT SHOULD be obvious that employers' adoption of consumer-driven health care plans is no flash in the pan.

Hundreds of employers—ranging from Fortune 500 companies to very small firms—now offer the plans to employees with many more soon to come, as we report elsewhere in this issue.

Will the plans finally begin to put an end to the annual double-digit increases that employers sponsoring more traditional plans have experienced over the last few years?

The answer to that question won't be known for several years, at least. Indeed, when it comes to predicting the future of health care costs, caution is in order. It wasn't that long ago when managed care supporters boasted that those plans were the answer to soaring costs. That prediction turned out to be far off the mark.

Still, there is reason to be cautiously optimistic about CDHP plans and their potential positive impact on health care cost.

That optimism is grounded in the plans' basic designs, which links a high-deductible health insurance plan with an account—funded by employers, employees or both—that pays for only a portion of expenses not covered by the insurance plan.

Simply put, employees have skin in the game. If employees don't use health care services wisely, they will quickly blow through their accounts and have to pay out of pocket what could be some hefty health care bills.

That kind of incentive is totally lacking in traditional plans where a third party—the employer—pays just about everything, except, perhaps, small copayments for services.

Our optimism also is based on the fact that the introduction of CDHPs almost always comes in tandem with other plan changes that also should help to ease the cost-increase spiral. For example, employers are giving employees financial incentives to fill out health risk appraisals—to spot medical problems early on—and incentives to get treatment to ease those problems.

Additionally, employers, as the information becomes more available, are giving employees the tools to compare the cost and quality of providers, which is key if costs ever are to be brought under control.

To be sure, CDHPs do not address some of the fundamental reasons—such as hospital consolidation in some markets that has eroded provider competition—for rising costs.

But their potential is promising and all employers would be wise to consider their adoption.

Schillerstrom

Letters to the Editor

Congress should impose med mal sanctions

To the editor: Regarding Mark A. Hofmann's Jan. 24 article, "Tort Reform Bill Introduced in Congress," tort reform advocates are hailing the introduction of legislation that imposes sanctions on attorneys who file frivolous lawsuits. If a lawsuit is truly frivolous, I have no problem with an attorney who files such a lawsuit being sanctioned. Congress, however, shouldn't stop there.

I have a modest proposal. Congress should impose sanctions on doctors who commit malpractice. The white wall of silence that protects doctors because other doctors almost never censure their own should be demolished. If the medical profession will not tear down that wall, Congress should do so.

Surely saving money is what is motivating the legislators who are seeking to censure lawyers who file frivolous lawsuits. Shouldn't saving lives be a worthy motivation for legislators, which would be the result of censuring doctors who make a practice of committing malpractice?

Perhaps my proposal isn't politically correct, but it is morally correct.

Jane Marshall
Clarksville, Tenn.

Corruption charges vilify 'decent' professionals

To the editor: Now, Eliot Spitzer is calling me out. By suggesting that the entire industry is corrupt, in the Jan. 31 *www.businessinsurance.com* story "Spitzer says industry 'rife' with corruption," he casts a doubt over every insurance transaction that every consumer and business is involved in.

The bid-rigging practices of which Marsh has been accused, and for which they may apologize, are abhorrent to most decent insurance agents. Why? Because they smell. In fact, they stink.

Marsh may have to apologize, but I do not and will not apologize for how I earn a living.

I am sick and tired of Mr. Spitzer suggesting that what my family-owned business (and thousands like it across the country) has done for three generations is corrupt. I run a business that earns revenues that are paid to us by the companies we represent. Are we corrupt in the process? Absolutely not.

I earn a living, honestly and ethically. So do almost all of my peers.

W. Anderson Baker III, CPCU, ARM
President
Gillis, Ellis & Baker Inc.
New Orleans

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Savings not necessarily quick with consumer-driven offerings

By JOANNE WOJCIK

The adage "let the buyer beware" is an apt warning to benefit managers shopping for high-deductible consumer-driven health plans.

Not all employers are finding huge bargains, and those that are reaping some savings are sharing much of them with employees to encourage enrollment.

But there are ways that employers can structure these plans to make them winning propositions, if not the first year they are offered, then in subsequent years by driving down future claim costs, experts say.

According to a 2004 survey of health plan costs by Mercer Human Resource Consulting, consumer-driven health plans cost an average of $5,233 per employee per year, while preferred provider organizations—the most prevalent plan in today's market—cost an average of $6,095 per employee per year.

But when Ray Brusca, vp-benefits at Black & Decker Corp. in Towson, Md., went shopping for a high-deductible CDHP expecting similar savings, he couldn't find one.

"In terms of the pricing, the consumer-directed was priced 20% more than the 80/20 plan" that Black & Decker currently offers its employees, he said.

Because Black & Decker is self-insured, Mr. Brusca worked with Hartford, Conn.-based Aetna Inc. to develop premium equivalents for a plan that would have provided 90% coverage in network and 70% coverage out of network above a $1,000 individual deductible and $2,000 family deductible. The employer contribution amounted to $500 in the individual HRA and $1,000 in the family HRA.

Black & Decker decided to abandon the plan, though, after just 30 of its 10,000 eligible employees signed up for it.

"Because we weren't excessively funding the HRA account and because we weren't oversubsidizing it to make employees go into it, very few employees found it financially attractive," Mr. Brusca said.

What's currently offered

Employers shouldn't think that they will save money just by adding a consumer-driven plan to their other offerings, said Steve Logan, regional vp for Aetna's Northeast Middle Market in New York.

"If people are going into it with that mindset, they'd be wrong," he said.

Indeed, an employer that already has significant cost sharing with employees in its existing PPO plan may not be able to squeeze out any additional savings with a high-deductible CDHP, experts acknowledge.

"There are many employers that could have a plan design, say a 90/70 PPO with a large deductible or an 80/60, both of which are already among the lowest-cost options available on the market," said Mr. Logan.

"If consumerism is introducing elements of cost sharing," he said,

See **PRICING**/page 18

Employers seek optimal approach to stacking health care accounts

By SALLY ROBERTS

Since the Treasury Department and the Internal Revenue Service issued guidance last year ending uncertainty over how health savings accounts could interplay with flexible spending accounts and health reimbursement arrangements, employers have been contemplating their stacking options.

Because those options remain limited and somewhat complicated, though, the number of employers actually combining HSAs with HRAs and FSAs remains small, observers say.

And while there are instances in which it makes sense to combine accounts, especially HSAs and FSAs, most of the interest today centers around stacking HRAs and FSAs, observers say.

While the abbreviations are similar, there are marked differences among the three arrangements.

Created by federal law in 2003, HSAs must be linked to high-deductible health insurance plans and can be funded by tax-deductible contributions from either employers or employees or both. Those contributions cannot exceed the amount of the plan's deductible, but any unused balances can be rolled over year after year to pay for future expenses.

By contrast, HRAs, about which the IRS offered guidance in 2002, are funded solely by employers. Unused HRA contributions can be carried forward to pay for health care expenses in succeeding years.

FSAs, about which the IRS issued definitive guidance in the mid-1980s, typically are funded by employees' pretax contributions, but employers can contribute to them. Any unused FSA balances are forfeited at the end of a plan year.

While last year's guidance by Treasury and the IRS made it clear that an HSA could not be offered in conjunction with another health plan, including a general-purpose health FSA or HRA, an employer can offer an HSA with an FSA or HRA in the following situations:

- The FSA or HRA is used to pro-

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Stacking: Employers seek optimal combinations

Continued from page 10

vide reimbursement for a limited range of benefit expenses, including vision, dental and preventive care services. These are known as "limited purpose" FSAs or HRAs.

- The FSA or HRA is used to reimburse employees for health care expenses after the minimum annual deductible in the high-deductible health plan has been met. These are commonly referred to as "post-deductible" FSAs or HRAs.
- The HRA offered provides reimbursement for health care expenses only after an employee retires.

"The jargon is just awful," said Joe Martingale, national health care strategy leader for Watson Wyatt Worldwide in New York. "It's very complicated, and it isn't as if you can't have more than one of those accounts at the same time; it's just that there are some pretty important restrictions on how you can use them."

What little stacking that is going on today is confined mainly to HRAs and FSAs, observers say, although some employers have begun to offer HSAs with limited-purpose FSAs.

"What we are seeing a fair number of employers doing is using kind of a combination of FSAs and HRAs as training wheels to work into HSAs," said Bonnie B. Whyte, president of the Employers Council on Flexible Compensation in Washington. "Or, if they did go to an HSA or are contemplating going to an HSA, they are figuring out how they can package or stack an FSA or HRA around it so that it is not such a horrible change for people who are used to $10 or $20 copays," she said.

Limited-purpose FSAs

"When this all first came about, I think a lot of people were saying, 'Well, if you have a high-deductible health plan and an HSA, you can't have or wouldn't want to have an FSA.' But, in fact, there are a number of situations where you would want to have an FSA sitting side by side with an HSA," said Chris Byrd, executive vp of Avon, Conn.-based Evolution Benefits Inc., whose "Benny" debit card can access multiple accounts under one high-deductible health plan.

Mr. Byrd describes himself as a "poster child" for such a combination. "I wear eyeglasses and contact lenses, so does my wife, and my 13-year-old son just began orthodontia. And since all of those vision and dental expenses can be paid at any time during the year with an FSA, why wouldn't I want to set up an FSA to fund those expenses currently so that I could save my HSA funds? One of the wonderful things about HSAs is that it builds up tax free and you can take it with you wherever you go."

Being able to stretch those HSA dollars was one of the main reasons why Resco Products Inc. decided to offer a limited-purpose dental and vision FSA alongside its new HSA plan, said Marshall Stegall, director of human resources.

About 100 of the Pittsburgh-based refractory manufacturer's highly compensated salaried employees were put into a new HSA health plan at the beginning of the year. The remaining 150 or so salaried and nonunion hourly employees will move to the new plan beginning next January, Mr. Stegall said.

'The jargon is just awful. ...It's very complicated, and it isn't as if you can't have more than one of those accounts at the same time; it's just that there are some pretty important restrictions on how you can use them.'

Joe Martingale
Watson Wyatt Worldwide

Resco contributes half the amount of the health insurance plan's deductible into the HSAs, which comes to $600 each for employees with individual coverage and $1,200 for each employee with family coverage. An employee can then elect to contribute to the HSA up to the remaining portion of his or her deductible and also contribute up to $3,500 to an FSA to cover any dental and vision expenses.

Mr. Stegall said the decision to stack a limited-purpose FSA onto the HSA was easy.

"You're limited to the deductible as far as how much you can put into the HSA, but if you do an FSA, you can actually put more money in to stretch that," he said.

But Bill Sharon, a senior vp with Aon Consulting in Tampa, Fla., for one, questions how many other employers will follow suit.

"The question is, to what extent are these other limited-scope services significant enough to warrant paying for them on a pretax basis? The demand on the part of the employees is not that great, because the benefit to them is not that great," he said.

Mr. Sharon noted that, as with limited-purpose FSAs, employers could technically create dental or vision HRAs. "But I haven't seen that yet, and I don't know if we will see a lot of it, because the concept behind the HRA and the usage of the personal care account is real-

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Stacking: Employers seek optimal combinations

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ly to help you think differently about the way you purchase health care. It's really more to deal with the health care cost problem, and there isn't as big of a driver to do that on the dental and vision side," he said.

HRAs and FSAs

While some employers do see the benefit of offering an HSA together with a limited-purpose FSA, most of the stacking activity that is taking place today is coming from HRAs and FSAs, observers say.

"That product suite has been discussed for a few years already, although we haven't seen it in high volume," said Karli Dunkelberger, vp of business development in the Orange, Calif., office of Conexis, a benefits administration outsourcing firm.

"There's a lot of evaluation and discovery and quoting that's going on with the stacking of FSAs and HRAs and health plans, but right now there's more research and quoting going on than real buying or packaging," she said. But, "from our experience so far, we believe that the stacking is going to be driven by FSAs and HRAs, and that's because of the guidelines from the IRS around HSAs."

Not only is this type of arrangement simpler than trying to group an FSA or HRA with an HSA, it's also a way to assist employees in covering the "deductible gap" associated with an HRA, observers say.

So, for example, under a health plan with a $1,000 deductible, an employer could fund an employee's HRA with $500 and the employee could fund an FSA with an additional $500 to cover the remaining deductible.

"The FSA is a great place for the employee to put money aside on a pretax basis that will cover their deductible gap if they need it," Aon Consulting's Mr. Sharon said. "So the FSA coupled with an HRA is a very nice combination."

How the accounts are ordered is up to the employer, sources say.

"I would say more employers do it where the HRA is tapped first and then the FSA is tapped second because that is more comparable to the way the things are done today with a PPO or HMO," Mr. Sharon said. An individual first obtains health benefits from the health plan and then reimburses himself or herself for any of the out-of-pocket expenses the health plan doesn't cover, he said.

Other consultants say, though, that because of the "use it or lose it" feature associated with FSAs, it makes more sense for the FSA monies to be tapped first.

"I would recommend to my clients that they use (the FSA) monies first," said Michael Rosenfeld, a senior consultant with Model Consulting based in Trevose, Pa.

"It's your money at the end of the day either way, but if you use the HRA first, then you put yourself in a position of losing the money in the FSA," Mr. Rosenfeld said.

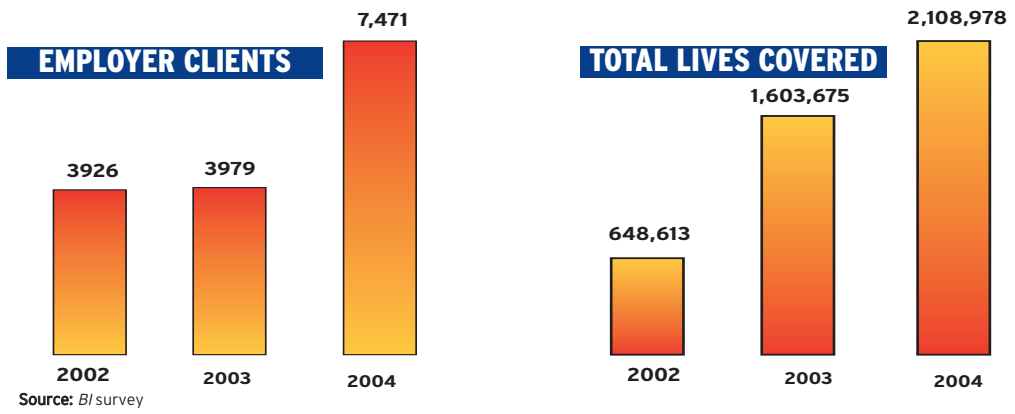
HOW HEALTH CARE SPENDING ACCOUNTS STACK UP

Issue	HSA	HRA	FSA
Funding	Employee and/or employer	Employer	Employee and/or employer
Contribution limits	$1,000 to $2,600 for individual coverage; $2,000 to $5,150 for family coverage *	Decided by employer	Decided by employer
Rollover of unused amounts	Permitted	Permitted	Not permitted
Distributions	No restrictions, but taxable if not used for health expenses	Only for qualified health care expenses	Only for qualified health care expenses
Combining arrangements	Can be combined with a post-deductible HRA or FSA and/or with a limited-purpose FSA or HRA Can be combined with an HRA being used as a retirement health care account Cannot be combined with a general-purpose health FSA or HRA	Can be combined with an FSA ; employer determines order of fund use	See discussion under HSA and HRA
Funds available on the first day of coverage	Only the accumulated balance is available for reimbursement	Decided by employer	The annual amount the employee elects is available on the first day of coverage regardless of the amount contributed by the date of the reimbursement request

* Contributions cannot exceed the health plan deductible

USAGE OF CONSUMER-DRIVEN HEALTH CARE PLANS

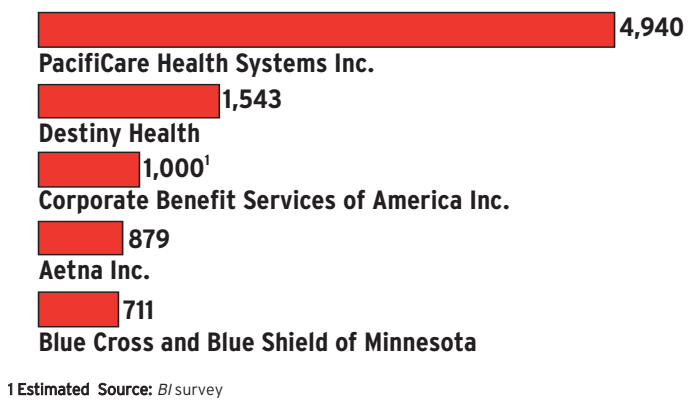
Number of covered lives and employer clients of the 10 largest providers



Source: *BI* survey

LARGEST BY NUMBER OF CLIENTS

Plan providers by number of employer clients as of Dec. 31, 2004



1 Estimated Source: *BI* survey

Largest consumer-driven health care plan providers

Ranked by number of total covered lives with employer clients in 2004

Rank	Company/Address	Phone/Fax/Web site	Health plan name(s)*	Total covered lives	Employer clients	Plan options	Principal officer
1	Definity Health- a UnitedHealth Group Co. 1600 Utica Ave. S., Suite 900, St. Louis Park, Minn. 55416	952-277-5500 Fax: 952-277-5501 *www.definityhealth.com*	–	850,000	350	Dental, FSA, HRA, indemnity, HSA, PPO, prescription drugs, vision	Dr. William McGuire, chairman/CEO-UnitedHealth Group
2	Aetna Inc. 151 Farmington Ave., Hartford, Conn. 06156	860-273-0123 *www.aetna.com*	Aetna HealthFund, Aexcel	285,000	711	Dental, FSA, HMO, HRA, HSA, PPO, prescription drugs, vision	Dr. John W. Rowe, chairman/CEO
3	Lumenos Inc. 1801 N. Beauregard St., Suite 10, Alexandria, Va. 22311	703-236-6300 Fax: 703-236-6510 *www.lumenos.com*	–	260,000	85	HRA, HSA, PPO, prescription drugs	Chip Tooke, CEO
4	Humana Inc. 500 W. Main St., Louisville, Ky. 40202	502-580-1000 Fax: 502-580-3127 *www.humana.com*	SmartSuite, SmartSelect, SmartExpress	253,179	165	Dental, FSA, HMO, HRA, HSA, PPO, prescription drugs	Michael B. McCallister, president/CEO
5	First Health 3200 Highland Ave., Downers Grove, Ill. 60515	630-737-7900 Fax: 630-737-7856 *www.firsthealth.com*	–	101,741	7	Dental, FSA, HRA, indemnity, HSA, PPO, prescription drugs, vision	Edward L. Wristen, president/CEO
6	Wausau Benefits Inc. 115 W. Wausau Ave., Wausau, Wis. 54401	715-841-2000 Fax: 715-841-6334 *www.wausaubenefits.com*	Wausau Benefits Consumer-Driven Health Plan	80,000	32	FSA, HRA, indemnity, HSA, PPO, prescription drugs, vision	Jay M. Anliker, president/CEO
6	WellPoint (Anthem Blue Cross & Blue Shield Plans) 120 Monument Circle, Indianapolis, Ind. 46204	317-532-6000 *www.anthem.com*	Anthem ByDesign Buy-Up, Anthem ByDesign Personal Care Account, Anthem ByDesign Health Savings Account	80,000	1,000 [1]	FSA, HRA, HSA, PPO	Larry C. Glasscock, president/CEO-WellPoint Inc.
8	PacifiCare Health Systems Inc. 5995 Plaza Drive, Cypress, Calif. 90630	714-226-3441 Fax: 714-226-3018 *www.pacificare.com*	PacifiCare SignatureFreedom, Self Directed Health Plan	79,752	4,940	Dental, FSA, HRA, indemnity, HSA, PPO, prescription drugs, vision	Howard Phanstiel, chairman/CEO
9	Blue Cross & Blue Shield of Minnesota 3535 Blue Cross Road, Eagan, Minn. 55122-1154	888-878-0139 Fax: 651-662-6882 *www.bluecrossmn.com*	Options Blue	65,306	690	Dental, FSA, HRA, indemnity, HSA, PPO, prescription drugs, vision	Dr. Mark Banks, president/CEO
10	Great-West Healthcare 8505 E. Orchard Road, Greenwood Village, Colo. 80111	303-737-3000 Fax: 303-737-0008 *www.greatwesthealthcare.com*	–	54,000	491	FSA, HRA, HSA, PPO, prescription drugs	William McCallum, president/CEO

* If different from company name 1 Estimated
Source: *BI* survey

Visit *www.businessinsurance.com* for more information and access to the full searchable directory of consumer-driven health plans.

Between the Lines

Compiled by Joanne Wojcik

Contingency plans for panel speaker

A session on contingent commissions slated for this year's Risk & Insurance Management Society conference lost one of its key speakers when he was forced to resign in the wake of New York Attorney General Eliot Spitzer's probe into insurance industry practices.

Christopher Treanor, chairman and chief executive officer of the Marsh & McLennan Cos. Inc.'s global placement unit, was scheduled to speak on a panel entitled "Broker Contingency Fees....What You Should Know," according to the session's coordinator, Jim Crockett, risk and benefits manager at Denver Water.

"You know how I found out he wasn't going to be my speaker any more? In *Business Insurance*, you had mentioned the five top people who were forced to resign, including the president, then I looked down and the fifth name was Chris Treanor, and I said, 'No wonder he hasn't responded to my e-mails.'"

"I had spoken to him once on the phone, and e-mailed him some information, and we were preparing to move ahead to develop the content of the session. But, apparently, he had other things to worry about," Mr. Crockett said.

Vivian Menna, a managing director at Marsh in New York, will be replacing Mr. Treanor, Mr. Crockett said. In addition, Mr. Crockett and Janice Ochenkowski, senior vp-global finance at Jones Lang LaSalle Inc. in Chicago and vp-external affairs at RIMS, will also speak on the panel.

Mr. Crockett said he might add a fourth speaker, because the session was expanded to 150 minutes. "We may have another risk manager," he said. "The brokers haven't been too eager to volunteer."

A blast from the past

Ever wonder what happened to the innocent bystander driving the car that gets rammed in the crowded intersection during the famous chase in the 1971 film "The French Connection"?

Well, according to some creative splicing by the folks at Daily & Associates Advertising, he gets out of his car, finds the nearest phone and calls his insurer to report: "Hello, 21st? You're not going to believe this."

PHOTO: 21st CENTURY INSURANCE

A 21st Century Insurance Co. commercial got traction by using a famous car chase scene.

"It's not just a car chase to get attention," said Mike Folino, chief creative officer of the Los Angeles-based advertising agency that made the commercial.

The objective is to convey the message that 21st Century Insurance Co. "cares about the poor guy who got hit," Mr. Folino said. "And even though this is a bizarre situation, they've got some coverage that could help."

The ad, which began airing recently in markets across the West, the Midwest and Texas, is the cornerstone of 21st Century's new branding campaign, according to Bruce Marlow, president and chief executive officer of the Woodland Hills, Calif.-based insurer.

"We were looking for a breakthrough approach to illustrate the superior product we offer and the peace of mind it provides. Integrating our message with a famous sequence from an Oscar-winning movie seemed perfect," Mr. Marlow said.

Helping out the unfortunate in a tight spot

An Atlanta-based fast-food company has offered to pick up some of the medical bills for a man who got caught in a cooking ventilation chute while attempting to break into one of its restaurants.

But the management of Philly Connection didn't do it to avoid the type of frivolous lawsuit that might be worthy of a Stella Award—the annual competition for the most outrageous use of the legal system.

"We really didn't consider that he was going to sue us, per se," said John Pollock, senior vp of the hot sandwich chain. "We felt bad that he got into this kind of situation."

"He's apparently a street person and tried to come in through the ventilation systems" during one of the coldest nights of the year. But rather than keeping warm, "he ended up getting stuck in there for nine hours and he got cut up and had some other injuries," he said.

Mr. Pollock added that he has no plans to file a claim against the company's liability insurance to recoup the $1,500 expense.

"It didn't happen in the normal course of doing business," he said.

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

Comings & Goings

Ms. Peterson

Mr. Ballardie

Mr. Lindsay

Insurers:

Nancy Peterson is the new president of KMC Insurance Services Inc., a member of the Dallas-based Curley Insurance Group. Previously, Ms. Peterson was a branch operations manager with the McCall Agency.

Adrian Ballardie has been named chief underwriting officer for London-based Tokio Marine Global Ltd. Before joining TMG, Mr. Ballardie was chief risk officer of Aspen Re.

Paris-based Coface Group has appointed **Jon Lindsay** managing director of its U.K. and Ireland business. Previously, Mr. Lindsay was country director for the United Kingdom and Ireland for Atradius N.V.

SVB Holdings P.L.C. has named **Mike Roffey** head of its discontinued business unit to manage the runoff of liability reinsurance, health care and third-party liability risks. Before joining Lloyd's of London-based SVB, Mr. Roffey was client director for Omni Whittington Insurance Services Ltd.

The Citizens & Hanover Insurance Cos. has appointed **M. Lee Patkus** regional vp of the company's Florida region. Before joining the Worcester, Mass.-based company, Mr. Patkus served in the position of president and chief operating officer of the Harleysville Insurance Group.

Other providers:

Alan Turnipseed has been named senior consultant in the insurance consulting practice of the Risk Navigation Group L.L.C. Before joining the Boston-based company, Mr. Turnipseed was a consultant in International Business Machines' supply chain operations solutions practice.

Towers Perrin has appointed **David Guilmette** managing director of the firm's health and welfare consulting business in Parsippany, N.J. Most recently, Mr. Guilmette led Towers Perrin's health and welfare business in the eastern United States.

Paul M. Bode, a former senior vp for CompManagement Inc., has been named senior vp of GAB Robins' Risk Management Services and MedInsights businesses in Parsippany, N.J.

Linda Brown has been appointed to the newly created position of senior vp of business strategy for Plantation, Fla.-based Broadspire. Formerly, she was a senior vp in Marsh Inc.'s national retail practice.

Agents/Brokers:

San Francisco-based Woodruff-Sawyer & Co. has named **Ron Packouz** senior vp to head the new Southern California operations. Previously, Mr. Packouz was a senior vp for Marsh & McLennan Cos. Inc.

Chicago-based Aon Corp. has made several senior-level appointments in its captive services management team.

- **Kieran O'Mahony** is the new deputy managing director of Aon Insurance Managers (Cayman). Formerly, he was a vp and chief underwriter.
- **Shaun Reape**, formerly executive vp, has been named deputy managing director of AIM (Bermuda).
- **Nancy Gray**, formerly managing director for AIM's North American operations, has been promoted to executive director in Burlington, Vt.

New York-based Willis Group Holdings has appointed **Paul Becker** North American Construction Practice group leader. Previously, he was managing director of the construction practice.

Managed care:

Shelton, Conn.-based Health Net Inc. has appointed **Steven Hale Nelson** president of Health Net of the Northeast. Previously, he was chief operating officer.

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

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

U.K. authorities owe duty of care to special needs students: Court

But significant barriers to compensation payouts remain

By CAROLYN ALDRED

LONDON—The liability of local education authorities that fail to provide suitable education for children with special needs has been extended by recent United Kingdom appeals court decisions, but the hurdle for winning such actions remains high.

Despite the findings that the local authorities had a duty of care to provide a suitable education for special needs children and that failure to provide that education was actionable in court, the court still dismissed the cases.

"Whilst the courts are prepared to find that professionals in the education sector may owe a duty of care, the courts do appear to appreciate the difficulties professionals face in this area and make judgments accordingly," said Alan Hunter, claims manager at Farnborough, England-based Zurich Municipal, one of the leading insurers for local authorities.

In the most recent case, *Carty vs. Croydon London Borough Council*, the Court of Appeal in London held that the council was not liable for the failure to reassess and amend the claimant's statement of special education needs.

The claimant had exhibited emotional and developmental difficulties from an early age and by 1987 was exhibiting disruptive behavior at his school. In 1988, he was transferred to a school that catered for children with emotional and behavioral difficulties. In 1991, an educational psychologist recommended that the child remain at the special needs school, but later in the year, a more senior psychologist recommend that he be transferred to another school. However, the child remained at the same school until 1993.

In his original complaint, which was dismissed by a lower court, the claimant alleged the local authority had breached its duty of care towards him by failing to provide him with a suitable education.

While the appeals court upheld the lower court decision in the local authority's favor, it rejected its argument that the making and reviewing of a statement of special education needs was an exclusively statutory process, the breach of which was not actionable in private law. The council had argued that there were good policy reasons for not recognizing the existence of a common law duty and that an education officer was not a professional person.

The appeals court, however, ruled that education officers might owe a duty of care where they enter into a relationship with, or assumed responsibilities toward, a child in the performance of their statutory functions. In this case, the education officer's actions did not give rise to a private law claim for breach of statutory duty or negligence, the court ruled.

In an earlier ruling, *DN vs. Greenwich London Borough,* in December 2004 the Court of Appeal ruled that a local education authority was li-

See COURT/page 26

House of Lords refuses to extend physician liability in malpractice ruling

Doctor cleared in 'failure to diagnose' case

By CAROLYN ALDRED

LONDON—A doctor who misdiagnosed a cancer patient should not be held liable for the claimant's reduced chance of recovery, the United Kingdom's highest court has ruled.

According to the Jan. 27 House of Lords ruling, holding the doctor liable for possible cause rather than probable cause would bring about such a profound change in U.K. law that it should first be approved by Parliament.

According to the complaint, Malcolm Gregg's chances of recovery from cancer reduced from 42% to 25% as a result of his doctor's failure to diagnose a lump under his left arm as a tumor. That failure led to a nine months delay in treatment. An appeals court had earlier ruled that because Mr. Gregg's chances of recovery at the outset were less than 50%, there was insufficient evidence of a link between the breach of duty and harm to the patient.

The claimant argued that he had suffered a "loss of a chance of recovery" as a result of the delay, but the Law Lords, in a majority verdict, rejected the claim.

"A wholesale adoption of possible, rather than probable, causation as the criterion of liability would be so radical in our law as to amount to a legislative act. It would have enormous consequences for insurance companies and the National Health Service," said Lord Hoffman, noting that such a change "should be left to Parliament."

Mutual medical malpractice insurer, the Medical Defence Union, which insured the doctor in the case, welcomed the ruling.

"If we had lost the case, it could have led to the number of compensation claims increasing dramatically, which would have had serious implications for our members and the National Health Service," said Christine Tomkins, head of professional services at the MDU.

Disasters not raising political risk, for now

By GLORIA GONZALEZ

Major events in 2004 such as the Asian tsunami and the train bombings in Madrid, Spain, had little immediate impact on affected countries' overall political and economic risk ratings, according to research by Aon Corp.

According to Aon's "2005 Political and Economic Risk Map," Spain remains a low risk, despite the terrorist attack that killed almost 200 people last March, because of the country's stable government and economy and attractiveness to foreign investment, Michel Leonard, chief economist of Aon Trade Credit, said in unveiling the 2005 map last week in New York.

Aon also believes relief efforts by the United Nations and certain countries will likely mitigate short-term political and social unrest that could have resulted from the recent tsunami disaster. However, Aon analysts do expect increased political risks resulting from the tsunami's medium- and long-term economic impact, particularly if unemployment increases or government relief efforts fail, Mr. Leonard said.

South and Central America have become areas of increasing concern from a political risk standpoint because of a resurgence of governments that have strong stances against foreign investment, he said. Venezuela, Colombia and Ecuador all continue to have high-risk ratings.

Compared with last year's map, ratings for Argentina, Azerbaijan, Bulgaria, Romania and Uruguay all improved, while the ratings for the Dominican Republic, Haiti, Bolivia and Saudi Arabia worsened. Aon's map rates the economic, currency and political risks of doing business in more than 200 countries.

PHOTOS: AFP, KRT

The tsunami that hit several Asian countries in December and the terrorist bombings in Spain last year are not expected to increase short- term political risks in those areas.

Despite the ongoing concerns in several regions, political risk insurance capacity has increased, as Lloyd's of London, insurers in Bermuda and new players have boosted their participation in the market, according to John Minor, national director, political risk, for Aon Trade Credit.

The 2005 map is available at *www.aon.com/politicalrisk*.

World Updates

Lloyd's estimates tsunami exposure

The Lloyd's of London market's exposure to the Indian Ocean earthquake and tsunami of Dec. 26, 2004, is likely to be about £100 million ($188.8 million), net of reinsurance, Lloyd's said last week. Lloyd's said that it had received loss estimates from insurers operating in the market, and that the tsunami losses for many of the insurers "will be within businesses' planning assumptions for expected catastrophe loss costs."

Sirius opens aerospace reinsurance unit

Stockholm, Sweden-based Sirius International Corp. has opened an aerospace reinsurance unit in Zurich, Switzerland. The unit is headed by Mario Montelatici, formerly the head of the aviation department of Converium Holding Ltd., and will write treaty and facultative aviation reinsurance.

Stephen Haddrill named director general of ABI

Stephen Haddrill has been appointed director general of the London-based Assn. of British Insurers. Mr. Haddrill, currently director general of the fair markets group at the Department of Trade and Industry, will succeed Mary Francis on May 3. Ms. Francis is leaving the ABI to take up nonexecutive posts with several unspecified companies, according to a spokesman.

ZFS renames London unit

Zurich London, the London-based arm of Zurich Financial Services Group, has been renamed Zurich Global Corporate U.K. The company said that the change, which took effect Jan. 31, recognizes the company's focus on offering services to corporate customers throughout the United Kingdom. The Zurich Global Corporate unit will be headed by David Martin, who will join the insurer from Aon Corp. in March, according to Zurich.

Cayman, BVI report captive growth

The Cayman Islands licensed 76 new captive insurance companies in 2004, bringing the total number of captives on the island to 694, the Cayman Islands Monetary Authority said. Of the new captives, 40 are funding health care-related risks. Meanwhile sixty-seven new captives were licensed in the British Virgin Islands during 2004, bringing the total number of captives operating in the domicile to 350 at year end, according to figures from the BVI Insurance Assn.

Court: Educators' liability extended

Continued from previous page

able for the negligence of an educational psychologist who had failed to identify the claimant's educational needs. However, the court also ruled that where expert evidence was uncertain about what the outcome would have been had the claimant's educational needs been met, any damages awarded would be small.

Carty vs. Croydon is "the first case to establish duty of care for an education officer. But the judgment will be of more use to defendants because it shows that the courts are taking a realistic attitude and it will not be easy to win these claims," said John Goodman, a partner for Barlow Lyde & Gilbert, a London-based law firm that represented the Croydon council.

As a result, the ruling should discourage future claims, he said, pointing out that few educational liability claims have succeeded and local authorities "have vigorously defended" those that have been brought.

The *Carty* case "extends liability to education officers, but it doesn't increase the possibility that claimants will get over the threshold of proof," said Caraline Johnson, an associate in the Bristol office of law firm Bevan Brittan and a member of the Education Law Association.

While educational liability claims are of concern to local authority risk managers, relatively few cases have been successful, she said.

However, "the case highlights the need to continually look at the processes, manage risk and ensure that the rationale for decisions is properly documented," said Zurich's Mr. Hunter.

St. Paul: Asbestos reserve boost

Continued from page 3

increase to conform St. Paul's accounting and actuarial methods with those of Travelers Property Casualty Corp.

The company's long-term viability, though, is sound, said Mr. Gallant. "The company is in a decent capital position today," which should be enhanced by its announced plan to sell its 79% interest in Nuveen Investments Inc., an asset management firm.

Michael Lewis, senior insurance analyst with UBS Warburg in New York, noted the asbestos charge was the result of an internal study. It would have been preferable "if they had a fresh set of outside eyes looking at it." The fact that this was an internal study may leave unanswered questions, he said.

But as the company points out, "they basically do a ground-up study every year, and this is the number they came to right now," he said. "Obviously, with escalating defense costs involved here, one can't say" the asbestos issue is totally addressed, just that St. Paul's action reflects the current situation. "It's still an overhang in the company," he said.

'Obviously, with escalating defense costs involved here, one can't say' the asbestos issue is totally addressed. 'It's still an overhang in the company.'

Michael Lewis
UBS Warburg

Other insurers may eventually report similar asbestos-related losses stemming from peripheral victims as well, say observers.

"They're not the only ones who wrote this type of business, so presumably, if they felt the need to address it directly, others may as well," said James Inglis, managing director at Philo Smith & Co., a Stamford, Conn.-based boutique investment bank that specializes in the insurance industry.

Separately, the insurer announced last week that Douglas G. Elliot, who was chief executive officer of commercial and personal lines, is leaving the company. St. Paul said in a statement that Mr. Elliot had decided "to pursue other career opportunities."

The insurer said it has promoted T. Michael Miller and Brian MacLean to the new positions of co-chief operating officers. Mr. Miller, who is responsible for specialty business, previously was CEO of specialty commercial lines. Mr. MacLean, who was previously executive vp-claims, is now responsible for commercial business and will retain his claims responsibilities at the company.

COMPENSATION CRISIS: MARSH SETTLEMENT

Marsh's non-U.S. clients won't see settlement funds

U.K. market has found no evidence of bid rigging

By SARAH VEYSEY

LONDON—Most Marsh & McLennan Cos. Inc. clients outside the United States will not receive any of the $850 million in compensation the company has agreed to pay as part of its settlement of misconduct charges.

Furthermore, MMC is unlikely to face similar litigation or claims from clients in Europe, risk managers and legal experts believe. That is because, at the moment, the brokerage is not facing any legal or regulatory proceedings in the United Kingdom or elsewhere in Europe.

Non-U.S. risk managers will only be able to claim compensation from Marsh if they bought insurance through one of the company's U.S. operations. That could change, however, if wrongdoing is unearthed at Marsh's European operations, sources said.

The United Kingdom is one of Marsh's largest markets outside the United States, with about 6,000 employees in 30 offices.

Andrew Cornish, head of insurable risk at Centrica P.L.C. in Windsor, England, and chairman of the Assn. of Insurance & Risk Managers, said that buyers who have U.S. subsidiary companies and whose coverage was placed through Marsh's U.S. operations would likely seek compensation from the fund.

But he said he thought a similar compensation arrangement was unlikely in the United Kingdom because there is "no proof of wrongdoing (by Marsh) in the U.K."

Another risk manager for a large U.K. company, who asked not to be named, thought that, since there has been no published allegation of wrongdoing by Marsh Ltd., the U.K. arm of Marsh Inc., it is unlikely that U.K.-based buyers will seek compensation. But he said if evidence of bid rigging or similar misconduct does come to light, U.K. clients likely would seek compensation.

New York-based MMC announced last week a settlement of a civil suit brought last fall by New York Attorney General Eliot Spitzer, who accused the brokerage of fraud, bid rigging and steering business to insurance companies paying the highest contingent compensation.

No proof of wrongdoing

London-based law firm Freshfields Bruckhaus Deringer in December published its findings of a probe that Marsh Ltd. commissioned (*BI*, Dec. 6, 2004). While that investigation found that brokers at Marsh Ltd. had, on occasion, steered business to insurers that paid the highest contingent fees, the firm did not discover any evidence of bid rigging.

A spokesman for the Financial Services Authority, which took over regulation of the U.K. insurance brokering industry Jan. 14, said it was not investigating Marsh or business practices in the brokerage industry as a whole.

He did say, however, that the London-based FSA was in regular dialogue with the industry. And he noted that, in response to calls for greater transparency, the FSA last week clarified its stance on unfair inducements and conflicts of interest (see story, page 28).

Legal sources said several bodies in the United Kingdom that have power to investigate allegations of wrongdoing by commercial insurance brokers.

The FSA has authority to investigate regulatory breaches, while the Office of Fair Trading can investigate anti-competitive practices, said Nigel Montgomery, partner at DLA Piper Rudnick Gray Cary U.K. L.L.P. in London. In cases of fraud, agents of the criminal justice system, perhaps the City of London police, if a company were based in that area, or the Serious Fraud Office, would likely become involved, he noted.

In such cases, the allegations would likely be referred to the U.K. director of public prosecutions, explained another lawyer who asked not to be named. The director is an appointed official in the Crown Prosecution Service, which conducts all criminal proceedings in England and Wales.

Large group actions, similar to class actions in the United States, against commercial defendants are

See EUROPE/next page

COMPENSATION CRISIS: MARSH SETTLEMENT

Risk managers hope settlement spurs greater transparency

By SALLY ROBERTS

Risk managers last week welcomed the $850 million settlement between Marsh & McLennan Cos. Inc. and New York Attorney General Eliot Spitzer over alleged fraud and bid-rigging charges with the hope that it leads to greater transparency throughout the industry.

And Marsh clients remain supportive of the brokerage and are optimistic that the settlement will remove at least some of the problems that have surrounded MMC and its Marsh Inc. brokerage unit since Mr. Spitzer filed suit against them last October.

In addition to establishing an $850 million fund to compensate certain U.S. policyholder clients, the settlement, reached last Monday, also formalized several changes to Marsh's business practices, including formal agreement to cease collecting contingent commissions and to provide clients with full disclosure of its compensation.

Risk managers are hopeful these new and more transparent practices will permeate the industry.

"The investigation of the New York attorney general into broker compensation practices has served as an important catalyst to improving industry practices," Nancy Chambers, president of the New York-based Risk & Insurance Management Society Inc., said in a statement.

"It is our belief that the settlement…represents the beginning of a new era of cooperation and transparency, concepts that RIMS has championed," said Ms. Chambers, who also is risk manager for the Waterloo Region Municipalities Insurance Pool in Waterloo, Ontario. "We hope that Marsh's settlement will provide satisfactory restitution for all parties involved and will serve as a first step toward the rebuilding of trust between brokers and their clients."

Mr. Spitzer's investigation comes nearly six years after RIMS first voiced its concern about potential conflicts associated with contingent commissions.

At that time, RIMS urged greater transparency by brokers to clients and was successful in negotiating with Marsh to adopt a policy of reporting commission information to those clients who requested it.

RIMS again addressed this issue last August, in the wake of Mr. Spitzer's and other related investigations into contingent commission arrangements. The organization changed its policy statement to advocate complete transparency and the full disclosure of compensation agreements even without a client request.

But despite the moves by RIMS, the insurance brokerage industry refused to address the conflict of interest issues that are inherent in the payment of contingent commissions, said Mark DiLillo, North American risk manager for homebuilder Taylor Woodrow Inc. in Brandenton, Fla.

"The industry had the opportunity to correct what buyers viewed as a potential conflict of interest several years ago," Mr. DiLillo said, referring to RIMS' efforts in 1999. "They chose not to. They chose to wait until someone with enforcement powers compelled them to do it."

"It's just mind-boggling to me that it took this long and took this type of intervention and scrutiny to get them to understand that (a contingent commission arrangement) was a potential problem and that it created opportunities for wrongdoing by its very nature," Mr. DiLillo said. "For firms that are supposed to be in the risk management business, they missed it."

"The amount of the settlement, the way it's distributed, that's all fine, but it's not the most important outcome, in my view," Mr. DiLillo said. "The most important outcome is that the procedures have been changed and the processes have been altered to prevent that type of thing from happening again."

Indeed, risk managers agree that an industrywide movement toward greater openness in compensation arrangements, including the elimination of contingency fees, may prove to be a positive outcome from the scandal.

"I think it will lead to greater transparency, especially among the larger brokers," said James E. Crockett, manager of risk and benefits for Denver Water.

Mr. Crockett said that, prior to Mr. Spitzer's investigation, "I don't think very many risk managers actually made the inquiry (to their brokers) for full disclosure. They were kind of happy with the status quo."

"I think risk managers are more aware now of the importance of getting full disclosure from their brokers so they can evaluate their services. I think many of us just took status quo, and we assumed our broker had our best interest at heart when they went through the bidding process and market review," Mr. Crockett said.

Continuing client support

In the meantime, Marsh enjoys some significant client support.

"We support what Marsh has done in regard to trying to bring to closure its dealings with the attorney general," said Lance Ewing, vp-risk management for Caesars Entertainment Inc. in Las Vegas. "I think it's the first step, because…there are other states out there that may look at this as a bellwether for them to move forward with their own agreements with Marsh."

As to what that means for the brokerage's future, "it may be a slimmer, leaner Marsh than what we've seen in the past," Mr. Ewing noted. But Caesars continues "to support Marsh in regard to the brokerage service they provide to us as a client. I'm not ready to walk the funeral procession yet," he said.

Lesley Cohen, risk manager for the Coachella Valley Water District in Coachella, Calif., also maintains her loyalty to Marsh. "I definitely think that they needed to get out from underneath it," she said of Mr. Spitzer's lawsuit against Marsh.

"I know it did not happen on my account; I was not pushed into a particular provider," she said. "But for those Marsh clients that that happened to, I feel sorry, and I'm happy they are doing the right thing."

John Phelps, director of risk management for Blue Cross & Blue Shield of Florida Inc. in Jacksonville, also is supportive.

"At this point, I have no reason to believe that there was any fraud associated with our account," Mr. Phelps said. "If that changes in the future, my opinion is going to change 180 degrees. I will not tolerate, and no competent experienced professional risk manager would, anything that has to do with fraud."

As far as contingent commissions are concerned, Mr. Phelps said he's known that the fees have been part of the industry for decades and that Marsh was collecting them. "The quid pro quo for that has been the volume and the expertise of services that we've received from them over the years that have not had a specific consulting charge associated with it," he said. The extra fees gave Marsh "the opportunity to maintain a very expert broking operation that inured to our benefit over the years as they negotiated coverages. So I think that our company has accrued value from the total relationship with Marsh, including the receipt of contingency fees," he said.

"Don't get me wrong; if they're going to send me a check, I'm going to cash it, but what I think this all has led to is the need for greater transparency in the industry and…that can be nothing but a good thing," Mr. Phelps said.

FSA clarifies inducement rules

By SARAH VEYSEY

LONDON—The United Kingdom's financial services regulator has outlined to policyholders and the insurance market situations in which it believes contingent commissions and other inducements represent a conflict of interest, but it has reaffirmed its position that not all such payments should be banned.

In a letter to insurance market trade associations and the Assn. of Insurance & Risk Managers, the Financial Services Authority clarified its rules on unfair inducements, which were first issued last year and came into force in January.

The rule—2.2.3R in its Insurance: Conduct of Business regulations—states that: "A firm must take reasonable steps to ensure that it, and any person acting on its behalf, does not: offer, give, solicit or accept an inducement; direct or refer any actual or potential business in relation to an insurance mediation activity to another person on its own initiative or on the instructions of an associate."

In response to questions regarding how the rule would be interpreted by the FSA, the regulator cited two broad examples of when an inducement would be determined to be a conflict:

- If an intermediary "holds himself out as getting the best deal for his customers, and the inducement influences his placement of business in a way that is contrary to his customers' interests."
- If an intermediary "is involved in settlement of claims and also receives a profit commission that influences how he settles claims on behalf of his customers in a way that is contrary to his customers' interests."

The letter also stated that while it is not mandatory for brokers to disclose their commission arrangements to clients, such information must be provided to commercial buyers of insurance if they request it.

In addition, while the nondisclosure of an inducement would not necessarily mean there had been a breach of the unfair inducements rule, "it is a factor which generally would increase the potential for an inducement to be unfair to customers."

David Gamble, executive director of AIRMIC, said that if brokers were transparent about the placement of risks, then buyers would better be able to see where inducements are being offered and what levels of service they are being provided.

The Lloyd's Market Assn., which represents underwriters at Lloyd's of London, welcomed the FSA's clarification of its rules on inducements and managing conflicts of interest.

Bill Rendall, head of underwriting and claims at the LMA, said that the association welcomed the FSA's "overall support for greater transparency for customers."

A spokesman for the International Underwriting Assn., which represents London company market underwriters, also said it welcomed the FSA's clarification of its rules. And the British Insurance Brokers' Assn. said in a statement that it was pleased that the FSA had stood by its original rules on inducements.

—By Sarah Veysey

Europe: Small effect on non-U.S. clients

Continued from previous page

rare in the United Kingdom, added Mr. Montgomery.

Another legal source noted that, unlike in U.S. class action suits, all plaintiffs in U.K. group actions must be identified when the case is brought and plaintiffs cannot join the suit at a later date.

A spokeswoman for the London-based Office of Fair Trading said that it does not comment on cases where individual companies or alleged cartels are being investigated. But she said the OFT is not currently conducting a marketwide investigation into insurance brokering practices.

The Marsh settlement is unlikely to have a huge effect in Europe, according to Thierry Van Santen, executive vp in the corporate risk management department of Paris-based Groupe Danone and chairman of the Federation of European Risk Management Assns.

"I would be quite surprised to see any action to seek compensation," he said. "This does not mean that some European group with major interests in the U.S. will not seek compensation for their U.S. portion," however, he said, "but it would be marginal."

FERMA is currently working with European broking and insurance company groups to devise a set of Europe-wide standards for broker conduct, a spokeswoman for Brussels, Belgium-based FERMA added.

Impetus for change

Although few non-U.S. risk managers will likely benefit financially from the Marsh settlement, buyers overseas will probably welcome the fact that a settlement deal has been struck, experts said. Risk managers generally are seeking greater transparency of broker remuneration.

Mr. Cornish said the settlement should "allow Marsh to move on and changes (to its business model) to take place."

When any major player in any industry is undergoing a period of upheaval, it can bring uncertainty to clients, suppliers and the marketplace, noted David Gamble, executive director of AIRMIC. If the U.S. settlement helps Marsh to get greater certainty about its position going forward, then this will benefit insurance buyers, he said.

Some U.K. market sources had expected changes to Marsh Ltd.'s business model to be announced late last month, but a spokesman for Marsh Ltd. in London said in January that such changes would likely not be announced until this month.

A spokeswoman for Marsh in New York said last week that changes to Marsh's business model would be discussed at the company's earnings call slated for March 1.

COMPENSATION CRISIS: MARSH SETTLEMENT

Spitzer expects more guilty pleas

New York attorney general says industry 'rife' with corruption

By MARK A. HOFMANN

WASHINGTON—The insurance industry "has corruption that is rife throughout it," says New York Attorney General Eliot Spitzer, stressing that his investigation will bring more guilty pleas soon.

During a Jan. 31 address at Washington's National Press Club, Mr. Spitzer—who earlier that day announced that Marsh & McLennan Cos. Inc. had agreed to pay $850 million to settle his fraud and bid-rigging charges related to contingent commissions—said that corruption touches every line of insurance. And the result, he said, is higher premiums.

Mr. Spitzer said that the funds from the settlement were going into a compensation fund rather than being levied as a fine, because fines would have gone to the state of New York. "The state should not be the beneficiary," he said; rather, those victimized by the business practices should receive restitution.

Although he criticized Marsh's practices with regard to contingent commissions, Mr. Spitzer declined to condemn such commissions categorically.

Mr. Spitzer also noted that his investigations into the insurance industry have already resulted in six guilty pleas, and he said there are "more to come very shortly."

He also promised that there would be "many more" in the future.

Ken Crerar, president of the Washington-based Council of Insurance Agents & Brokers, disputed Mr. Spitzer's contention of widespread corruption in the insurance industry.

"The attorney general has made broad claims of corruption. That's just not the industry we know," said Mr. Crerar at a Feb. 2 press briefing. Both Mr. Crerar and Joel Wood, the CIAB's senior vp-government affairs, stressed that the organization supports full disclosure of compensation by brokers to customers.

"Disclose the compensation. That's our position. Period," said Mr. Wood.

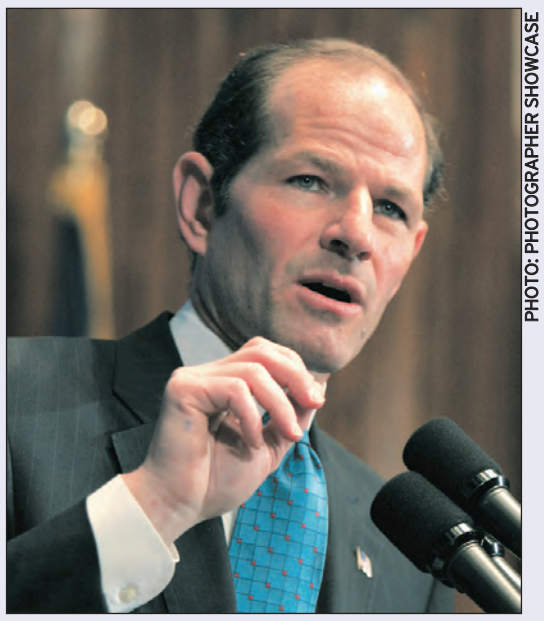


PHOTO: PHOTOGRAPHER SHOWCASE

New York Attorney General Eliot Spitzer says more guilty pleas will "come very shortly."

Future: Questions remain after N.Y. settlement

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Cunningham, a partner in the Chicago-based insurance brokerage consulting firm OPTIS Partners Inc. "I'm sure a lot of their motivation is, they'd like to get this behind them and move on," said Mr. Cunningham.

Donald Light, a San Francisco-based senior analyst with Celent Communications, a business and technology research and consulting firm, said, "I think that it was very important for Marsh to get the settlement done. This was a very dark, very large cloud that was hanging over their business prospects, and this gets that behind them. They still have some pretty large battles they're going to have to fight, I think, before they can think about growing their business, but, in terms of damage control, I think it's a major step forward."

Other states not satisfied

Observers say they remain concerned about what may lie in Marsh's future. Steven Ader, associate director at Standard & Poor's Corp. in New York, whose Marsh ratings remain under review with negative implications, said, "We do have continuing concerns regarding potential additional regulatory and civil actions" and their ramifications, both in terms of their financial impact and their impact on Marsh's business position.

John Ward, a Cincinnati-based independent insurance analyst, said that momentum is "already beginning to build with other states, such as Connecticut, and the mounting private litigation." Mr. Ward said he believe those two fronts will continue and will probably be stepped up.

In a suit filed Jan. 21, Connecticut Attorney General Richard Blumenthal accuses MMC, its Marsh USA Risk Services Inc. unit and ACE Financial Solutions Inc. of violating Connecticut's unfair trade practices act by engaging in a scheme whereby ACE paid Marsh a secret $50,000 commission to steer an $80 million state workers compensation contract to the insurer.

Meanwhile, other regulators' interest in Marsh apparently remains undiminished. Georgia Insurance Commissioner John Oxendine said in a statement that he finds it "highly questionable" whether the $850 million settlement is sufficient, "when it has been alleged that Marsh may have overcharged its clients billions of dollars." Mr. Oxendine said his department's investigation into Marsh's practices continues.

Similarly, Florida Attorney General Charlie Crist said his office's investigation continues. The New York attorney general's settlement "will serve as part of a broader framework for resolving this matter on behalf of Floridians affected," Mr. Crist said.

A spokesman for California Insurance Commissioner John Garamendi said Marsh's settlement with Mr. Spitzer "will not affect our investigation of the industry at all."

But Mark Geistfeld, a professor at New York University School of Law in New York, questioned how vigorously regulators will now pursue Marsh. This is a prominent issue and politically attractive, "but this isn't like automobile insurance or health insurance or something like that, that ends up affecting most people. It's really insurance purchased by large businesses, so it's hard to really have a feel for how much of a political benefit there's going to be in terms of being aggressive on the regulatory front," said Mr. Geistfeld.

UNRESOLVED LAWSUITS:

Litigation against MMC filed with the SEC as of Nov. 2, 2004

- Three lawsuits filed on behalf of those who purchased MMC securities.
- Nine suits alleging violations of the Employee Retirement Income Security Act filed on behalf of participants in one of MMC's employee benefit plans.
- Seven derivative actions filed against MMC's directors and officers.
- A suit filed on behalf of the general public.

Source: U.S. Securities and Exchange Commission

Civil lawsuits unresolved

A raft of private litigation continues as well. Five lawsuits have been filed with the U.S. Securities and Exchange Commission (see chart) and subsequent litigation includes a pair of identical suits over alleged bid rigging by Marsh that were filed in U.S. district courts in Boston and Chicago.

The company also faces considerable litigation and regulatory attention over the issue of market timing in connection with its Putnam Investments subsidiary (*BI,* Nov. 10, 2003). Furthermore, an independent consultant appointed by Massachusetts Secretary of the Commonwealth William Galvin, Massachusetts' top securities regulator, now estimates that the trading scandal may have cost clients about $100 million, or 10 times as much as the mutual fund company initially estimated.

Insurance brokerage client litigation may continue. "Marsh is clearly hoping to get the aggrieved policyholders to take money from the settlement fund rather than filing separate suits," said Mr. Geistfeld. The possibility of being awarded punitive damages would be an incentive for Marsh clients to file suit, because the settlement funds would pay only compensatory damages, he said.

Mr. McDonough said, "When you consider that Marsh admitted to receiving over $800 million in 2003, and the settlement covers four years, you might speculate the $850 million settlement only covers one-fourth of the potential contingent commissions that were collected, so clients are going to have to decide whether or not what is offered in the fund is sufficient compensation."

Mr. McDonough said, "They're also going to have to look at the coverage that was obtained by Marsh and decide whether or not the covers meet the standards in the industry for covers of various risks, because if they end up signing a release and then discover later they had inadequate coverage for a particular risk when they present a claim, they may have to give up their rights to proceed against Marsh."

"At this point, I think most clients are approaching this rather cautiously, and trying to analyze what the situation is for them individually, and will be having discussions, certainly, with Marsh about it and will, in many cases, be speaking to their lawyers as well," he said.

Some observers believe, though, that the worst may be behind Marsh. Reimbursing clients throughout the United States "mitigates some of the concerns some of the attorney generals or insurance departments may have had. It kind of short-circuited some of this," in terms of achieving resolution for Marsh's client base, said Michael Lewis, senior insurance analyst with UBS Warburg in New York.

The settlement addressed "the lion's share of the concerns" and should speed up the resolution of any remaining issues, Mr. Lewis said. He noted also that Marsh did not admit any guilt in its apology, which "has important ramifications on the legal front."

Viability questioned

But Marsh faces other issues as well. James B. Auden, senior director at Chicago-based Fitch Ratings, said that, with Marsh's settlement behind it, "the more pressing issue going forward is how they retain clients and attract new clients, and how they can maintain revenue or grow revenue."

Marsh is "losing $800 million in contingent commissions. Is that capital gone, or is it replaced through different mechanisms? I think it'll take some time to see what happens," Mr. Auden said.

Mr. Light said, "It's a double whammy—they'll have to try to rebuild revenues and profitability and, at the same time, I think, take a series of hits to their capital position." Marsh's long-term viability "is certainly on the table," although less so than before the settlement was announced, he said.

The question is, Mr. Light said, whether enough customers decide to punish them for what they did, as opposed to staying with them for dealing with the problem the way they did.

Marsh will ultimately survive, predicted Mr. Ward. But it "will emerge from the series of problems a smaller company and somewhat reinvented" as a result of dealing with its onslaught of problems, he said, noting that he would not be surprised to see Marsh sell off parts of its business.

COMPENSATION CRISIS: MARSH SETTLEMENT

Terms: Global Broking disbanded

Continued from page 1

this industry," a spokesman for Mr. Spitzer said of the settlement.

The size of the Marsh settlement is not likely to be duplicated, though. "It was like the Wright brothers building a 747," Mr. Spitzer's spokesman said, explaining that the attorney general tackled the largest case first to set a standard.

The $850 million that Marsh will pay clients over four years is only slightly more than the $845 million in contingent commissions it collected in 2003, industry observers note. Applying the same rule of thumb, similar settlements would cost Aon up to $200 million and Willis as much as $80 million, their one-year contingent commission totals, observers speculate.

Any monetary settlement with Aon or Willis–which have not been charged with any wrongdoing–may also be considerably less if Mr. Spitzer finds no evidence of bid-rigging, the most egregious charge against Marsh, they add.

"I really think Marsh is in a league of its own unless another broker, such as Aon or Willis, (is charged with) something more problematic than what we see now," said Thomas A. Player, an insurance and reinsurance partner with law firm Morris, Manning & Martin in Atlanta.

"I don't think there is going to be anything of the enormity of what Marsh did" in any other cases, agreed an industry consultant who requested anonymity. "If there was a smoking gun out there, Spitzer would have shown it to us."

After weeks of negotiations, Marsh agreed last week to create an $850 million fund to reimburse brokerage clients in settlement of Mr. Spitzer's October 2004 fraud and price-fixing complaint, and issued a public apology to its clients. The agreement also settles similar charges brought by the New York Insurance Department (see box).

Separately, Marsh also announced last week that it has disbanded its Global Broking unit, which Mr. Spitzer cited as the epicenter of alleged client-steering and bid-rigging at the brokerage. The controversial unit was created in the early 1990s to centralize certain large placements.

'I really think Marsh is in a league of its own unless another broker, such as Aon or Willis, (is charged with) something more problematic than what we see now.'

Thomas A. Player
Morris, Manning & Martin

Although he defended the model on several grounds late last year, Michael G. Cherkasky, president and chief executive officer of Marsh & McLennan Cos. Inc., said the unit has been shuttered and "we have a more decentralized model" now.

"Marsh no longer has a functioning division made up entirely of placement professionals," a Marsh spokesman said. "We have distributed our placement professionals to our risk practice and product line divisions."

Marsh officials would not comment further on the organizational change, details of which are still being worked out, the spokesman said.

While it neither admitted nor denied wrongdoing in the settlement, Marsh nevertheless apologized to clients and others in a document attached to the agreement.

"Marsh Inc. would like to take this opportunity to apologize for the conduct that led to" Mr. Spitzer's lawsuit and New York regulators' charges, the statement read. "The recent admissions by former employees of Marsh and other companies have made it clear that certain Marsh employees unlawfully deceived their customers. Such conduct is shameful, at odds with Marsh's stated policies and contrary to the values of Marsh's tens of thousands of other employees."

Asked about the apparent inconsistency between the company's apology and its refusal to admit wrongdoing, Mr. Cherkasky explained that individual employees–rather than the corporate entities–were responsible for the alleged illegality.

MMC and Marsh remain defendants in policyholder and shareholder lawsuits stemming from the scandal, and Mr. Cherkasky and industry observers noted that the corporations would not concede wrongdoing for that reason.

A corporate admission of illegal acts could jeopardize directors and officers liability and errors and omissions coverage for the policyholder and shareholder actions, said one insurance industry consultant who requested anonymity.

HOW THE MARSH SETTLEMENT WORKS

Marsh & McLennan Cos. Inc. will create an $850 million fund to compensate U.S. policyholder clients that used Marsh Inc. to place coverage incepting between Jan. 1, 2001, and Dec. 31, 2004, on which Marsh collected contingent commissions or overrides.

MMC will pay into the fund over four years, with two payments of $255 million in June 2005 and 2006 and two payments of $170 million in June 2007 and 2008. Along with a $232 million reserve it set up late last year, the broker will take a $618 million pretax charge against fourth-quarter 2004 earnings to cover its costs.

Clients will receive a pro rata share of the fund based on the premiums they paid and on an estimate of Marsh revenue from market service agreements with insurers from 2001 through 2004. They will not have to show wrongdoing in order to collect but as a condition for accepting the payments the clients must sign waivers releasing Marsh from further liability.

Clients based in California would collect the largest share of the fund, at about $131 million. New York-based clients follow with a total of about $94 million in payments, while Pennsylvania clients will collect $58 million, Texas clients $55 million and Illinois clients $45 million.

Marsh cannot recover any of the settlement amount from its professional liability insurers or other insurers, but it will continue to try and recover outstanding contingent commission payments owed by insurers before Marsh agreed to halt the practice last year, an amount the broker put at $230 million. So far, is has collected only $25 million.

In addition to the restitution payments, Marsh formally agreed to stop: collecting any form of contingent compensation from insurers; soliciting fictitious or "throw-away" quotes from insurers intended to channel business to a favored company; leveraging insurance placements to obtain insurers' reinsurance brokerage business; and using wholesale affiliates to siphon additional commissions on placements without clients' knowledge.

Marsh will accept only fees or commissions from clients as compensation for placing client risks, and will disclose that compensation before coverage is bound. Marsh also agreed to notify clients that it earns investment income on client premiums before forwarding them to underwriters.

Marsh also must file annual compliance reports with New York regulators and is subject to yearly regulatory examination.

DEMISE OF GLOBAL BROKING

Marsh Inc. announced last week that it would disband its controversial Global Broking unit. The Global Broking model of centralized placements was developed over several decades, but it first became a formal system in the early 1990s.

1992: Marsh makes plans to centralize some large commercial placements through a new unit named Global Broking. The move is touted as a means to use technology to create a more efficient placement method for large insurance placements.

1993: A pilot program in London is launched to handle worldwide placements for certain policyholders, with 18 insurers linked to the system.

Early 1997: The Global Broking system is rolled out with a New York-based Global Broking Center and Global Broking offices in London, Bermuda and other key locations. Under the system, Global Broking employees, rather than account managers, deal directly with insurers and local Marsh offices.

Oct. 1997: A leaked memo in which Marsh executive Robert J. Newhouse III directs local offices to channel business through Global Broking, in part, to maximize contingent commission payments sparks controversy.

April 1998: The contingent commission controversy snowballs and is the feature of a special session at the Risk & Insurance Management Society Inc. conference in San Diego.

Feb. 1999: Under an agreement with RIMS, Marsh pledges to disclose estimated contingent commissions paid on individual accounts if risk managers request the information.

April 2004: New York Attorney General Eliot Spitzer launches investigation into contingent commissions.

Oct. 2004: Mr. Spitzer sues Marsh. In the suit, Mr. Spitzer alleges that the main purpose of the Global Broking structure was to maximize contingent commissions rather than to improve client service. Marsh says it will eliminate contingent commissions but stick with the Global Broking model.

Nov. 2004: Marsh fires several high-ranking employees in the Global Broking unit.

Jan. 2005: Marsh settles with Mr. Spitzer for $850 million and announces that it will disband Global Broking.

Class action: Tort reform bill headed to Senate

Continued from page 3

although he would like to amend the bill to make it stronger, he would not do so during the markup.

Even before the markup, supporters of class action reform expressed optimism that their time may finally have arrived. "I feel very bullish it is going to go through," said Joel Wood, senior vp-government affairs for the Council of Insurance Agents & Brokers in Washington. "I don't think anybody can feel cocky," he added, but also reiterated his optimism that a "good bill" could be passed in this Congress.

"We're very pleased it was reported out" of the Judiciary Committee, said Melissa Shelk, vp-federal affairs at the American Insurance Assn., minutes after the vote.

"We look forward to Senate floor debate," she added.

The Risk & Insurance Management Society Inc. is sending a letter to all senators requesting that they support S.5. In the letter, which was signed by RIMS President Nancy Chambers, RIMS calls the measure "a timely bill that provides reasonable yet meaningful reforms to the class action system."

The letter also says, "Class action reform is long overdue and critical to the continued recovery of the American economy, and S.5 represents a unique opportunity to improve a class action system that is in desperate need of repair. Therefore, I strongly urge you to support this measure."

"The fact that the bill was reported so early in the Congress without amendment is a very positive sign. Supporters of the bill have worked hard to keep the bipartisan support in place. I think the challenge going forward will be to make sure that opponents don't sink it with amendments that have nothing to do with the underlying issue," said Sherman Joyce, president of the American Tort Reform Assn.

And opponents are already drafting amendments on the Senate floor. In a paper handed out at the Feb. 3 markup, Public Citizen said, "it is unlikely that we can stop this unfair bill. But we believe we can get the votes to amend it to lessen the damage.

Public Citizen cites two potential amendments as "particularly critical." One, which Sen. Jeff Bingaman, D-N.M., is expected to introduce, would allow federal judges to decide which state's law would apply to a given class action. The amendment would also, according to Public Citizen's analysis, "let the federal court use the 'grouping' technique that has been used by some state courts. Such an approach would not allow a federal court to certify a nationwide class if there are material differences in state laws, but would not allow denial of a multi-state class simply because of nuanced differences in state laws."

The other amendment Public Citizen supports is likely to be introduced by Sen. Edward Kennedy, D-Mass. That amendment would exempt civil rights and wage-and-hour cases from S.5's provisions.

Late News

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hired two top executives from one of those units. John P. Woods Jr., founder and chairman of John P. Woods Co. Inc., and his son, John "Jay" Woods III, president of the firm, have joined Towers Perrin Reinsurance as executive vps. Gallagher, which acquired John P. Woods in 2000, last month merged the unit with Arthur J. Gallagher Intermediaries Inc. into a new company called Gallagher Re Inc. Randall S. Jensen, former president of Gallagher Intermediaries, heads that company.

Coverage prices drop in quarter: RIMS survey

Most major commercial insurance lines experienced premium declines in the fourth quarter, according to a survey of risk managers done by the Risk & Insurance Management Society Inc. and Advisen Ltd. Property rates fell the most—by about 7% on average—while directors and officers liability, umbrella/excess liability, fiduciary liability and general liability premiums declined about 2%. Workers compensation premiums, however, rose by 1.5% on average in the quarter. Although a full year of premium declines marked the longest sustained soft market since the 1990s, overall economic conditions should prevent any pricing free-fall, the survey notes.

Magistrate supports PBM disclosure law

A federal magistrate has recommended the U.S. District Court of Maine dismiss the Pharmaceutical Care Management Assn.'s suit seeking to overturn the state's Unfair Prescription Drug Practices Act. The recommendation now goes to a federal judge to determine whether to lift an injunction on the law, which is designed to promote transparency of prescription benefit managers' operations. The PCMA filed its suit in 2003, charging the law violates PBMs' civil rights and is unconstitutional, among other concerns.

Insurers tallying claims from Australian storms

Severe storms that raged across the Eastern Coast of Australia last week will result in at least $120 million Australian ($90.8 million) in insured damages, Australia's Insurance Disaster Response Organisation reported. The hail-packed storms pounded automobiles and battered homes and businesses for two days across New South Wales, Victoria and Tasmania, while heavy rains and strong winds uprooted trees and caused widespread power outages.

Briefly noted

A management buyout of Bermuda-based CNA Risk Services Ltd., led by senior managers Thomas McMahon and Michael Larkin, has been completed. The former captive management unit of Chicago-based CNA Financial Corp. has been renamed **Cedar Management Ltd.**....New Jersey Insurance Commissioner **Holly C. Bakke** is voluntarily resigning for personal reasons, effective March 1. No replacement has been named....South Carolina Gov. Mark Sanford has appointed Eleanor Kitzman as **director of the state's Department of Insurance**, subject to confirmation by the Senate. Ms. Kitzman is the founder and former president of Driver's Choice Insurance Services, an auto insurance business....**Liberty Mutual Group Inc.** is opening a captive management office—Liberty Mutual Management (Vermont) L.L.C.—in South Burlington, Vt. The office will be run by Kathryn Boucher, a long-time Vermont captive management executive....The National Risk Retention Assn. and the Captive Insurance Cos. Assn. have **terminated merger discussions**, which they launched last year. The boards of the two organizations concluded that a merger would not provide sufficient additional benefits for their members....**Citigroup Inc.** is selling its Travelers Life & Annuity and most of Citigroup's international insurance businesses to MetLife Inc. for $11.5 billion, marking the last step in the unraveling of the landmark merger of Citicorp and Travelers. Citigroup acquired the Travelers Life business as part of that $70 billion deal in 1998, which created the first major U.S. bank/insurer combination. Travelers Group's P/C business was spun off in 2002 into Travelers Property Casualty Corp.

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Merrill Lynch dismissed from WorldCom suit

By JOANNE WOJCIK

NEW YORK—A court ruling dismissing Merrill Lynch from a lawsuit filed by the former WorldCom Corp.'s 401(k) plan participants seeking to hold it liable for plan losses could discourage similar suits against pension plan trustees in the future, attorneys say.

U.S. District Court Judge Denise Cote ruled Feb. 1 that Merrill Lynch had no duty to warn plan participants against investing in company stock because it did not have inside information about accounting irregularities at WorldCom that eventually led to a drop in the company's share price.

Specifically, Merrill Lynch's liability was limited because it was a "directed trustee," whose duties and liabilities under the Employee Retirement Income Security Act are "significantly limited," the judge found, citing a December 2004 Labor Department bulletin describing the scope of duties of such trustees, which should be the governing authority in such cases, the judge said.

The decision could put a damper on future lawsuits against pension plan trustees involved in similar situations, attorneys say.

"It will certainly deter a lot of frivolous lawsuits because there have been a lot of lawsuits filed solely for the reason that there's a deep pocket on the other side," said Sherwin Kaplan, a benefits lawyer at Thelen Reid & Priest in Washington and a former Labor Department attorney who was closely following the case.

The decision also should provide some relief to pension plan trustees concerned about the recent spate of lawsuits filed by plan participants suffering losses, Mr. Kaplan added.

"It will have a very positive impact because before this decision, and also before the Department of Labor's December guidance on the issue, there was really a lot of uncertainty among directed trustees and they were unsure of what the limits of their liability were," he said.

The decision "doesn't completely draw the line," but it clarifies "to a very large extent how great their exposure is," he said. "And I think that's good for the entire industry."

But limiting trustees' liability could do even more harm to plan participants who already are victims of corporate fraud, said Jeffrey Lewis, a partner at Lewis, Feinberg, Renaker & Jackson P.C. in Oakland, Calif., and a member of the steering committee for the WorldCom plaintiffs.

"In our view, this advisory bulletin given to field offices shouldn't have been given a lot of deference," he said. "We think the bulletin is ill-advised, wrong, and would leave 401(k) plan participants and other pension plan participants with less protection against self-interested or grossly imprudent transactions by their employers."

Because most of the WorldCom executives named in the ERISA suit settled late last year, Judge Cote's granting of summary judgment to Merrill Lynch essentially renders the suit dead unless it is resurrected on appeal, according to Mr. Lewis.

But an appeal could be difficult as other litigation against a WorldCom executive is pending and courts generally don't permit appeals unless underlying litigation has been resolved against all defendants, he said.

Last June, more than a dozen top WorldCom executives reached a partial settlement with plan participants. The settlement, which was approved by the court in October 2004, will provide $47.15 million in cash, less attorneys' fees and court costs, to pay claims to all plan participants or beneficiaries between Sept. 14, 1998, and July 21, 2002.

In Re WorldCom Inc. ERISA Litigation, decided by the U.S. District Court for the Southern District of New York Feb. 1, 2005. Case No. 02 Civ. 4816 (DLC).

WorldCom: Settlement unravels

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finding that holds the former directors liable for an amount exceeding their net worth would preclude the fund from collecting its full award, a spokesman said.

As a result, the former directors will go to trial later this month along with WorldCom's auditor and bond underwriters. But, because of the nature of the claims, the plaintiffs would be able to seek 100% of any jury award from the bondholders and auditor, the fund spokesman said. Those defendants then would have to subrogate against the directors, he said.

A bondholder's spokesman declined to comment.

With no settlement, the former directors face not only a trial but also a D&O coverage battle. Their excess insurers had initiated policy recision efforts before the settlement but agreed to contribute less than half of their $85 million of aggregate limits to quickly end their involvement in the case, according to court papers. Primary insurer National Union Fire Insurance Co. of Pittsburgh, Pa., a New York-based unit of American International Group Inc., earlier had settled with the defendants.

The excess insurers now will attempt to obtain formal court approval to rescind their policies, the source said.

But a day after ruling on the settlement provision, Judge Cote ordered the D&O insurers to continue providing the former WorldCom directors a defense until the recision issue has been fully adjudicated.

CNA Financial Corp., WorldCom's first-layer excess insurer, is the first insurer on the hook to cover the former directors' legal costs, according to court documents, which note that the insurer wrote $15 million of excess limits. A representative of CNA declined to comment.

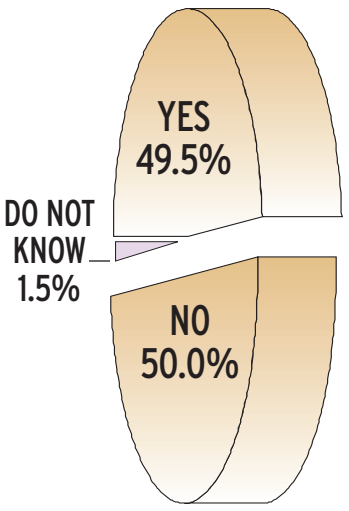
If the insurers are allowed to rescind their coverage, they can try to recover the defense costs they had advanced to the former directors.

While the 1995 securities litigation reform act was designed to provide directors some measure of financial protection, Judge Cote's ruling "has the perverse effect of inhibiting their ability to settle" in the WorldCom case, said policyholder attorney Larry S. Gangnes, a partner at Lane Powell P.C. in Seattle.

Online Poll

[1/31-2/4]

Do you think it is good policy for employers to require employees to use mail-order pharmacies to fill prescriptions for maintenance drugs?



BI Stock Index

[2/1 - 2/4]

Up-to-the-minute data for all 87 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**	**2411.21**	**2.81**
Dow Jones	**10716.13**	**2.77**
S&P 500	**1203.03**	**2.70**

Largest gains

Gainsco Inc.	14.00%
Selective Insurance Group	13.83%
Allmerica Financial	13.60%
Sierra Health Services	13.14%
Argonaut Group	9.70%

Largest losses

American Safety Insurance	-5.29%
Clark Inc.	-4.44%
Hilb, Rogal & Hobbs	-4.37%
Aspen Insurance Holdings	-2.93%
EMC Insurance Group Inc.	-2.17%

Weekly change by market segment

Brokers	1.46%
Insurers/Reinsurers	3.11%
Managed Care Organizations	4.04%

Source: FinancialContent Inc. *(http://financialcontent.com)*