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In Brief

9th Circuit to weigh health spending rule

A three-judge panel of the 9th U.S. Circuit Court of Appeals will hear oral arguments April 17 on whether San Francisco's 2006 health care spending ordinance is pre-empted by federal law. The ordinance requires employers to spend a certain amount of money on employee health care coverage or pay a fee to the city to fund coverage for uninsured residents. Late last year, a federal judge ruled that the law ran afoul of a provision in the Employee Retirement Income Security Act that pre-empts state and local laws that relate to employee benefit plans.

AIG, Pennsylvania settle charges

American International Group Inc. will pay \$13.5 million, including a \$6.6 million fine, to

See **IN BRIEF** page 26

XL picks outsider as its next CEO

Ex-SAFECO chief McGavick to succeed O'Hara

By **JUDY GREENWALD**



WATCH a video interview with longtime insurance executive Michael S. McGavick as he discusses his priorities and challenges as incoming CEO of XL Capital Ltd. at www.BusinessInsurance.com/video.

HAMILTON, Bermuda—XL Capital Ltd. selected a seasoned insurance executive with proven leadership abilities in its appointment of former SAFECO Corp. President and Chief Executive Officer Michael S. McGavick as its CEO, say many observers.

XL Capital said last week that Mr. McGavick will replace its longtime CEO Brian O'Hara, effective May 1. Mr. O'Hara, who held the CEO post for 13 years, will serve as chairman of the board during the final year of his term as a director, which expires in April 2009.

Mr. McGavick was president and CEO of Seattle-based SAFECO from 2001 to 2005,

See **McGAVICK** page 25



ZUMA PRESS

The CNN Center and the Omni Hotel were among structures that sustained damage when a tornado struck downtown Atlanta as part of a larger storm system that swept through Georgia in mid-March.

Insurers tally claims after Atlanta twister

Storm losses statewide may hit \$250 million

By **MARK A. HOFMANN**

ATLANTA—Storms that included a rare tornado that struck downtown Atlanta earlier this month could result in as much as \$250 million in insured damage across Georgia, according to state officials.

State-owned properties sustained much of the damage in Atlanta. Although damage to the Georgia Dome proved less extensive than feared initially, the neighboring Georgia World Congress Center suffered considerable damage, according to the state's property insurance program officer. The weather forced cancellation or postponement of several events at the state-owned properties.

The fierce weather did not spare the private sector, either, with both the CNN Center and the Omni Hotel at the CNN Center among structures that sustained damage.

"The \$250 million insured damage estimate figure includes damage from across the state, such as Polk and Bartow counties, where damage was quite extensive," Insurance and Safety Fire Commissioner John W. Oxendine said in a statement. "This storm caused the largest loss yet recorded in our state for tornado damage."

Tornadoes killed two in north Georgia but caused no deaths in

Atlanta.

"The damages are currently under investigation," said Marlene Butler, state property insurance program officer for the state's risk management services division in the Department of Administrative Services. At the Georgia Dome, "we believe the damages will be limited to around \$1 million or so."

"Originally, it appeared to be severe structural damage to the roof, but as it turns out, the damage is pretty limited around the roof frame," she said.

The story was different at the Georgia World Congress Center, though. During a tour of the facility last week, "we discovered more damage," including collapsed walls, extensive roof damage and severe damage to the main ballroom, Ms. Butler said. Other damage included extensive window breakage. The total insured loss will not be known for some time, she said.

Ms. Butler said the state self-insures the first \$3 million per occurrence. Above that is \$500 million all-risk program in which numerous insurers participate. She said the state also has business interruption coverage.

The storms caused the cancellation or postponement of all events at

See **TORNADO** page 26

Vendors held to account

Benefit managers seek performance guarantees

By **GLORIA GONZALEZ**

Seeking ways to improve the efficiency of health care benefits, benefit managers are requiring health care providers to commit to a range of performance guarantees and customize their product offerings.

Providers of health care products and services say they welcome tough requests from their employer clients, but they also say clients should have reasonable expectations and be ready to partner with their vendors to achieve their health care objectives, such as more predictable health costs.

Benefit managers have spent a great deal of time and effort in recent years restructuring benefits programs to focus on increased

employee cost-sharing and audits of health care plan eligibility, but essentially have achieved all the savings they can through such methods, said Helen Darling, president of the National Business Group on Health in Washington.

Because employers are spending a sizeable portion of their benefit dollars on health improvement initiatives, such as wellness or disease management programs and tools designed to engage their employees in health care decisions, they are saying that "now is a reasonable time" to seek evidence of the return on investment, she said.

Generally, performance standards have revolved around opera-

See **PROVIDERS** page 25

SPOTLIGHT

SELF-INSURANCE CLAIMS MANAGEMENT

Build mutual understanding before the policy goes into effect; bulk transporter drives its claims-handling process; workers comp guidelines gain usage;



stop-loss pricing rests on claims experience; largest TPAs for P/C, workers comp, benefits and multiline claims. **Page 9**

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KATHY BURNS

CEO of Aon's eSolutions Group
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On the Web

BI VIDEO

BI interviews new XL CEO

In a video interview, longtime insurance executive Michael S. McGavick talks about his priorities, challenges and opportunities as the incoming chief executive officer of Bermuda-based XL Capital Ltd. To view the interview, go to www.BusinessInsurance.com/video.

BI AUDIO

Listen to Ellison podcast online

Policyholder attorney John Ellison of Reed Smith L.L.P. discusses some defenses that



insurers are raising on property and professional liability claims, and offers tips on how policyholders

can protect their coverage. To access a podcast of this interview, go online to www.BusinessInsurance.com/audio.

CONFERENCE EXTRA

Read more from NBGH, PLUS conferences

Business Insurance offers additional coverage from the National Business Group on Health's Business Health Agenda 2008, as well as from the Professional Liability Underwriting Society's Medical Professional Liability Symposium earlier this month. Follow additional coverage of these conferences at www.BusinessInsurance.com/extra.

BI DIRECTORIES

Directory of third-party administrators updated

Business Insurance has updated its directory of third-party administrators for 2008. Review this and all of *BI's* directories at www.BusinessInsurance.com/directories.

Business Insurance®

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Aon chairman Ryan plans to retire in August

Brokerage founder, who stepped down as CEO in 2005, says leadership transition complete

By SALLY ROBERTS

CHICAGO—With Aon Corp.'s leadership transition complete, founder and Chairman Patrick G. Ryan said last week that the time has come for him to retire from the brokerage he built over more than four decades.

Mr. Ryan, 70, who will retire Aug. 1, three years ago handed over the reins of Chicago-based Aon to Gregory C. Case, a young, relatively unknown McKinsey & Co. insurance consultant. Mr. Ryan stayed on as executive chairman, building client relationships and supporting Mr. Case through the management change.

That change, Mr. Ryan said in a statement, is now complete, and

Aon is well-positioned for continued growth and success under what he described as "the sound leadership" of Mr. Case.

"After 41 years as CEO and three years as executive chairman, it is time to retire from active involvement," he said. "I will of course continue to be a dedicated and interested shareholder."

Aon's origins date back to 1964, when Mr. Ryan created Pat Ryan Associates, a small managing general agency that distributed specialty credit life insurance products to automobile dealers.

Through a series of major acquisitions in the 1980s and 1990s—including Combined Inter-



'I'm still the founder, and I have a great love for the company, its people and its clients. I'll be helping them out when they need me.'

Pat Ryan, Aon Corp.

national Corp., Rollins Burdick Hunter Group Inc., Hudig-Langeveldt Group B.V., Frank B. Hall & Co. and Alexander & Alexander Services Inc.—Mr. Ryan built his agency into a global brokerage powerhouse.

Today, Aon has more than 500

offices in 120 countries, generating revenues in excess of \$7 billion.

Mr. Ryan was named Insurance Leader of the Year by the College of Insurance in 1997 for his efforts in creating Aon.

"Pat was a visionary in seeing the need to push consolidation within the insurance brokerage industry," said Mark Lane, a

research analyst with William Blair & Co. in Chicago. "He understood that clients were getting more sophisticated and that brokers needed deeper and broader global resources to better serve clients."

See **RYAN** page 6

Bear Stearns' insurers don't have to fund pact

Failure to get insurer consent voids cover: Court

By SALLY ROBERTS

NEW YORK—Bear Stearns Cos. Inc. cannot recover from its professional liability insurers part of its \$80 million settlement with state and federal regulators in 2002, because it failed to gain the insurers' consent for the pact, New York's highest court has ruled.

Attorneys say the decision should remind policyholders to keep their insurers abreast of claim developments, including potential settlements.

The New York State Court of Appeals case, *Vigilant Insurance Co. et al. vs. The Bear Stearns Cos. Inc.*, centers on an insurance provision in Bear Stearns' professional liability policies that requires the New York-based investment bank to obtain insurer consent before settling any claim in excess of \$5 million.

Bear Stearns had a \$10 million professional liability policy from Vigilant Insurance Co., with an additional \$40 million in excess coverage from Federal Insurance Co. and Gulf Insurance Co., according to court papers. Vigilant and Federal are subsidiaries of Warren, N.J.-based Chubb Corp., while Gulf is a subsidiary of St. Paul, Minn.-based Travelers Cos. Inc.

In December 2002, Bear Stearns signed a settlement-in-principal document with federal and state regulators, and then in April 2003 executed a consent agreement to settle investigations of alleged conflicts of interest within its research analyst practices. As part of the settlement, Bear Stearns agreed to pay \$80 million, \$25 million of which was a penalty that Bear Stearns agreed not to fund with insurance coverage.

Three days after executing the settlement—but six months before

a federal court gave it final approval—Bear Stearns sent letters to its insurers requesting their consent and coverage of \$45 million of the settlement, the remaining portion above the penalty and a \$10 million self-insured retention.

The insurers denied coverage, claiming, among other things, that Bear Stearns breached the policy provision obligating it to obtain the insurers' consent before settling.

Lower courts ruled in favor of Bear Stearns, saying that triable issues of fact existed as to whether Bear Stearns had breached the policy clause, because the federal court did not approve the settlement until it entered a final judgment in October 2003.

But in reversing the lower court rulings, the New York State Court of Appeals said it was "unpersuaded" by that argument and ruled that Bear Stearns breached the policy provision and forfeited any insurance recovery.

As a result of the ruling, "there is now without a doubt a reserved seat at the settlement table for insurers if the insured contemplates using insurance to pay for any part of a settlement," said Joseph G. Finnerty III, an attorney with DLA Piper L.L.P. in New York, who represented the Chubb subsidiaries in the case but argued the appeal for all three insurers.

He noted there is a "dearth of authority" from the courts on the issue of settlement consent and, therefore, he believes the decision will be influential.

"Every liability policy either expressly or implicitly assumes the insurance company will be involved in the decision to settle," said Marc S. Mayerson, a policy-

See **BEAR STEARNS** page 22



NYT PHOTOS

Seven people were killed and seven buildings were either damaged or destroyed when a crane being raised on a Manhattan high rise collapsed March 15.

N.Y. project where crane collapsed lacks wrap-up

Situation complicates determining liability

By DAVE LENCKUS

NEW YORK—The Manhattan building project that was the flash point of a deadly and destructive crane collapse is not covered by a wrap-up—or master—insurance program, even though most large projects use wrap-ups to ensure seamless coverage, sources say.

As a result, the project's developer and contractors will have to sort out blame for the March 15 accident while likely also defending against third-party lawsuits and claims filed by the families of six

workers killed in the accident, insurance experts said.

While the workers' employers would be responsible only for providing workers compensation benefits, their families could recover additional damages from the developer and other contractors if they are found liable for the accident, experts noted.

The expected finger pointing in determining liability will make the claims process far more complex than if everyone involved in the

See **CRANE** page 6

Walgreens buying two worksite health clinic operators

Addition of CHD Meridian, Whole Health boosts care facility offerings

By KRISTIN GUNDERSON HUNT

DEERFIELD, Ill.—Walgreen Co. is expanding its health care operations, announcing plans last week to acquire two major worksite health center operators.

The Deerfield, Ill.-based drugstore chain said it will acquire I-trax Inc., the Chadds Ford, Pa.-based parent of CHD Meridian Healthcare Inc., and Whole Health Management Inc. of Cleveland, pending regulatory approval.

Walgreens said in a statement it will pay about \$278 million in cash and assume about \$18.3 million in debt to acquire I-trax, which reported \$143 million in 2007 revenues. Walgreens did not disclose

the terms of the Whole Health Management acquisition.

The transactions are expected to be finalized within 60 days, Walgreens said.

Once the acquisitions are complete, Walgreens will manage about 350 worksite health centers and pharmacies, the company said. Clients that Walgreens would add as a result of the two health center operator acquisitions include Eastman Chemical Co., Florida Power & Light Co. and Toyota Motor Corp., among others.

The acquisitions would bring Walgreens its first worksite health clinics, although it manages several worksite pharmacies for large employers.

For now, the worksite health centers will continue to operate as they have under the I-trax and Whole Health models but will be managed by the new Walgreens Health and Wellness division.

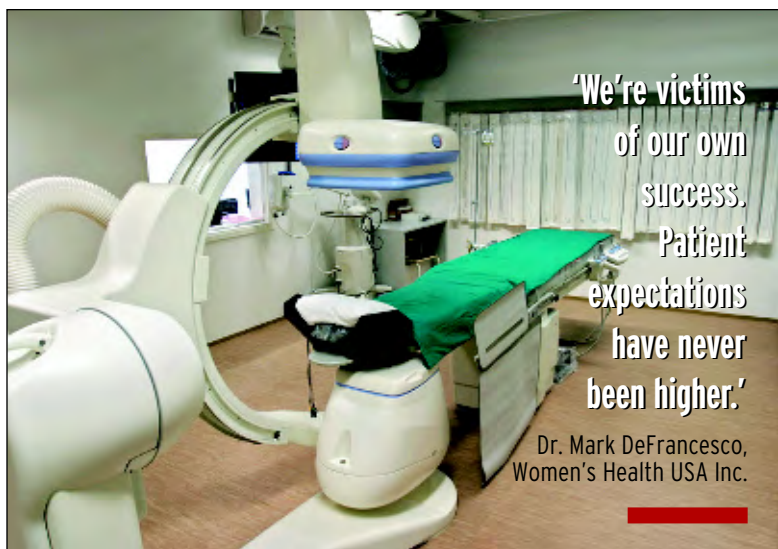
That division will manage Walgreens' health centers and pharmacies at large employer worksites as well as the in-store health clinics the company runs under the brand Take Care Health Clinics. Walgreens acquired Take Care Health Systems L.L.C. last year and operates 146 retail clinics in its drugstores.

Eventually, Walgreens will build a consistent brand identity for all the clinics, the company said.



WHOLE HEALTH MANAGEMENT, INC.

Walgreen Co. said that it will buy two worksite health clinics: Whole Health Management and I-trax Inc., which is the parent of CHD Meridian Healthcare. Whole Health's onsite health centers include physical therapy suites as shown above.



Health care facilities are adopting more risk management and patient safety initiatives due to advances in technology, which can increase exposures.

Safety push, technology add to health care risks

As patient expectations rise, so do exposures

By KRISTIN GUNDERSON HUNT

Risk management practices have become critical to health care facilities attempting to reduce liability, and medical provider risk managers wrestling with advances in technology and heightened patient expectations are trying to ensure their programs don't fall by the wayside, experts say.

"Risk management has come to the forefront in the last 10 years," said Paul Greve, senior vp in the health care practice of Willis Group Holdings Ltd. in Nashville. He participated in a session at the Professional Liability Underwriting Society's Medical Professional Liability Symposium March 11-12 in Chicago.

Helping to heighten awareness of risk management practices for providers, Mr. Greve said, include the Institute of Medicine Report on medical errors; the formation of the Leapfrog Group, a voluntary program aimed at patient safety; the

Institute for Healthcare Improvement's 100,000 Lives Campaign, a campaign to save 100,000 lives in American hospitals; evidence-based patient safety practices; and improved patient safety standards.

Continued coverage of the Professional Liability Underwriting Society's Medical Professional Liability Symposium can be found at www.BusinessInsurance.com/conferenceextra

Applying risk management practices and focusing on patient safety have become critical for health care providers. And insurers are paying attention to what risk managers are doing; organizations that make quality patient care their top priority have become the most attractive policyholders, said panelist Bruce Dmytrow, vp of U.S. specialty lines at CNA Healthcare in Chicago.

Panelists said health care facilities are adopting risk management and

See **AWARENESS** page 22

Benefit managers crunch numbers

Access to new, better data and technology enhances program analysis

By JOANNE WOJCIK

WASHINGTON—Now that detailed health care plan data is becoming more readily available to employers as well as the technology to interpret it, benefit managers are putting the information to use.

In fact, more than one-third of the sessions at the National Business Group on Health's Business Health Agenda 2008 focused on employer use of data and technology, ranging from making benefit design decisions, to measuring the return on investment of wellness and disease management programs, to managing their provider contracts more effectively.

Part of the reason for this heightened focus is because employers have only recently gained access to

this data, said Mark Bukowski, a Pittsburgh-based senior health and clinical consultant with Hewitt Associates Inc.

Five or 10 years ago, most employers had little or no access to their health care data, but "that has changed and it has changed dramatically," Mr. Bukowski said during a session about using evidence to select networks and drive benefit design.

Whereas employers relied in the past mostly on provider reports to determine effectiveness of their health management programs, now they are using consultant-developed modeling tools to objectively measure the ROI of such programs or the financial effect of instituting value-based benefit designs, Mr. Bukowski said.

The Lincolnshire, Ill.-based consultant offers a "population profiler" that examines the health of an employer's population across all programs, both from a baseline perspective and how risk profiles change over time. Employers can use this information to gear their health management programs toward plan members who would benefit the most, he said.

Stamford, Conn.-based General Electric Co. used data culled from calls to its health coaching program to guide its development and evaluate its effectiveness, said Anna Fallieras, program leader of health care initiatives, who spoke during session on using innovative data-driven strategies.

See **DATA** page 24



Continued coverage of the National Business Group on Health conference can be found at www.BusinessInsurance.com/conferenceextra

Communication aids generics effort

Lowe's says employees persuaded by campaign to promote drug switch

By JOANNE WOJCIK

WASHINGTON—A behavioral science experiment conducted by a pharmacy benefit manager to persuade plan members to switch to a generic statin after Zocor lost patent protection helped save Mooresville, N.C.-based Lowe's Cos. Inc. \$1.5 million annually in health care costs.

The experiment was the brainchild of Bob Nease, chief scientist at St. Louis-based Express Scripts Inc. His role is to advance the understanding of consumer behavior and help develop tools that enable employers and other health plan sponsors achieve better value from

their pharmacy benefit programs.

"Consumerology...is the science that's emerging around understanding what makes people do what they do, of human behavior," Mr. Nease said during a session at Business Health Agenda 2008, the annual meeting of the Washington-based National Business Group on Health.

"We have seen a movement in which rational economics is being complemented by behavioral economics," he said. "Market norms are being displaced or overshadowed by social norms. We do things that are not just about price."

To research how such economic and behavioral influences are affect-

ing plan members' use of their pharmacy benefits, Express Scripts also created a Center for Cost-Effective Consumerism, a group of health industry experts.

When Zocor, which is manufactured by Merck & Co. Inc. and is prescribed to lower cholesterol levels, lost its patent protection in 2006, Express Scripts used the opportunity to test how well consumerology worked.

It developed a communications campaign to persuade plan members to switch to simvastatin, the generic version of Zocor.

Employers participating in the

See **COMMUNICATION** page 24



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Emerging Risk STRATEGIES

ERM needs central risk role

By John J. Hampton

Enterprise risk management encourages organizations to establish a central risk function. The term describes an individual or unit responsible for coordination of risk discussions across the entity. General characteristics are:

Hierarchical level: The individual occupies a high position in an organizational hierarchy.

Scanning activities: Identifies external and internal exposures that senior executives involved with day-to-day responsibilities might miss.

Sharing activities: Uses technology to share relationships among exposures and information to help owners develop risk mitigation strategies.

Nonactivity: Does not manage risk directly. This is the job of risk owners, who have the responsibility and resources to pursue the goals of the organization.

Evolving trends

We are seeing a trend that may provide renewed impetus for creating a central risk function. It goes like this:

2002 compliance: Enron and other corporate scandals produced new legislation that required chief executive officers and chief financial officers to be on top of internal controls. Auditors had to be independent, boards had to know what was going on and senior executives had to change behaviors. This was the compliance phase of ERM.

2004 governance: Regulators realized that organizations have larger problems than simply fixing internal control processes. Led by individuals, such as attorneys general, and agencies, such as the Department of Justice, regulators pursued boards and executives that inflated prices, spun the perceived value of securities, overpaid CEOs, and engaged in or allowed practices involving conflicts of interest or fraud. Companies evaluated ERM in terms of improving organizational governance.

2008 hard-to-quantify risks: Now we have a growing recognition that ERM is reaching maturity, not in the sense of getting old but rather in getting it right. The real benefit of understanding and coordinating risk management does not lie in legal exposures of failed compliance or governance. Rather, it exists because we live in an uncertain world where the most critical risks are rarely identified let alone quantified in advance.

We are about to see a paradigm shift in ERM. We had a period where the Committee of Sponsoring Organizations auditors, regulators and consultants encouraged sometimes elaborate processes to identify and mitigate exposures. While not a bad idea in theory, the problem is the world is moving too fast for detailed measurement tools even if we identify the right exposures. A new approach is needed.

The traditional management practice is to develop a strategy (the plan), pro-

vide resources (the budget), approve the plan and budget at various hierarchical levels, give individuals goals and incentives, and execute the plan. In most cases, the model does not contain a risk management component.

The emerging ERM model builds upon the U.S. Marines who "shoot, move and communicate." This is anathema to many senior executives. They raise objections. How can you move before you know where you are going? What do you shoot at? Where is the plan? How will we know whether resources are being used as approved?

To better understand the Marine concept, imagine a landing on a beach by an amphibious force facing a dug-in enemy in coastal hills. What is the plan? Nobody cares once the landing door drops. Shoot at the bad guys. Get out of harm's way. Talk about what is happening. Figure out what to do.

It was different in the 1950s when organizations operated largely in a domestic economy. In 2008, we have a global battleground requiring constant motion. Areas at greater risk include:

China and India: With 36% of the global population, these countries need constant surveillance. In 2002, China was the place to be. In 2004, intellectual property problems in China and improvements in India sent everyone to Mumbai, Chennai and Bangalore. What is the life cycle of a fixed strategic plan?

Technology: Almost everything we need with respect to information and amusement can be carried in cell phones. Today's innovative product is tomorrow's obsolete relic. What is the validity of a budget prepared six to 18 months ago?

Logistics: A firm's raw materials may come from three continents. Components may be fabricated in 16 countries. The supply chain might be supported by Indians who update a massive data base and Bulgarian engineers who upgrade the information systems themselves. All products designated for customers in North America may be shipped at the last minute through the congested and vulnerable port of Long Beach, Calif. Where is the risk management in the supply chain?

Soon we will be using 100 million barrels per day of oil, and China alone will consume incredible resources. Still, there is no viable plan for the allocation of resources. We cannot refine 100 million barrels a day even if we could find and ship the crude oil. Population cannot grow indefinitely. We are not planning. People and countries are shooting, moving and communicating. Organizations must do the same.

The world is in flux. What can organizations do? Create a central risk function. Scan emerging markets, technology, logistics and the global conundrum. Share the findings with key executives. Respond quickly to changing circumstances on the worldwide battlefield. This is the future of enterprise risk management.



John J. Hampton is the KPMG Professor of Business and Dean of the School of Professional and Graduate Business Programs at St. Peter's College in New Jersey. He specializes in business ethics, legal liability and enterprise risk management. He is a former executive director of the Risk & Insurance Management Society Inc. To read Mr. Hampton's columns and interviews, visit www.BusinessInsurance.com/ERM.

Ryan: Retiring from Aon, will focus on Olympic bid

CONTINUED FROM PAGE 3

Mr. Lane said the timing of Mr. Ryan's retirement makes sense. "Aon's relative competitive advantage is as strong as it's been in the past 10 years," he said.

"The transition there was for the most part done," said Gretchen Roetzer, a credit analyst with Fitch Ratings in Chicago. "Aon's trends are positive. They've entered into the next chapter of the company with a new management, a new business model and a new core operating company. Everything is positioned for Pat Ryan to make his transition."

Mr. Ryan said last week that upon retirement he plans to devote more time to his roles as chairman and CEO of Chicago 2016—the effort to bring the 2016 Olympic and Paralympic Games to Chicago—and as chairman of the Board of Trustees

of Northwestern University in Evanston, Ill.

"I'm not going to play golf. I've got a lot of things to keep me very, very busy," he said.

'Everything is positioned for Pat Ryan to make his transition.'

Gretchen Roetzer, Fitch Ratings

And while Mr. Ryan may no longer play an active role in Aon's management, he said he will be available to assist the brokerage.

"I'm still the founder, and I have a great love for the company, its people and its clients. I'll be helping them out when they need me," Mr. Ryan said.

Crane: Building project lacked wrap-up coverage

CONTINUED FROM PAGE 3

project were covered by a single group of insurers providing wrap-up coverage, the experts said.

The 200-foot crane collapsed as workers attempted to extend it at a planned 43-story condominium project, currently about 50% complete, that is being developed by Kennelly Development Co. L.L.C. of New York. The crane fell away from the building and toppled across a city block, killing the six construction workers and a woman in one of the seven buildings that the equipment struck and either demolished or damaged.

Representatives of Kennelly, general contractor Reliance Construction Group of Montreal and crane operator Joy Contractors Inc. of Elizabeth, N.J., would not comment about their insurance.

Crane owner New York Crane & Equipment Corp. of Brooklyn is covered for any losses by an indemnity agreement in its contract with crane lessee Joy Contractors, said Glenn Fuerth, the crane owner's attorney and a partner with Wilson Elser Moskowitz Edelman & Dicker L.L.P. in New York. Mr. Fuerth said he did not know how Joy Contractors is insured.

However, insurance market sources confirmed that the project was not insured through a wrap-up program covering the owner and the contractors or only the contractors.

Aside from statutory workers comp limits and building construction costs, wrap-ups generally provide \$50 million to \$100 million of general liability insurance limits, brokers said. Individually, contractors often cannot purchase more than \$5 million to \$10 million of coverage, which usually has more restrictive terms and conditions,

brokers said.

Projects valued at about \$70 million or greater typically are covered by wrap-ups, brokers said. But wrap-ups also have covered much smaller projects located in densely populated areas, noted Paul Primavera, senior vp-claims in Washington with Lockton Construction Services Group, a unit of Lockton Cos. Inc.

The Kennelly project is valued at \$100 million, a spokesman said.

"A loss like this demonstrates that a wrap-up is very much a benefit to contractors and owners," because it would minimize finger pointing and speed up claim resolution, which would mitigate litigation costs, said broker Rick White, a senior vp with Hilb Rogal & Hobbs Co. in Stamford, Conn.

The Kennelly project accident provides "no better example" of how a wrap-up program would benefit developers and contractors, said Kevin Dolan, a managing director in New York at Aon Construction Services Group, a unit of Aon Corp.

Noting the greater limits that wrap-ups provide, both Messrs. White and Dolan said insufficient liability coverage after an accident has resulted in a developer losing its property to plaintiffs.

Wrap-ups also help ensure the consistency of project safety efforts, brokers noted.

However, some contractors, even on large projects, opt not to participate in wrap-ups for a variety of reasons, including that they are not advantageous given the contractors' roles, noted attorney Ken Erickson, a partner with Ropes & Gray L.L.P. in Boston.

In addition, some collective bargaining agreements prevent contractors from covering their workers in a wrap-up insurance policy, experts said.



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Mass. health care law worth extra expenses

AS THE SECOND anniversary of the enactment of Massachusetts' health care reform law nears, it's an appropriate time to assess what the pioneering law has and hasn't accomplished.

On the positive side, the law has made a huge dent in the number of uninsured Massachusetts residents.

More than 300,000 who were uninsured previously now have insurance coverage. With estimates of the number of uninsured prior to enactment of the reform legislation ranging from about 400,000 to 650,000, nearly half to as many as three-quarters of the uninsured have obtained health insurance since then.

That is no small achievement, especially coming at a time when the ranks of the uninsured are swelling in other states.

It is no mystery how Massachusetts has dramatically reduced the number of uninsured. The reform law established Commonwealth Care, a program that heavily subsidizes health insurance premiums for low-income uninsured residents. Just over 175,000 people are enrolled in Commonwealth Care, with more than 70% of those receiving fully state-subsidized coverage because of their low incomes.

With the surge in the number who do have coverage, there has been a significant drop in the amount of uncompensated care, the costs of which typically are shifted to patients with health insurance.

Also on the positive side, the Massachusetts law has had minimal impact on employers with health insurance plans. Other than for certain filing requirements, the law has not caused much extra work or affected the way employers offer coverage.

On the negative side, the cost to the state of expanding coverage has been more than was estimated, likely because it turned out that more people are eligible for state-subsidized premiums than originally anticipated.

We believe that extra cost is more than offset, though, by the law's chief accomplishment: expansion of coverage. Over time, the state will see improvement in the health status of many of individuals who, because they have coverage, will get treatment before minor medical problems become major ones.

That extra cost is more than offset by the law's chief accomplishment: expansion of coverage.

Aftermath of disaster is no time to test cap plan

THE UNUSUAL TORNADO that struck downtown Atlanta a few days ago underscores the importance of making sure that a catastrophe plan is in place and up to date.

That's particularly true given the nature of the Atlanta tornado, which touched down only minutes after warnings went out. The city and its citizens were fortunate indeed that no lives were lost, despite heavy damage to parts of the city. Other areas of Georgia were not so fortunate.

With both tornado season already here in some parts of the country and Atlantic hurricane season approaching as well, risk managers should use this opportunity to review their cat plans. Plans that sit on the shelf—whether physically or electronically—without regular review can prove to be of less than optimal value when catastrophe strikes. While there's usually considerable advance notice of an approaching hurricane, the Atlanta tornado shows that some perils can descend with little or no warning.

Taking the time to look over and test a cat plan now could prove to be time well-spent if an emergency—particularly an unusual one—should arise unexpectedly.



Letters to the editor

Hiring 'prohibited person' a federal felony

TO THE EDITOR: I read with great interest the article "Criminal Convictions Pose Hiring Dilemma," written by Judy Greenwald in the March 3 issue of *Business Insurance*. I thought the article did a fine job discussing the nuances between hiring practices relative to "ex-cons" and state anti-bias law.

I thought, however, given the audience of *Business Insurance*, that a short discussion of the Federal Violent Crime Control and Law Enforcement Act of 1994 might be warranted. This federal law prohibits "any individual who has been convicted of any criminal felony involving dis-

honesty or breach of trust, or who has been convicted of an offense under" Section 1033, from willfully engaging in the business of insurance. If such a "prohibited person" engages in the business of insurance, he or she may be fined or imprisoned under this federal law. Further, and perhaps more importantly, any person who is engaged in the business of insurance, and who willfully permits the participation of a "prohibited person" is also guilty of a felony and subject to both fines and imprisonment.

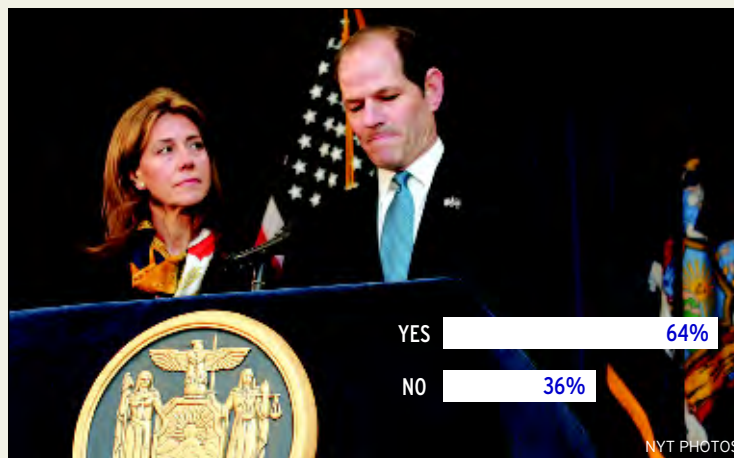
See **LETTERS** page 22

Write us

Business Insurance welcomes letters to the editor. The section is intended to be a forum for readers' opinions and comments. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Please send your letters to: Letters to the Editor, *Business Insurance*, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; fax: 312-280-3174; e-mail: rcoccia@businessinsurance.com

Online Poll at www.businessinsurance.com

Do you think the changes that Eliot Spitzer forced on the insurance industry will be long-lasting?



NEXT WEEK'S POLL: How satisfied is your organization with the health care benefit providers with which it does business?

BI Online Poll tool sponsored by Wausau Insurance Cos.

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Online



LISTEN:

In a podcast interview, policyholder attorney John Ellison, a partner at Reed Smith L.L.P. in Philadelphia, discusses how insurers have mounted their strongest coverage defenses against claims for property and D&O liability losses, and offers measures policyholders can take to safeguard their coverage. Hear it now at www.businessinsurance.com.

People knowledge sets the tone

Preparation, regular communication speed resolution of claims

BY ROSEANNE WHITE GEISEL

A major mistake that a policyholder can make in trying to resolve liability claims is not keeping all relevant parties in the loop. Sometimes, the boundaries of inclusiveness must be extended beyond the obvious to avoid costly mistakes, experts say.

The groundwork to achieve the communication and understanding necessary for the desired end result should be done before the policy goes into effect, experts say.

Risk managers should work with a broker who has expertise in the type of policy or program they are seeking, said David Siesko, principal of New York-based claims consultant Siesko Partners L.L.C.

The broker's expertise is particularly important if the policyholder requires a unique endorsement or has a unique need. The broker also can ensure that the submission to the insurer is complete and accu-

rate, Mr. Siesko said.

One lesson learned from the World Trade Center terrorist attack in 2001 and Hurricane Katrina in 2005 is that "contract certainty is crucial," Mr. Siesko said. The administration of some claims from those events was complicated because the renewal terms on some policies had not been finalized, he said.

Another role that a broker can play, said Barton Douglas, managing director of the claim advocacy practice group for Arthur J. Gallagher Risk Management Services Inc. in Miami, is to help the policyholder identify potential claims issues that could arise from the contract.

"The clearer you make the language, the less chance of coverage disputes," Mr. Douglas said.

Along with the duty to defend, the insurance contract should state who has the right to hire an attor-

ney, said Alan Maluse, Detroit-based managing director of casualty claims for Marsh Inc.

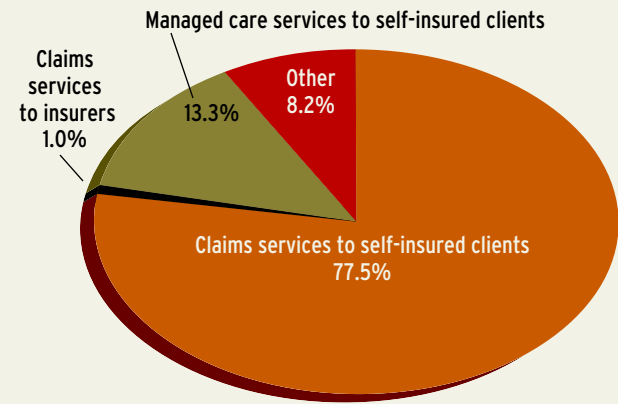
"The right might fall to the policyholder that has a significant self-insured retention, or it might fall to the insurer," Mr. Maluse said. That clarification cannot be kept just between the policyholder's risk management department and the insurer, he said. "In a large company, the legal department may assume authority that the risk management department doesn't know about," he said.

If the policyholder is responsible for hiring the attorney, the reasonableness of fees should be discussed with the insurer, Mr. Maluse said. "One of the more common policyholder mistakes is not communicating with regularity with insurers and making unilateral decisions," he said.

See **CLAIMS** page 12

BREAKDOWN OF REVENUE

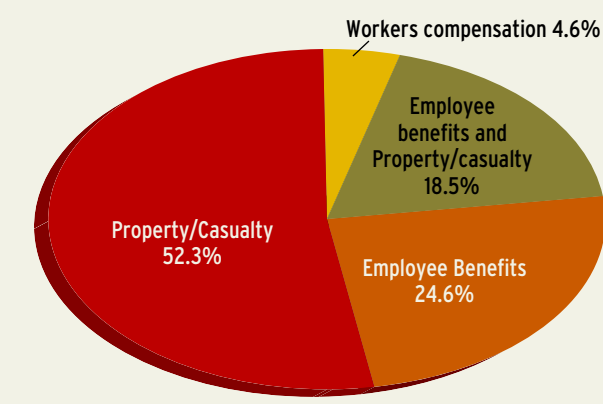
Top 10 companies' revenues by services provided



Source: BI survey

TYPE OF CLAIMS ADMINISTERED

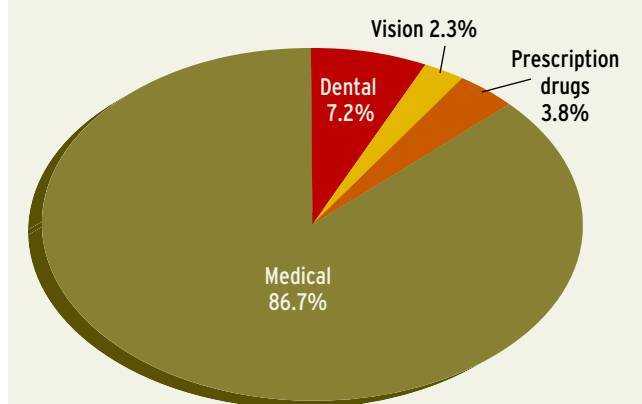
Type of claims handled by all companies listed in the directory



Source: BI survey

HEALTH INSURANCE CLAIMS BY TYPE

Of those companies that have a majority of health insurance claims



Source: BI survey

Largest claims administrators

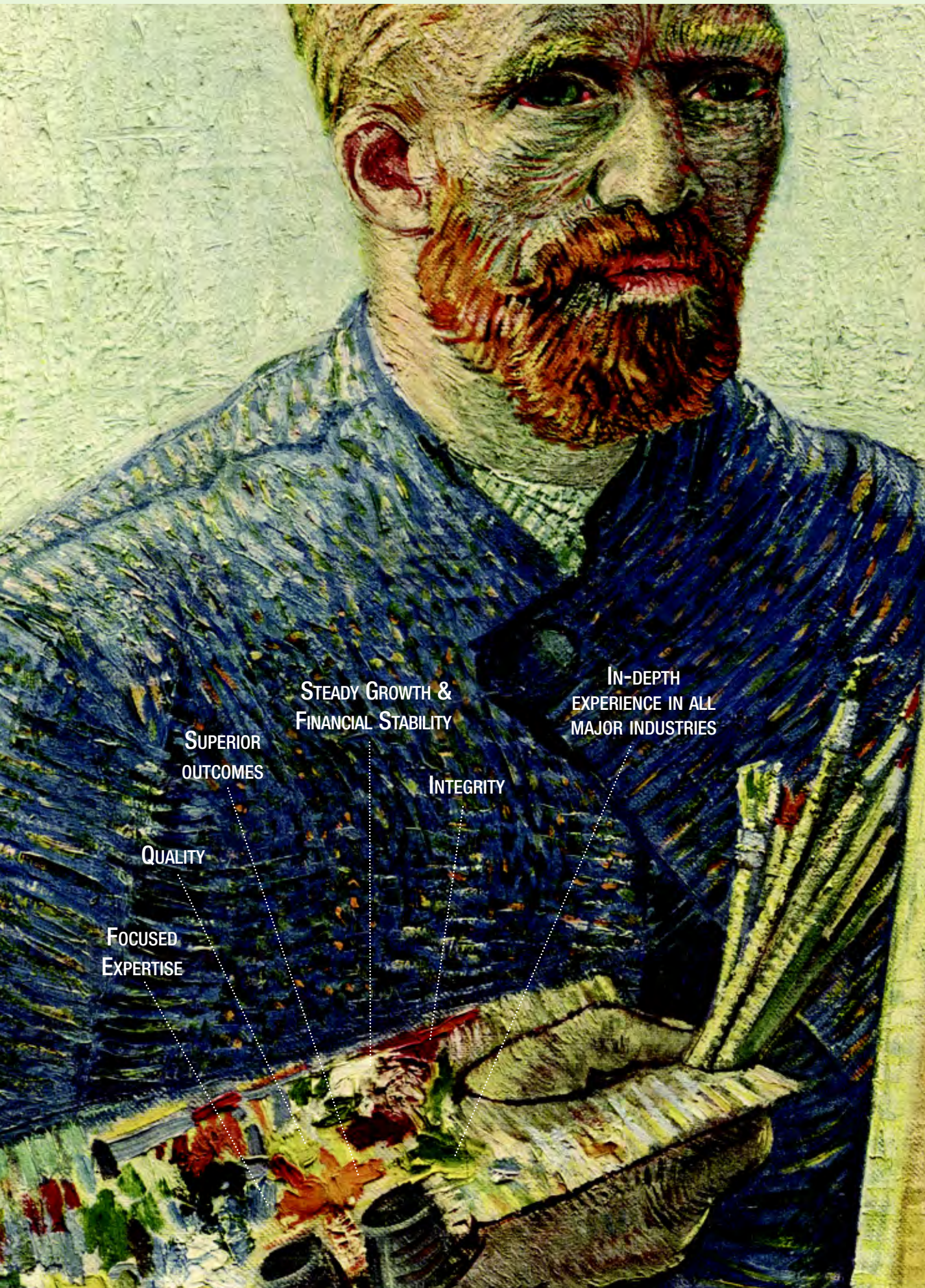
Ranked by 2007 revenues from claims handled for self-insured clients

Rank	Company/Address	Phone/Web site	Parent company	2007 revenues from self-insured clients	2007 claims paid to self-insured clients	Total clients	Claims staff	Principal officer
1	Sedgwick Claims Management Services Inc. 1100 Ridgeway Loop, Memphis, Tenn. 38120	901-415-7400 www.sedgwickcms.com	Sedgwick CMS Holdings Inc.	\$576,344,047	\$6,500,996,828	955	5,730	David A. North, president/CEO
2	Gallagher Bassett Services Inc. The Gallagher Centre, 2 Pierce Place, Itasca, Ill. 60143-3141	630-773-3800 www.gallagherbassett.com	Arthur J. Gallagher & Co.	\$391,500,000	\$4,800,000,000	3,120	2,686	Richard J. McKenna, president
3	Fiserv Health Inc. 5500 Wayzata Blvd., Suite 500, Minneapolis, Minn. 55416	763-549-3350 www.fiservhealth.com	UnitedHealth Group Inc.	\$301,133,000	\$7,771,943,889	1,001	2,047	Mike Gantt, group president
4	Specialty Risk Services L.L.C. 225 Asylum St., Goodwin Square, 16th Floor, Hartford, Conn. 06103	888-236-4684 www.specialtyriskservices.com	Hartford Financial Services Group Inc.	\$221,300,000	\$2,100,000,000	1,073	1,395	Joe Boures, president
5	Cambridge Integrated Services Group Inc. 340 Pemberwick Road, Second Floor, Greenwich, Conn. 06831	800-662-1170 www.cambridgeclaims.com	Cambridge Solutions Ltd.	\$220,000,000	\$2,851,000,000	566	2,100	Christopher Sinclair, executive chairman/CEO
6	Broadspire Services Inc., a Crawford Co. 1601 S.W. 80 Terrace, Plantation, Fla. 33324	800-726-8898 www.choosebroadspire.com	Crawford & Co.	\$184,506,167	\$2,203,804,433	770	1,504	Dennis Replogle, CEO
7	ESIS Inc. 436 Walnut St., Philadelphia, Pa. 19106	215-640-1000 www.esis.com	ACE USA	\$180,000,000	\$2,368,000,000	710	1,210	David Patterson, president
8	Meritain Health 300 Corporate Parkway, Buffalo, N.Y. 14226	800-828-6922 www.meritain.com	Prodigy Health Group	\$157,000,000	\$1,800,000,000	1,400	235	Jacob Canova, chairman/CEO
9	Principal Financial Group/National Accounts 1275 N.W. 128th St., Suite 100, Clive, Iowa 50325	877-273-0900 www.principal.com	-	\$140,410,763	\$2,302,253,549	363	773	Maria Volante, vp-national accounts
10	CoreSource Inc. 400 Field Drive, Lake Forest, Ill. 60045	800-832-3332 www.coresource.com	Trustmark Insurance Co. Inc.	\$109,235,196	\$2,725,000,000	760	1,020	Chris Martin, executive vp

Source: BI survey
Researched by Kevin Edison and Karen Tucker

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LARGEST PROPERTY/CASUALTY TPAs

Third-party administrators that specialize in P/C claims administration

Company	2007 revenues from self-insured clients
Gallagher Bassett Services Inc.	\$391,500,000
Specialty Risk Services L.L.C.	\$221,300,000
Cambridge Integrated Services Group Inc.	\$220,000,000
ESIS Inc.	\$180,000,000
Avizent ¹	\$62,500,000
Cannon Cochran Management Services Inc. dba CCMSI	\$59,612,000
GAB Robins Group of Cos.	\$47,700,000
Helmsman Management Services L.L.C.	\$42,427,952
Risk Enterprise Management Ltd.	\$37,345,000
York Insurance Services Group Inc.	\$36,300,000

¹ Formerly Frank Gates Cos. Inc.
Source: BI survey

Claims: Combine knowledge, advocacy

CONTINUED FROM PAGE 9

But nailing down contract specifics isn't enough.

One of the most important steps in purchasing coverage is to get to know the insurer's claims staff, said Lance Ewing, vp-risk management for Harrah's Entertainment Inc. in Memphis, Tenn.

"Risk managers tend to get embroiled in the underwriting side," Mr. Ewing said. "Then when a claim occurs, there is no relationship."

He suggested going to lunch or dinner with those who will handle company claims and learn how they think, specifics of their claims

guidelines and difficulties they have had with claims in your industry.

Communication is valuable only when it is timely, experts say.

"Provide a notice of occurrence of loss as soon as possible," said Robert Horkovich, a policyholder attorney with Anderson Kill & Olick P.C. in New York. "Let the insurance company know that a loss has occurred. The insurer may want to investigate, and could be prejudiced by not having timely notice of the loss."

Policyholders sometimes confuse a notice of occurrence of loss and a notice of claim, Mr. Horkovich said. A notice of occurrence states that a

loss has happened that could lead to a claim. A notice of claim is a request to be indemnified.

"Make all deadlines (for reporting losses and claims) even if the insurance company tells you verbally that you do not need to," Mr. Horkovich said.

Those deadlines may involve more than one insurer and type of coverage, said Marsh's Mr. Maluse. For example, an employment liability suit may also involve directors and officers liability and general liability.

"Make sure all coverage is identified and notice is provided to those insurers accordingly," Mr. Maluse said.

When a claim is filed, policyholders should ensure their interests are protected.

When the reservation of rights letter is received, 'don't be offended, because it's just part of the process.'

David Siesko, Siesko Partners L.L.C.

"Claims advocacy is one of the best-kept secrets in brokerage houses," said Gallagher's Mr. Douglas, who conducts regular claims reviews with his clients. Each quarter, Mr. Douglas picks significant claims to review in a daylong session that provides an opportunity to discuss coverage issues, such as whether adequate reserves have been posted. The handling of litigated claims also can be reviewed.

"The goal is to have a game plan at the end of the day" to settle claims, Mr. Douglas said.

"An intermediary can play a significant role in conflict resolution," said Mr. Maluse. Marsh's team "helps the client understand the scope and breadth of the coverage with respect to the claim," as well as coverage issues and steps that need to be taken. Additionally, the broker "can get to the right parties to open a dialogue," he said.

Everyone agrees that negotiation and mediation should be given every possible chance before moving to the courts.

"Always keep an open dialogue and good relationship with the insurer during the claims process," said Mr. Siesko. When the reservation of rights letter is received, "don't be offended, because it's just part of the process."

Offer to meet with the insurer's claims staff and explain the circumstances of complicated claims, Mr. Siesko said.

Eric Larson, vp of claims technical oversight with Fireman's Fund Insurance Co. in Novato, Calif., agrees that effective communication is essential "from the get go."

"The policyholder should be comprehensive," Mr. Horkovich said, "and persistently and aggressively pursue every penny to which they are entitled."

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DISCOVER **RE**

Corporate risk management team works to settle claims swiftly

By ROSEANNE WHITE GEISEL

Bulk chemical transporter Quality Distribution Inc. has orchestrated its claims management with the precision and timing of a pit crew changing tires on a race car during the Indianapolis 500.

The Tampa, Fla.-based company, with 3,500 vehicles on the road in the United States and Canada, invests in professional services up front to settle claims in the most cost-effective and amicable manner, said W. Michael McDonald, vp of risk management.

Doing so is essential for a company with a high self-insured retention for liability risks, he said.

Because it assumes a large portion of the risks, Quality Distribution also calls the shots on everything from accident investigation procedures to hiring attorneys and mediators, Mr. McDonald said.

'We're organized to respond to very large self-insured retentions.'

W. Michael McDonald,
Quality Distribution Inc.

"We pick insurance companies that understand we need lots of flexibility and we need to make most decisions, because it is our money," Mr. McDonald said.

The company's claims agreement with insurers outlines the responsibilities of everyone involved.

The top priority in the claims process is to report incidents immediately. That responsibility is drummed into every employee and contractor, Mr. McDonald said.

A company call center is always available via a toll-free number. Failure to comply results in disciplinary action that could include termination.

The call center operator electronically transmits the claim form to Quality Distribution's eight-person risk management department. Six are claims adjusters and the other two, one of whom is Mr. McDonald, are generalists who also spend most of their time on claims.

"We're organized to respond to very large self-insured retentions," Mr. McDonald said.

Once the report is made, the company dispatches the pertinent people from its established networks to the accident scene, Mr. McDonald said. If there is an environmental risk, for example, an emergency response company that handles such hazards is deployed.

When the company assembles its network of professionals, the attempt is "to get the appropriate geographic spread," Mr. McDonald said. "Our objective is always to get the necessary people to the sites in one hour."

Many companies do not employ these professionals to collect and preserve evidence that may help their defense "until the case goes South on them," Mr. McDonald said.

Mediation is the favored approach when claims have to be worked out. "All mediation is face-to-face," Mr. McDonald said. "We make a great effort to secure a mediator that's experienced and won't take sides."

The size of the exposure deter-

mines who from the risk management department will represent the company in the mediation. No matter who attends the mediation, "everyone has sufficient monetary authority to settle the case," Mr. McDonald said.

Half of the cases are settled immediately, he said, and another 25% are settled within 30 days of mediation. The rest are litigated.

"Our objective is always to settle," but the company will sue if necessary, Mr. McDonald said.



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INSURANCE CLAIMS-PAYING RATINGS

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More states implement workers comp treatment guidelines

Some physicians question adequacy of treatment guidelines

By **ROBERTO CENICEROS**

Applying medical treatment guidelines to the management of workers compensation claims is gaining greater acceptance as more states adopt rules encouraging their use, advocates say.

However, some doctors that treat injured workers say strict adherence to medical treatment guidelines can hamper care in special cases.

But the benefits of treatment guidelines will only increase as medical science produces more pharmaceutical and surgical options that must be vetted for effectiveness, said Dr. Adam Seidner, national medical director in Hartford, Conn., for Travelers Cos. Inc.

Evidence-based medical guidelines, advocates say, eliminate unnecessary procedures that can further injure employees suffering from a work-related accident or illness. Advocates also say such guidelines apply best practices to eliminate treatment disputes, return employees to work soon and reduce claims costs.

The guidelines, which describe treatment most appropriate to address common work-related injuries, are developed through peer reviews process and consensus among occupational doctors.

Organizations such as the Elk Grove Village, Ill.-based American College of Occupational & Environmental Medicine and the Encinitas, Calif.-based Work Loss Data Institute develop them.

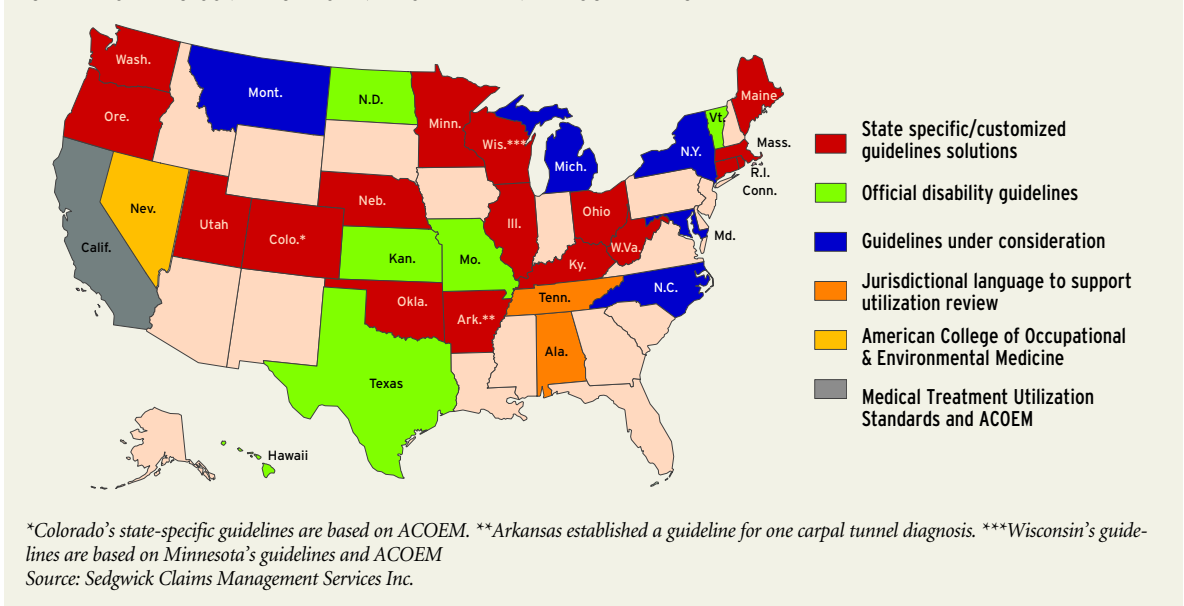
But a growing number of states are creating their own workers comp medical treatment guidelines, using a hybrid approach, said Darrell Brown, workers comp practice lead for Sedgwick Claims Management Services Inc. in Long Beach, Calif.

"It seems like every other month a new state is adopting a guideline or a hybrid, so the trend is definitely moving toward more states adopting a specific guideline or guidelines," Mr. Brown said.

Hybrid approaches generally combine existing guidelines with a state's own measures, Mr. Brown said (see chart).

While using medical guidelines to manage workers comp cases is not yet mainstream, it is "trending that way" as states look to improve care and reduce costs, said David Deitz, national medical director at Liberty Mutual Group Inc. in

STATE WORKERS COMPENSATION MEDICAL TREATMENT GUIDELINES



Boston.

Other experts say the use of treatment guidelines in workers compensation has already become a mainstream practice with some states sanctioning or mandating their use for more than a decade.

The state of Washington, for instance, has applied treatment guidelines to address workers comp claims since 1989.

Interest in applying guidelines to workers comp claims increased after 2003, when California lawmakers, as of part reforms adopted that year, mandated their use. Now ACOEM guidelines are presumed correct when deciding treatment for specific work-related injuries in California.

Then in 2007, Texas' Division of Workers' Compensation issued a

ruling that any physician not in an insurer's contracted doctor network must apply the WLDI's Official Disability Guidelines when treating injured workers.

Also last year, New York passed reforms that prompted its State Insurance Department in December to announce state guidelines for

Continued on next page

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treating lower back, cervical spine, knee and shoulder injuries. The state's Workers' Compensation Board is readying regulations to apply those guidelines.

Even without states sanctioning or mandating their use, claims managers say they consult guidelines as part of their utilization review process.

Sedgwick, for instance, has applied treatment guidelines nationally since 2004. Even in states where their use is not required, their laws do not say "you cannot apply evidence-based medicine," said Kimberly George, vp and managed care practice lead for Sedgwick in Chicago.

As one successful example, many observers point to California's experience in which the state Department of Insurance says insurer costs have decreased 70% since 2003.

But determining treatment guidelines' specific contribution to California's cost reductions is impossible, several sources said. The state adopted reform measures during 2003 and 2004, such as capping chiropractic visits and requiring claimants to use in-network doctors, that all contribute to savings.

However, studies by the insurer-supported California Workers' Compensation Institute found differences between claims where medical treatments fell within ACOEM guidelines and those where treatments exceeded the guidelines. Treatments within the guidelines showed reduced duration, faster returns to work, and reduced medical and indemnity payments, the Oakland-based CWCI found.

The same is occurring in other states where treatment guidelines have been adopted along with other reforms, Sedgwick's Ms. George said, such as Texas.

Yet physicians regularly question applying such guidelines.

For example, the Paducah, Ky.-based American Society of Interventional Pain Physicians and other physician groups treating chronic pain recently questioned the adequacy of ACOEM guidelines in treating lower back disorders.

Guidelines developed based on scientific studies are successful in treating about 95% of cases, said Dr. Peter Mandell, chairman of the workers compensation committee for the Sacramento-based California Orthopaedic Assn. Inc. But claimants with chronic problems often are among the 5% of patients who need additional treatments.

"In California, we have seen treatment that probably would be useful and appropriate, denied from time to time because individuals are not the usual, are not the average," Dr. Mandell said.

Insurers say the guidelines are just that, guidelines, and they listen when a doctor suggests more treatment is necessary.

In California, though, applying treatments beyond those in the ACOEM guidelines often requires proving the need to claims adjusters, Dr. Mandell said. Such appeals are difficult and "hit or miss" because few studies are done on the 5% of patients who do not

respond to standard treatment, he said.

But the treatment guideline industry continues to mature with improvements made to address the criticisms, observers say.

Early guidelines were broad-based and developed for primary care physicians, said Shelley Boyce, chief executive officer for King of Prussia, Pa.-based MedRisk Inc., a provider of workers comp managed care services.

But expect to see such guidelines evolve for use by specialist doctors and areas such as physical therapy, Ms. Boyce said.

"Treatment guidelines will continue to be on the forefront of (medical) research and (workers comp) reform," Ms. Boyce said.

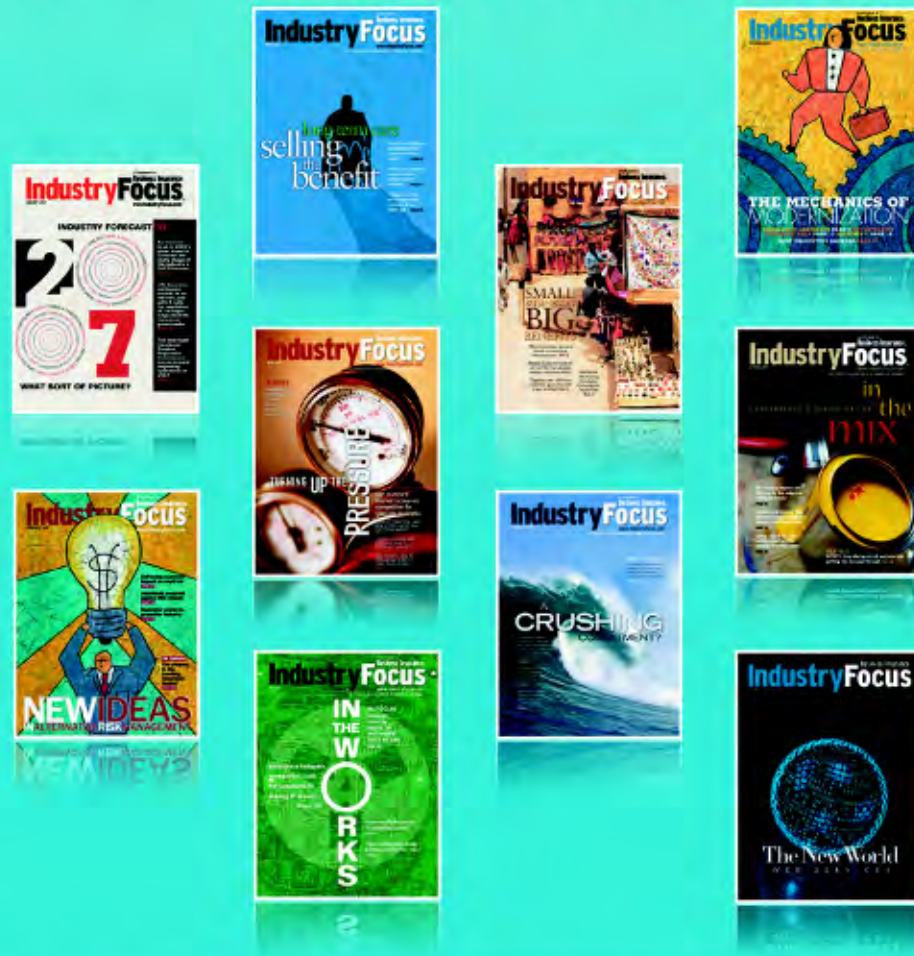
LARGEST WORKERS COMPENSATION TPAs

TPAs that specialize in workers compensation claims administrations

Company	2007 claims paid to self-insurers	Percentage from workers compensation claims	2007 revenue from workers compensation claims*
Gallagher Bassett Services Inc.	\$391,500,000	68%	\$266,220,000
Sedgwick Claims Management Services Inc.	\$576,344,047	44%	\$253,591,381
Specialty Risk Services L.L.C.	\$221,300,000	73%	\$161,549,000
ESIS Inc.	\$180,000,000	75%	\$135,000,000
Broadspire Services Inc., a Crawford Co.	\$184,506,167	69%	\$127,309,255
Cambridge Integrated Services Group Inc.	\$220,000,000	48%	\$105,600,000
Cannon Cochran Management Services Inc. dba CCMSI	\$59,612,000	70%	\$41,728,400
Avivent ¹	\$62,500,000	64%	\$40,000,000
TRISTAR Risk Management	\$38,400,000	80%	\$30,720,000
Helmsman Management Services L.L.C.	\$42,427,952	64%	\$27,153,889

*BI estimate based on the percentage of workers compensation claims to self-insured clients. 1 Formerly Frank Gates Cos. Inc.
Source: BI survey

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Feb 18	Alternative Risk Markets	Published
Mar 17	Reinsurance Technology	Published
Apr 21	Specialty Markets	Mar 24
May 12	Information Technology	Apr 14
Jun 18	Emerging Markets & Globalization	May 19
Jul 28	Special Insert - Industry Focus Guide	Jul 30
Aug 11	Reinsurance Strategies	Jul 14
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Oct 20	Benefits & Financial Services	Sep 22
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Rate hikes for specific stop-loss range from zero to 40%

Market still competitive for self-funded health plans with good claims history; those with greater risks face higher prices

By LOUISE KERTESZ

Self-funded health plans are seeing rate increases for specific stop-loss coverage while the market remains "very competitive" for employers with the best claims experience, industry experts say.

Meanwhile, aggregate stop-loss rates are not increasing significantly, they say.

"We're anticipating increases of 15% to 25%, depending on the level of deductible" for specific stop-loss coverage for renewals this year, said Curtis W. Olson, president of

ING Employee Benefits in Minneapolis. Aggregate rates "generally aren't changing or, if so, very minimally," he added.

"There's a lot of competition" in the market, said John Dawson, vp and actuary for Willis Group Holdings Ltd. in Milwaukee. For employers, this environment compares favorably with two years ago when "it was common to see in excess of 25% increases" for specific stop-loss coverage, or medical claims from any one individual that exceed a specified amount.

"The market is very competitive right now," agreed John Snyder, chief executive officer of Medical Excess L.L.C. in Costa Mesa, Calif., a member company of American International Group Inc.

"Increases are all over the board," he added, "from no increase (for companies with the best claims experience) to 30% to 40% increases" for accounts with "a dramatically higher risk profile."

"We're seeing rates (increase)... from 9% to 35%, depending on the carrier. We see increases of 15% to 20% for clean cases without a lot of ongoing claims," said Donna Cowden, senior vp at Aon Consulting in Charlotte, N.C.

"The market is still competitive,

particularly for clean cases, but for any of the employers with large ongoing claims, carriers are declining business" or requiring higher deductibles for those large claims, Ms. Cowden said.

Specific stop-loss rate increases are higher than the health care cost trend, which industry sources place at 7% to 10%. Specific stop-loss rates will always be higher than the general medical trend because catastrophic claims often use the newest treatment techniques and technologies, the cost of which is absorbed by the insurer when paying claims above the deductible.

As companies are confronted with potentially large rate increases, they increase their deductibles to moderate the higher cost, the experts said.

"What we've seen as the most effective mitigator" of increasing rates is increasing the deductible, Mr. Olson said. "We see the attachment point rising every year," he added.

"A few years ago it was unusual to see an attachment point above \$250,000. Now we see up to \$350,000 sometimes," said Tom Bilet, senior consultant at Watson Wyatt Worldwide in Stamford, Conn.

To further mitigate rate increases, employers are adding medical management approaches for specific types of conditions or accidents, Mr. Olson said.

Analytical tools, such as predictive modeling, are available to help employers identify and manage disease states in their populations, which can lead to better health and fewer catastrophic claims, Medical Excess' Mr. Snyder said.

Richard Bukovinsky, president of national sales at Meritain Health Inc., an Amherst, N.Y.-based third-party administrator, said, "What we'll prove ultimately to the carrier is a reduced amount of claims" as a result of network contracting, medical management, wellness initiatives and education tools.

Jim Hawks, city administrator of North Platte, Neb., and a Meritain client since 2002, said, "Our biggest emphasis has been on educating employees on using the program" set up by Meritain that includes a provider network as well as wellness and medical management programs.

As a result, the city did not see specific stop-loss rate increases for two years, he said. Faced with an

CONTINUED ON NEXT PAGE

LARGEST EMPLOYEE BENEFIT TPAs

Third-party administrators that specialize in employee benefit claims administration

Company	2007 revenues from self-insured clients
Fiserv Health Inc.	\$301,133,000
Meritain Health	\$157,000,000
Principal Financial Group/National Accounts	\$140,410,763
CoreSource Inc.	\$109,235,196
HealthSCOPE Benefits ¹	\$60,306,000
Alicare Inc.	\$53,594,000
American Administrative Group Inc.	\$52,348,794
Brokerage Concepts Inc.	\$40,674,500
Health Plans Inc.	\$17,900,000
Professional Benefit Administrators Inc.	\$14,154,134

¹ Formerly CenBen USA Inc.
Source: BI survey

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8% to 9% increase at this year's renewal because a few major claims have appeared, a city committee is considering options that include paying a higher deductible for certain individuals with high claims, Mr. Hawks said.

To hold rate increases down, Dave Wilson, president of Windsor Strategy Partners L.L.C. in Princeton Junction, N.J., said his company works with administrators "to get a more effective PPO network," particularly focusing on hospital contracts and discounts as well as more effective care.

In another strategy, about 800 employers have bought an AIG organ transplant carve-out product that removes large claims from a stop-loss program, resulting in discounts on specific stop-loss coverage, Mr. Snyder said.

Another strategy that employers are using is "aggregating specifics," or not paying the full premium unless claims reach the attachment point, at which time the entire amount comes due, Aon's Ms. Cowden said.

Aggregating specifics can save money "in a year when an employer does not have large claims," said Willis' Mr. Dawson. In a competitive market, insurers offer this avenue to get the business, he said.

Additionally, an aggregate-only policy is an emerging product that

once was offered by a only few insurers, Mr. Dawson said.

"What employers really need is protection if the overall claim bill gets to be too big," but the traditional aggregate coverage of "expected claims plus 25%" attachment point does not provide "true budget protection," he said. Willis developed a program that provides aggregate-only coverage at expected claims plus 10%.

Jeff Walker, director of risk manager for Collier County, Fla., in Naples, found the aggregate-only program "quite appealing" and about 30% less expensive than specific stop-loss coverage. Mr. Walker stayed with the program for about three years but moved back to specific stop-loss coverage last year

after anticipating large catastrophic claims.

The county's incumbent insurer wanted a 57% rate increase for 2008, "so we found a carrier—Symetra Financial Corp.—that would do it for about a 30% increase," Mr. Walker said. Because of anticipated claims, "we feel that we will see a return despite the increased premium," he said.

"It's not a bad market for employers," Mr. Wilson said. "But sooner or later, it has to harden."

"I don't have any reason to believe rates will be lower," said Mr. Billet. "Chances are over the next few years, (the medical cost) trend will be higher rather than lower," so specific stop-loss rates will be higher.

LARGEST MULTILINE TPAS

Third parties that offer employee benefits and property/casualty claims administration

Company	2007 revenues from self-insured clients
Sedgwick Claims Management Services Inc.	\$576,344,047
Broadspire Services Inc., a Crawford Co.	\$184,506,167
Wells Fargo Third Party Administrators and Wells Fargo Disability Management	\$70,191,707
TRISTAR Risk Management	\$38,400,000
Keenan & Associates	\$32,500,000
Loomis Co.	\$28,450,000
CAS-Claims Administrative Services Inc.	\$14,163,409
Claimetrics	\$7,000,000
HM Benefits Administrators	\$6,488,923
Hewitt, Coleman & Associates Inc.	\$4,000,000

Source: BI survey



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Business Insurance PERSPECTIVE



Bruce S. Zaccanti is a principal and national practice director with Ernst & Young L.L.P.'s Insurance and Actuarial Advisory Services in the Insurance Risk and Claim Advisory Services Group in Chicago. William J. O'Brien is an actuarial adviser in the same practice.

Consider auditing workers comp premiums

Process ideally includes the policyholder and insurer, could aid corporate bottom line

By Bruce S. Zaccanti
and William J. O'Brien

Risk managers are under constant pressure to demonstrate that they have scrutinized corporate insurance programs and are providing effective coverage at competitive prices.

There are several ways to achieve this goal, but one that often is overlooked is the premium audit for workers compensation programs, which is required by policy language and is the method used by insurers to determine final earned premium.

The audit is a valuable chance to communicate with your insurer and review annual results for possible premium adjustments. Unfortunately, risk managers often do not actively participate in the process, potentially positioning their organizations to lose money. Frequently, auditors are handed exposure documentation for the past year and relegated to the back room with little to no interaction. One can only assume that these risk managers are unaware of the impact they can have on their final premium calculation.

In an ideal world, insurers would have all the information needed to properly calculate premium at policy inception, but the reality is that initial quotes and underwriting often are calculated with stale information. Not surprisingly, the policy premium

is estimated inaccurately, affecting financial forecasting and budgeting. Therefore, when renewals approach, it is essential to be prepared regardless of the type of premium audit.

Audit options generally depend on premium and/or classes of business, and there are two general types: in-person, which is most preferred, and voluntary (by mail or telephone), which is cost-effective and increases turnaround time for insurers. If the policyholders are well-prepared, telephone and mail audits should be straightforward. However, an in-person audit should be requested at least once every three to five years.

The role of the premium auditor is to confirm that all companies are following the same rules when determining their workers comp premium and that no policyholders are paying more or less than they should. Auditors are professionals and will review everything provided to them in detail; however, they do not have time to search for information. Without the right support, they will have to make assumptions to calculate premium.

Preparation is key to a successful audit. The following are several steps to consider as soon as a company is contacted to schedule an audit:

- Allow enough time. Gather your documents together and review them beforehand.

- Look back. Review your prior year's audit; request it from the insurer if necessary.

- Examine payroll. Ensure your documents clearly break out payroll by straight-time and overtime:

Contractors. If your employees perform work in multiple states, break out your payroll by state and be ready to discuss your employee territory classifications. State rates vary for specific job classifications and may be substantially lower or higher than the state in which you are domiciled.

Clerical, outside salespeople and drivers. Classifications of certain jobs, called standard exceptions, are key. If the groups are not delineated, the auditor will default to the higher general class of your business.

Subcontractors. Not only can you be held legally liable for losses from the acts of your subcontractors, you also can be held responsible for paying the premium for their workers comp exposure if you cannot show that the subcontractor procured its own insurance. It is extremely important to have and retain a certificate of insurance for every subcontractor you hire.

- Keep a copy of records. Secure a copy of your audit and review it thoroughly for accuracy and completeness before your auditor leaves. It is easier to make changes while your

auditor is onsite and it will be your document to prepare for next year.

The premium audit process can have a big effect on renewals. Take, for instance, a policy underwritten with an original estimated premium of \$25,000 for the effective period of Oct. 1, 2006, to Oct. 1, 2007. The policyholder completed its premium audit within 60 days of renewal. There was no classification of employees within the policyholder's payroll documents and the auditor moved some employees' payroll into a higher class code. "Additional premium" for the policy year could surge significantly.

A 20-point change would result in a \$5,000 charge for your expiring policy and more than likely result in a midterm endorsement of \$5,000, which could have a significant effect on a small business. Payment of the additional premium is expected rather quickly because this is premium due on last year's policy. Failure to pay could result in pro-rata cancellations or collection actions from the insurer, and leave the business uninsured.

With increased pressure to keep a close eye on the bottom line, risk managers cannot afford to overlook cost savings opportunities. Simply put, those who do not actively participate in the premium audit are potentially leaving money on the table.



Harold J. Moskowitz is a partner with law firm Wilson, Elser, Moskowitz, Edelman & Dicker L.L.P. in New York. Nancy L. Vanderlip is vp and general counsel, Electronic Components, for IIT Corp. in Santa Ana, Calif. Both are members of the Conflict Prevention & Resolution executive committee.

When coverage disputes arise, try mediation

Conflict resolution initiative uses a proven, credible process to find a mutually beneficial solution

By Harold J. Moskowitz
and Nancy L. Vanderlip

The International Institute for Conflict Prevention & Resolution, based in New York, launched an initiative this year to promote mediation use in policyholder-insurer disputes. This new initiative provides a clear and straightforward framework for commencing and using mediation in these types of disputes.

At first glance, no commercial relationship is perhaps more prone to potential conflict than that of a policyholder and its insurer. The policyholder's desire to fully protect itself from a claim can be perceived to directly conflict with the insurer's goal to minimize costs. Coverage disputes can add strain to the parties' relationship. A sense of conflict also can grow where there is no current commercial relationship, if there is insufficient information or uncertainty regarding actual underlying

damages. Unfortunately, these perceived conflicts often overshadow the parties' actual mutual interests in reaching a quick, negotiated resolution of coverage disputes.

Through the conflict prevention institute's policyholder/insurer initiative, all members and other providers or consumers who are active in today's insurance marketplace can participate in negotiation and resolution; accelerate the investigation and analysis of the coverage questions; agree on a prompt, voluntary exchange of information; define the damages; and focus on their shared interests in resolving the underlying litigation intelligently, all under the umbrella of a high-quality, experienced mediator.

The conflict prevention initiative for policyholders and insurers essentially follows from positive experience with the initiative's interinsurer dispute resolution "facility," which essentially is a nonbinding protocol

with a framework for conducting negotiations and/or mediations between the participants. The protocol allows for assistance from the institute when the parties are unable to reach agreement on certain points, such as the selection of a mediator. The protocol was produced by a roughly 40-member insurance committee, which meant that the ideas used had wide support among the institute's insurer members, and has worked well.

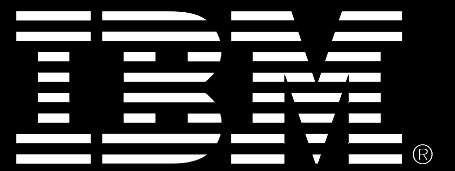
The institute's experience with this facility has shown the importance of the nonbinding nature of the mediation process. No legal or contractual rights are necessarily waived or lost by participating. However, a signatory insurer's involvement in the protocol has signaled to its claim handlers and managers alike that the use of negotiation and/or mediation, where potentially useful, is both approved and encouraged by top management. Use of the protocol has effectively

created a hotline for communications between the participants, with many interinsurer disputes being resolved after the initial request for negotiations.

A combined committee of insurers and corporate Conflict Prevention & Resolution members collaborated in the development of the new facility for the use and benefit of insurers and corporate policyholders. One major aspect was developing a resource databank of experienced neutral mediators, respected by both insurers and policyholders for their work with complex coverage issues and claims. The other major aspect of the facility is the Mediation Principles for Insurer-Insured Disputes that arose from the committee's work with the institute.

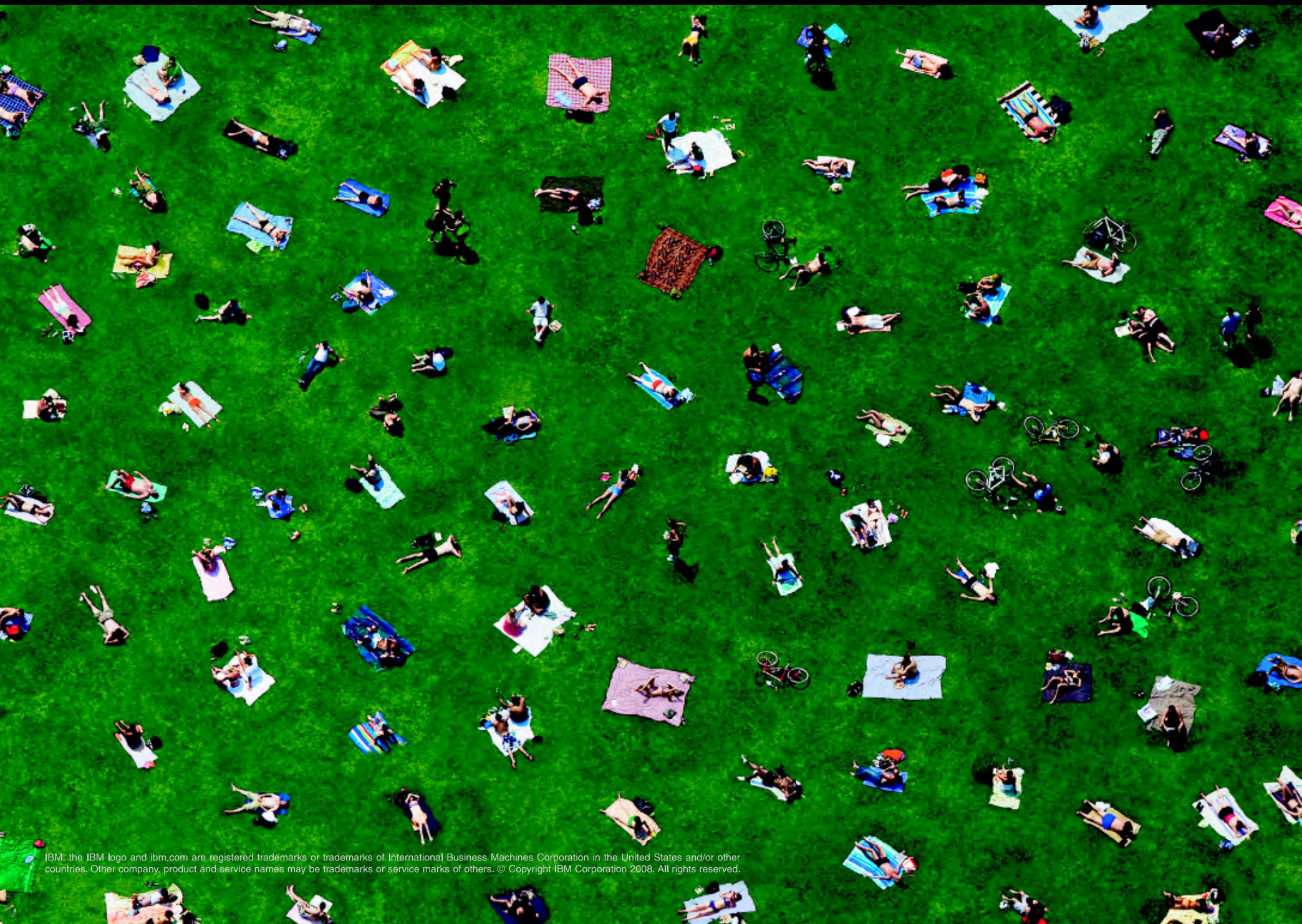
The mediation principles are as follows:

- They provide for good faith con-



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Mediation: Allows mutually beneficial resolution of policy disputes

CONTINUED FROM PAGE 18

fidential mediation pursuant to the provisions of the mediation procedure.

- The parties agree, upon written request of any party, to engage in good faith confidential mediation, and further agree that either party can apply for a stay of 30 days while the parties engage in direct negotiations.

- There is a further process for selecting a mediator either from the institute-approved coverage and mediation panel or by way of a process on which the parties agree. In the event that the parties cannot agree, Section 2 of the mediation procedure provides a method of selection.

- The mediator may encourage the exchange of information as necessary to resolve the dispute, but does not have the authority to order the production of any information.

The bedrock of these principles is really the expressed willingness and commitment of the protocol participants to use mediation rather than immediately commencing arbitrations or lawsuits to attempt to resolve disputes. Mediation, with its inherent focus upon enabling the

parties to reach a mutually agreeable solution built on common interests, offers interested parties a pragmatic alternative to the time and expense of litigation.

Further, all parties also can benefit from the use of interim agreements during a mediation process on questions such as the selection and payment of defense counsel and cost-sharing among multiple insurers, which can reduce transactional costs and build trust among stakeholders.

Assuming that voluntary agreements cannot be achieved, intervention by the institute and a neutral mediator in a coverage dispute can provide the political or emotional space required to let the parties make interim compromises and accept coverage interpretations that they may not be able to do on their own. The institute's new insurer-policyholder forum for resolving disputes should be seen as the functional equivalent of outside intervention by a court, rather than as a cheaper alternative suitable only for claims of little financial importance. Indeed, if adopted as a standard business practice, these Mediation Principles for Insurer-Insured Disputes offer real opportunity for

insurers and policyholders alike to realize material economic benefits.

In short, the Conflict Prevention & Resolution policyholder/insurer

protocol provides an officially sanctioned, credible facility to bring parties together in a workable process to resolve disputes, with the oppor-

tunity to involve any other interested parties that may be able to contribute to the resolution of the dispute.

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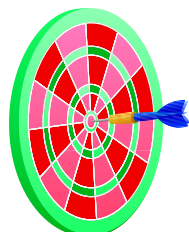
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International NEWS

Regulator still eyeing broker transparency

U.K. intermediaries urged to respond to paper

By RICHARD MILLER

LONDON—The United Kingdom's insurance regulator is still considering mandating disclosure of broker commissions.

The Financial Services Authority said in a discussion paper last week that requiring brokers to disclose all commissions is one of way to address its lingering concerns about whether there is enough transparency in insurance transactions.

Other options considered in the discussion paper are "more rigorous enforcement of existing rules," and an "enhanced regime to improve quality of disclosure of commission (on request by the customer), services and status," the FSA said in a statement.

Last year, the FSA said in a report that it had decided against making disclosure compulsory at that time, noting concerns that the costs associated with requiring U.K. insurance brokers to disclose their commissions outweigh the benefits that would arise from such regulatory intervention (*BI*, Dec. 17, 2007).

But the paper released last week shows that the mandatory approach is still under consideration.

Dan Waters, FSA director of retail policy and themes, said: "It is important that insurance buyers know what they're paying for when they use an intermediary. We remain concerned that for some buyers of commercial insurance, this is not the case."

"Our discussion paper offers some potential regulatory solutions, but the door also remains open for an industry-led response," he said.

Among draft rules suggested in the paper, the FSA proposes a rule to require all U.K. intermediaries to inform commercial buyers automatically of all commission paid on their business throughout the chain.

The European Commission also currently is considering changes to its Insurance Mediation Directive, to which brokers in the United Kingdom are subject.

The FSA noted that disclosure rules are on the Commission's agenda for consideration as part of the review of the Insurance Mediation Directive. The Commission had concluded in its September inquiry into competition in business insurance that the current market environment does not go far enough in protecting intermediaries' customers.

"Against this background, we have concluded that we need to take a broader, more holistic view of the issues before deciding how best to address them," the FSA said. "This will also put us in a good position to influence the discussion in the European context," it added.

The FSA discussion paper, "Transparency, Disclosure and Conflicts of Interest in the Commercial Insurance Market," is available on its Web site at www.fsa.gov.uk. The period for responses ends June 25.



FSA

'Our discussion paper offers some potential regulatory solutions, but the door also remains open for an industry-led response.'

Dan Waters,
Financial Services
Authority

New reinsurer formed in Mideast

Gulf Re will offer reinsurance to buyers in Gulf Cooperation Council

By ADRIAN LADBURY

DUBAI, United Arab Emirates—Reinsurance buyers in the rapidly growing Gulf region of the Middle East will soon be offered additional local capacity from Gulf Re, a new company backed by Bermuda's Arch Capital Group Ltd. and the government-backed Gulf Investment Corp.

Arch and GIC announced the new venture last week at the opening of the World Insurance Forum in Dubai.

Arch and the GIC have committed \$200 million each to the venture, with \$200 million paid up immediately and \$200 million set aside for future growth.

Gulf Re will be led by Chief Executive Officer Gail Norstrom, who previously was a managing director of Aon Risk Services' property practice group, Arch Capital and GIC said in a statement.

The reinsurer will write a range of property/casualty lines of reinsurance, including aviation, energy, commercial transportation, marine, engineered risks and property, the statement notes. Gulf Re will offer both treaty and facultative reinsurance to reinsurance buyers in the Gulf Cooperation Council region, which is made up of Bahrain,



ZUMA PRESS

New reinsurer Gulf Re, backed by Arch capital Group Ltd. and Gulf Investment Corp., will be based in the Dubai International Financial Centre. The reinsurer intends to start underwriting in the first half of this year.

Kuwait, Qatar, Oman, Saudi Arabia and the United Arab Emirates.

Subject to regulatory approval, Gulf Re will start underwriting in the first half of this year and will be based in the Dubai International Financial Centre.

Arch Capital President and CEO Dinos Iordanou said that the company would initially focus on high-value oil and gas, industrial, utility and transportation assets in the six GCC states.

"The joint venture will allow Arch to expand its platform in a region where there is a strong need for local reinsurance capacity and specialist expertise for these assets...By partnering with GIC, a successful and highly regarded sponsor in the GCC, Gulf Re will be well-positioned for opportunities in the marketplace. Gulf Re will also benefit from an outstanding management team," Mr. Iordanou said in the statement.

Munich Re places \$268M cat bond

European windstorm risks shifted to the capital markets

By RICHARD MILLER

MUNICH, Germany—Munich Reinsurance Co. has issued a €170 million (\$267.7 million) catastrophe bond to transfer European windstorm risks to the capital markets, the German reinsurer said last week.

Through Munich Re's new Queen Street program, peak windstorm risks are being placed on the capital market through a first tranche with a volume of €100 million (\$157.5 million). A second tranche with a volume of €70 million (\$110.2 million) securitizes windstorm frequency, Munich Re said.

Thomas Blunck, a member of Munich Re's board of management, said in a statement that such bonds provide relief for Munich Re when several moderately severe wind-



LANDOV

Earlier this month, Windstorm Emma tore across parts of Central Europe and caused insured losses near \$2 billion.

storms occur in any one year.

"Among our clients, we also see a growing demand for such coverage of frequency losses. The Queen Street bond program can therefore be deployed quickly and cost-effectively

for our clients too," he added.

The bonds issued by Queen Street Ltd. are variable rate notes with a term of three years. For the first time, a substantial part of the securities—more than €50 million (\$78.8 million)—was placed with investors in the European Union and in Switzerland via the Munich Re subsidiary Munich Re Capital Markets, the company said.

"Catastrophe bonds with their transparent and uncorrelated risks are currently in big demand among investors in view of the credit market crisis," said Mr. Blunck.

Several other bonds have been placed in recent months to address European windstorm exposures, including securitization deals by Swiss Reinsurance Co., SCOR S.E. and Allianz S.E. (*BI*, Jan 14.)

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Commentary

ERM a way to make sense of the madness

By some scheduling quirk, it's been my good fortune more than once over the past few years to be slotted for one of these commentary pieces in the midst of March Madness, one of the happiest times of year for a college basketball fan like myself.

I've gotten to write about everything from experts' suggestions that office NCAA basketball pools might actually have a positive impact on business by improving employee morale to apocalyptic pronouncements last year that CBS' March Madness on Demand online video offering would bring the U.S. economy to its knees.

It's been fun. And I did think long and hard about going back to the March Madness well this week. But, with another kind of madness manifesting itself this year—the subprime mortgage variety—and other factors causing some genuine wobble in the U.S. economy's knees, it seemed there were more pressing issues to write about.

At dinner with friends a few Saturdays back, we talked about Bear Stearns and the fact that, with the subprime situation, no one seems to know where the bottom might be.

Like almost everyone else, none of us foresaw the events already being put in motion that weekend: JPMorgan Chase acquiring Bear Stearns the following Monday for \$2 a share with the backing of a \$30 billion credit line from the Federal Reserve. Those same Bear Stearns shares had been trading for \$160 a share a year earlier and, when the weekend began, closed at \$30 a share on March 14.

Obviously, the Fed felt a need to step in to maintain the strength of U.S. financial markets, recognizing the very direct connection between Wall Street and Main Street.

Many companies in the United States are also aware of that connection. Some have seen business hit by tightening credit markets. Others by the downturn in construction. The falling dollar has hit many relying on overseas markets for raw materials or product components, and the economic slowdown—recession, if you prefer—has cut into many companies' sales.

You wonder how many nonfinancial/nonconstruction-related U.S. businesses realized they had a subprime exposure a year ago.

Businesses are starting to recognize other exposures, too. Companies outsourcing production abroad have become aware in recent months of product recall risks they need to manage.

Businesses with outsourcing



RODD ZOLKOS

Senior Editor Rodd Zolkos can be reached at: rzolkos@businessinsurance.com

arrangements involving third-party providers handling their customers' personal information are realizing that the risk of privacy breaches facing their outsourcing partner is very much their exposure as well.

The overarching theme, I believe, is the need for companies that have not yet done so to embrace an enterprisewide approach to risk management. Threats to the company's bot-

Identifying exposures—and their possible interrelations—requires a comprehensive view.

tom line, and even perhaps to its survival, lurk across the organization, and identifying many of those exposures—and their possible interrelations—requires a comprehensive view. *BI* columnist John J. Hampton offers ERM insights on page 6 of this issue and online at www.BusinessInsurance.com/ERM.

Standard & Poor's Corp. recognizes the importance of such an approach. While S&P has included enterprise risk management efforts as part of its rating analysis of insurers and other financial industry companies, the rating agency recently announced it was moving toward including ERM in its evaluation of the creditworthiness of nonfinancial businesses as well.

Though it has expressed concerns about how S&P will implement including ERM among its rating criteria for nonfinancial companies, the Risk & Insurance Management Society Inc. has supported the concept.

Obviously there's a whole world of risks—literally in some cases—facing many businesses today, many of them interrelated in ways previously unconsidered. ERM can be a way to make sense of the madness.

Bear Stearns: Can't recover \$80 million

CONTINUED FROM PAGE 3

holder attorney in the Washington office of Spriggs & Hollingsworth. "It's not unfair if you're going to ask me to pay—as an insurance company—to give me some opportunity to shape what (the settlement) is and know what it is in advance."

"I advise my clients in essentially all circumstances that the best tactical approach is to notify the insurer

of what's going on and what it intends to do," Mr. Mayerson said.

Policyholder attorney William G. Passannante with Anderson Kill & Olick P.C. in New York, described the ruling as "a cautionary tale" for policyholders.

The consent clause in professional liability policies is "almost like a false exclusion," he said. "You have an insurance company asked to consent to a settlement that's clear

they are not going to consent to," he said. "It's almost like an empty act."

Bear Stearns' attorney referred calls about the decision to the company. Calls to Bear Stearns were not returned.

Vigilant Insurance Co. et al. vs. The Bear Stearns Cos. Inc., New York State Court of Appeals No. 25, March 13, 2008.

Letters to the editor

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A "prohibited person" may engage in the business of insurance only if he or she obtains the written consent of the insurance regulator responsible for regulating that individual entity for which he or she works, usually the state insurance department of the state of domicile of the employing entity. The National Assn. of Insurance Com-

missioners has promulgated extensive guidelines for state insurance regulators relative to their role under the Violent Crime Control and Law Enforcement Act of 1994. These materials are available from the NAIC and would assist any employer who is seeking to employ a "prohibited person" through the necessary regulatory steps to permit that employment. Again, I think the article did an excellent job of balancing conflicting issues, but

those employers who are in the business of insurance need to be particularly aware of the requirements of this federal law.

Further information concerning this law can be found under the keywords "violent crime" at www.foley.com/publications/articles.aspx.

Kevin G. Fitzgerald
Partner
Foley & Lardner L.L.P.
Milwaukee

Products & Services

Zurich policy targets carbon credit projects

WASHINGTON—Zurich Financial Services Group is providing political risk insurance for companies that invest in programs to limit greenhouse gas emissions.

The PRI coverage for carbon credit projects targets emerging markets and is part of Zurich's recently launched global climate initiative focusing on risks associated with climate change.

Under the Kyoto Protocol, the international treaty targeting greenhouse gas emissions, certain projects are eligible for carbon credits based on their level of greenhouse gas reduction. According to Zurich, the protocol is providing a vehicle to monetize the environmental benefits of reducing such emissions and creating a carbon credit market with an estimated value of \$60 billion.

Zurich's policy is designed to protect against the risk of host government actions that might prevent an investor from receiving benefits associated with emission credits, with policy limits of up to \$125 million.

For more information, contact Daniel Riordan, executive vp and managing director for Zurich's emerging markets unit, at 202-585-3100 or visit www.zurichna.com.

Travelers Aviation offers workers comp program

ST. PAUL, Minn.—Travelers Aviation, a unit of Travelers Cos. Inc.,

has introduced a new workers compensation program for corporate flight departments.

The program includes coverage for pilots, ground crew and administrative staff and is designed to help control rising loss-cost trends of corporate general aviation departments.

The program supplements aircraft hull and liability policy forms for flight departments ranging from a single pilot to large departments.

Workers comp policyholders also have access to Travelers TravComp, a workers comp claim management processing service. TravComp technology integrates the claim, medical and billing platforms to issue payments and provides access for injured workers to review their claim payment information online.

For more information, contact Jeff Novak, vp of Travelers Aviation, at 770-521-4065 or jnovak@travelers.com.

Records, information service offers risk assessments

STAMFORD, Conn.—Pitney Bowes Management Services Inc., a wholly owned subsidiary of Pitney Bowes Inc., has introduced its Records and Information Management Consulting Service to help companies store records more efficiently and comply with new federal regulations.

The records offering, which expands Pitney Bowes onsite mail and document service, was developed in response to changes in the Federal Rules of Civil Procedure; a growing transition from paper to electronic records processing; and increased mergers, acquisitions and consolidations.

The Pitney Bowes service comprises five key offerings including records program assessments, technology reviews and recommendations, risk assessments, facilities recommendations and records project work. Risk assessments consist of

operational reviews of risk and compliance to verify that procedures are in place and functioning to maintain corporate operations and to reduce or prevent any potential loss.

For more information, contact a member of the management services team at 888-245-7267 or by e-mail pbmsinfo@pb.com.

Storm surge report expands to Md., Va.

BOSTON—CDS Mapping L.L.C. has expanded its RiskMeter Online Storm Surge Report to include Maryland and Virginia.

The additions allow real-time reports for the entire Atlantic and Gulf coasts, as well as Hawaii and Puerto Rico.

The RiskMeter Online Storm Surge Report uses Internet mapping technology to determine a property's proximity to natural hazards, and potential risks due to floods and hurricanes of a specific strength.

The online tool gives users a detailed assessment of coastal flooding and provides the maximum storm surge height for each storm category.

The service allows primary insurers, reinsurers, agents and financial institutions to perform automated property lockups online and can be accessed at www.riskmeter.com.

For more information, contact Dan Munson, founder of RiskMeter Online, at 617-737-4444 or at dmunson@cdisys.com.

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Data: Access to better technology

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Piscataway, N.J.-based Trane Inc. examined its claims data to determine the best way to direct its health management programs, said Heidi Lattig, director of health and productivity programs, who spoke at the same session.

"What we found was that people weren't taking care of themselves," Ms. Lattig said.

For example, Trane's data showed that nearly 65% of the diabetics at one Florida location were not getting regular hemoglobin A1C tests. As a result, they were using hospital emergency rooms more frequently, which was increasing Trane's health care costs, Ms. Lattig said.

"There was an opportunity to intervene because we know as our population continues to age, these numbers are going to spiral out of control," she said.

Kraft Foods Inc. is using a tool developed by Woburn, Mass.-based HighRoads Inc. to collect benefits data worldwide, said Joanne Armenio, director of international benefits for the Northfield, Ill.-based foodmaker, during a session

about leveraging data in designing benefits.

Kraft has 104,000 employees worldwide, more than half of whom are outside the United States, Ms. Armenio said. Before the HighRoads tool came along, she relied on spreadsheets to keep tabs on benefits offered at foreign locations. But they weren't always accurate or up-to-date, she said.

Having a single, easily updatable database was particularly helpful when Kraft recently acquired the global biscuit business of Paris-based foodmaker Groupe Danone, she said.

"I was able to go to the HighRoads database and show the benefits offered at all the locations that would be affected by the merger," Ms. Armenio said.

Staples Inc. hired HighRoads to handle its request for proposals process, which had become unwieldy given that the office supplier tracks some 7,300 documents for 65 different suppliers, said Nancy Lazgin, director of global benefits at the Framingham, Mass.-based office supply retailer.

With only six people on staff and about a dozen RFPs renewing

each year, "that's a lot for them to handle in addition to other functions," including the company's employee stock purchase plan, its 401(k) plan, communications, etc., Ms. Lazgin said during the session on leveraging data in benefit design.

"The solution was to get everything in one place," she said.

So far, the single database is making it easier for Ms. Lazgin to prove that she is effectively managing both providers and their contracts.

When her department was audited recently, "we weren't 100% clean, but we were pretty close," Ms. Lazgin said.

HighRoads said it plans to introduce a new benchmarking tool next month that culls the benefit program information of all of its clients into a single database that employers can use to compare their benefits with those offered by other employers in their industry or geographic area, said Lori Dustin, chief marketing officer for HighRoads, during the data leveraging session. Employers also can use the database to compare what they pay for certain administrative services, among other things, she said.

Awareness: Exposures rise with patients' expectations

CONTINUED FROM PAGE 4

patient safety initiatives that include technologies such as bar-coded medication systems and electronic intensive care units, as well as improvements in obstetrics, such as fetal heart monitor training.

Taking action is imperative, said panelist Mark DeFrancesco, medical director of Women's Health USA Inc., in Avon, Conn., as advances in medical science and health care technology have created an expectation among patients that every condition can be cured and mistakes never happen. He said many patients expect perfect tests and perfect results, and any error is worthy of a lawsuit.

"We're victims of our own success," Dr. DeFrancesco said. "Patient expectations have never been higher."

Additionally, increased access to information—driven by the expansion of the Internet—has heightened patients' awareness and expectations of treating diseases, Mr.

Dmytrow said, which ultimately is a good thing. Still, he said, doctors must be careful when talking to patients and set realistic expectations. Doctors should not minimize any condition or procedure when talking to a patient, he said. Promising much and not delivering might come back to haunt physicians, he said.

When mistakes do come to light, Dr. DeFrancesco said, achieving an early resolution is key to minimizing the damage of a patient's claims. He said risk managers should really try to solve problems that come up and not just write a check to settle the matter.

Focusing on patient safety, Dr. DeFrancesco said, should keep more cases from the courts, which is the ultimate goal, especially since tort reform on a national level that establishes caps on payouts is unlikely.

A risk management program for providers requires buy-in from doctors and practitioners. To get physician buy-in, give doctors evidence and data, said Dr. Daniel Sullivan, president and CEO of the Sullivan Group, a consulting firm focused on patient safety, risk management and performance improvement solutions for health care professionals in Oakbrook Terrace, Ill. He said doctors should be shown a record of improvement in morbidity and mortality from such programs that highlight the success rate in reducing adverse events, medical errors and litigation.

"We want to see the data," he said. "We'll work with it and change our behavior. We're interested in improving our practice if it's based on data."

Still, panelists said despite their effectiveness, risk management and patient safety, these programs are the first to go when money gets tight because they don't generate revenue. The long-term benefits, though, should outweigh the immediate costs, and risk managers should make that clear to other administrators, they said.

"No matter what cycle you're in," Mr. Dmytrow said, "catastrophic risk always hangs over you, and if you don't have someone to come in and manage that, you're putting the organization at risk."

Communication: Aids generic effort

CONTINUED FROM PAGE 4

experiment were divided into two groups. One group simply removed Zocor and Lipitor—another popularly prescribed brand-name statin that is produced by Pfizer Inc. and has patent protection at least through 2010—from their prescription drug formularies, but did not increase communications urging plan members to switch. This group served as the control.

The other group of employers also removed Zocor and Lipitor from plan formularies, which like the first group increased copayments. In addition, the second group stepped up communications urging plan members with brand-name prescriptions to switch to

generic drugs.

The campaign incorporated three features: First, focus groups and surveys gauged plan members' views on generics. Second, the campaign was linguistically based, or "framed," Mr. Nease said. "We worked hard to use phrases and words that already had equity in the members' heads," he said in noting the approach has been used very effectively in politics and direct-to-consumer advertising by drug companies but underused in employee benefits communications.

Finally, the message was reinforced through repetition. "It was a single message repeated in every channel in every opportunity that Express Scripts talked to them," Mr. Nease said.

The results: While just removing brand name drugs from the formulary prompted 20% of plan members taking the medications to switch to a generic, conversion rates were two to three times greater among those also exposed to the communications campaign.

The experience of Lowe's, which served a test subject participating in the second group with stepped-up communications, exemplifies these findings.

Lowe's Zocor utilization rate dropped by proportionately the same amount that simvastatin utilization grew: approximately 40%, Bob Ihrle, senior vp of employee rewards and services at the retailer, reported at the NBGH meeting. Lipitor utilization also dropped significantly.

In addition, he said Lowe's generic drug utilization rate now is 75%, which is considered optimal by pharmacy benefit experts.

Lowe's offers employees a choice of either enrolling in a health maintenance organization or the company's self-insured preferred provider organization, Mr. Ihrle said.

Both plans offer drug coverage using a five-tiered formulary, in which copayment charges vary for generics, brands without generic equivalents, formulary drugs, non-formulary drugs and "other" drugs that include lifestyle-enhancing drugs such as Viagra.

"I feel we've got Lipitor down to the people who really need it instead of it being the world's largest drug because it's got the best advertising," Mr. Ihrle said.

Moreover, Lowe's prescription drug costs dropped by \$1.5 million, helping to produce a 2007 health care cost trend of 1.3% compared with 3.6% in 2006, he said.

Business Health Agenda draws 508 to Washington

WASHINGTON—A total of 508 employee benefits professionals attended Business Health Agenda 2008, the annual meeting of the National Business Group on Health.

Session topics at the March 12-14 gathering in Washington included employer use of data and technology to manage their health plans, educate employees and promote better communication and decision making; using behavior change theory to enhance consumer engagement; improving employee health management through strategic integration of onsite medical

clinics; and an update on consumer-driven health care.

Next year's event is again slated to be held in Washington on March 11-13.

For more information about Business Health Agenda or other programs sponsored by the NBGH, visit www.businessgrouphealth.org.

The NBGH, based in Washington, is a consortium of 290 employers dedicated to finding innovative solutions to the nation's health care and other employee benefits-related challenges.

—By Joanne Wojcik

570 attend conference

CHICAGO—About 570 medical malpractice underwriters, brokers, attorneys and risk managers attended the Professional Liability Underwriting Society's eighth annual Medical Professional Liability Symposium held March 11-12 in Chicago.

More than three dozen medical malpractice experts presented or led discussions on topics such as health care facility liability, risk management, medical malpractice market conditions, long-term care and the changing landscape of health care delivery.

Next year's symposium will be held March 24-25, 2009, in Chicago.

More information will be available later this year on the society's Web site at www.plusweb.org.

—By Kristin Gunderson Hunt

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McGavick: Former SAFECO chief named CEO of XL Capital

CONTINUED FROM PAGE 1

when he left to launch a race for the U.S. Senate in 2006 for the seat of Sen. Maria E. Cantwell, D-Wash. Mr. McGavick, who ran as a Republican, lost to the incumbent senator.

Before joining SAFECO, he spent six years with Chicago-based CNA Financial Corp., eventually becoming president and chief operating officer of the insurer's largest commercial insurance operating unit.

In an interview last week, Mr. McGavick said, "XL is one of the great franchises in insurance. I love that it's a global franchise; those are great opportunities. XL's best days are still ahead." A video interview with Mr. McGavick can be viewed at www.BusinessInsurance.com/video.

Observers say Mr. McGavick's successful turnaround of SAFECO could make him the right person to take the helm of XL Capital, which has suffered from depressed stock prices and earnings volatility.

There had been speculation that XL Executive Vp and Chief Operating Officer Henry C.V. Keeling would be named to replace Mr. O'Hara, but observers say XL's board may have wanted a fresh set of eyes to view XL's problems.

XL reported \$430 million in 2007 net income vs. \$1.76 billion in 2006. Results reflect \$1.5 billion in charges that are primarily related to XL's investment in financial guarantee insurer Security Capital Assurance Ltd.

XL stock closed at \$32.03 on March 20, down from a 52-week

high of \$85.67.

XL has had other problems as well. In 2005, after reporting \$1.47 billion in catastrophe losses for that year's third quarter, it announced a \$182.9 million increase in reserves for the North American reinsurance operations it acquired in its 1999 takeover of NAC Re Corp. XL also was forced to take an \$830 million pretax fourth-quarter charge against earnings after losing an arbitration case with Winterthur Swiss Insurance Co. over reserves for a Winterthur unit it had acquired in 2001.

Observers give Mr. McGavick high scores, both for his tenure at SAFECO and for his prospects at XL. Mr. McGavick "clearly has proven leadership skills and knows how to identify problems" and execute changes, said Cliff Gallant, an analyst with Keefe, Bruyette & Woods Inc. in New York.

SAFECO may have been on the brink of bankruptcy before Mr. McGavick came in and executed a successful turnaround that included the 2004 sale of the insurer's life and investment operations and an insurance brokerage operation, say observers.

"He simplified a lot of things," said Anthony Diodato, group vp with Oldwick, N.J.-based A.M. Best Co. Inc. He took the opportunity to remove whatever was not integral to the operation's success from the enterprise, making "those hard decisions that weren't made up to that point" and created "a better-run machine," he said.

Mr. McGavick presided over SAFECO while the broader market

MICHAEL S. MCGAVICK

Career highlights

MARCH 2008: Named chief executive officer of Bermuda-based XL Capital Ltd.

2006: Unsuccessfully ran as Republican candidate for U.S. Senate seat in Washington state.

2001-2005: Served as president and chief executive officer of SAFECO Corp. Assumed role of chairman in 2003.

1997: Named president of CNA Commercial Insurance, the largest business unit of CNA Financial Corp.

1996: Promoted to executive vp and senior financial officer of CNA's commercial insurance business.

1995: Joins Chicago-based CNA's marketing department as group vp responsible for new business ventures.

1992-1995: Director of the Superfund Improvement Project for the American Insurance Assn.

1989-1991: Chief of staff to Sen. Slade Gorton, R.-Wash.

1986-1988: Vp of the Seattle-based Washington Roundtable, a nonpartisan public policy research group.

was hardening, and "was able to point the ship in the right direction after some missteps from prior administration and...take advan-

tage of a tailwind," said Paul Latta, an analyst with McAdams, Wright, Ragen Inc. in Seattle.

He said many believed a lawsuit filed in 2006 against Mr. McGavick and SAFECO, which charged he had received a golden parachute of up to \$28 million even though he had resigned voluntarily, was a politically motivated response to his Senate run. The lawsuit was dismissed by a federal judge last year.

Insurance giant XL, with more than 90 operating subsidiaries in 27 countries, is a much different company from the far smaller SAFECO, which specializes in personal lines and commercial lines for small to midsize businesses.

But John Andre, a group vp at Best, pointed to Mr. McGavick's CNA background and said he imagines there were some new issues he encountered at SAFECO as well. "I'm sure Brian (O'Hara) will help make that transition smooth," said Mr. Andre.

Jim Auden, managing director at Fitch Ratings Ltd. in Chicago, said Mr. McGavick needs to look at XL's portfolio "on an aggregate basis and see which are the best parts" and which would present challenges in a soft market. "That'll take some time, I think."

Steven Ader, a director at New York-based Standard & Poor's Corp., said XL has been very successful in establishing a "global footprint." The challenge now, he said, is "tying it altogether and getting a consistent earnings stream."

Paul Newsome, an analyst with

Sandler O'Neill + Partners L.P. in Chicago, said he is concerned about Mr. McGavick's lack of expertise in the financial guarantee business. However, there have been instances in the past elsewhere where an executive was brought in to fix a particular problem, he said, but could not successfully run the company afterwards.

"In that regard, I think this is a smart choice," because Mr. McGavick can do the job, said Mr. Newsome.

"I have a lot of respect for Mr. McGavick and like him personally," he said. "He's quite outgoing." And as a former politician, "I think he's always done a good job of explaining what he wants to do," he said.

"I think he's charismatic, hard working and hard driving. I think he's a motivator. He speaks without notes. He speaks from the heart," said Mr. Latta, who recalls a 2004 SAFECO shareholder meeting where Mr. McGavick received a standing ovation. "He got people fired up."

"He's very involved in what he's doing and believes in every word that he's saying," S&P analyst Polina Chernyak said.

Mr. McGavick has "a unique package of skills, from the insurance industry to the political world, and will round out his capabilities and I think serve to lead the company in a very effective manner," said John L. Ward, chief executive officer of Cincinnati-based Cincinnati Partners L.L.C., an advisory firm that specializes in the insurance industry.

Providers: Working with benefit managers to customize programs

CONTINUED FROM PAGE 1

tional metrics such as the vendor's ability to pay claims in an accurate and timely manner, but the range of standards used by employers has broadened recently, employers and consultants say.

"We've seen a shift in the nature of performance standards and commitment employers are asking for,"

said Ron Fontanetta, a principal in Towers Perrin's health and welfare consulting practice in New York.

When Towers Perrin restructured its benefit program to add a consumer-driven health plan option for its employees, the company placed performance standards in its contract with its health plan vendor related to implementing the new plan design, said Susan Crown, director of global HR programs for the consulting firm in Stamford, Conn.

"You hope that when you enter into one of these relationships that it's symbolic," Ms. Crown said. "Really, you don't want them to pay (a penalty), because if they pay, something went wrong."

During recent negotiations, Kohler Co. insisted its health plan and pharmacy benefit manager commit to a system in which 100% of their administrative fees were at risk, said Laura Kohler, senior vp-human resources, for the Kohler, Wis.-based company.

"We applied a vigorous vendor accountability model and that goes beyond just a few metrics to include a broader relationship," Ms. Kohler told attendees of last month's 2008 Employee Healthcare Conference presented by the Conference Board and sponsored by Towers Perrin.

Traditionally, employers have asked health insurers, such as

Humana Inc., for performance guarantees related to physician networks and utilization management programs, but these metrics "really haven't added up to the solution" to rising health care costs, said Rick Remmers, vp-large group segment, for the Louisville, Ky.-based insurer.

Humana now is focusing on implementing programs that guarantee employers a certain level of predictability on their medical cost trends, he said.

In May 2007, Humana launched a product aimed at self-funded employers with 300 or more employees that guarantees health care cost trends of 6% to 9% if the employers take certain actions related to employee engagement. Humana places up to 40% of its administrative fees at-risk for these employers.

"We're willing to put our money where our mouth is on predicting claims cost and allow employers to hold us accountable for our service performance," Mr. Remmers said.

West Bend Savings Bank turned to Humana about four years ago after several years of more than 20% medical cost increases, said Nancie Heaps, senior vp-human resources, for the West Bend, Wis.-based company.

The company selected a product in the insurer's SmartSuite program that offered one comprehensive

health plan with four contribution and deductible levels from which employees could choose depending on their financial needs and anticipated medical utilization.

"My expectations were reducing the costs to the bank, reducing the costs to the employee and also offering some flexibility of choice," Ms. Heaps said.

The Humana plan has met those expectations as the bank's medical cost increases declined to less than 10% per year, she said. "The savings have been excellent," Ms. Heaps said.

Vendors are willing to guarantee their performance, but they want to ensure that employers also participate in efforts to affect employee behavior and control health care costs.

Self-insured employers participating in Humana's new plan, for example, are asked to encourage as many employees as possible to complete a health risk assessment. "It can't just be a health insurer guaranteeing this and the customer doing nothing," Humana's Mr. Remmers said.

Towers Perrin's Ms. Crown said she prefers developing active relationships with vendors in which financial guarantees play only a small role. "Their willingness to put money on the line is indicative of their willingness to work with you,"

she said.

Employers must have reasonable expectations for return on investment. David Hines, president of Pembroke, Mass.-based Consumer's Medical Resource Inc., expressed concern about vendors that make unrealistic promises on the cost benefits of their programs, such as achieving a 7:1 return on investment.

"I don't believe that those numbers are real," said Mr. Hines, whose company provides decision support services. "I think that doesn't serve (vendors) well and it doesn't serve customers well."

Benefit managers want their vendors to target their programs or services to the specific needs of the company. Kohler expects its vendors to provide customized products even if it means additional development work on their part, Ms. Kohler said.

Vendors say they are eager to comply with such requests because they understand the importance of customizing a program to an individual company's employee population to achieve success.

"You need to tailor your messaging for (different) kinds of companies," said Evan Falchuk, president and chief operating officer of Boston-based Best Doctors Inc., which provides medical consulting services.

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News In Brief

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the Pennsylvania Insurance Department to settle an investigation into financial misreporting involving its alleged sham reinsurance deal with General Re Corp., among other matters. The settlement also resolves client-steering and bid-rigging allegations and calls for AIG to provide annual reinsurance reports as well as maintain certain producer compensation disclosure and ongoing compliance initiatives. AIG said it has already paid \$4.4 million of the settlement amount and neither admits nor denies the allegations made by the Pennsylvania Insurance Department. Last month, five former executives of Gen Re and AIG were convicted of fraud for helping AIG inflate its loss reserves with an allegedly bogus loss portfolio reinsurance deal.

WellPoint faces investor suit

WellPoint Inc. faces a securities lawsuit charging the company with making false and misleading statements and failing to disclose material facts about its medical costs and enrollment trends. The insurer misled the market by issuing false and misleading earnings guidance, which led to the company's stock trading at "artificially inflated prices," according to the lawsuit, filed in the U.S. District Court for the Southern District of Indianapolis. The potential class includes investors who acquired WellPoint stock between Jan. 23 and March 10, the day the company revised its 2008 earnings projections due to higher-than-expected medical costs and lower-than-anticipated enrollment. That announcement led to a 28% decline in the company's share price, according to the suit. WellPoint said the allegations are baseless.

Zipper maker seeks captive benefits OK

YKK Corp. of America, the U.S. subsidiary of the Japanese zipper manufacturer YKK Corp., is asking the Labor Department for authorization to fund benefit risks

through its Vermont captive. YKK Corp. of America wants to use its Vermont captive, YKK Insurance Co. of America, to reinsure group basic life insurance and accidental death and dismemberment policies. The policies would be written by AIG Life Insurance Co., while the AIG unit would reinsure up to 100% of the risk with the YKK captive. Currently, the captive is used to fund workers compensation and property risks.

Humana to buy Illinois company

Humana Inc. has agreed to acquire OSF HealthPlans, a Peoria, Ill.-based managed care company, for \$90.5 million in cash. Humana said the transaction would increase its fully insured commercial membership by about 34,000, its self-insured business by approximately 30,000 members and its Medicare membership by nearly 14,000. Acquiring OSF HealthPlans will also significantly expand the Louisville-based insurer's provider network in Central and Northern Illinois, Humana said.

UnitedHealth options suit gets class action status

Class action status has been granted in a lawsuit over UnitedHealth Group Inc.'s alleged backdating of stock options, and a trial is expected to begin July 1, according to a UnitedHealth spokesman. The securities lawsuit was filed in 2006 against the health insurer and its current and former executives over the company's practice of backdating stock options for executives. The lawsuit, filed in federal district court in Minneapolis, seeks to recover billions of dollars in alleged investor losses and disgorgement of hundreds of millions of dollars of insider trading profits.

ACE holding company moving to Switzerland

ACE Ltd.'s board has approved a re-domestication of its holding company from the Cayman Islands to Zurich, Switzerland. The relocation must be approved by ACE shareholders and regulators. In addition to the re-domestication, ACE plans to establish a corporate holding company office in Zurich. ACE Ltd., holding company for the ACE Group of Cos., will continue to operate and maintain executive offices in Hamilton, Bermuda. The company also said that no changes will be made to its insurance and reinsurance segments.

Tornado: Georgia damage assessments under way

CONTINUED FROM PAGE 1

the Georgia Dome, Georgia World Congress Center and Centennial Olympic Park scheduled for March 14-15. Affected events included the Southeastern Conference Basketball Tournament, the Atlanta Home Show, the Hinman Dental Meeting and the Red Bull Illume sports photo exhibit as well as smaller private events, according to a statement by the Georgia Dome. The SEC tournament was moved to Georgia Institute of Technology's Alexander Memorial Stadium.

Mel Bangs, risk manager for Irving, Texas-based Omni Hotels, said the Atlanta Omni's south tower sustained the most damage.

"It took a pretty good hit," Ms.

'It's so fortunate that people hadn't been let out of the game. With all the flying debris and glass, it would have been really nasty.'

Kevin Innes, McLarens Young International

Bangs said. "We had a lot of glass blown in—almost every room that has a window was damaged. We probably have 160 to 170 rooms that are substantially damaged by wind and water."

As of late last week, Omni had no guests in the south tower because of safety concerns, she said. The north tower fared much better, with only 10 to 15 rooms with substantial damage.

"We're still kind of in the emergency repair mode," she said, adding that the structure was covered under the "Turner property insurance program" placed by Turner Broadcasting System Inc. to cover the CNN Center, to which the Atlanta Omni was attached.

CNN declined to discuss its program, with a spokeswoman describing damage to the CNN headquarters as "basically exterior damage; it's window damage; it's roof damage. And we are in the process of making the repairs. It's a work in progress."

A spokesman for Wachovia Insur-

ance Services said the brokerage's Atlanta office had received five claims totaling about \$2 million as of late last week.

Adjusting claims in the wake of the Atlanta tornado was no easy task, said Kevin Innes, Atlanta branch manager for McLarens Young International.

"It's an oddity" to have a tornado strike downtown Atlanta, he said. "One of the problems we're having is access. It's just difficult to get in and out. Streets are blocked and there's still debris. We started assessing on Sunday. We've had people in both the downtown area as well as an industrial area" east of downtown.

"There's a lot of broken glass, particularly downtown," Mr. Innes said. "There is structural damage and it is being evaluated by a number of engineers. We're still days away from knowing the full extent of what the structural damage is. We're very fortunate that the area downtown is limited" to "a couple of blocks. It appears as though the funnel cloud touched down within the area of Centennial Park."

He said the human toll could have been far worse had the basketball tournament in the Georgia Dome ended even a few minutes earlier. "One of the big stories here is the basketball tournament—it's so fortunate that people hadn't been let out of the game. With all the flying debris and glass, it would have been really nasty," Mr. Innes said.

"This has been quite an event for us—obviously being Atlanta-based," said Kevin Frawley, chief executive officer, property and casualty for the Americas, at Crawford & Co.

"We were able to get involved in the claims our clients wanted us to handle almost within hours," said Mr. Frawley. In addition to dealing with damage to from common exterior building components, "we're in the process of doing content loss evaluations of everything from office furniture, fixtures and other office equipment, because you've had extensive damage from tornado wind as well as subsequent water damage."

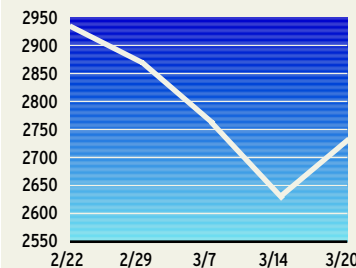
Mr. Frawley noted that in addition to making the emergency repairs, Crawford had to prepare for the next severe weather pattern that came the day after the tornado, which forecasters said was the first to hit Atlanta in recorded history.

Stock Index

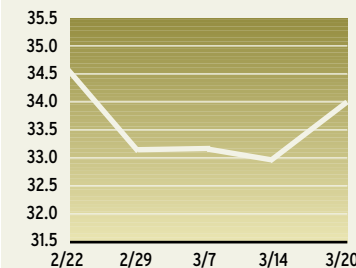
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Up-to-the-minute data for all 82 companies that comprise the BI Stock Index can be found at www.IndustryFocus.com.

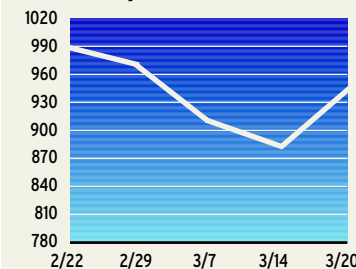
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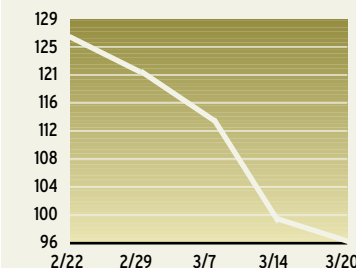
BI BROKERS INDEX



BI INSURER/REINSURERS INDEX



BI MANAGED CARE ORGANIZATIONS INDEX



Percentage change of BI Stock Index vs. key indicators

Index	Value	Change
BI STOCK INDEX	2733.60	▲ 1.37%
DOW JONES	12361.32	▲ 1.77%
S&P 500	1329.51	▲ 1.07%

LARGEST GAINS

United Fire & Casualty	10.85%
MBA Inc.	10.37%
Selective Insurance Group	9.02%
Hartford Financial Services	7.36%
UNICO American Corp.	7.18%

LARGEST LOSSES

Gainsco Inc.	-13.77%
Health Net Inc.	-13.06%
American Safety	-10.00%
UnitedHealth Group Inc.	-7.73%
Aspen Insurance Holdings	-5.80%

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Business Insurance END PAGE

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



Scents and sensibility protected by insurance

Lloyd's of London has a nose for business when it comes to unusual coverage. A syndicate at Lloyd's reportedly has written a policy to cover Dutch winemaker Ilja Gort's nose—which he considers the most important asset in his profession—for 5 million euros (\$7.8 million).

Mr. Gort owns Chateau de La Garde in the Bordeaux region of France and produces Tulipe Wines. His policy reportedly was coinsured by Watkins Syndicate and Allianz Nederland, a unit of Allianz S.E.

Mr. Gort's nose isn't the first to be insured in the Lloyd's market. Lloyd's underwriters also insured the nose of famous sherry maker José Ignacio Domecq, who was known as El Nariz, Spanish for "The Nose," according to press reports.

Many wine tasters opt to insure their tongue, but Mr. Gort said he chose to insure his nose because it can distinguish millions of different scents, as opposed to the tongue's five areas of taste. He reportedly said his sense of smell guarantees the constant quality of his wine.



Berkshire Hathaway Chairman Warren Buffett will appear in an upcoming episode of soap opera 'All My Children' with actress Susan Lucci.

What he really wants to do is direct...

Warren Buffett is the richest man in the world, according to Forbes.

The chairman of Omaha, Neb.-based Berkshire Hathaway Inc. got that way through hard work and an investment savvy most people can only envy. But anyone who has attended Berkshire Hathaway's annual meeting also knows that the Oracle of Omaha is also a bit of a showman. So perhaps it's fitting that the ukulele-playing billionaire might be tempted to try his hand at acting.

And that's just what he's doing by playing himself in an upcoming episode of ABC's

soap opera "All My Children." In the episode, Mr. Buffett is called upon to help Erica Kane, played by Susan Lucci, deal with charges of insider trading. The episode, slated to run in May, will be previewed at Berkshire's annual meeting on May 3.

According to CNBC, the episode will mark at least the second time Mr. Buffett has appeared on the show. Berkshire Hathaway stockholders can only hope that Mr. Buffett does as he's done before and sticks with his day job rather than throw it all away for the allure of the screen.



Do you Yahoo? You may need help, doc says

Do you ever lose track of time while surfing the Web, or have feelings of anger, tension or depression when your computer is inaccessible? Do you feel compelled to constantly upgrade computer equipment so it's the newest and fastest? Are you tired and irritable, especially when asked about your excessive computer usage?

If you answered, "Yes," to any of these questions, you could be suffering from Internet addiction.

To make more medical professionals aware of the condition, Dr. Jerald Block of Portland, Ore., is proposing that it be added to the next edition of the Diagnostic and Statistical Manual of Mental Disorders under the category of compulsive-impulsive spectrum disorders.

The proposed condition involves online and offline computer usage that consists of at least three subtypes: excessive gaming, sexual preoccupations and e-mail/text messaging.

All sufferers share four components: excessive use, often associated with a loss of sense of time or a neglect of basic drives; withdrawal, including feelings of anger, tension or depression when the computer is inaccessible; tolerance, including the need for better computer equipment, more software or more hours of use; and negative repercussions, including arguments, lying, poor achievement, social isolation and fatigue.

While Dr. Block appears sincere in his plea, which was published in the March issue of the American Journal of Psychiatry, he may have an ulterior motive. A footnote to the article states that the doctor owns a patent on technology that can be used to restrict computer access.

Ruling on libel lawsuit is stranger than fiction

A well-known New York attorney will be allowed to proceed with his \$15 million libel lawsuit against the creators of the television drama "Law & Order," a Manhattan court ruled last week.

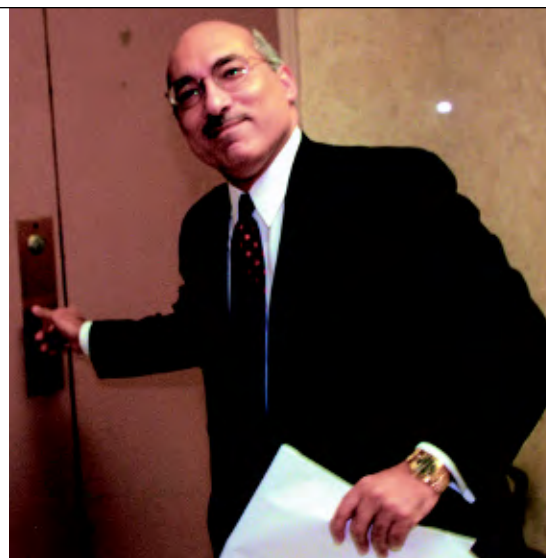
Attorney Ravi Batra is suing producer Dick Wolf and NBC Universal for defamation of character. According to press reports, Mr. Batra claims the popular show patterned a character—"Ravi Patel," a "bald Indian-American" lawyer who bribes a Brooklyn Supreme Court judge—after him. He claims that the November 2003 episode, "Floater," is based on a judicial corruption scandal involving Justice Gerald Garson, lawyer Paul Siminovsky and Mr. Batra.

Judge Marilyn Shafer rejected bids for the case to be dismissed and ruled that viewers might link Mr. Batra with the crooked

lawyer character because of the similarities with the name and appearance. Judge Shafer deemed the ruling the first "libel-in-fiction" claim to survive a summary motion in 25 years.

The episode aired after an associate of Mr. Batra's was charged with pressuring judges to hire favored consultants. While Mr. Batra was not charged with any crime, he has been linked to the scandal, which is portrayed in the episode.

According to reports, NBC and Mr. Wolf argued that any similarities between the character and Mr. Batra are abstract and that there are notable differences, including the fact that Mr. Batra practices in Manhattan, while the character practices in Brooklyn. In her ruling, though, the judge said that there was a "reasonable likelihood that the ordi-



NYT PHOTOS

Attorney Ravi Batra filed a defamation of character suit over an episode of 'Law & Order' that he says too closely resembles him.

nary viewer, unacquainted with Batra personally, could understand that Patel's corruption to be the truth about Batra," reports said.



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