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CALIFORNIA HIGH COURT RULING SEEN AS WIN FOR EMPLOYERS ON RETALIATION SUITS / PAGE 3

ROD FOX TO HEAD NEW REINSURANCE BROKER / PAGE 3

FORMER WILLIS CAPTIVE EXEC ARRESTED ON FRAUD CHARGES OVER MISSING $2.2M / PAGE 3

In Brief

Proposed reforms would broaden access to Lloyd's

The U.K. government would widen access to Lloyd's of London and allow managing agents once again to own brokers, under a slew of market reform proposals released last week. One proposal would "allow managing agents to deal with any intermediary...or directly with insureds," the government said. Currently, all business placed at Lloyd's must be placed through a so-called Lloyd's broker. The government says that rule is unnecessary because the U.K. Financial Services Authority now regulates all insurance intermediaries.

Judge blocks order barring stop-loss RRG

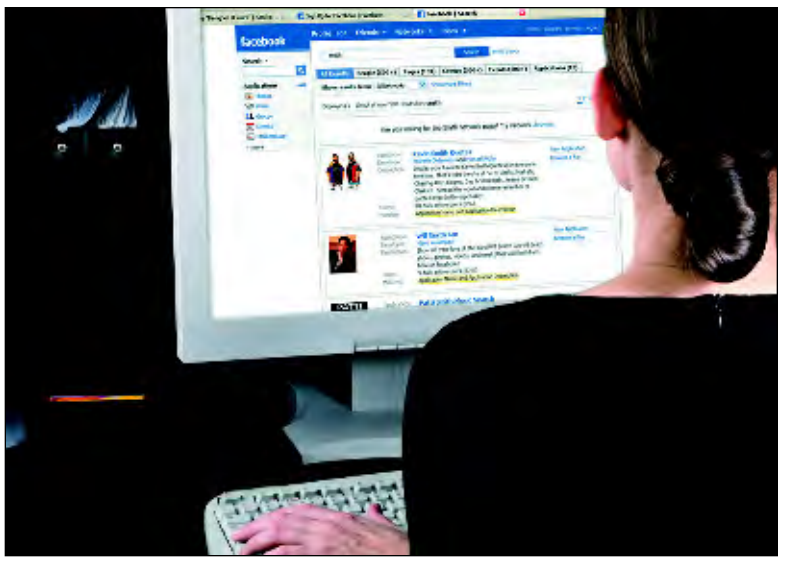
U.S. District Court Judge Frank Damrell Jr. issued a preliminary injunction last Friday that

See **IN BRIEF** page 26

BENEFITS MANAGEMENT

HEALTH CARE COST CONTROL

Some employers turn to "medical homes" to help improve the delivery of health care; value-based health plans use carrot and stick approach to cut costs; medical consulting firms gain traction with employers; medical tourism packages find few buyers in U.S. **Page 9**



As employers increasingly use social networking Web sites such as Facebook and MySpace to conduct informal background checks on job applicants, legal experts warn that discrimination suits could soon follow.

Web-based screening may lead to bias suits

Experts advise caution as employers use sites to vet job applicants

By JUDY GREENWALD

Employers' growing use of social networking sites such as Facebook and MySpace to scrutinize job applicants could lead to charges of employment discrimination and litigation, experts warn.

Observers say that without adequate policies in place, employers may be leaving themselves vulnerable to charges that they are using the data available on the Web sites to cull minorities, homosexuals and other applicants who are members of protected classes.

With Palo Alto, Calif.-based Facebook alone claiming 66 million active users, more employers are using these popular sites to check out job applicants, observers say.

A survey of about 350 employers in October 2007 by New York-based Vault.com, a media company focused on careers, found that 44% of employers use social networking sites to examine the profiles of job candidates, and 39% have looked up the profile of a current employee.

Observers say "failure to hire" lawsuits are far smaller in number than other types of employment litigation, such as those involving termination or charging retaliation, but they do expect litigation to emerge from employers' growing use of social networking sites. Use of these sites could be used as evidence in litigation, even if it is not necessarily the primary motivation behind a lawsuit, they say.

Few firms, however, have formal policies on this issue, experts say.

Looking someone up on a Web site is not illegal because the Internet is public property, said Sue Murphy, manager of the Nashua, N.H.-

See **BIAS** page 6

Mental parity bill steps closer to law

Measure would force employers to upgrade health care benefits

By JERRY GEISEL

WASHINGTON—Federal legislation that would mandate mental health benefits receive insurance coverage equal to other health care benefits is heading to a congressional conference committee, which likely will agree on a compromise bill, benefit experts say.

The House of Representatives last week cleared its version of the parity legislation on a 268-148 vote. That action, following last year's Senate passage of a more limited parity measure, sets the stage for a conference committee to try to work out the differences between the two bills.

Many provisions in the measures are identical. Both, for example, go well beyond a 1996 law that made it illegal for employers to impose lower annual or lifetime dollar limits in their health care plans for coverage of mental health care conditions and substance abuse-related disorders than other medical conditions.

Under the two bills, employers would have to provide the same coverage for mental disorders as they do for other medical conditions.

That would force the overwhelming majority of employers to upgrade their mental health coverage to eliminate common discriminatory designs, such as providing a lower reimbursement level for mental health care services compared with other medical conditions or capping the annual number of outpatient visits to mental health therapists but having no comparable limit for other medical services.

The House bill goes even further—too far in the view of most business lobbyists—by mandating that health care plans provide equitable coverage for any diagnosis listed in the psychiatric industry's

See **PARITY** page 24

N.Y. seeks more data on comp payments

Employers may face added admin costs as reforms continue

By ROBERTO CENICEROS

REUTERS

Gov. Eliot Spitzer is reviewing proposed changes to workers comp reporting requirements in New York.

ALBANY, N.Y.—New York employers would face a bigger administrative burden if plans to increase workers compensation claims data requirements go into force, but the changes will make the system more efficient, state officials say.

The recommended changes, which were in a 143-page report that Superintendent of Insurance Eric R. Dinallo sent last week to Gov. Eliot Spitzer, calls for employers and other workers comp payers to provide wide-ranging claims information to a centralized information bank set up by the state.

Centralized data then could be analyzed to help policymakers

See **COMP** page 25

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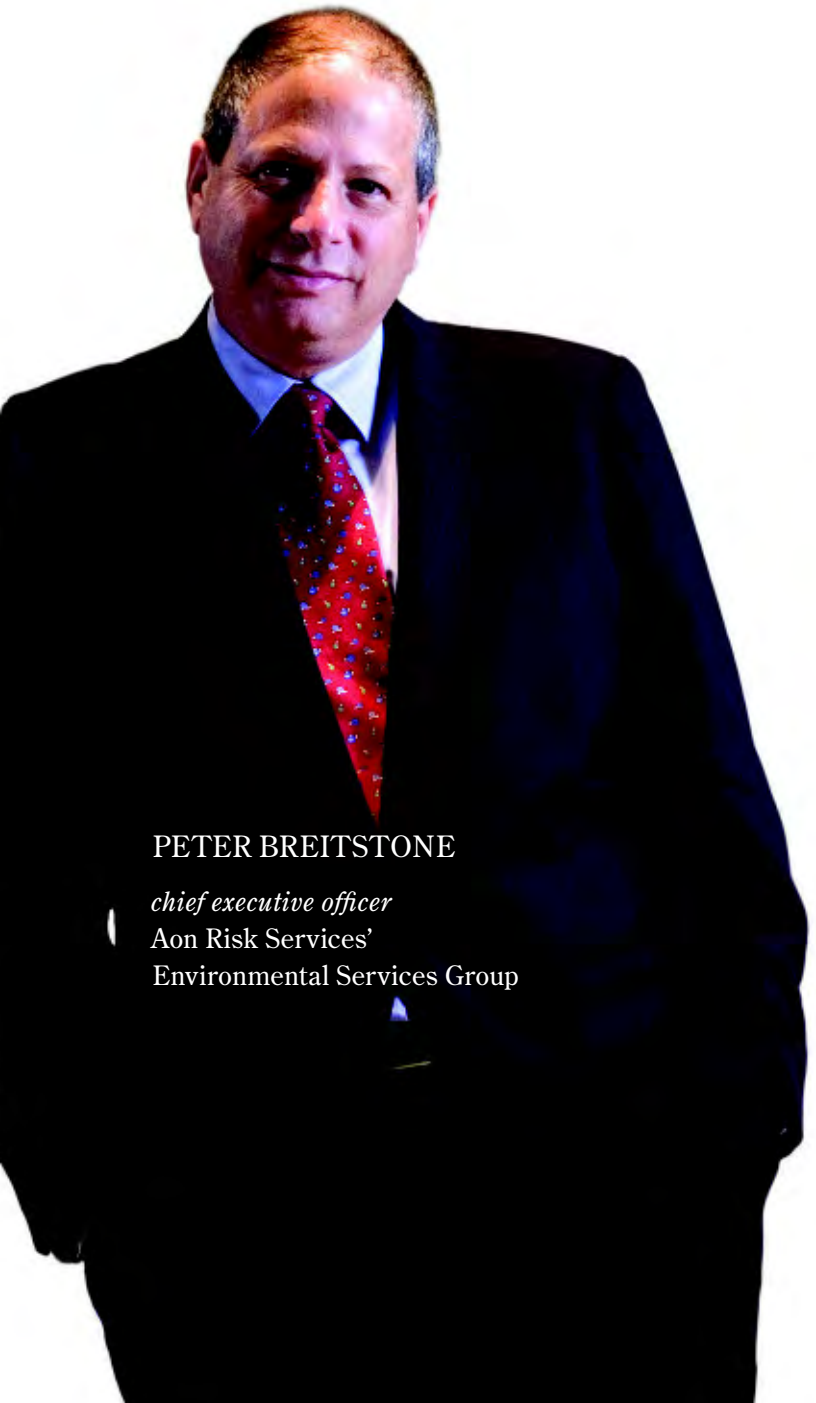

PETER BREITSTONE

chief executive officer
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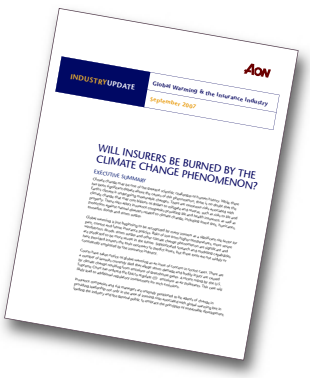

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AON RISK SERVICES

On the Web

BI AUDIO

More about 'medical homes' available online

Dr. Paul Grundy, IBM Corp.'s director of health care technology and strategic initiatives, talks about the concept of medical homes and how they can bring physicians closer to their patients and improve the delivery of health care. To hear his interview, go to *www.BusinessInsurance.com/audio*.

BI PHOTO GALLERIES

Share your industry news through photos

Is your business or organization involved in charitable endeavors, or do you have awards and other highlights you'd like to share? Submit photos of these events to *Business Insurance's* online photo galleries. For guidelines on how to send photos, go to *www.BusinessInsurance.com/submitphoto*. To view photo galleries, go online to *www.BusinessInsurance.com/gallery*.

BI DIRECTORIES

Case manager, PBM directories updated

Business Insurance has updated its Case Management Providers and Prescription Benefit Managers directories for 2008. Both are available online. Review all available directories at *www.BusinessInsurance.com/directories*.

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Business Insurance®

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Court rules for employers in retaliation case

Individuals can't be held liable, California court says

By JUDY GREENWALD

SAN FRANCISCO—A California Supreme Court ruling that individual managers and supervisors cannot be held personally liable for retaliation is a victory for employers on several fronts, observers say.

The ruling will lower legal costs by reducing the number of defendants in cases alleging retaliation and it will make it easier for multistate employers with California operations to move cases to friendlier federal courts because local defendants will not be involved, they say.

The court's March 3 decision in *Scott Jones vs. The Lodge at Torrey Pines Partnership* extends a 1998 ruling that held that individuals cannot be held liable for discrimination, to include retaliation.

However, co-workers, supervisors and managers, still can be named defendants in suits claiming sexual harassment, attorneys say.

According to the opinion, Mr. Jones, who had been responsible for restaurant and other operations at the La Jolla, Calif.-based Torrey Pines Golf Course sued his employer, his supervisor and others on various counts, including retaliation, after he resigned from the company.

Mr. Jones claimed he was retaliated against after he complained about vulgar remarks made to him by his supervisor Jean Weiss and another co-worker in 2001, according to court papers.

A jury awarded Mr. Jones $1.4 million in compensatory damages against the Lodge and $155,000 against Mr. Weiss.

The trial court ruled that Mr. Weiss, as an individual, could not be held liable for retaliation. An appeals court overruled that decision.

But the California Supreme Court in its 4-3 decision agreed with the trial court, citing the California Fair Employment and Housing Act, which says it is unlawful for "any employer, labor organization, employment agency or person" to engage in retaliation.

Mr. Jones argued that, according to that law, an individual can be held personally liable. "Its language does lend itself to plaintiff's interpretation, but...that is not the only reasonable interpretation of the statutory language," the court said.

After a lengthy analysis, the majority opinion concluded that

See **RETALIATION** page 6

RETALIATION RULING

WHAT THE COURT SAID
Individual managers and supervisors cannot be held personally liable for retaliation claims.

IMPACT ON EMPLOYERS
Multistate employers with operations in California may find it easier to move retaliation lawsuits to federal courts. Also, legal costs will drop as fewer defendants are named in suits.

GLENN RUSSELL/WWW.BURLINGTONFREEPRESS.COM

Prosecutors allege that Kenneth MacKay built this $1.9 million home in Williston, Vt., with money he stole from his employer, Willis Management (Vermont) Ltd., and Willis clients.

Ex-Willis exec accused of stealing $2.2 million

Captive management senior vp faces charges of bank, wire fraud

By SALLY ROBERTS

BURLINGTON, Vt.—A former senior vp of Willis Group Holdings Ltd.'s Vermont-based captive management operations was arrested last week on charges that he stole more than $2.2 million from Willis and its clients.

In a criminal complaint filed in U.S. District Court for the District of Vermont, the U.S. Attorney's Office accused Kenneth MacKay, 36, of bank fraud, wire fraud and money laundering in a multiyear scheme while he was employed at Willis Management (Vermont) Ltd.

Mr. MacKay was fired last month after an 11-year career with Willis, a spokeswoman for the London-based brokerage said.

According to the criminal complaint, Mr. MacKay allegedly used some of the stolen funds to build a $1.9 million home in Williston, Vt.; to fund five college savings plans, totaling about $240,000, for his children; and to purchase a $238,000 condominium in Orlando, Fla.

Using various schemes, Mr. MacKay diverted and laundered money he controlled at Willis into RCM Financial, a shell corporation he created in 2000, court papers say.

In one instance, Mr. MacKay in 2004 opened an account in the name of a Cayman Islands-domiciled captive managed by another subsidiary of Willis and fraudulently wrote more than $600,000 in checks drawn on the account to pay for construction of his Vermont home and to fund his shell company, according to court filings.

In another scheme, which began in October 2006, Mr. MacKay altered invoices sent by American

See **FRAUD** page 25

Industry veterans open reinsurance brokerage

Fox, Stanard launch Alpha Re to target catastrophe business

By JUDY GREENWALD

SHELTON, Conn.—Insurance industry veterans Rod Fox and James N. Stanard have started a new reinsurance intermediary, Alpha Re, Mr. Fox said.

Alpha Re, which may change its name later, began operations on Feb 1. The company so far has focused on catastrophe business but is already expanding into other lines, Mr. Fox said.

Mr. Fox

Mr. Stanard

"We expect to build a high-end, private boutique reinsurance brokerage firm and focus on a small group of clients, and provide a very high level of expertise and capabilities to those clients."

He did not disclose expected revenues for the operation.

Alpha Re now is headquartered in Shelton, Conn., but eventually will be based in Greenwich, Conn., Mr. Fox said. It also has offices in San Antonio and Minneapolis.

Messrs. Fox and Stanard are financing the privately held firm primarily through Greenwich, Conn.-based F&S Ventures, their privately held investment company, Mr. Fox said.

Late last year, the two announced they had set up a separate operation, New Asset Class Management, an underwriting management firm in Greenwich, Conn.

Mr. Fox, who previously was CEO of New York based Praetorian Financial Group Ltd. and a reinsurance brokerage executive before that, is chairman and chief executive officer of Alpha Re. Mr. Stanard will act as a consultant and advise Alpha Re's clients, but have no formal title, said Mr. Fox.

Mr. Stanard, who previously served as chairman and chief executive officer of Pembroke, Bermuda-based RenaissanceRe Holdings Ltd., resigned in 2005 following regulatory investigations of the reinsurer. He faces civil fraud charges by the Securities and Exchange Commission in connection with a finite reinsurance deal completed by the reinsurer in 2001, and his case is pending, according to the SEC.

Another industry veteran, Ted Blanch Jr., formerly chairman and CEO of E.W. Blanch Holdings Inc., is vice chairman of Alpha Re.

Other partners in the firm, which has nine employees, include Larry LaMere, who built Dallas-based E.W. Blanch Holdings' backroom operation, said Mr. Fox. Also on board is Marc Lauricella, Praetorian's former chief marketing officer.

"We have formed a partnership with the BMS Group in London" to provide services including claims handling, contract writing, catastrophe modeling and a "London intermediary capability," Mr. Fox said.

Mr. Fox said one factor behind

See **ALPHA RE** page 22

Discrimination filings with EEOC the highest since 2002

Race still No.1 issue; retaliation overtakes gender at No. 2

By SALLY ROBERTS

WASHINGTON—The U.S. Equal Employment Opportunity Commission in fiscal year 2007 received the highest number of discrimination charge filings in five years, the agency reported last week.

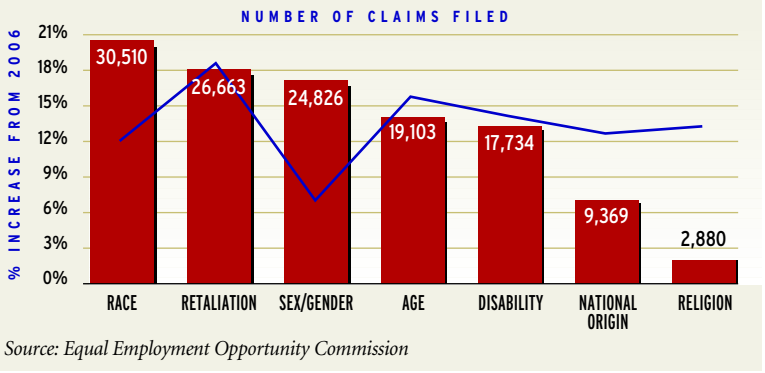
The federal agency received 82,792 private-sector discrimination charge filings in fiscal 2007, compared with 75,768 in 2006. The 9.3% annual increase is the largest since 1993.

Of the seven major discrimination charge categories, all but one—gender-based charges—saw double-digit increases in the number of filings in 2007 vs. 2006, which the EEOC called a "rare occurrence."

The Washington-based EEOC attributed the jump in charge filings to a combination of greater awareness of the law, changing economic conditions, and increased diversity and demographic shifts in the labor force.

"Corporate America needs to do a better job of proactively preventing discrimination and addressing complaints promptly and effectively," EEOC Chair Naomi C. Earp said in a statement.

Allegations of discrimination based on race, retaliation and gender remain the most frequently filed charges, according to the agency's fiscal 2007 statistics. The EEOC said multiple types of discrimination may be alleged in a single filing.



Race discrimination charges continue to top the list, with 30,510 charges filed in 2007, the EEOC said. The 12% increase over 2006 marks the highest level since 1994, the agency noted.

The number of retaliation charges surpassed gender-based charges for the first time in 2007, the EEOC said. The number of retaliation charges increased 18.2% in 2007—the biggest jump among the seven major charge categories—to a record 26,663, while gender-based discrimination charges grew 6.8% to 24,826.

Among the gender-based charges, pregnancy discrimination charges surged to a record 5,587, up 14% from 2006, the EEOC said.

At the same time, the number of sexual harassment filings increased

See **EEOC** page 22

AP

Supreme Court Chief Justice John Roberts recused himself from a case involving a drugmaker owned by Pfizer, leading to an evenly divided ruling.

Supreme Court allows Rezulin suit to go to trial

By DAVE LENCKUS

WASHINGTON—A divided U.S. Supreme Court last week allowed a group of plaintiffs to sue the manufacturer of the diabetes drug Rezulin in a case that centered on when federal laws supersede state laws.

In a one-sentence ruling, the high court on March 3 affirmed a lower court ruling that the plaintiffs' damages case against a Pfizer Inc. unit could go to trial. The Supreme Court affirmed the ruling by the 2nd U.S. Circuit Court of Appeals in a 4-4 vote, with Chief Justice John Roberts not taking part in the case.

Under the court's rules on tied votes, underlying decisions are affirmed, and the court does not reveal how each justice decided. In a 2004 financial disclosure report, Chief Justice Roberts disclosed he had an investment in Pfizer valued at between $15,000 and $50,000.

UNUSUAL CIRCUMSTANCES

WHAT HAPPENED

The Supreme Court split 4-4 in a suit against the maker of diabetes drug Rezulin, which resulted in upholding a lower court of appeals decision.

WHAT'S NEXT

A separate suit involving another drugmaker could result in clearer guidance on how federal pre-emption applies in product liability cases.

The case, *Warner-Lambert Co. L.L.C. et al. vs. Kimberly Kent et al.*, stems from a product liability lawsuit filed against Pfizer unit Warner-Lambert in 2000 in Michigan state court. The plaintiffs are seeking damages for injuries allegedly

See **REZULIN** page 25

Errors & Omissions

An item in the March 3 issue misidentified the law firm of Dewey & LeBoeuf L.L.P.

Optional federal charter backers encouraged

Administration becoming convinced of need

By MARK A. HOFMANN

WASHINGTON—The Bush administration appears to be moving toward support of an optional federal charter for insurers and producers, according to the co-sponsor of a House bill that would create such new charters.

The Bush administration "is inescapably coming to the same conclusion" that a federal role is necessary, Rep. Ed Royce, R-Calif., told those attending last week's Washington insurance reform summit sponsored by the Networks Financial Institute at Indiana State University.

Rep. Royce, who introduced the House version of the National Insurance Act with Rep. Melissa Bean, D-Ill., noted that the Treasury Department is expected to issue its report on financial services regulation within a few weeks.

"From what I've heard," the OFC will be part of that report, Rep. Royce said. "We're getting a lot of momentum" on the OFC issue.

He pointed out that the House Financial Services Committee, on which he serves, plans to hold another series of hearings on financial services regulation next month.

Insurance "doesn't have a seat at the table" in international trade negotiations because it lacks a federal regulator such as the securities

See **CHARTER** page 24

'From what I've heard,' the OFC will be part of that report. 'We're getting a lot of momentum' on the OFC issue.

Rep. Ed Royce, R-Calif.

Health insurer payment info sought

By JOANNE WOJCIK

NEW YORK—New York Attorney General Andrew Cuomo is broadening his investigation into health insurers' practices related to payments for out-of-network services, issuing new subpoenas to several companies seeking additional information.

Mr. Cuomo last month announced plans to sue Minnetonka, Minn.-based UnitedHealth Group Inc. and several of its subsidiaries for dramatically under-reimbursing out-of-network medical expenses using data provided by Eden Prairie, Minn.-based Ingenix, also a unit of UnitedHealth. No suit has yet been filed.

Last week, the attorney general's office issued eight new subpoenas to four large health insurers: Aetna Inc., CIGNA Corp. and WellPoint Inc. and UnitedHealth. Four of these were document subpoenas, and four were deposition subpoenas seeking testimony from company officers. The document subpoenas include requests for all e-mail correspondence involving the companies' chief executive officers, chief operating officers, chief fiscal officers, presidents and employees supervising claims.

"We believe consumers have been defrauded, that it has happened for a number of years, and it's occurred all across the country," said a spokesman for the New York attorney general. "The CEOs are responsible for their corporations, and these actions had a significant impact on working families."

Mr. Cuomo's office also issued 12 subpoenas under New York fraud statutes, four of which went to the aforementioned companies. The other eight subpoenas were issued to: Capital District Physicians Health Plan Inc., Empire Blue Cross Blue Shield, Excellus BlueCross Blue Shield, Group Health Inc., HIP Health Plan of New York, HealthNow New York Inc., Independent Health Association Inc. and MVP Preferred Care.

Mr. Cuomo also is reviewing the information his office received in response to subpoenas that were issued last month to many of the same companies.

Mr. Cuomo's investigation centers around Ingenix's Prevailing Healthcare Charges System, which is used by most of the nation's health insurers and third-party administrators to calculate out-of-network reimbursements to providers based on usual, customary and reasonable charges. The attorney general asserts that because the reimbursement rates were set too low, consumers were forced to pay higher than necessary out-of-pocket medical expenses.

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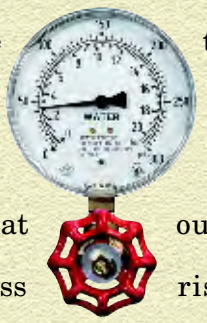
WAUSAU PROPERTY AT WORK. A building material supply customer of ours recently moved into a larger building. Despite the extra space, it still had inventory stacked nearly to the ceiling. This presented a bit of a problem for the existing sprinkler system, which was not designed for high-pile storage. The system didn't have the necessary water and pressure to combat the type of intense fires that could result from the primarily wood materials. Our loss prevention experts estimated the entire $4 million inventory could be lost in a fire. Working together, we found a solution that appealed to both the company and its landlord. The existing system was replaced with one designed for high-pile storage and the building was outfitted with new heaters to prevent the pipes from freezing. In addition to protecting its inventory, the company saved almost $30,000 a year in premiums. It's all part of Wausau TotalValue℠ and our commitment to lowering our customers' total cost of risk. A commitment backed by the financial strength of the Liberty Mutual Group. To learn more, visit wausau.com or contact your Wausau representative.



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U.S. COAST GUARD

The insurer of container ship Cosco Busan, which spilled fuel into the San Francisco Bay in November, made an initial payment of $2 million to the city.

Shipowner pays $2M to help fund oil cleanup

By JUDY GREENWALD

SAN FRANCISCO—The insurer of a ship that spilled fuel oil into San Francisco Bay following a November accident has made an initial payment of $2 million in compensation.

San Francisco City Attorney Dennis Herrera said in a statement last week that Pennsauken, N.J.-based Hudson Marine Management Services, the agent of the ship's insurer, Steamship Mutual Underwriters Assn. (Bermuda) Ltd., has wired the funds to the city to begin payment for the cleanup effort.

The M/V Cosco Busan on Nov. 7 collided with the Bay Bridge, causing the vessel to spill more than 54,000 gallons of bunker fuel into the bay.

The city in December sued the ship's owner, Regal Stone Ltd. of Hong Kong, as well as several other parties.

The suit charges that the spill from the Cosco Busan killed or injured at least 2,200 birds as well as other marine life, damaged waterfront property, harmed the livelihoods of San Francisco Bay area fishermen, impaired the public's recreational enjoyment and compelled the city to "expend substantial sums of money."

Mr. Herrera said the $2 million is not a final settlement "and does not preclude the city from recovering further damages."

Others being sued include Hong Kong-based Fleet Management Ltd., the ship's operator; Seoul, South Korea-based Hanjin Shipping Co. Ltd., the owner of the spilled fuel; Synergy Management Services and Synergy Marine Ltd., which are both identified as agents of Regal Stone; and John J. Cota, the ship's pilot at the time of the spill.

Bias: Site use may cause liability issues

CONTINUED FROM PAGE 1

based National Human Resources Assn. "But where the liability starts to come into play is when people are making hiring decisions based on that information without coming back and talking to the applicant," she said. "I think it is going to be tested in the courts."

Observers say employers long ago stopped asking job applicants to submit photos with their job applications to avoid being accused of rejecting applicants on the basis of their age, race or other factors. Today, however, it often takes no more than the click of a mouse to locate an image of an applicant.

If it is found employers have been looking at the sites, "I have a feeling you're probably going to see lawsuits, and the burden is going to be back on the employer to show the protected category" did not enter into its "decision to hire or not hire," said Anthony Zaller, an attorney with Van Vleck Turner & Zaller L.L.P. in Los Angeles.

Matthew S. Effland, an attorney with Ogletree, Deakins, Nash, Smoak & Stewart P.C. in Indianapolis, said he knows of no decision so far "that says using this information is a violation of some employee's rights, but the law is notoriously slow to catch up to technology," and "I very much see this becoming an issue in the future."

Nondemographic information also can be found on the Web sites. Miriam Wugmeister, an attorney with Morrison & Foerster L.L.P. in New York, said employers should be wary of laws in some states, including New York, that say employers "can't discriminate against somebody in employment based on activities they engage in, in their private time," such as smoking.

Many states' laws also forbid making job decisions based on applicants' political activities, said Ms. Wugmeister.

This issue will lead to increased litigation, at least in the short term, "until some parameters are set" as to what is private and public knowledge, she said. "We haven't yet settled on where the boundary is," she said. As a result, "we may see legislation even more than litigation" on this issue, she said.

"We have good sense policies," said Tim DeMello, founder and chief executive officer of Boston-based Ziggs Inc., a firm that helps its clients manage their Internet "online brand."

Mr. DeMello said as an employer, he occasionally looks at applicants' social networking sites to get some sense of their character. If you go

Should employers use social networking sites such as MySpace in hiring decisions? Legal experts say doing so may increase employers' risk of job discrimination lawsuits.

to Facebook and see someone pictured with swastikas and then do not hire them, "do you call that discrimination?" he asked rhetorically.

Employers should have a policy in place that "details what the purpose of the Internet search is," and that specifically spells out that the firm does not base its decision on race, color or national origin, said Mr. Effland.

Jennifer M. Bombard, an attorney with Morgan, Brown & Joy L.L.P. in Boston, said, "Make sure there's a legitimate business rationale for rejecting applicants and that your hiring decisions are not motivated by information you found on an applicant's social networking site. Make sure you can point to a legitimate reason for rejecting" the applicant and document and be prepared to justify that decision, she said.

Neal D. Mollen, an attorney with Paul, Hastings, Janofsky & Walker L.L.P. in Washington, advised employers to avoid looking at the social networking sites altogether. "I think it's unlikely employers are going to learn a good deal of job-related information from a Facebook page they won't learn in the context of a well-run interview, so the potential benefit of doing this sort of search is outweighed by the potential risk."

Tim Best, president of Arlington, Texas-based PreScreen America Inc., a background investigation agency, said he tells his clients not to use these sites. If the information an employer learns turns out to be false, and it relies on it in making a decision, the company is in danger of being sued, he said. "It's at best risky doing that," said Mr. Best, who is chairman of the Privacy and Personnel Information Management Council of the Alexandria, Va.-based ASIS International, a security organization.

Refraining from checking the Web sites in the prescreening stages protects "the employer from an unfair inference that they relied on demographic data that was not visible on the application," said Manesh K. Rath, an attorney with Keller & Heckman L.L.P. in Washington.

But once the candidate has been met, "I think that employers are entitled to consider the whole of an applicant," said Mr. Rath, who is a member of the Alexandria, Va.-based Society for Human Resource Management's expertise panel.

Gerald L. Maatman Jr., an attorney with Seyfarth Shaw L.L.P. in Chicago, said the pros and cons of seeking out this information should be weighed. If there is a subsequent discrimination suit, and an employer honestly acknowledges having looked at a social networking site, "it makes that case more problematic to defend."

Retaliation: Individuals can't be held liable, California court says

CONTINUED FROM PAGE 3

the court's 1998 decision in *Reno vs. Baird*, which held that "non-employer individuals" are not personally liable for discrimination, applies to retaliation as well.

The same reasons in reaching the conclusion for discrimination apply to retaliation as well, the opinion states. Among them is supervisors would be placed in a position of conflict of interest with their employers when they were making personnel decisions if they could be held personally liable.

The court quoted an earlier opinion, which stated that the supervisor "would be pressed to make whatever decision was least likely to lead to a claim of discrimination against the supervisory employee," putting him in a position of "choosing between loyalty to the employer's lawful interests" versus protecting his own personal interests, according to court papers.

Observers say this decision will make it easier for multistate employers with California-based operations to move cases to friendlier federal courts under the "diversity" legal concept, which gives federal courts the power to decide cases between citizens of different states.

A multistate employer with no California resident named as a defendant could have cases moved to federal court, observers say. Typically, to preclude that, a plaintiff attorney will name a California individual as a defendant in order to keep his case in state court, said Thomas McInerney, an attorney in the San Francisco office of Ogletree, Deakins, Nash, Smoak & Stewart P.C., who is not involved in the case. This decision makes that harder to accomplish, he said.

Employers prefer having their cases heard in federal court, observers say. Regina A. Petty, an attorney with Wilson Petty Kosmo & Turner L.L.P. in San Diego, who represented Torrey Pines in the litigation, said, "Federal courts are more conservative in the handling of civil litigation. And many federal courts, unlike a lot of state courts, still require a unanimous jury verdict, and the federal court standards for granting summary judgment is more favorable to defendants."

Additionally, by barring individuals as defendants, litigation costs will be reduced because separate attorneys won't be needed, observers say.

The decision "is a particularly excellent result" because it eliminates the need to have multiple counsels in these cases, said Ms. Petty.

Having fewer defendants "will just make defending the case more manageable," said Mr. McInerney.

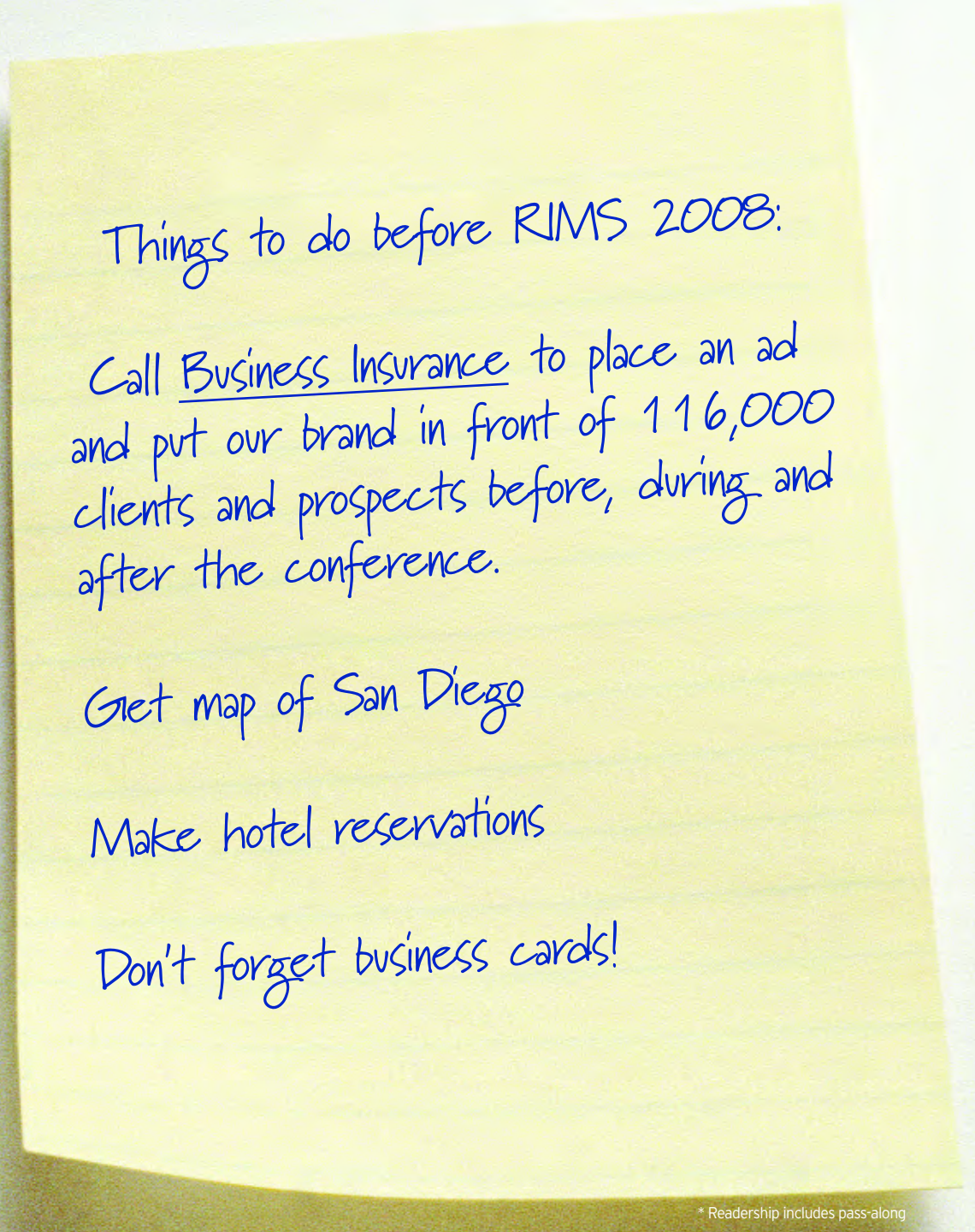
Melanie M. Poturica, an attorney with Liebert, Cassidy Whitmore in Los Angeles, representing the League of California Cities, who submitted an amicus brief in the case on behalf of Torrey Pines, said the decision also "enables employers to ensure getting the best and the brightest in their supervisory and management positions, people that will not be concerned with holding back on taking legitimate, nonretaliatory personnel actions."

"The Supreme Court was very mindful of the practical implications of personal liability of managers" in retaliation suits, said Christopher Olmsted, an employer attorney with Barker Olmsted & Barnier in San Diego, who is not involved in the case.

But Scott Toothacre, an attorney with Toothacre & Toothacre in San Diego, who represented Mr. Jones, said, "The court engaged in judicial activism in imposing their policy over the stated policy of the legislature."

There were two dissenting opinions in the case, with both asserting the majority opinion misinterprets the law. The majority opinion rejects "the most commonsense reading of the statute," said one of the dissenting opinions.

Scott Jones, plaintiff and appellant, vs. The Lodge at Torrey Pines Partnership et al., defendants and respondents, Supreme Court of California, S151022; March 3, 2008



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Business Insurance OPINIONS

Preferential treatment undermines parity goal

WHILE MANDATED MENTAL HEALTH care benefits parity legislation is probably an idea whose time has come, we don't think the approach favored by some parity advocates is the way to achieve it.

As we report on page 1, the House of Representatives last week approved parity legislation that, like a measure earlier approved by the Senate, would require employers to offer the same level of benefits and cost-sharing for mental health care services as they do for other medical conditions.

Whatever justification employers may have once had for making distinctions between mental health and other medical services—such as paying 50% of a bill for a mental health care service but 80% for another medical condition—seems outdated.

That said, the House approach, as Rep. Howard McKeon, R-Calif., said during last week's debate on the legislation, is not parity but is, in fact, preferential treatment for mental health services.

If there is logic in an overly broad requirement to cover mental health care, it escapes us.

What Rep. McKeon is referring to is a provision in the House bill stipulating that any diagnosis listed in the psychiatric industry's manual of disorders would have to be covered on the same basis as any other medical condition.

If there is logic in such an overly broad requirement, other than enriching mental health care providers, it escapes us. What the provision effectively says is regardless of whether a few people or many have a diagnosis in the manual, all such disorders require coverage.

To the extent that more and more employer dollars go to covering diagnoses that affect very small numbers of patients, that means fewer dollars will be available for medical conditions that affect far more people.

We hope that provision is the first to be removed when federal lawmakers put together a final bill.

Weigh Internet sources carefully when hiring

MINING SOCIAL NETWORKING SITES for information on potential employees is another example of how business and pleasure aren't always easily mixed.

As we report on page 1, more and more employers are using Web sites such as Facebook and MySpace—which were designed for people to connect, share common interests and build online communities—as a resource to check out job applicants.

The sites are yet another example of how the Internet has opened numerous opportunities for companies and individuals to conduct both serious and trivial research. Whether it be Googling a college roommate or looking for a new business partner in China, a few mouse clicks are all it takes.

When it comes to vetting candidates, however, companies may face some troublesome liabilities if they don't have a policy in place to detail how they should use Internet resources. Claims that companies discriminated against applicants based on what they saw on their MySpace pages could lead to costly litigation.

Banning human resources departments or other personnel involved in recruitment decisions from using the Web as a research tool is unrealistic. Before they hit the search button, however, managers and recruitment staff should have formal guidelines on what they should and shouldn't do and the potential consequences.

Let someone else be the test case for using social networking sites as a discrimination tool.

BI beats list

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

Agents/brokers: Sally Roberts.

Benefits—health care and ancillary benefits: Joanne Wojcik.

Benefits—retirement savings/pensions: Jerry Geisel.

Canada—risk management and benefits: Gloria Gonzalez.

Commercial auto: Jeff Casale

Employment practices: Judy Greenwald.

Environmental risk management: Sally Roberts.

Federal regulation/ legislation—benefits: Jerry Geisel.

Federal regulation/ legislation—risk management: Mark A. Hofmann.

Health care industry operations: Gloria Gonzalez.

Industry Focus: Rodd Zolkos, Meg Fletcher.

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Insurance fraud: Douglas McLeod.

Latin American markets: Roberto Ceniceros.

Marine: Gloria Gonzalez

Property/casualty industry operations: Judy Greenwald.

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Property loss control/ cat risks: Mark A. Hofmann.

Regulation of insurance: Meg Fletcher.

Reinsurance: Judy Greenwald.

Risk management profession: Dave Lenckus.

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Safety/ergonomics: Meg Fletcher.

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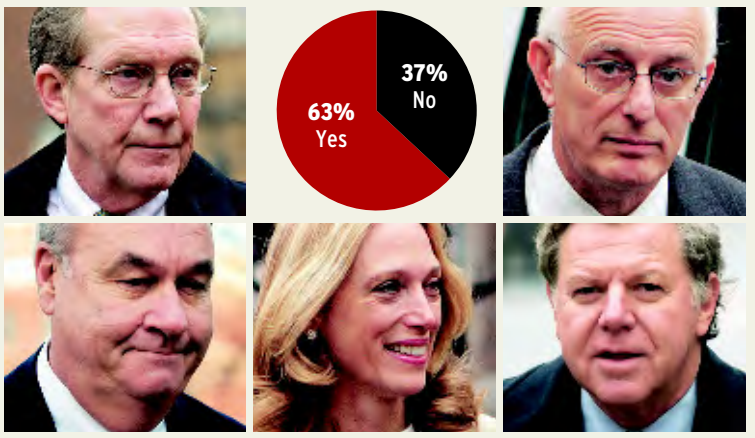
Tort reform: Mark A. Hofmann.

Work/life benefits and EAPs: Sally Roberts.

Workers compensation: Roberto Ceniceros.

Online Poll at *www.businessinsurance.com*

Do you agree with the jury verdict finding the five defendants in the General Re finite trial guilty of fraud and conspiracy in a scheme to help American International Group Inc. inflate its reserves?



NEXT WEEK'S POLL: *Should employers consider personal information posted on Internet social networking sites when vetting potential employees?*

***BI* Online Poll tool sponsored by Wausau Insurance Cos.**

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HEALTH CARE COST CONTROL

Medical consultants drive effective care to get the most from employer dollars / Page 11

Value-based plans improve utilization and compliance, but jury still out on savings / Page 14

Medical tourism, long used abroad, has yet to catch on with U.S. employers / Page 15

BENEFITS MANAGEMENT

'Medical home' shifts emphasis to patient-centered care

Approach taps coordinated, comprehensive service delivery directed by a primary physician, who may receive a bonus

By JOANNE WOJCIK

When an IBM Corp. executive suddenly developed chest pain, he made an appointment with a cardiologist, who performed a battery of tests that had inconclusive results except an unidentifiable abnormality in the neck region.

The cardiologist referred the executive to a neck surgeon, who removed the abnormality. The chest pain, however, persisted.

Several months later, the executive visited an IBM doctor to receive vaccinations prior to traveling overseas and again reported the nagging pain. The company doctor pressed on the executive's chest, reproduced the pain and asked whether the executive had made any changes in his routine before it started.

"It began when I started weed-whacking," the executive said.

It turned out the executive was experiencing muscle soreness and inflammation due to overexertion. But the correct diagnosis was not made until after $168,000 had been spent on tests, surgery and several visits to specialists.

ON THE WEB

Hear a podcast with IBM's Dr. Paul Grundy on the concept of 'medical homes' and how they work at www.businessinsurance.com/audio.

If that executive had a "medical home," a primary care doctor providing comprehensive, holistic care, the cause of his pain may have been identified much earlier, said Dr. Paul Grundy, IBM's director of health care technology and strategic initiatives in Armonk, N.Y.

He said the hallmarks of a "medical home" are an ongoing relationship with a doctor; a team approach to delivering comprehensive, coordinated care that is integrated across the health care system; the use of tools, such as electronic medical records, to ensure that care is delivered safely and prevents redundancy and medical errors; and expanded access, including evening and weekend office hours and the use of e-mail and telephone consultations (see story, page 10).

While in some ways the medical home sounds like the primary care physician in a closed-network health maintenance organization, the medical home does not serve as a gatekeeper but rather as a gateway to the health care system, Dr. Grundy said.

"A medical home is a real and virtual relationship with a doctor centered around a patient's needs," he said.

IBM was one of the founders of the Patient-Centered Primary Care Collaborative, a coalition of large employers and employer groups, consumer organizations and medical providers dedicated to promoting the medical home concept to improve the quality of care and hopefully lower its cost.

"It started about three years ago with a discussion around my boss' swimming pool," Dr. Grundy recounted. "We were talking about the things large employers had done (to control health care costs and improve quality) and realized that we were not addressing the fundamental issue…that the primary care system is broken."

See **MEDICAL HOMES** next page

RANKINGS: Case Managers / Page 12 Prescription Benefit Managers / Page 16

Coming up April 21: Wellness Programs

Medical homes: Primary care re-evaluated

CONTINUED FROM PREVIOUS PAGE

After that discussion, Dr. Grundy said IBM approached its health plans, asking to buy comprehensive care for its employees, but the plans said they couldn't do that.

"They said they could only sell what Medicare allows: episodic care based on code numbers," Dr. Grundy said.

For example, the current system compensates a surgeon for amputating the gangrenous limb of a diabetic patient, but it doesn't adequately compensate that patient's doctor for managing the care to prevent the amputation, Dr. Grundy said.

"So we reached out to primary care physicians and formed an organization that can change the way we pay for care," he said. "It would make sense for buyers of care to pay more upfront if they get the value on the back end. Companies like ours are committed to doing that."

Backers of the medical home model all agree that changing the provider compensation system is essential to shifting the focus of medical delivery away from episodic care toward more comprehensive, holistic care.

"There needs to be a re-emphasis on the importance of primary care," said Dr. Bruce Bagley, medical director for quality improvement at the American Academy of Family Physicians based in Leawood, Kan., which is a member of the collaborative. "The thing that's wrong with the health care system is we value high tech, impersonal care for some vs. primary care for all. This is the antidote."

Medical homes also could prevent an impending shortage of primary care physicians, Dr. Bagley said.

Because the payment environment has undervalued primary care for the last decade, "fewer doctors are going into it. This is a way to reshape the payment environment to get a greater proportion of health care dollars to flow to family physicians for these services," Dr. Bagley said.

It also can help finance advances such as electronic medical records, he added.

'There needs to be a re-emphasis on the importance of primary care.'

Dr. Bruce Bagley,
American Academy of
Family Physicians

"EMR and the medical homes are on parallel tracks," Dr. Bagley said.

Bridges to Excellence, a coalition of employers devoted to improving the quality of patient care, recently launched the BTE Medical Home Program to reward physicians who demonstrate they have adopted good systems and processes of care and are using those systems to deliver positive results in the management of their patients.

"These doctors will be compensated differently," said Francois De Brantes, chief executive officer of BTE based in Newtown, Conn. "We believe very strongly…that these practices deserve somewhere around $125 per patient per year in some form of additional incentive. How that incentive is distributed is up to each plan or employer. Some plans are focusing more on fee schedule increases; others are paying a basic capitation fee for care coordination."

In addition to capitation payments, "providers will receive a bonus based on the quality of care they deliver based on a set of standard performance measures," Mr. De Brantes added.

But it is uncertain at this point whether payments such as the annual $125 per patient stipend BTE provides will be enough to induce primary care doctors to serve as medical homes.

Paul Keckley, executive director of the Center for Health Solutions at Deloitte L.L.P. in Washington, estimates it will cost at least $100,000 annually per practice to fully implement the medical home model, based on a study the center published in February titled "The Medical Home: Disruptive Innovation for a New Primary Care Model."

To foster a transformation of the medical delivery system to emphasize primary care, the Washington-based National Committee for Quality Assurance recently launched a new version of its Physician Practice Connections program to evaluate medical homes.

The new Patient-Centered Medical Home designation program will emphasize the systematic use of patient-centered, coordinated care management processes, said Margaret O'Kane, NCQA's president.

"It's trying to assess whether you're a 21st century practice," Ms. O'Kane said. "It's much more proactive than the old model of just thinking about you when you show up for an office visit. It's creating an ongoing relationship with the patient."

Pilot programs examine medical home concept

Insurers, employer groups and even the federal government have initiated pilot programs around the United States to determine whether medical homes can stem the rising cost of health care.

UnitedHealth Group Inc., for example, was among the first insurers to launch a medical home pilot program in conjunction with various medical societies. The test, which began last August, is being conducted in Florida, Colorado, Rhode Island and in New York's Hudson Valley, said Dawn Bazarko, the insurer's senior vp of clinical in Minnetonka, Minn.

To qualify for payment, medical practices need to meet the National Committee for Quality Assurance's process requirement, she said. While practices do not have to offer an electronic medical record, they do need to have a patient registry and e-prescribing tools, she added.

UnitedHealth is providing some of these tools to the participating practices as well as "useful claims information such as missed mammograms" or eye exams for diabetics, Ms. Bazarko said. "We also notify practices if there's an ER event."

A pilot program in New Jersey involving Newark-based Horizon Blue Cross Blue Shield of New Jersey in collaboration with Partners in Care Corp., a physician organization based in East Brunswick, was among the first to produce empirical data demonstrating the effectiveness of the patient-centered medical home concept.

The one-year program, which involved New Jersey State Health Benefits Program members with diabetes, showed increased compliance for the key HbA1c blood test from 43% to 91%., BCBS said in January. The HbA1c blood test is a primary indicator of how well diabetes is being managed.

Because of the success of the diabetes pilot, Horizon BCBS is expanding its medical home program to other chronic illnesses, said Dr. Richard Popiel, vp and chief medical officer.

In some cases, employers are experimenting with the medical home concept by using their onsite clinics as the first point of care for their employees and dependents, said Tom Lerche, a senior vp at Aon Consulting, a unit of Chicago-based Aon Corp.

"With onsite clinics, some of the providers are actually doing full primary care as a medical home," said Dr. Larry Levy, medical director at Lockton Cos. L.L.C. based in Dallas, who said he, too, is seeing such employer experimentation.

Before the medical home concept takes hold beyond these isolated incidences, however, "we need some proof that changing the payment system and rewarding doctors this way really helps people and lowers costs," said Steve Raetzman, a senior consultant at Watson Wyatt Worldwide based in Arlington, Va.

"The pilots should provide this," he said.

—By Joanne Wojcik

Medical homes aim to improve delivery of care

The patient-centered medical home is a health management model in which each patient has an ongoing relationship with a primary care physician who serves as their personal "health coach," leading a team of medical professionals that takes collective responsibility for delivering care.

The physician-led team is responsible for meeting all of the patient's health care needs, sometimes coordinating care with specialists and other providers. The medical home also provides patients with greater doctor access through expanded hours and enhanced communication, including e-mail and phone consultations.

The approach also incorporates greater use of technology, including the use of an electronic medical record and maintaining registries of patients with certain chronic conditions.

The physicians serving as medical homes receive additional compensation to deliver this more comprehensive care and to be more accessible to patients after regular office hours. The payments generally are made on a capitation basis and sometimes include bonuses for improved patient outcomes.

Pilot projects testing this model have found that when patient care is coordinated by a medical home, they are subjected to fewer redundant or unnecessary tests and have fewer emergency room visits, hospitalizations and surgeries. Because these patients have greater doctor interaction, they also are more likely to adhere to their medication and treatment regimens.

The American Academy of Pediatrics introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. Other medical societies later adopted the idea as a way to promote greater use of primary care.

The medical societies joined with a group of major employers, consumer organizations and other stakeholders to form the Patient-Centered Primary Care Collaborative in late 2006 to further the medical home concept, issuing a set of principles to which providers agreed to adhere in exchange for additional compensation.

In January, the National Committee for Quality Assurance retooled its Physician Practices Connection program to evaluate patient-centered medical homes.

For more information about the medical home concept, visit *www.pcpcc.net*.

—By Joanne Wojcik

Returns on medical consulting services worth cost: Employers

Programs help employees make informed health care decisions, avoid unnecessary treatments

By GLORIA GONZALEZ

Medical consulting companies that advise employees are gaining popularity among benefit managers for their ability to empower employees to take control over health care decisions while avoiding costly, unnecessary or inadequate treatment.

Employers that have purchased medical consulting services say they have reaped a favorable financial return on investment and improved employee morale and productivity.

The decision support services give employers a way to help employees facing difficult medical choices, particularly those suffering from chronic conditions. The up-to-date information offered by the companies helps alleviate uncertainty about medical conditions and enables employees to make informed decisions about their health care.

"They feel like more of an active participant than a victim in the health care arena," said Jan Kelly, director of health and welfare programs for Campbell Soup Co. in Camden, N.J., which offers a medical consulting benefit. "They feel more in control, which is helpful."

Although medical consulting companies have been around for years, they are gaining traction in the marketplace amid the consumerism movement, health care experts say.

"They differentiate themselves because they allow consumers to be engaged," said John Bigalke, U.S. leader of the health science and government practice for Deloitte L.L.P. in Orlando, Fla.

Employees who have questions about a medical diagnosis or treatment plan can call Best Doctors Inc., a Boston-based decision support service provider with which their employer has contracted. The employees sign a waiver, allowing the company to collect their medical information and consult with the employee's doctor. Practicing internists do an initial review of the patient's file with specialists participating in subsequent reviews.

"We work with the patient and their doctor to make sure the right thing is being done," said Evan Falchuk, president and chief executive officer of Best Doctors.

In the Best Doctors reviews, more than 20% of the patients received the wrong diagnosis and about 60% have received the wrong treatment or treatment that can be improved, Mr. Falchuk said. The average reduction of inappropriate medical costs is more than $21,000 per case.

Its closest competitor, Consumer's Medical Resource Inc., takes a different approach. When employees call CMR with questions or concerns about a medical condition, it researches the condition or treatment plan and creates a package of information sent directly to the patient rather than interacting with their doctor or reviewing their medical records.

"We're trying to change the way employees participate in health care decisions throughout the health care process," said David Hines, president of the Pembroke, Mass.-based company. With the information they receive, employees "now feel they're back in the driver's seat and they're able to participate with their doctors in a meaningful way."

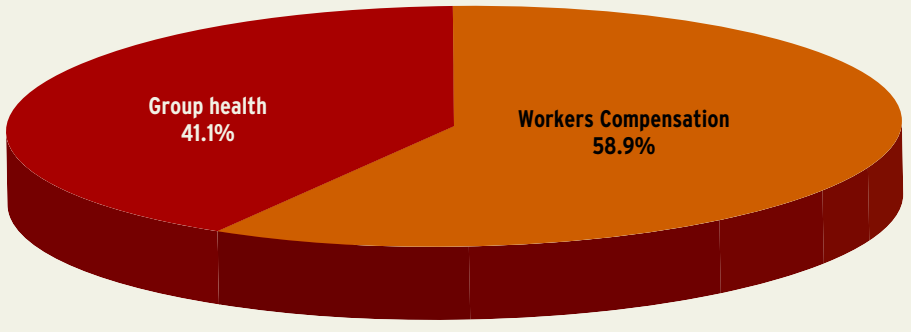
In 2006, 19% of the people who called CMR for information changed treatment procedures to follow best practices, 16% changed doctors, 10% discontinued some form of care while 2% found out they were misdiagnosed, Mr. Hines said.

Benefit managers says they are seeing similar results in their employee populations.

See **CONSULTING** page 14

TYPES OF CLAIMS MANAGED

Percentage of total cases managed



Source: BI survey

LARGEST CASE MANAGERS BY EMPLOYER CLIENTS

Ranked by the number of employer clients in 2007

Company	Employer clients
Broadspire Services Inc., a Crawford Co.	660
Intracorp	272
FARA Health Management	250
GENEX Services Inc.	231
CorVel Corp.	200

Source: BI survey

Largest case management providers

Ranked by 2007 gross revenues from case management services

Rank	Company/Address	Phone/Web site	Parent	Case management revenues	Total employees assigned to case management	Certified case managers	Total cases managed	Principal officer
1	**Intracorp** 1601 Chestnut St., 2 Liberty Place, Philadelphia, Pa. 19192	800-345-1075 *www.intracorp.com*	CIGNA Corp.	$418,000,000	2,295	812	1,400,000	Margaret Aslakson, vp-case management operations
2	**Coventry Workers' Comp Services** 3200 Highland Ave., Downers Grove, Ill. 60515	630-737-7900 *www.cvty.com*	Coventry Health Care Inc.	$187,145,485	2,173	650	365,261	James McGarry, president
3	**GENEX Services Inc.** 440 E. Swedesford Road, Suite 1000, Wayne, Pa. 19087	610-964-5100 *www.genexservices.com*	–	$123,800,000	1,130	609	131,130	Peter C. Madeja, president/CEO
4	**CorVel Corp.** 2010 Main St., Suite 600, Irvine, Calif. 92614	949-851-1473 *www.corvel.com*	–	$101,000,000	1,500	275	80,000	Daniel Starck, CEO
5	**Broadspire Services Inc., a Crawford Co.** 1601 S.W. 80th Terrace, Plantation, Fla. 33324	954-452-4000 *www.choosebroadspire.com*	Crawford & Co.	$85,600,000	841	261	116,237	Dennis Replogle, CEO
6	**Avidyn Health** 1 Hanover Park, Suite 500, 16633 Dallas Parkway, Addison, Texas 75001	214-920-9076 *www.avidynhealth.com*	UnitedHealthcare	$22,000,000	134	95	30,025	Chris Thomas, senior vp/COO
7	**MedInsights Inc.** 206 Gothic Court, Suite 308, Franklin, Tenn. 37067	615-778-5000 *www.medinsights.com*	GAB Robins North America Inc.	$14,900,000	63	44	15,500	Paula Woolworth, executive vp
8	**American Health Holding Inc.** [1] 100 W. Old Wilson Bridge Road, Worthington, Ohio 43085	866-614-4244 *www.americanhealthholding.com*	Prodigy Health	$13,000,000	287	52	16,155	Rhonda Crowe, vp-operations
9	**Cambridge Integrated Services Group Inc.** 340 Pemberwick Road, Second Floor, Greenwich, Conn. 06831	800-662-1170 *www.cambridgeclaims.com*	Cambridge Solutions Ltd.	$10,200,000	82	27	22,000	Wesley O'Brien, president
10	**FARA Health Management** 400 E. Kaliste Saloom Road, Suite 4500, Lafayette, La. 70508	800-215-3272 *www.fara.com*	F.A. Richard & Associates Inc. dba FARA	$7,757,394	75	17	25,000	M. Todd Richard, president/CEO

1 Purchased Guided2Health in December 2006.
Source: BI survey
Researched by Kevin Edison and Karen Tucker

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200815

Value-based plans an investment in a healthy workforce

Programs give employees financial incentive to seek preventative services, disincentive to pursue ineffective care

By KRISTIN GUNDERSON HUNT

Value-based health benefit plans are increasing in popularity, employee benefit consultants say, as medical costs continue to rise and cutting benefits seemingly provides little relief.

The burgeoning concept calls upon employers to determine how much they will pay for certain medical services or products based on their critical nature and the value they bring to the patient and organization. The more beneficial a procedure, drug or treatment, the more the employer will pay.

"Value-based benefit design is going beyond cost," said Randall Abbott, a senior consultant with Watson Wyatt Worldwide in Wellesley Hills, Mass. "It's shifting the mindset to recognize you need to invest in the health of the workforce to achieve peak organizational performance."

Value-based health plans offer financial incentives, such as reduced copayments, to encourage employees to use preventative health services, quality providers, and proven treatments and drugs for costly health conditions, said Larry Boress, president and chief executive officer of the Chicago-based Midwest Business Group on Health.

Further, financial disincentives such as higher copayments are used to discourage employees from using health care services and providers when evidence does not justify their cost, he said.

The incentives and disincentives attached to value-based health plans can be applied to everything from prescription drugs and medical treatments to preventative services and tests.

In 2003, Gulfstream Aerospace Corp., a Savannah, Ga., subsidiary of General Dynamics Corp., began tackling the concept of value-based health benefits after Bob Holben, director of compensation and benefits , came across several national studies attributing up to 30% of health care costs to poor quality of care.

"As a manufacturing organization, that is like blasphemy to have that poor quality control," Mr. Holben said.

When he took a closer look at Gulfstream, he found more than half of women over age 40 weren't receiving annual mammograms, 35% of diabetics weren't receiving critical hemoglobin tests regularly, and only 33% of employees' drug prescriptions were being dispensed as generic drugs—all of which increase medical costs and can eventually result in more expensive treatment down the road.

That revelation, Mr. Holben said, prompted the company to focus on improving quality as opposed to cutting costs. It partnered with other employers in the Savannah area to identify and recognize quality physicians by giving them financial bonuses for meeting certain criteria such as driving up generic drug dispensing rates and improving adherence to chronic disease treatments. Additionally, Gulfstream employees and their dependents received lower co-pays for visiting the noted doctors.

Mr. Holben said the results have been outstanding. More doctors are providing quality service, and more employees are taking preventative care measures, he said.

Since 2003, there has been a 7% increase in women getting annual mammograms, a 22% rise in diabetics taking regular hemoglobin tests and a 24% increase in generic drug dispensing rates. Between 2004 and 2006, the average medical cost per diabetic fell 21%. In addition, Mr. Holben said Gulfstream's four-year average health care cost trend of about 3.4%, compared with other companies' double-digit increases, is proof that the concept works.

Prompted by its double-digit increases in medical costs, consumer product giant Procter & Gamble Co. in Cincinnati began implementing a value-based health care design in 2004, said Sandra Morris, the company's senior manager of health care benefit design. While it introduced a broad-based and integrated value-based benefits plan in 2006, its first initiative was a tiered pharmacy benefits program, separating prescriptions based on their necessity to an employee's health.

The company pays most of the cost for drugs that treat infections, stomach disorders and pain; half the cost for drugs with some medical value but mostly value for the employee, such as those for toenail fungus or acne; and covers none of the cost of purely lifestyle-enhancing drugs, such as those that treat sexual performance, dieting or personal appearance. In 2006, P&G added a fourth tier for specific diseases such as diabetes and asthma, among others, and took on most of those drugs' cost.

Ms. Morris said by reducing the amount of money employees pay for critical medications, utilization and compliance increased and improved the long-term health of employees with chronic and serious conditions.

The resulting increased company costs were offset by not covering lifestyle-enhancing drugs and sharing less of the cost for drugs providing significantly higher value to employees than the employer, she said. Additionally, in-patient care rates dropped as well as the company's medical cost trend, which she attributed to the pharmacy program and other initiatives. She could not quantify the impact of the value-based program on P&G.

Continued on next page

Plans based on incentives

Value-based health care benefit plans are designed around offering employees financial incentives and disincentives to encourage healthy behaviors to get the maximum value for every dollar spent.

Employers gauge the value of various treatments, procedures, prescriptions and providers using clinical evidence and data, and then determine how much of the cost they will cover for those health care products and services.

Such plans are intended to reduce the financial barriers to highly valued services and products for patients with chronic and serious conditions, thereby increasing their adherence to treatment and positively affecting employees' long-term health as well as the financial health and productivity of the organization.

—By Kristin Gunderson Hunt

Promoting medical consulting programs raises utilization rates significantly

Employers that actively inform employees about medical consulting benefits have the highest rates of utilization, vendors and benefit managers say.

Medical consulting companies offer decision support services that give employers a way to help employees facing difficult medical choices, particularly those suffering from chronic conditions.

The employees of EMC Corp. have been utilizing the medical consulting program offered by Best Doctors Inc. at an "outstanding" rate, said Delia Vetter, senior director of benefits and programs for the Hopkinton, Mass.-based company.

About one out of every 250 EMC employees called Best Doctors, which is four times the normal utilization rate, because the EMC benefits staff has aggressively communicated the program to employees, said Evan Falchuk, president and chief executive officer of Boston-based Best Doctors.

J.B. Hunt Transport Services Inc. recently concluded a campaign about the Best Doctors program for its employees.

"We know we have to keep that constant communication online and hopefully they think about that when they actually have the need and make that call," said Rick George, director of benefits for the Lowell, Ark.-based company.

In the 18 months since Campbell's Soup Co. has offered a medical consulting program provided by Consumer's Medical Resource Inc. in Pembroke, Mass., nearly 3% of its employees have used the service, said Jan Kelly, director of health and welfare programs for Campbell's in Camden, N.J.

"While we recognize it's a small percentage that needs the services, they're going to be the ones most in need of this information," Ms. Kelly said.

Although the programs have the potential to disrupt the doctor-patient relationship, particularly if the consulting doctors reach a drastically different diagnosis or treatment plan, employers say they are not aware of any negative feedback from doctors, who are becoming familiar with the programs.

Regina Herzlinger, a professor of business administration at the Harvard Business School in Boston, expressed concern about the transparency of the information provided by medical consulting programs, but also said consumers need such information because health care quality is "highly erratic."

A system in which the consumers pay for the programs themselves would be preferable because employers tend to want a return on investment for the benefit programs they purchase, she said

Employers, though, say the savings on avoided and unnecessary treatment are merely an additional advantage of the programs.

"We think it's driving improved savings, but our primary driver is getting employees the tools to enhance the value of the plan," Ms. Kelly said.

—By Gloria Gonzalez

Consulting: Programs worth cost to employers

CONTINUED FROM PAGE 11

For EMC Corp. employees who called Best Doctors during the first nine months of 2007, 11% received a changed diagnosis and 87% changed their treatment plan, said Delia Vetter, senior director of benefits and programs for EMC, a technology company in Hopkinton, Mass.

"Those numbers are pretty high," Ms. Vetter said.

As for Campbell's employees who have used the CMR program, 86% say they are more involved in treatment plans that drive better quality of care, Ms. Kelly said.

Benefit managers say they most appreciate the positive response they receive from employees who have used the services.

J.B. Hunt Transport Services Inc. is approaching its first anniversary as a Best Doctors client and the benefits staff has received positive feedback from employees who have used the program, said Rick George, director of benefits for the Lowell, Ark.-based company.

Several employees were experiencing medical conditions that never were properly diagnosed or treated despite visiting numerous doctors. They were able to contact Best Doctors and receive a proper diagnosis and effective treatment plan. "They feel so relieved because of that," Mr. George said.

The programs are relatively inexpensive at a cost of $1 to $2 per employee per month, consultants say.

The investment is worth every penny, employers say, particularly considering the peace of mind their employees receive.

"We would be happy if it was cost-neutral quite frankly," Ms. Kelly said of the CMR program for Campbell's. "We've seen it exceed those expectations."

The Best Doctors program saves money for employers in avoiding unnecessary treatments or recommending treatments that are consistent with best practices, Mr. George said.

"I feel the value is very fair for what we're paying for the service," Mr. George said. "We're spending the right amount of money on the product."

Aside from avoiding unnecessary costs, employers benefit from improved employee morale from having such a health care benefit available, employee peace of mind in getting their questions answered and enhanced productivity, which produces a "high-dollar" return, Ms. Vetter said.

CONTINUED FROM PREVIOUS PAGE

Other value-based health plan initiatives include incentives for those participating in wellness programs or reduced premiums for employees who complete health risk assessments.

Benefit consultants said the plans and initiatives vary as much as the companies taking on the value-based models.

Cyndy Nayer, president of the Center for Health Value Innovation in St. Louis, said every size and type employer can integrate some of these concepts. She said she has seen companies ranging from 450 to 350,000 employees turn to value-based benefits.

Michelle LeVecque, a director at Buck Consultants L.L.C. in Tampa, Fla., said knowing and understanding the employee population is key to effectively implementing value-based health initiatives. Companies must understand the conditions that most affect the organization and incentives most likely to drive the behaviors they desire from their employees.

"Organizations have cultures," Ms. LeVecque said. "Know what (employees) like, what they don't like and what their hot buttons are."

Data is essential to understanding the population and is critical to value-based health care plan designs. Aggregate data tells the story of which health conditions present the greatest challenges to the organization, how well people with conditions adhere to treatment and spending on conditions that do not affect the company, all of which guide leadership on strategic use of health care resources, experts say.

Consultants say as more data becomes available on the savings gained from value-based plan designs, more companies likely will adopt the plans.

"We need data to show the return on investment if this is in fact going to be more than just a fad," said Mr. Boress of Midwest Business Group on Health.

"As that increases and as the knowledge spreads, the positive impacts will become apparent. If we can't show it's working in the long run, it will just go away," he said.

Few U.S. employers book passage on the ship of medical tourism

Estimates vary widely on savings achieved by surgery performed abroad

By ROSEANNE WHITE GEISEL

Despite the cost savings floated by the medical tourism industry, few employers have plunged into the unknown waters surrounding the integration of medical tourism into group health plans.

Medical tourism is the term used for patients seeking health care, predominantly nonemergency surgery, outside the United States. Participating hospitals—mainly in Asia, Central America and South America—are accredited by the international arm of the Joint Commission on Accreditation of Healthcare Organizations or have received the quality certification of the International Standards Organization. Many doctors providing the services have been trained in the United States.

Although medical tourism has yet to make major inroads with employers, some companies are exploring the cost-saving potential and practicality of the approach, experts say. Experts also say benefit managers must consider many factors and analyze the population they are serving before opening the medical tourism door to their employees (see story, page 18).

Some employers, however, are ready to learn as they go.

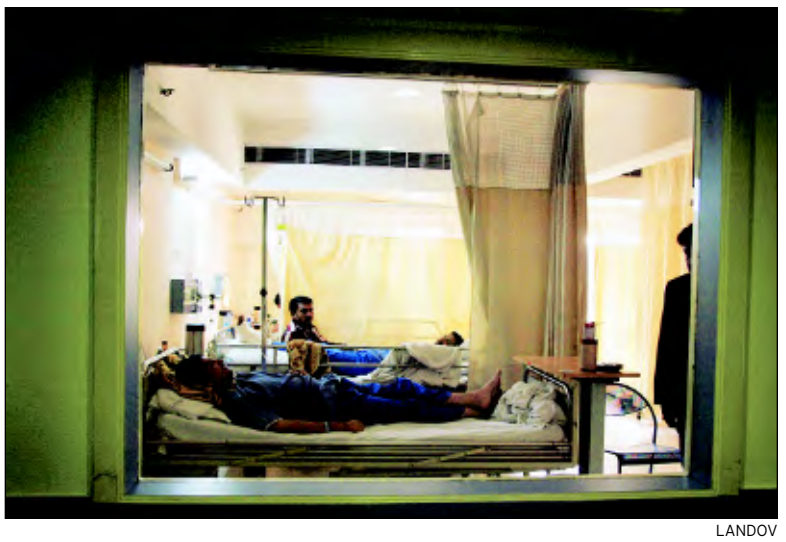
Hannaford Bros. Co., a Scarborough, Maine-based supermarket chain, made medical tourism available to its employees effective Jan. 1. Initially, company-covered employees and dependents who need hip or knee replacements can elect to have the surgery in Singapore at a cost significantly lower than in the United States (see story, page 18).

"We hope we have a handful of cases and find out their experiences," said Peter Hayes, Hannaford director of associate health and wellness. "It's part of our responsibility to make health care more affordable for our members."

Hartford, Conn.-based Aetna Inc. provides the health plan services for the care in Singapore, an extension of its U.S. program for Hannaford. Employees interested in using the benefit contact Aetna and the insurer puts them in contact with the hospital to make the arrangements.

Hannaford's program includes paying airfare and lodging for the patient and one person accompanying them.

Dr. Charles Cutler, Aetna's chief medical director of national accounts, said the health insurer is doing this "to learn more about the opportunities and pitfalls" in offering medical tourism as an option.



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New Delhi has been a popular destination for those seeking cheaper medical care costs by traveling abroad, including international patients during 2005 treatment at Apollo Hospital in the capital of India.

Early stages

"It's in the very early stages and will take years to develop," said Joe Marlowe, senior vp of Aon Consulting's health and benefits practice in Radnor, Pa. "We've had a number of clients ask questions about this who aren't on the verge of putting this in their benefit coverage."

If a Fortune 500 company were to offer this benefit and communicated it well, that would spur other employers to do the same, he said.

There's no way for employers to know in advance of instituting such a program how receptive their employees would be, said Dr. Arnold Milstein, San Francisco-based chief physician at Mercer L.L.C. "You go into it knowing you will learn."

While the concept is relatively new in the United States, the "practice is well-established in other countries," said Victor Lazzaro Jr., chief executive officer of Bridge-Health International, a Greenwood Village, Colo.-based worldwide health care network that provides medical tourism services.

As health care costs continue to rise, employers must consider non-traditional alternatives to "deliver a benefit better, faster and cheaper," said Jay Savan, a St. Louis-based principal with Towers Perrin.

If a surgery costs $25,000 or more in the United States, there would be a significant savings by going abroad for the operation, even after airfare and lodging expenses, said Mercer's Dr. Milstein. Even so, "if every single surgery that is very expensive in the United States was a reasonable fit to do overseas, the impact on health care spending

See **TOURISM** page 18

LARGEST PBMs BY WORKERS COMP LIVES

Ranked by the number of workers compensation lives enrolled

Company	Active workers compensation lives
RESTAT L.L.C.	1,345,677
National Pharmaceutical Services	225,000
ScripNet	210,000
BioScrip	40,000
IdealScripts	9,000

Source: BI survey

LARGEST PBMs BY NUMBER OF PRESCRIPTIONS

Ranked by the number of prescriptions filled in 2007

Company	Prescriptions filled
Medco Health Solutions Inc.	748,300,000
CVS/Caremark Corp.	681,100,000
Express Scripts Inc.	507,000,000
HealthTrans	90,046,000
RESTAT L.L.C.	30,003,642

Source: BI survey

Largest prescription benefit managers

Ranked by 2007 revenues from unbundled PBM services

Rank	Company/Address	Phone/Web site	Parent	PBM revenues	Total staff	Total clients	Covered lives	Principal officer
1	**Medco Health Solutions Inc.** 100 Parsons Pond Drive, Franklin Lakes, N.J. 07417	201-269-3400 *www.medco.com*	–	$44,500,000,000	20,000	N/A	60,000,000	David B. Snow Jr., chairman/CEO
2	**CVS/Caremark Corp.** 211 Commerce, Suite 800, Nashville, Tenn. 37201	800-633-9509 *www.caremark.com*	–	$43,349,000,000	16,000	N/A	N/A	Howard McLure, president
3	**Express Scripts Inc.** 1 Express Way, St. Louis, Mo. 63121	800-332-5455 *www.express-scripts.com*	–	$18,273,600,000	11,820	16,000	N/A	George Paz, chairman/president/CEO
4	**RESTAT L.L.C.** 724 Elm St., West Bend, Wis. 53095	800-926-5858 *www.restat.com*	F. Dohmen Co.	$1,172,100,067	120	3,755	4,269,434	Michael Clark, president
5	**National Pharmaceutical Services** 13660 California St., Omaha, Neb. 68154	402-964-9030 *www.pti-nps.com*	Pharmaceutical Technologies Inc.	$650,000,000	110	3,600	2,300,000	Douglas M. Pick, president/CEO
6	**BioScrip** 100 Clearbrook Road, Elmsford, N.Y. 15013	888-818-3939 *www.bioscrip.com*	BioScrip Inc.	$235,000,000	935	1,265	7,000,000	Richard Friedman, chairman/CEO
7	**HealthTrans** 8300 Maplewood Ave., Suite 100, Greenwood Village, Colo. 80111	800-950-9120 *www.healthtrans.com*	–	$182,227,031	160	81	15,100,000	Jack McClurg, CEO
8	**IdealScripts** 16 International Way, Warwick, R.I. 02886	877-274-7871 *www.idealscripts.com*	AmWINS Inc.	$84,000,000	18	106	94,000	Samuel Fleet, president
9	**ScripNet** 10050 Banburry Cross Drive, Las Vegas, Nev. 89144	888-880-8562 *www.scripnet.com*	–	$30,000,000	60	61	N/A	Dennis Sponer, president
10	**Intracorp** 1601 Chestnut St., 2 Liberty Place, Philadelphia, Pa. 19192	800-345-1075 *www.intracorp.com*	CIGNA Corp.	$3,330,000	2,295	11	N/A	Margaret Aslakson, vp-case management operations

N/A=Not available
Source: BI survey
Researched by Kevin Edison and Karen Tucker

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Tourism: Aims to pressure high medical prices in the United States

CONTINUED FROM PAGE 15

would be no more than 1.5%," he said. Though, for companies with high labor costs, that "is not a small amount of money."

Aon's Mr. Marlowe estimates that the overall savings on an employer's total health care costs by using medical tourism would be less than 3%.

Employers must look very closely at the cost savings, said Aetna's Dr. Cutler. Providers abroad "make comparisons that maximize the differences" in costs, he said. But when the U.S. cost is analyzed and the negotiated health plan discount is factored in, the savings from surgery abroad are less impressive, particularly for U.S. areas where health care costs are lower, he said.

The bottom line is that "we don't have any experience to base cost savings projections on. Actuarial tables show that on procedures that lend themselves to doing this, there are dramatic savings—40% or more (per individual surgery)," said Mr. Lazzaro. An employer's overall savings will depend on how many employees decide to have surgery abroad, he added.

Beyond cost savings, employers have other factors to consider before offering medical tourism.

"The most important factors are the availability of accredited hospitals and the availability of surgeons and anesthetists who have trained and been board-certified in the United States," Dr. Milstein said.

While certain assumptions are made when individuals seek health care within the United States, medical tourists traveling abroad cannot take for granted that the blood supply is safe or that prosthetic joints came from a reliable manufacturer, Dr. Cutler said.

Employers 'can't even get people to go to the Mayo Clinic or the Cleveland Clinic. They want to go to familiar hospitals close to their homes.'

Larry Boress,
Midwest Business Group on Health

To facilitate comparing surgical outcomes, the West Palm Beach, Fla.-based Medical Tourism Assn. is trying to get top-rated hospitals outside the United States to work with a single method of reporting outcomes data. "This will change global health care and medical tourism," said Jonathan Edelheit, association president.

Medical tourism could start within the United States if quality information improved, said Ted Nussbaum, Stamford, Conn.-based director of health care consumerism in North America for Watson Wyatt Worldwide. "If one would be willing to provide employees data across geography and offer incentives, we can do this in the United States. Once we change behavior, it will be easier to get people to go to different countries."

But that behavior is entrenched, said Larry Boress, executive director of the Midwest Business Group on Health in Chicago. In an informal 2006 survey of its board members, there was "little interest" in sending employees abroad for health care. In addition to quality and liability concerns, the employer board members believed it would be difficult to get employees to get health care services abroad.

"They can't even get people to go to the Mayo Clinic or the Cleveland Clinic," Mr. Boress said. "They want to go to familiar hospitals close to their homes."

Two years from now, the Medical Tourism Assn. hopes to have 400-450 employers on board with medical tourism options, said Mr. Edelheit. That is a huge jump from the current handful of employers currently using it.

"Three to five years from now, I see (medical tourism) as being an accepted, routine part of benefit offerings," said BridgeHealth's Mr. Lazzaro. "We're not going to empty hospitals or put doctors out of jobs here in the United States, but at the same time we want to add some healthy, appropriate competition and help reduce costs."

Successful medical tourism rests primarily on design

Benefit managers can take certain steps to ensure that integrating a medical tourism option into an employer-sponsored health plan is successful and worthwhile.

The first step is to "analyze the potential impact that offering the benefit might have," said Jay Savan, a Towers Perrin principal based in St. Louis. "If you have a lot of hourly employees standing on their feet all day, you might have a lot of musculoskeletal issues," he said. In that case, allowing employees the opportunity to go to a quality institution abroad where surgery costs significantly less may be a big boost to the bottom line, he said.

Secondly, "diagnose the issue," Mr. Savan advised. Determine whether there are non-emergency elective procedures that are in the top five to 10 cost drivers for the company and the plan participants, he said. Then identify procedures that would be appropriate to offer outside the United States.

"An employer's savings potential is very dependent on that diagnostic element," Mr. Savan said.

Third, decide where to authorize care abroad, and negotiate terms, for example, per diem expense or capitation, so the selected hospital will not raise prices, Mr. Savan said.

"The engagement of an intermediary is very important," Mr. Savan said. He suggests working with a benefit provider and a vendor with expertise in communicating medical tourism options to employees.

"The difference between success and failure" is to have someone with expertise help establish the program, said Jonathan Edelheit, president of the West Palm Beach, Fla.-based Medical Tourism Assn. It's necessary to know what hospitals specialize in what procedures, to understand the dynamics of each country and each hospital, and to understand the cultural sensitivities of employees, he said.

Above all, employees must be willing to go abroad for care. For that to happen, "the employers must get behind the program," said Victor Lazzaro, chief executive officer for BridgeHealth International, a Greenwood Village, Colo.-based provider of medical tourism plans.

"The No. 1 thing is the benefit design," Mr. Lazzaro said. "There has to be an incentive for an employee to choose (to go abroad for care). We all work through economic incentives."

Mr. Lazzaro suggested employers wanting to promote a network outside the United States could drop the coinsurance on overseas treatment and give that amount to the employee to spend for incidentals on the trip.

Dr. Arnold Milstein, chief physician for Mercer L.L.C. in San Francisco, said a survey of more than 1,000 people indicated those who were worried about how much health care will cost them would be interested in medical tourism for a cash bonus exceeding $2,500. Those unworried about paying for health care would need a bonus exceeding $5,000 to travel outside the United States for health care services. He discussed the survey in a 2007 article in Health Affairs magazine.

—By Roseanne White Geisel

Organic grocery chain offers surgery abroad in 'dialogue' with U.S. medical community

Perhaps it's no surprise that Hannaford Bros. Co., the Northeast's largest certified organic grocery chain, is miles ahead of other large companies in offering a medical tourism option in its employee health plan.

Scarborough, Maine-based Hannaford has a progressive health and wellness program that it sees as part of its corporate social responsibility to employees and customers in the communities served by its 165 stores.

Hannaford's wellness initiatives include providing financial incentives to its 27,000 U.S. employees and their adult dependents to take three steps: complete a risk appraisal, be smoke-free or enrolled in a smoking cessation program, and set health care goals for chronic medical conditions.

The company also staffs its stores with nurses to coach employees on health issues.

Since the start of the year, Hannaford has given its health plan participants the option of going to Singapore to have hip or knee replacements at a substantially lower cost than having the surgery in the United States.

"Health care is becoming unaffordable," said Peter Hayes, director of associate health and wellness at Hannaford, which is part of Brussels, Belgium-based food retailer Delhaize Group. "The European owners are used to health care being 10% of (gross domestic product)," Mr. Hayes said.

In contrast, the Congressional Budget Office has estimated that health care would represent about 16% of the 2007 U.S. GDP.

But there's more to the problem, Mr. Hayes said. "There's a real dichotomy here between what we spend and the quality of care," he said. "If we're going to have to compete in a global economy, we have to get health care costs down. We have to rethink and re-engineer and really focus on value."

Hannaford decided to establish a program with National University Hospital in Singapore so its employees can pay less for quality care and to "start a dialogue with our (U.S.) medical community," Mr. Hayes said.

Hannaford employees pay 30% of their health care costs, including copayments, deductibles and premiums. The average copay for a surgical procedure is 20% if employees choose from the company's list of providers of distinction.

A hip replacement averages $40,000 in the United States, Mr. Hayes said. In Singapore, the surgery costs $10,000.

"Twenty percent of $40,000 is a lot different than 20% of $10,000" that employees would have to pay, Mr. Hayes said.

Before instituting the benefit, Hannaford held focus groups to get grocery store and warehouse employees' opinions.

"In focus groups, the first question employees asked was about quality of care," Mr. Hayes said.

Employees wanted outcomes information for the hospital and information about the surgeons. Once satisfied with the quality of care, employees looked favorably on the idea because it permitted them to travel internationally, he said.

The hospital provided outcomes information, including infection rates, number of patients that underwent corrective surgery after a problem with the initial surgery, and outcomes data by individual surgeons. The outcomes data was comparable to or better than results at U.S. hospitals, Mr. Hayes said.

"Success for me is if we have some members go have a great experience and a great outcome, and we've made health care more affordable to them," Mr. Hayes said.

He also said he hopes that the U.S. medical community takes notice.

—By Roseanne White Geisel

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More employers offer 401(k) automatic enrollment feature

By JERRY GEISEL

The number of employers offering a 401(k) plan automatic enrollment feature continues to grow, with 44% of employers now doing so, up from 36% in 2007, a study shows.

The Hewitt Associates Inc. study released last week of 190 midsize and large U.S. employers also found that of the employers that do not currently offer automatic enrollment, 30% said they are very likely to add the feature this year, while 27% are somewhat likely to do so.

Automatic enrollment is aimed at those employees who neither elect or decline to enroll in their employer's 401(k) plan. Under automatic enrollment, such employees are told that they will be enrolled—with a specified percentage of their salary deferred to the 401(k) plan—unless they object.

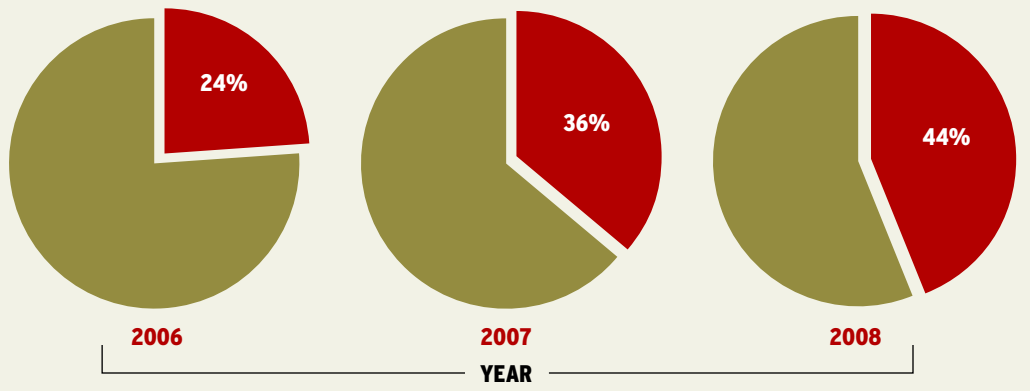
Such programs have been rapidly growing in recent years for several reasons, including the passage of legislation in 2006 that pre-empted any state laws that could have interfered with the programs.

In addition, as more employers phase out their defined benefit pension plans, 401(k) plans have become employers' sole retirement savings plans.

Adding an automatic enrollment feature increases the likelihood that more employees will have at least some retirement plan savings.

ON THE RISE

Growth of 401(k) plan automatic enrollment programs by year



Source: Hewitt Associates Inc.

International NEWS

REUTERS

Workers remove wires from a high-voltage tower that toppled across a roadway in Mlada Boleslav, Czech Republic, northeast of Prague when Windstorm Emma produced high winds and heavy rain March 1 across much of Europe.

Insured losses near $2B from Windstorm Emma

By STUART COLLINS

BOSTON—Insured wind losses from Windstorm Emma, which tore across parts of Central Europe on March 1, could cost as much as $1.99 billion, with Germany and Austria accounting for more than half the total.

According to Boston-based catastrophe modeling company, AIR Worldwide Corp., insured losses from the windstorm could cost between €750 million and €1.3 billion ($1.15 billion and $1.99 billion).

Rival catastrophe modeling company, Risk Management Solutions Inc., had earlier estimated that Windstorm Emma could cost insurers between €300 million and €700 million ($455.4 million and $1.1 billion).

The windstorm, with recorded wind speeds nearing 100 mph, hit Central Europe, including Germany, Austria, the Czech Republic, Belgium, the Netherlands, Switzerland and the United Kingdom.

AIR's estimate does not include losses in the Czech Republic or the Baltic States.

The storm brought heavy rain and hurricane-force winds, which caused significant damage to residential buildings, AIR said in a statement. It also disrupted highway, rail, and air traffic, and prompted flood alerts in the Netherlands along the North Sea, it added. "Well-engineered commercial structures fared well," AIR said in its statement.

Some 15 people were reported dead as a result of the storm.

"Emma was not as large as last season's most severe event, Windstorm Kyrill, which produced damaging winds in more than 10 countries across Europe and resulted in the largest damage footprint in decades," said Peter Dailey, AIR's director of atmospheric science.

Captive owners strongly urged to find their voice in Solvency II

E.C. official: Take part in upcoming quantitative studies

By MICHAEL BRADFORD

Picturesque Luxembourg Feb. 20-21 hosted the captive industry at the Luxembourg Rendezvous to discuss Solvency II's impact and other issues.

LUXEMBOURG—The European Union's proposed revamp of insurance regulation, as it stands now, is not a captive-friendly framework and captive owners need to raise their concerns with the proposed directive, experts advise.

The "spirit and philosophy" of the Solvency II directive, which is scheduled to be implemented in 2012, does not fit captives, said Mark Lauer, chief operating officer at Foyer S.A., a Luxembourg-based insurer.

Solvency II calls for regulators to consider risk-based capital adequacy when evaluating the financial soundness of insurers. It also will require insurers to verify that risk management processes are adequate. As drafted, the framework that also increases disclosure requirements applies to captives with more than €5 million ($7.59 million) in annual premiums.

"The workings of captives, especially small and medium-sized ones, differ totally from the techniques upon which the Solvency II framework is based," Mr. Lauer said at the Luxembourg Rendezvous, a Feb. 20-21 meeting that focused on issues facing captives. The drafters of Solvency II considered large, international multiline insurance groups, but most captives are small, monoline insurance operations, he said.

"The spirit of Solvency II is different from the goals captives have been created for and run for," Mr. Lauer said.

Sources say most captives will see their capital needs increase under the directive, although some may find the new requirements will allow them to decrease their capital if they desire.

Administrative costs for captives are likely to rise under the directive, according to market sources. Additional services from auditors and actuaries will be needed to comply with the new regulations, they say.

Jérôme Lecoq, senior manager with Deloitte S.A. in Luxembourg and a speaker at the conference, said in an interview that the enhanced risk management requirements under Solvency II will generate more work for captive service providers and, therefore, add costs to the operations.

> **'The workings of captives, especially small and medium-sized ones, differ totally from the techniques upon which the Solvency II framework is based.'**
>
> Mark Lauer, Foyer S.A.

Captive owners have expressed concern about how the directive will affect captives, but have been slow to make their voices heard in the Solvency II debate, Mr. Lauer said.

"There has been very little lobbying up until now for the interest of captives," with most trade organizations keeping quiet, he said.

Large insurance groups, on the other hand, have been involved in the Solvency II process and their efforts have allowed regulators to address their concerns, Mr. Lauer said.

In addition, captive owners largely have ignored the quantitative impact studies that the European Commission has carried out to help gauge the effect of Solvency II and address insurer and reinsurer concerns with the framework, Mr. Lauer said.

Some captive owners may have ignored the studies, he said, because Solvency II will contain special regulations that apply to small and medium-size insurers.

"I am convinced that these simplified regulations for small and medium-sized enterprises will, nevertheless, provoke an increase of solvency requirements compared to today's rules. And furthermore, it is far from sure up to now that these new rules will really fit the needs of captive insurers and reinsurers," Mr. Lauer said.

Captive owners have argued that the studies are too complicated, too time-consuming and not applicable to the business captives are writing, he said. But those concerns need to be heard, said Mr. Lauer in urging

See **SOLVENCY** next page

Solvency: Captives urged to get involved

CONTINUED FROM PREVIOUS PAGE

captives to participate in the next round of quantitative studies from April to July.

Ignoring the studies and failing, until recently, to lobby for their interests means that captive owners are providing the European Commission with little means to determine how Solvency II might affect their operations, Mr. Lauer said.

Karel van Hulle, head of the commission's insurance and pensions unit, agreed during a conference presentation that captive owners would do well to take part in the studies.

Premium threshold

A higher level of participation than in the previous three studies will, for example, help the commission make decisions such as whether to keep the threshold for exemption at €5 million in annual premiums, Mr. Van Hulle said.

Input from captive owners also is needed to work out issues including proportionality, how protected cell companies and their cells should be treated, and treatment of captives that are based outside the European Union but write coverage on risks within countries governed by Solvency II, Mr. Van Hulle said.

"We need enough participation to see the problems so that we can address them," he noted.

Victor Rod, president of the management board of the Insurance Commission of Luxembourg, said during the conference that he also would like to see captives make sure their concerns are considered by Solvency II's drafters.

'I think it is essential that the definition of captives comes into the new directive.'

Victor Rod
Insurance Commission of Luxembourg

"I think it is essential that the definition of captives comes into the new directive," said Mr. Rod. Otherwise, captives could find themselves with problems operating throughout the European Union once the directive is in force, he said.

The directive also will change the way captives address corporate governance, Mr. Lauer said. Few, if any, captives have all the risk management, internal controls, audit and other processes that the directive proposes, he said, while many large insurers already have much of their governance infrastructure in place.

"Solvency II has been developed for big, multiline insurance groups with a high level of corporate governance and is not focusing at all on small, specialized monoline companies like captives," Mr. Lauer said.

Experts urge captive owners to act quickly if they are not already preparing for Solvency II's implementation.

Captive owners should have their managers develop a simplified roadmap that assesses the potential changes the directive could have on risk management, reporting and other processes, said Ming Roest, senior consultant with Towers Perrin in London.

Mr. Roest, who spoke at the conference, said earlier that captives also need to decide on the type of model they will use to measure their risks and ensure they have adequate capital to cover their exposures.

"Solvency II is coming in 2012," said Mr. Lauer. "It is coming; there is no doubt about that. And it is coming fast. The time to prepare for it is short, and even shorter is the time you have to influence the framework. It is important that intensive lobbying for the interest of captives takes place now."

EEOC: Discrimination claims hit five-year high

CONTINUED FROM PAGE 4

for the first time since 2000, rising 4% to 12,510 charges filed in 2007. And of those sexual harassment charges, a record 16% were filed by men, up from 9% in the early 1990s, the EEOC said.

Behind retaliation claims, age discrimination allegations saw the second largest jump in filings, a 15.4% increase to 19,103, the EEOC said.

The remaining three major discrimination charges—disability, national origin and religion—all saw double-digit increases in the number of charges filed in fiscal 2007, the EEOC said (see chart, page 4).

The EEOC said it recovered approximately $345 million in total monetary relief for job bias victims in 2007, a 26% increase over 2006. Nearly $55 million was obtained through EEOC litigation and more than $290 million through administrative enforcement, including mediation.

The EEOC said it resolved 8,649 charges through its voluntary National Mediation Program in 2007, up 5% from 2006.

The EEOC's fiscal year 2007 enforcement and litigation statistics are available online at *www.eeoc.gov*.

Alpha Re: Industry vets set up reinsurance brokerage

CONTINUED FROM PAGE 3

Alpha Re's formation is "some dislocation in the market with management changes at various brokers. There are brokers out there getting out of the business."

Another is "employees that want to work in a private firm rather than in a public firm. The brokerage business, frankly, is more conducive to a private firm, and we see clients that are looking for experienced capability from an advisory perspective," he said."I think it's well-understood that…most people can place transactions in this marketplace, but we think we can deliver a higher level of solutions to the customers out there."

Market Moves

OptumHealth rebrands financial services arm

GOLDEN VALLEY, Minn.—OptumHealth, a Golden Valley, Minn., division of UnitedHealth Group Inc., has changed the name of Exante Financial Services to OptumHealth Financial Services.

"The name change reflects our belief in the power of combining financial services with health care support," Dawn Owens, OptumHealth chief executive officer, said in a statement.

The renamed financial services arm includes OptumHealth Bank, formerly Exante Bank; and Administration Resources Corp., a voluntary employees' beneficiary association administrator. OptumHealth Financial Services provides benefits administration for 20,000 employers, the company said.

Humana puts specialty offerings under one banner

LOUISVILLE, Ky.—Humana Inc. has aligned its previous dental offerings with dental, vision and voluntary benefit programs, which it gained through $547.7 million in acquisitions last year, under the Humana Specialty Benefits banner.

The arm of the Louisville, Ky.-based insurer and health benefits administrator "encompasses the products Humana now offers to employer groups and individuals other than medical coverage," Humana said in a statement.

Humana Specialty Benefits has 6.8 million members, more than triple the number it had before the acquisitions of Atlanta-based CompBenefits Corp. and Minnetonka, Minn.-based KMG America Corp., Humana said.

BB&T expands in Florida with Burkey purchase

MAITLAND, Fla.—BB&T Insurance Services said it plans to acquire Maitland, Fla.-based Burkey Risk Services for an undisclosed sum to expand its Florida operations.

All 28 Burkey employees, including CEO Gary Burkey, will remain with the risk management and employee benefits service provider, BB&T said.

National Equipment Register expands database, access

JERSEY CITY, N.J.—Construction and farm equipment included in the database of the National Equipment Register will be made more widely available to law enforcement under an alliance between the Des Plaines, Ill.-based National Insurance Crime Bureau and the Jersey City, N.J.-based Insurance Services Office Inc.

"The ability to access NER's data will enable NICB to achieve even greater success in identifying and recovering stolen and/or cloned heavy equipment," Robert Bryant, NICB president and CEO, said in a statement.

Separately, the ISO said Home Depot has added its nationwide rental fleet to the NER database, which the Atlanta retailer said would combat a high theft rate.

Kinloch enhances middle-market focus

WEST ORANGE, N.J.—New York-based brokerage Kinloch Holdings Inc. said it has purchased Olympic Insurance Agency Inc., a West Orange, N.J., employee benefits and property/casualty agency.

With the purchase, New Jersey Senate President Richard Codey has sold all interests in OIA and will have no day-to-day involvement, Kinloch said in a statement. Mr. Codey, who had been president of the agency, will be a consultant to Kinloch on mergers, acquisitions and client relations, Kinloch said.

Regions Insurance Group expands Southern footprint

JACKSON, Miss.—Memphis, Tenn.-based Regions Insurance Group has acquired multiline insurance agency Barksdale Bonding & Insurance Inc. of Jackson, Miss., for an undisclosed amount.

"This acquisition enables Regions Insurance Group to establish a platform agency in Mississippi, as well as growing our footings in Tennessee and Alabama," CEO Casey Bowlin said in a statement.

Argo public entity unit buys Massamont

BOSTON—Trident Insurance Services, a unit of Bermuda-based Argo Group International Holdings Ltd., has acquired Boston-based Massamont Insurance Agency Inc., Argo said in a statement.

Business for public entity risks will continue under the Trident and Massamont names with offices in Boston; Greenfield, Mass.; Chicago and San Antonio. The purchase price was not disclosed.

Brown & Brown adds benefits, services agency

CHARLOTTE, N.C.—Brown & Brown Inc. has acquired the assets of Charlotte, N.C.-based group employee benefits and services agency W.J. Fowler & Co., which does business as the Benefits Dept. and has annualized revenue of about $2.3 million, the brokerage said.

Law firms join forces for Bermuda clients

HAMILTON, Bermuda—London-based Edwards Angell Palmer & Dodge U.K. L.L.P. and Bermuda-based Marshall Diel & Myers said they have entered into a cooperation agreement to better serve insurers and reinsurers doing business in Bermuda as well as the United States, the United Kingdom and Hong Kong, the firms said.

Commentary

Bond insurers playing 'good bank/bad bank'

DOUGLAS McLEOD

Senior Editor Douglas McLeod can be reached at: dmcleod@businessinsurance.com

Look out, believers in rational markets, another segment of the financial services industry may be ready to do its impression of Dr. Jekyll and Mr. Hyde.

This time it's bond insurers, which have been talking for weeks about splitting their staid, reliable municipal bond insurance business (that's Dr. Jekyll) from their unpleasant and potentially lethal guarantees of credit derivatives like subprime mortgage-backed securities (Mr. Hyde).

The idea generally is to keep the muni business in one company that would hold onto its AAA credit rating while locking up the derivative policies in a separate company that may not be viewed as favorably by rating agencies.

How many insurers will actually go through this transformation remains to be seen. So far, only Financial Guaranty Insurance Co., already downgraded to A by Standard & Poor's Corp., has asked regulators to approve a split.

MBIA Inc., which has raised more than $2 billion to head off a downgrade, could split its business in the future to make attracting new capital easier, but is in no hurry to do so right now, CEO Jay Brown has said.

Ambac Financial Group Inc. last week backed away from a plan to divide its muni and structured finance businesses, saying that it will try to raise $1.5 billion in an offering of stock and equity units. The announcement disappointed investors, who've already lost their shirts on Ambac stock and who were hoping for a $2 billion bank bailout.

Let's pause for a moment to consider how handy it would be if we ordinary citizens could follow the "good bank/bad bank" strategy ourselves.

Say I've made unwise, heavily leveraged investments in a 50-inch flat screen TV, a BMW 7-series sedan and annual trips to the Bahamas with my family, then find that my mortgage and home equity loan rates are about to adjust. As a responsible borrower, I make it a priority to cover my mortgage payments; it's everything else that could be trouble.

The solution: I retain my mortgage debt and my sterling credit score, but spin off my consumer debt to a New Self, who may or may not be able to handle it. That's his problem.

The only difficulty with this plan is that, while bond insurers have regulators, banks and investors desperate to prop them up, there is little concern that I might default on my car loan. I lack economies of scale in fecklessness.

But I digress.

Amid the turmoil, unsurprisingly, vultures—um, opportunistic investors—have moved in. Warren Buffett quickly formed a financial guarantee unit of Berkshire Hathaway and offered, unsuccessfully, to reinsure $800 billion of his rival bond insurers' least risky business. Billionaire investor Wilbur Ross agreed last week to invest up to $1 billion in Bermuda-based Assured Guaranty Ltd., the only financial guarantor with a stable AAA rating.

If some bond insurers go ahead with the 'good bank/bad bank' idea, they'd only be the latest to do so.

How all of it will shake out is uncertain. But if some bond insurers go ahead with the "good bank/bad bank" idea, they'd only be the latest to do so.

It started, of course, with banks, as a way of performing Depression-era financial triage. More recently, insurers adopted the strategy: CIGNA Corp. spun off the long-tail liabilities of its Insurance Co. of North America unit to a separate insurer in the 1990s before selling INA to ACE Ltd. a couple of years later.

Insurers' motives then were the same as they would be today: to limit the consequences of a serious miscalculation of risk.

For the property/casualty insurers, it was exploding asbestos and pollution losses and the effects of years of soft-market underwriting. For financial guarantee insurers, it is the revelation that derivatives built on subprime loans are still shakier than municipal bonds, no matter how much financial engineering undergirds them.

Things work out badly for Dr. Jekyll in Robert Louis Stevenson's story. Insurers opting for the "good bank/bad bank" approach to credit market woes have to hope it goes better for them.

Parity: Heading to conference committee

CONTINUED FROM PAGE 1

compendium of mental health care disorders.

Despite that and other differences, Washington benefit observers say the odds favor lawmakers reaching and agreement on the legislation, noting legislators' strong interest in passing a bill that would be popular among voters.

"There is room for compromise. This stands a good chance of passage," said Frank McArdle, a consultant in the Washington office of Hewitt Associates Inc.

"With each branch passing a bill, I don't see why a compromise can't be worked out" since there is strong bipartisan support for parity legislation, said Lynn Dudley, senior vp-policy for the American Benefits Council in Washington.

Opinions are divided on whether such a compromise would more closely resemble the House or Senate version of the bill.

Mark Ugoretz, president of the ERISA Industry Committee in Washington, said he sees parity advocates in the Senate accepting the House requirement to cover diagnoses in psychiatric industry's manual of mental health disorders, or something close to it.

"This is something Sen. Kennedy wanted to do in the first place," Mr. Ugoretz said, referring to the senior Democratic senator from Massachusetts, who is the sponsor of the Senate bill. He also will be a member and possibly the chair of the upcoming conference committee.

Others are less certain, noting the unanimous Senate vote for its parity bill and considerable opposition in the House to such a requirement.

For example, Rep. Howard McKeon, R-Calif., said the House bill doesn't mandate parity but would actually result in "preferential treatment for mental health benefits over and above all other categories of medical benefits."

But some House members aren't ready to give up such a requirement. For example, Rep. Frank Pallone, D-N.J., said earlier that the Senate approach in which employers would retain the ability to decide which mental health care conditions they would cover, "would not accomplish much. It would be practically no coverage at all."

Rep. Patrick Kennedy, D-R.I., one of the chief architects of the House bill, said he wants to work with Senate negotiators to reach a compromise that can become law.

"We're ready to sit down with the Senate and hash out the differences and get a bill passed," Rep. Kennedy said last week at a news briefing. "We're serious about getting something to the president's desk."

For the first time, the Bush administration last week formally threw its support to the Senate parity bill, saying the measure strikes the right balance of expanding coverage without significantly increasing health care costs.

By contrast, the administration said the House bill would have a "negative effect" on the availability and affordability of employer-provided coverage.

PARITY BILL COMPARISON

How mental health care parity bills differ in the House and Senate

WHERE THEY AGREE

- Group health care plans could not impose higher cost-sharing requirements for mental health care expenses than for other medical conditions.
- Discriminatory treatment limitations for mental health care services would not be allowed.
- Employers with fewer than 50 employees would be exempt from parity requirements.
- Employers would be exempt from parity requirements if upgraded mental health benefits boost costs at least 2% the first year after the legislation goes into effect and 1% in succeeding years.

WHERE THEY DIFFER

- House bill would require equitable coverage of any diagnosis listed in the psychiatric community's compendium of mental disorders.
- House bill would require equitable out-of-network coverage for mental health care services; Senate bill would not require out-of-network coverage for mental health services, but it must be equitable if out-of-network coverage is offered.
- House bill would not pre-empt stronger state parity laws; Senate bill generally would pre-empt such laws.

REUTERS/LANDOV

'We're ready to sit down with the Senate and hash out the differences and get a bill passed.'

Rep. Patrick Kennedy, D-R.I.

Charter: Administration signals support

CONTINUED FROM PAGE 4

industry has in the Securities and Exchange Commission, he said. This frustrates Europeans in particular as they try to work out insurance-related trade issues, and hampers the ability of U.S. insurers to compete, he said.

As he has before, Rep. Royce cited the United States' experience with the Articles of Confederation. The articles didn't guarantee interstate commerce, with states erecting trade barriers against their neighbors. But when the Constitution replaced the articles, there was one industry "not addressed—and that was insurance," he said. "We Balkanized the insurance market."

But an opponent of the OFC chose another historical example to bolster his argument. Illinois Insurance Director Michael T. McRaith noted that the McCarran-Ferguson Act of 1945, which re-established state primacy in insurance regulation after a Supreme Court decision overturned it, came after more than a decade of the New Deal. Mr. McRaith said that despite the expansion of federal regulatory power over much of the economy during that period, he believes that President Franklin D. Roosevelt and his advisers made a "conscious" decision to avoid federal regulation of insurance because they knew consumers were better served by a state system closer to the people.

He also pointed to the savings and loan crisis of the 1980s as an argument against federal regulation of insurance. "Do we want to risk" a repeat of that financial meltdown in insurance, Mr. McRaith asked his audience.

He urged his listeners to be careful what they wish for if they wished for a federal insurance regulator. Many political leaders want more rather than less regulation of insurance, he said, adding that none of the presidential candidates runs on a platform of "we support the insurance companies."

The debate over the OFC continued later as a panel of insurance industry representatives tackled the issue. Gregory Wren, executive director of the Washington-based Coalition Opposed to a Federal Insurance Regulator, said the proposal "solves a crisis that doesn't exist' and noted that lawmakers are concerned about the lack of consensus on the issue amongst insurers and producers.

But J. Kevin McKechnie, executive director of the Washington-based American Bankers Insurance Assn., said that an OFC is critical to assure adequate capital formation for the domestic insurance industry. Absent change, the industry could move offshore in response, he said.

Rezulin: Suit to go to trial

CONTINUED FROM PAGE 4

caused by Rezulin, which has been linked to liver failure.

Warner-Lambert, which introduced the drug in 1997, agreed to a series of product warning label changes before pulling the drug off the market in 2000.

A 1995 Michigan law bars most product liability lawsuits against pharmaceutical companies that market drugs that have been approved by the U.S. Food and Drug Administration and carry FDA-required warning labels. But the law does not apply if a drug maker withheld information that would have convinced the FDA not to approve the drug.

Because Warner-Lambert faced similar claims in California, all of the cases were consolidated and transferred to a federal court judge in New York.

In 2005, the federal judge—applying Michigan law—agreed with Warner-Lambert that because a Michigan court would have to review the FDA's approval of Rezulin before deciding whether the product liability case could proceed, the Food, Drug and Cosmetics Act and the Medical Device Act by implication pre-empt the litigation. The judge based his decision on a 2001 Supreme Court ruling in *Buckman vs. Plaintiffs' Legal Committee* and a 2004 6th Circuit court ruling in a different lawsuit filed in Michigan state court against a pharmaceutical company.

In January 2007, however, a 2nd Circuit panel overruled that decision. The appeals court ruled, among other things, that the plaintiffs do not want to "police fraud against the FDA"—as the plaintiff in the 2001 Supreme Court case attempted—but rather are trying only to recover damages.

The Supreme Court is scheduled to revisit how the federal pre-emption issue applies in pharmaceutical product liability cases in *Wyeth vs. Levine*, which the court in January agreed to hear.

In that case, the court will address whether the labeling requirements that the FDA imposes on drug manufacturers pre-empt state law product liability claims that assert that different labeling judgments were necessary to make the drugs reasonably safe for use.

Comp: N.Y. reform calls for more data from employers

CONTINUED FROM PAGE 1

gauge the necessity of systemwide improvements.

The report follows a workers comp reform package that Gov. Spitzer signed into law last year. At the time, he directed the insurance superintendent to gather data on statewide system costs and provide an annual report. That direction followed findings by the governor that reform efforts were being hampered by a lack of basic data.

Some of the information that the report recommends be provided by workers comp payers—such as medical costs—is very specific and beyond the information normally captured by employers and third-party administrators, said Debra Drinane, senior vp of strategic outcomes in Schaumburg, Ill., for Broadspire Services Inc., a TPA.

"It's certainly a lot of data they are looking for," said Steven M. Scotti, assistant general counsel for Consolidated Edison Inc. in New York.

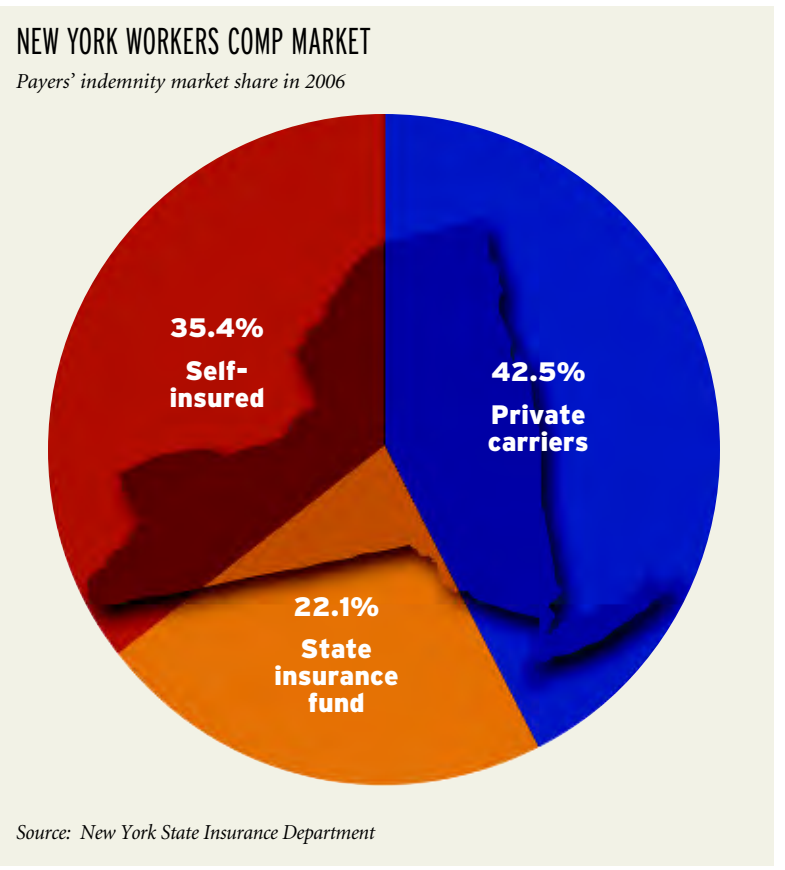
The report, for instance, calls for employers to submit information on the total number of doctor visits provided per payment made to the physicians, said Mr. Scotti, who also is a board member of the New York Self-Insurers Assn.

Mr. Scotti said Consolidated Edison's TPA, Sedgwick Claims Management Services Inc., currently does not capture such data for his company. Mr. Scotti has requested that Sedgwick evaluate how much it could cost Consolidated Edison to comply with the report's numerous proposals.

The report recommends that public and private self-insured employers be required to submit data quarterly. That could help the state overcome a "major gap" in information available for accurate analysis of total system costs, the report states.

Workers comp market

Currently, 150 large, private employers self-insure in New York, while another 21,000 employers are self-insured through 75 group arrangements. Additionally, public entities account for more than half of employees covered by self-insured employers in the state. Overall, 35% of New York's $5.5 billion workers comp market self-insures, the report states.



'How this originally starts out, and how it looks, ultimately could be a different thing.'

Debra Drinane
Broadspire Services Inc.

But state regulators currently are limited in their ability to demand information from self-insured employers, according to the report.

The document, compiled by a Workers' Compensation Reform Task Force created within the Insurance Department, contains numerous other recommendations.

For instance, it notes that claim resolutions are slow in New York and data, such as information on workers' access to medical care and the quality of care, would help.

The document also contains several benchmarks comparing New York's performance with national averages. For example, it notes that New York experiences high "frictional costs," with more than 30% of 2004 claims involving an independent medical evaluator compared with 17% in 13 other states.

The report is a good first step toward measuring the effect of the reforms adopted last year, said Ken Pokalsky, senior director of government affairs for the Business Council of New York State Inc., an employer advocate group in Albany, N.Y.

It should be applauded for attempting to quantify the "strengths, weaknesses, and bottlenecks" in New York's workers comp system, Mr. Pokalsky said. But because the report is wide-ranging, the Business Council will need time to assess whether its recommendations are practical and whether the resources that would be required of employers are reasonable.

Whether employers ultimately will have to produce the information called for in the "far reaching" report remains to be seen, said Broadspire's Ms. Drinane. Requiring certain workers comp payers to provide some data would necessitate passing legislation, she added.

So "how this originally starts out, and how it looks ultimately could be a different thing," Ms. Drinane said.

Requests for additional information from employers "will doubtless require some resources," a spokesman for the insurance superintendent said. "But this is clearly a positive for all involved, as it will lead to a more efficient, effective workers compensation system for all."

Data-driven

While some of the report's recommendations would require legislation, others can be implemented by the governor, such as creating a data analysis division within New York's Workers Compensation Board to collect and analyze the data, the spokesman said.

The task force that compiled the report recommends that an advisory committee selected by the governor from the Legislature, state agencies, labor, industry and academia guide the data analysis division's research efforts.

Although details of how New York would proceed remain to be determined, Gov. Spitzer's workers comp experts are serious about their efforts to collect data, said Keith Bateman, vp of workers comp for the Property Casualty Insurers Assn. of America in Des Plaines, Ill.

"His people are very data-driven and they want to be data-driven to understand the system," Mr. Bateman said. 'I think their motivation is just what they say it is."

Fraud: Ex-Willis exec accused of stealing $2.2 million

CONTINUED FROM PAGE 3

International Group Inc. to inflate the amount owed to AIG on various insurance contracts, court papers say. Upon receiving the processed check, prosecutors charge, Mr. MacKay would deposit it into his shell company account, write a check from the account to AIG for the amount due under the correct invoice and keep the rest.

The alleged activity began in February 2004 and continued through February of this year, when Willis became aware of Mr. MacKay's activities, prosecutors said.

"Willis discovered financial irregularities involving (Mr. MacKay) and undertook an immediate internal investigation," the Willis spokeswoman said. "The company contacted federal law enforcement authorities and is working with them to resolve the matter. The amount of financial exposure for Willis is not material."

According to the sworn FBI statement detailing the allegations in the criminal complaint, Mr. MacKay agreed voluntarily to be interviewed Feb. 21 by FBI agents about the alleged activities. During that interview, court papers say, Mr. MacKay admitted that he embezzled and/or fraudulently obtained between $2 million and $2.5 million from Willis while he was employed there.

Mr. MacKay surrendered to the FBI March 3, was arrested and later appeared in federal court in Burlington, Vt. He was released on various conditions, including that he surrender his passport and not travel outside of Vermont, authorities said.

Mr. MacKay admitted that he embezzled and/or fraudulently obtained between $2 million and $2.5 million from Willis while he was employed there.

Under federal law, a grand jury indictment has to be returned on the criminal complaint within 30 days of arrest, U.S. Attorney Tom Anderson said. If an indictment is returned, Mr. MacKay then will enter a plea.

Mr. MacKay's attorney—Nancy Waples of Hoff, Curtis, Pacht, Cassidy, Frame, Somers & Katims P.C. in Burlington, Vt.—would not comment on the pending investigation except to say in an e-mail that Mr. MacKay "has had a stellar reputation throughout his career in the insurance field" and is presumed innocent.

The Vermont Department of Banking, Insurance, Securities & Health Care Administration, which Willis also notified about Mr. MacKay's alleged fraudulent activities, has commenced its own inquiry into the case and the overall impact, if any, on Vermont captives, according to Peter Young, assistant general counsel.

ADVERTISER INDEX

Issue of March 10

News In Brief

CONTINUED FROM PAGE 1

prevents the California Insurance Department from enforcing a cease-and-desist order that would bar a Montana-domiciled risk retention group from providing medical stop-loss coverage to a group of California auto dealers. The California Insurance Department said it has authority to stop an RRG licensed in another state from operating in California, contending that neither California law nor the federal Liability Risk Retention Act allows medical stop-loss coverage to be written by RRGs. The RRG industry disagrees that out-of-state regulators have the authority to decide what risks RRGs can write and argued that such regulators need to obtain an injunction to stop an RRG from operating.

Vermont names captive regulator

David Provost, assistant chief examiner at the Vermont Captive Insurance Division, will become the domicile's top captive regulator in June. Mr. Provost will succeed Len Crouse as deputy commissioner and head of the Captive Insurance Division when Mr. Crouse retires in June after 18 years as Vermont's chief captive regulator. Mr. Provost has 18 years of captive experience. He spent the past seven years as a Vermont captive regulator.

Senate panel OKs bill to limit sealed pacts

The Senate Judiciary Committee has approved a bill that would make it more difficult to seal settlements reached in federal court. Among other things, the bill would require judges to consider the health and safety implications of settlement agreements and court documents—including information emerging from discovery—before sealing documents. No companion bill has been introduced in the House.

IRS clarifies taxes on offshore cover

The Internal Revenue Service, in Revenue Ruling 2008-15, said federal excise taxes imposed on insurance and reinsurance purchased from foreign insurers and reinsurers apply each time the risk is ceded. In what tax practitioners described as a "cascading" effect, the excise tax—which is 4% for insurance purchased from a foreign insurer and 1% for reinsurance—will be imposed whenever one reinsurer cedes the risk to another. However, the IRS said no penalties will be imposed for earlier periods when the excise tax was not paid, so long as payments are made by Oct. 1, 2008.

Fitch: Bermuda strong but price pressure looms

The Bermuda market remains strong, but softening prices and other forces will challenge the island's insurance and reinsurance companies this year, according to a report from Fitch Ratings Ltd. Fitch notes that it has a stable ratings outlook on the Bermuda market, which it says has had "tremendous" success in the past two years, due in part to modest catastrophe losses. But in addition to price pressures, challenges for the market include managing the risk related to some companies' expansion strategies; coping with unique infrastructure challenges, such as obtaining work permits; and retaining financial and competitive advantages derived from the island's tax status, according to the report.

Noted

Fireman's Fund Insurance Co. has appointed Michael LaRocco as president and chief executive officer. Mr. LaRocco, who served as president and chief operating officer of Seattle-based Safeco Corp. until 2006, will assume the post from interim CEO Chuck Kavitsky on March 17. Mr. Kavitsky, CEO and president of Fireman's Fund's American parent, Allianz of America, has served as interim Fireman's Fund CEO since June 2007, when Joseph Beneducci resigned after six months of service....**Vermont employers** buying workers compensation insurance will see a rate reduction averaging 4.2% effective April 1, Gov. Jim Douglas said.

Alert

Business Insurance has learned of instances recently where persons misidentifying themselves as *BI* reporters have contacted insurance industry executives, seeking information. Questions about *BI* may be directed to *biweb@businessinsurance.com*. In addition, a list of *BI* staff members is available at *www.BusinessInsurance.com*.

AIG's National Union ordered to pay $32.1M

Insurer to appeal bad faith finding in D&O cover dispute

By DOUGLAS McLEOD

LOS ANGELES—A federal judge has ordered a unit of American International Group Inc. to pay $32.1 million to a Seattle-area biotechnology company, finding that the insurer failed to respond adequately to a directors and officers liability claim for nearly three years before denying coverage.

The award is more than triple the $10 million limit of the D&O policy issued to Mukilteo, Wash.-based CombiMatrix Corp., but U.S. District Judge Philip S. Gutierrez ruled that AIG's National Union Fire Insurance Co. of Pittsburgh, Pa., acted in bad faith and that damages are therefore not confined to the policy limits.

New York-based National Union will appeal, an AIG spokesman said.

The coverage battle stemmed from a 2000 lawsuit in which Nanogen Inc., a rival biotech company based in San Diego, charged that CombiMatrix's chief technology officer, Donald Montgomery, misappropriated Nanogen technology after leaving Nanogen to join its rival.

CombiMatrix settled the case in 2002 after nearly $2 million in legal bills, agreeing to pay Nanogen $1 million in cash along with almost $18 million in CombiMatrix stock and royalties on certain patents.

Five claims representatives

In his coverage ruling, Judge Gutierrez noted that there was no evidence to support the charges against Mr. Montgomery, but that CombiMatrix settled after deciding that continued litigation would destroy the company.

CombiMatrix notified National Union of the lawsuit soon after it was filed, but heard little from the insurer for the next three years as the claim file was shifted among five successive National Union claims representatives, Judge Gutierrez found.

One representative promised a "preliminary coverage evaluation" soon after the claim notification, but never provided one, the judge wrote. A few months later, another representative requested more information about the claim, which CombiMatrix quickly supplied. In April 2001, CombiMatrix's general counsel requested payment of about $60,000 in legal bills, and a month later wrote to National Union with an update on the case; the insurer did not respond to either letter, the judge noted.

After a four-month period during which no one at National Union was assigned to handle the claim, a fourth claims representative told CombiMatrix in a phone call that two policy exclusions barred coverage of the settlement; the representative later acknowledged at trial that the policy did not contain either exclusion, according to Judge Gutierrez's ruling.

A fifth claim representative finally wrote to CombiMatrix to deny coverage in November 2003, nearly three years after Nanogen filed suit and more than a year after the settlement.

Policy limit doesn't matter

National Union "improperly and unreasonably withheld benefits" under the D&O policy and its claims handling amounted to bad faith, Judge Gutierrez concluded. Because of this, CombiMatrix is entitled to recover the full amount of its settlement and defense costs with interest, regardless of the D&O policy limit, he ruled.

Judge Gutierrez also rejected several National Union coverage defenses, including a policy provision barring voluntary settlements without the insurer's consent.

The CombiMatrix settlement was not voluntary, but was an "economic necessity" for the company that resulted from National Union's breach of its duties under the policy, the judge wrote.

The coverage case was filed against National Union by Acacia Research Corp., the Newport Beach, Calif.-based parent of CombiMatrix.

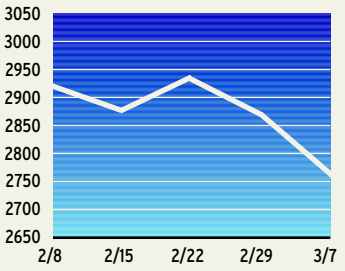
Acacia Research Corp. et al. vs. National Union Fire Insurance Co. of Pittsburgh, Pa.; U.S. District Court for the Central District of California, Western Division; Case No. CV 05-501.

Stock Index

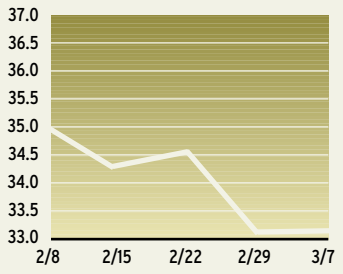
[3/3 - 3/7]

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

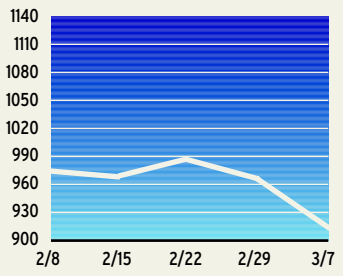
BI STOCK INDEX



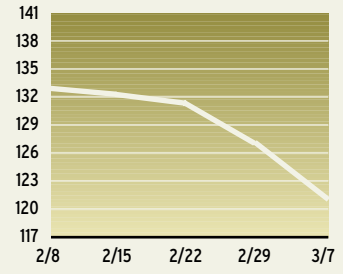
BI BROKERS INDEX



BI INSURER/REINSURERS INDEX



BI MANAGED CARE ORGANIZATIONS INDEX



Percentage change of BI *Stock Index vs. key indicators*

BI STOCK INDEX	2760.15	-4.45%
DOW JONES	11893.69	-3.04%
S&P 500	1293.37	-2.80%

LARGEST GAINS

EMC Insurance Group Inc.	14.33%
Gainsco Inc.	7.94%
Baldwin & Lyons Inc.	3.45%
Selective Insurance Group	1.01%
Arthur J. Gallagher & Co.	0.76%

LARGEST LOSSES

Ambac Financial Group	-14.72%
Citigroup Inc.	-11.81%
Allmerica Financial Corp.	-9.70%
XL Capital Ltd.	-9.65%
Tower Group Inc.	-9.19%

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

Business Insurance END PAGE

PENNEBAKER HEGEDUS FILMS/ZUMA PRESS

Comedian-turned-politician Al Franken, shown in the 2006 film "Al Franken: God Spoke," is accused of failing to get workers comp cover for New York employees.

Franken to pay workers comp fine but keeps right to appeal

Al Franken is both a funny guy and a candidate for the Minnesota Democratic Farmer Labor Party nomination for the U.S. Senate.

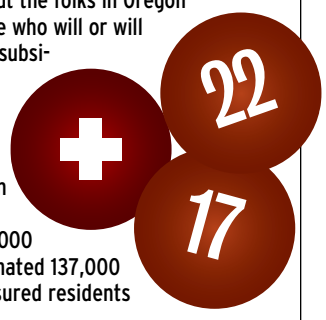
But the "Saturday Night Live" comedian-turned-politician found himself facing a serious charge last week involving alleged failure to provide workers compensation coverage for employees of his then-New York-based company, Alan Franken Inc. The New York State Workers' Compensation Board says Mr. Franken failed to provide the required coverage between 2002 and 2005 and levied a $25,000 penalty on Mr. Franken, who now lives in Minneapolis.

According to a report in the Minneapolis Star Tribune last week, a spokesman for Mr. Franken's campaign said the candidate was unaware of the problem until recently.

And late last week, a spokeswoman for the Franken campaign told the Associated Press that Mr. Franken would pay the fine but also would reserve the right to appeal it.

For a funny guy who enjoys the support of unionized workers, being accused of failing to protect your own employees was no laughing matter.

Low-income uninsured bet cover on lottery



It may not be as macabre as Shirley Jackson's legendary short story "The Lottery," but the folks in Oregon are using a drawing to decide who will or will not be covered by the state-subsidized health plan for low-income residents.

Because of budget cuts, the Standard Benefit Plan, which now covers fewer than 18,000 adults, can support a monthly average of only 24,000 members. However, an estimated 137,000 of the state's 600,000 uninsured residents qualify for the plan.

To fill those 6,000 openings, the Oregon Department of Human Services is hosting a lottery in which it will randomly select names from a reservation list until all of the slots are filled. A total of 91,675 uninsured Oregonians made the Feb. 29 deadline for being included on that list.

Though the odds of being picked may be long, few low-income residents are objecting to the selection process, according to Ellen Pinney, health policy advocate for the Oregon Health Action Campaign.

"This is such a wonderful opportunity," she is quoted as saying in the local press. "We've heard absolutely no complaints, just a lot of hope that they are the ones who will be selected."

LISA HAUN/MICHAEL OCHS ARCHIVES/GETTY IMAGES

"Everybody Have Fun Tonight," the hit 1980s tune by Wang Chung, has helped an Illinois insurance brokerage play up its "quirkiness" and "culture," an official said.

Assurance motivates 'wang-chungy' culture

Assurance Agency Ltd. tapped a "terrible" song to make benefits fun for its roughly 185 employees.

The Schaumburg, Ill., insurance brokerage chose the 1980s Wang Chung hit "Everybody Have Fun Tonight" as last year's theme to promote a culture that makes people excited to come to work, said Steven Handmaker, vp of marketing and communications.

"We know it's a terrible song, but it said something fun about our quirkiness and our culture," he said.

Playing off the lyrics, the company created a Wang Chung Wheel that employees deserving of recognition can spin twice a year to win prizes worth $300 to $500. In addition, periodic cash prizes are given to celebrate employees' value to the company, which offers onsite fitness facilities, lunchtime yoga, fresh fruit Tuesdays and salsa lessons.

The theme had such an effect that employees now describe Assurance's culture as "wang-chungy," Mr. Handmaker said. While this year's theme keys off the 1970s David Bowie tune "Heroes," the prize wheel and other fun activities will remain.

The company hosts an employee appreciation day for all staff to attend an entertaining offsite activity such as an architectural boat tour or a theatrical performance.

In addition, employees who pass a class or achieve a professional designation receive cash attached to helium-filled balloons.

"We find ways to continually make the day fun and interesting," Mr. Handmaker said.

Contributing: Jeff Casale, Kristin Gunderson Hunt, Mark A. Hofmann, Joanne Wojcik

On-the-job sleepiness blamed on extra work

Wipe the drool from your face and shake the dreams from your head: It's time to get back to work.

A recent survey by the National Sleep Foundation discovered that 29% of respondents fell asleep or became "very sleepy" at work in the past month, which isn't good for productivity.

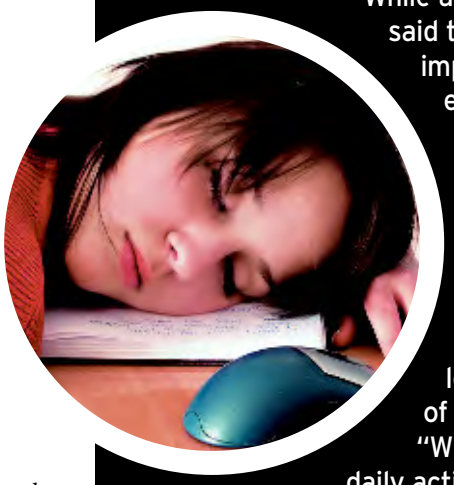
The Washington-based nonprofit surveyed 1,000 people and found that participants slept an average of six hours and 40 minutes a night during the week. Those same people, however, say they need a little more than seven hours of sleep each night to be at their best the next day.

Of those surveyed, 63% said they ignored their sleepiness, while 32% loaded up on caffeine to fight it off. Meanwhile, more than 54% said that they use the weekends to catch up on some much-needed Zzzs.

"Nearly 50 million Americans chronically suffer from sleep problems and disorders that affect their careers, their personal relationships and safety on our roads," Darrel Drobnich, acting chief executive officer of NSF, said in a statement.

The main culprit for the loss of sleep is work, with 20% saying they spend 10 or more additional hours each week working at home and 25% saying they spend at least seven additional hours each week doing job-related duties at home.

Nearly one-quarter of those surveyed said they did something work-related in the hour before going to bed a few nights a week.



While at work, 40% said they become impatient with others at least a few times a month, and 20% said that a lack of sleep had gotten in the way of meeting the productivity levels expected of them.

"When work and daily activities demand so much of our time, sleep is often sacrificed," Mr. Drobnich said. "People tend to give up sleep, when getting a good night's sleep should be at the top of everyone's list."

Walter Curtis, Master Machinist.

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