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In Brief

**Convicted Marsh execs
get weekends in jail**

Two former Marsh Inc. executives convicted of violating New York's antitrust law have been sentenced to 16 weekends in jail plus five years probation and 250 hours of community service. New York Supreme Court Judge James A. Yates last week sentenced William Gilman, a former managing director and executive marketing director in Marsh's Global Broking unit; and Edward J. McNenney, a former managing director and global placement director. Both had been indicted on various counts of bid rigging and fraud by then-New York Attorney General Eliot Spitzer in connection with his probe of Marsh. Judge Yates in February found the men guilty of violating the New York's Donnelly Act in rigging bids for coverage but acquitted them of all other charges.

See **IN BRIEF** page 26

BENEFITS MANAGEMENT

WELLNESS PROGRAMS

Lines blur in wellness and disease management services; ranking of the largest disease management providers; health coaches tackle risks and goals; successful wellness



plans require advance analysis; incentives must comply with federal rules; ROI remains elusive. **PAGE 9**

Brandon steps down as Gen Re chief

Departure of top executive seen as clearing way for reinsurer to resolve federal investigation

By **SALLY ROBERTS**

STAMFORD, Conn.—Joseph P. Brandon's resignation from General Re Corp. last week likely marks the end of the government's criminal investigation into the company and its chief executive over any role they may have played in helping American International Group Inc. inflate its loss reserves with a pair of sham reinsurance transactions, legal experts say.

Gen Re and Mr. Brandon have not been charged in the case but neither is completely off the hook, observers say. Both could still face charges or penalties from the U.S. Securities and Exchange Commission, which filed civil charges against five former Gen Re and AIG

executives following their federal grand jury indictment in February 2006, they say.

Gen Re parent Berkshire Hathaway Inc. gave no reason for Mr. Brandon's departure April 14, saying only that Gen Re President Franklin Montross IV will succeed him as chief executive officer.

Observers last week said they expect a smooth transition and that Mr. Montross is a capable leader for the reinsurer (see story, page 25).

Berkshire Hathaway, Gen Re, Mr. Brandon and his attorney all declined to comment. Federal prosecutors involved in the Gen Re case did not return calls.

Observers say federal prosecutors likely pushed the reinsurer into ousting Mr. Brandon in return for

closing the case against him and Gen Re.

In February, five executives from Gen Re and AIG, including former Gen Re CEO Ronald E. Ferguson, were convicted of conspiracy and fraud and are awaiting sentencing in May (*BI*, March 3; www.BusinessInsurance.com/GenReTrial).

During the trial, prosecutors identified Mr. Brandon, who succeeded Mr. Ferguson as CEO in 2001, as an unindicted co-conspirator who was kept apprised of the deal's development and approved a series of wire transfers that prosecutors charged were designed to conceal AIG's payment of \$15 million to Gen Re for the transaction.

See **GEN RE** page 25



LANDOV

Former General Re Corp. CEO Joseph P. Brandon resigned last week without explanation.

House panel advances 401(k) disclosure bill

Employers concerned about new liability, duties

By **JOANNE WOJCIK**

WASHINGTON—Although a bill that would require greater disclosure of 401(k) plan fees is unlikely to become law this year, the issue is expected to remain in the forefront as lawmakers become increasingly concerned about the viability of the plans that have become the mainstay of most retirement income.

Regardless of whether any legislation is enacted, experts say plan sponsors and administrators still would be subject to greater fee disclosure under new Labor Department regulations under development.

On a 25-19 party-line vote, the House Education and Labor Committee last week approved the 401(k) Fair Disclosure for Retirement Security Act, which would greatly increase fee disclosure and effectively mandate that plans offer at least one low-cost market index fund.

Plan administrators would have to disclose in four distinct categories: plan administrative and record-keeping charges, transaction-based charges, investment management charges and other charges as they may be specified by

See **401(k)** page 24

HSA reporting rule faces uphill struggle

Bush threatens veto of House-passed plan

By **JERRY GEISEL**

WASHINGTON—Legislation that would force banks and others to substantiate how money is spent in the health savings accounts they administer cleared one Congressional hurdle last week but looks unlikely to make it into law this year.

While the House of Representatives passed the measure mainly along party lines, the Bush administration has threatened a veto and observers say the measure is unlikely to pass the Senate.

But the measure, which would increase HSA administrative fees and could lead some banks to withdraw from the HSA trustee market, is far from dead.

The HSA provision was attached to a broader tax bill, H.R. 5719, approved first by the Ways and Means Committee and then by the full House.

Both votes were fairly close—the Ways and Means Committee cleared the measure by a 23-17 margin and the full House voted 238-179 in favor of the plan, with near-

ly all Republicans opposed and virtually all Democrats in favor of the legislation.

Passage of the legislation came after a spirited debate on the House floor. For example, Rep. Ed Royce, R-Calif., warned that a substantiation requirement could cripple HSAs.

"Health savings accounts were created to reduce the growth of health care costs. And they have achieved some noteworthy successes. But this bill is going to increase health care costs for individuals by crippling HSAs," he said.

On the other hand, proponents said substantiation is needed to ensure that distributions, in fact, are to pay for health care expenses.

"We ask that there be some verification to show the money withdrawn was spent for health care. That's all. What drives us to this is a report that we had from one account manager that shows these funds being withdrawn for everything from body shop repair to fast food restaurants," said Rep. Earl

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Are you ready to generate the greatest value from your casualty risk program?

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managing director
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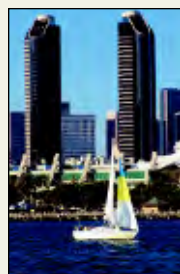
AON RISK SERVICES

On the Web

RIMS 2008

Preview upcoming RIMS conference online

Business Insurance's online preview of the 2008 Risk & Insurance Management Society Inc. conference in San Diego



features an overview of the conference itself, as well as a preview of what San Diego has to offer. Expanded

features include video interviews, a slideshow of attractions in and around San Diego and a PDF of San Diego-area restaurants. Go to www.BusinessInsurance.com/RIMS2008.

THIS WEEK IN BI

Podcast takes you behind the BI headlines

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Business Insurance®

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Lawmaker seeks federal insurance info office

Operation would gather, analyze data, report to Treasury

By MARK A. HOFMANN

WASHINGTON—Insurance industry backers of a bill that would create a federal office of insurance information within the Treasury Department want lawmakers to judge the measure on its own merits rather than viewing it as a stalking horse for broader federal insurance regulation.

They hold that the Insurance Information Act of 2008—introduced last week by Rep. Paul Kanjorski, D-Pa., chairman of the House Financial Services Committee's Subcommittee on Capital Markets,

Insurance and Government Sponsored Enterprises—is necessary to provide needed insurance expertise at the federal level.

But opponents of an optional federal charter view it as a step toward broader federal regulation.

The measure—H.R. 5840—calls for the creation of a new Office of Insurance Information that would collect and analyze data on insurance; advise the Treasury secretary on major domestic and international policy issues; report to Congress every two years; establish federal policy on international insurance matters; and ensure that state insurance laws remain consistent with federal policy in coordinating international trade agreements.

The bill would also establish an advisory group to help inform and advise the head of the office. Those



Rep. Paul Kanjorski, D-Pa., last week introduced a bill to create a federal Office of Insurance Information.

represented in this group would include state regulators, consumer groups and others in the insurance industry.

The office would function in many of the same ways as the office of insurance oversight that the Treasury Department advocated in its March 31 blueprint for financial services regulatory reform (*BI*, April 7).

H.R. 5840 enjoys bipartisan support as well as support within the industry.

"I think this was a big surprise and I think this was a terrific one," said Joel Wood, senior vp of the Council of Insurance Agents & Brokers, which backs the OFC. "There are few creative and bold acts of leadership that transform the dynamics of any insurance regula-

See **REGULATION** page 25

Measure would let RRGs write property coverage

Expansion would be first for facilities since 1986

By JERRY GEISEL

WASHINGTON—The nation's risk retention groups would be able to provide property insurance to member-owners under bipartisan legislation introduced last week in the House of Representatives.

The long-awaited legislation, introduced by Reps. Dennis Moore, D-Kan., and Deborah Pryce, R-Ohio, would be the first expansion of the Liability Risk Retention Act since 1986 when federal lawmakers amended the original 1981 law that gave RRGs their special status.

The original law that authorized risk retention groups was a delayed congressional response to the market crisis in the late 1970s when panic pricing in the commercial market led to huge product liability insurance premium increases. The legislation preempted state licensing requirements to ensure that after being licensed in one state, an RRG could immediately provide coverage to policyholders in any state.

Only a handful of RRGs were established due to the limited coverage they were allowed to write: product liability and completed operations coverage.

But the 1986 expansion allowing RRGs to provide all commercial casualty coverages except workers compensation led to a huge increase in the number of RRGs. Currently, 255 RRGs are operating, up from 177 in 2004 and 65 in

2000, according to the Risk Retention Reporter, a Pasadena, Calif.-based publication that tracks the industry.

Industry experts say allowing RRGs to provide property coverage will lead to a big expansion of the industry. Larry Mirel, a former District of Columbia insurance commissioner and now a partner with Wiley Rein L.L.P. in Washington, told a congressional subcommittee last week that such an expansion would lead to a doubling of the amount of premiums RRGs write over the next few years. Last year, RRGs generated about \$2.7 billion in premiums, according to the Risk Retention Reporter.

"There is demand for property coverage," said Robert Myers, general counsel for the National Risk Retention Assn. and a managing partner with Manning, Morris & Martin L.L.P. in Washington.

While conditions have improved recently in the property market, passing legislation to allow RRGs to fund the coverage will ensure that the groups will be ready to provide the coverage when the next crisis hits, said Larry Smith, a director of the Self-Insurance Institute of America and vp-risk management services in Columbia, Md., for Medstar Health Inc., which operates eight hospitals in Maryland and the District of Columbia.

The legislation has bipartisan



Reps. Dennis Moore and Deborah Pryce introduced a bill expanding the coverage that can be written by RRGs.

MAJOR MANAGED CARE ORGANIZATIONS: FULL YEAR 2007 RESULTS

Ranked by net income. Dollar figures in millions.

Company	2007 Net income	Percent Increase (Decrease)	2007 Revenues	Percent Increase (Decrease)
UnitedHealth Group	\$4,766.0	15.0%	\$75,431	5.0%
WellPoint Inc.	3,345.4	8.1	61,134.3	7.2
Kaiser Permanente	2,200.0	57.1	37,800.0	9.9
Aetna Inc.	1,831.0	8.0	27,599.2	10.0
CIGNA Corp.	1,115.0	(3.5)	17,623.0	6.5
Humana Inc.	833.7	71.0	25,289.9	18.1
Coventry Health Care Inc.	626.1	15.0	9,880.0	28.0
Health Net Inc.	200.2	(39.0)	14,100.0	9.3

Top managed care firms see profits rise in 2007

Tougher times ahead as medical costs grow in competitive market

By GLORIA GONZALEZ

NEW YORK—Major managed care companies posted sizeable profits last year, but several insurers already are experiencing profitability challenges this year.

Marketplace competition, though, is expected to deter efforts to raise commercial premiums significantly, analysts say. Commercial enrollment, meanwhile, will continue to be pressured as many employers reduce their workforces.

Medical costs and rate hikes hovered in a 6% to 8% range in 2007, a trend that had been expected to continue into 2008.

WellPoint Inc., though, reported recently that its overall trends in 2007 were about 0.5% higher than previous estimates just below 8%. The Indianapolis-based insurer—the largest U.S. managed care company by membership—also reported that its 2008 medical cost trends

for its commercial business are running higher than expected.

"We just know that we had it understated and that that was reflected in the pricing to date," Angela Braly, WellPoint's president and chief executive officer, said during a March conference call. "We know now that we are assuming a higher trend, and we're going to stick with disciplined pricing in our products going forward. And because we have the opportunity to price our products throughout the year, we're going to do that with discipline and with the higher claims projected than we had had in 2007."

In response, WellPoint reduced its earnings guidance for 2008 to 4% to 8% growth compared with 2007. In December, WellPoint had said it expected 15.3% net income growth in 2008.

"That was a little disappointing in early 2008," said Bradley Ellis, director at Fitch Ratings in Chicago. "We anticipate they will be able to straighten that out through the rest of the year."

See **RESULTS** page 24

See **RRG** page 23

Employers fight Florida law allowing guns in parking lots

Provision gives disgruntled workers easy access to personal firearms, raises liability risks, business groups say

By **ROBERTO CENICEROS**

TALLAHASSEE, Fla.—A Florida law that allows workers to keep guns in cars parked in company lots opens employers to more lawsuits and endangers their employees, employer groups say.

The law, which was signed last week by Gov. Charlie Crist, stops employers from banning handguns in their parking lots as long as employees and customers have a concealed weapons permit and keep their guns locked in their vehicles.

The Florida Chamber of Commerce and Florida Retail Federation say they will challenge the law in federal court arguing that it illegally

interferes with private property rights. The law is due to take effect July 1.

The National Rifle Assn. supports the law and has an ongoing drive to pass similar statutes in all 50 U.S. states. Alaska, Kansas, Minnesota and Oklahoma already have parking lot gun laws; similar legislation is pending in Alabama, Arizona and Louisiana, an NRA spokeswoman said.

About half a million Florida residents have concealed weapons permits and the new law prohibits employers from verifying who has a permit, said Chuck Magazine, speaking in his role as president of the Palm Beach Chapter of the Risk & Insurance Management Society

Inc. Mr. Magazine is also risk manager for Boynton Beach, Fla.

The RIMS chapter lobbied against the measure saying that supervisors and workers will face a greater threat of workplace violence.

Plenty of examples exist of employees who are disciplined or terminated and drive home to retrieve a weapon, Mr. Magazine said. Having a firearm closer by, in the parking lot, means there will be even less time for an angry and disgruntled employee to cool off.

"Safety just went out the window," he said.

Florida's law also prevents employers from: banning guns as a

See **GUNS** page 23

PARKING LOT GUN LAWS HAVE PASSED IN 5 STATES



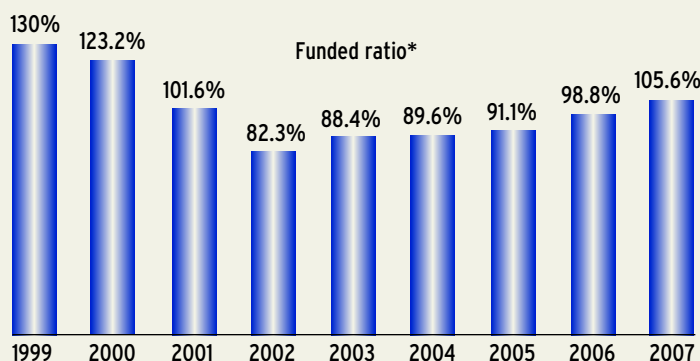
ALASKA
FLORIDA
KANSAS
MINNESOTA
OKLAHOMA

Similar legislation is pending in:

ALABAMA
ARIZONA
LOUISIANA

Source: National Rifle Assn.

HOW PENSION PLAN FUNDING LEVELS ARE IMPROVING



*Ratio of plan assets to liabilities for large employers
Source: Milliman Inc.

Pension plan funding tops 100% in 2007

But rough 2008 first quarter wipes out gains

By **JERRY GEISEL**

Aided by solid investment results and rising interest rates, large U.S. employers' pension plans were overfunded in 2007, the first time that has happened since 2001.

In the first quarter of 2008, though, investment losses and falling interest rates wiped out nearly all of last year's gains, according to a Milliman Inc. survey.

Defined benefit plans offered by 100 large U.S. employers were, on average, 105.6% funded last year, up from 98.8% in 2006, according to the survey released last week.

The Seattle-based consulting and actuarial firm analyzed financial reports of publicly held companies sponsoring the 100 largest pension programs for which full-year data was available. First-quarter 2008 funding levels are projections based on 2007 asset allocations and other factors, including changes in interest rates.

The 2007 funded ratio improvement resulted from solid invest-

ment returns and rising interest rates, which have the effect of lowering plan liabilities. On average, plans earned 9.9% on assets, higher than the 8.3% average return employers had expected.

Those factors, coupled with four consecutive prior years of double-digit investment returns, increased the average funded ratio of large employers' pension plans to the highest level since 2000, when the average funded ratio was 123.2%.

Funding levels have improved in recent years, but many pension plans still have a long way to go before reaching the levels of the late 1990s, when the bull equities market drove up the value of plan assets. In 1999, the first year Milliman began its funding survey, employers' plans were an average of 130% funded.

"Despite five years of stellar returns, we still have a bit of catching up to do," said John Ehrhardt, a Milliman consulting

See **MILLIMAN** page 6

Marsh revamps large risk division

Global reorganization effort includes new leadership structure

By **SALLY ROBERTS**

NEW YORK—Marsh Inc. is reorganizing its Global Risk Management Division in an effort to better serve its largest and most complex clients around the world, the broker was expected to announce Monday.

The changes include a new global leadership structure with regional leaders who will report to Timothy J. Mahoney, president of Global Risk Management in New York, in addition to reporting to their existing geographical heads.

The new regional leaders are: Peter Cleyne, Canada; George Davies, United Kingdom; Bruce Gordon and George Tarabaras, Pacific region; Michael Johnson, Asia; Andrew Perry, Latin America; and Bruce Trigg, Central Europe, Middle East and Africa.

Before their appointments, the regional leaders had various responsibilities within those regions for Marsh as managing directors.

Mr. Mahoney, who was named president of the Global Risk Management division in January, will serve as the division's U.S. leader on an interim basis, Marsh said in a statement.

"Our large multinational clients now more than ever are demanding that we operate as a seamless global team that provides consistent deliverables whether it's service standards or insurance program administration," Mr. Mahoney said. "I've identified key



Mr. Mahoney

leaders to run the risk management business...typically defined as companies that have annual sales of greater than \$500 million, who will be responsible within their regions for managing the large-account business," he said.

Within those regions, Marsh also has created a new Multinational Practice, which is responsible for coordinating the broker's delivery of insurance brokerage and risk consulting services for clients operating all over the world, Mr. Mahoney said. Howard B. Whitmore, former-

See **MARSH** page 6

Willis rolls out insurer rating tool to measure quality, claims response

Broker says system helps risk managers judge insurer service

By **REGIS COCCIA**

LONDON—Clients of Willis Group Holdings Ltd. this week will have complete access to a new global benchmarking tool for insurance companies.

Willis on Monday unveiled the Willis Quality Index to assist clients in measuring insurer performance in serving their needs and responding to claims. The London-based brokerage began developing its index about two years ago with the help of client advisory councils in

the United Kingdom and United States.

"We're very conscious of the need for transparency and improving service at Willis, and we've very much thrown down the gauntlet that we want to improve service in the industry for our clients," said Sally Bramall, managing director of global carrier management at London-based Willis.

In addition, "we've challenged risk managers that if they want quality service and performance from their carriers, they need to make decisions based not just on

37 days

AVERAGE TIME:
to deliver an insurance
policy in the United
States compared with

25 days

in the United Kingdom

price," she said. "We're trying to encourage clients to look beyond 'price and prejudice'" when it comes to insurers and to "recognize that there is a huge variety of performance among carriers around the world."

While Ms. Bramall noted that other efforts have focused on measuring industry quality in different areas, Willis considers its quality index to be the first by a broker to "look at the full range of service for our clients."

See **QUALITY INDEX** page 6



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—Karen Companion, Assistant Vice President
LIU Environmental

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Tire company settles retiree health suit

Deal with union includes agreement to fund VEBA to provide benefits

By KRISTIN GUNDERSON HUNT

PITTSBURGH—Continental Tire North America has agreed to pay \$158 million into a health insurance fund for its retirees, the United Steelworkers union said Wednesday.

The agreement stems from a lawsuit filed by the USW and a class of Continental retirees after the Charlotte, N.C.-based company reduced its retiree health care benefits and implemented a \$3,000 annual cap on health care spending in March 2007.

Previously, the company had paid for 100% of retirees' health care expenses, said Mark Cieslikowski, president of USW Local 850 in Charlotte.

The lawsuit claimed the company's reduction of retiree health benefits violated federal law, and a fed-

eral judge in the Northern District of Ohio ruled in July 2007 that the company had no right to reduce or terminate benefits.

The settlement requires Continental to contribute to a voluntary employees' beneficiary association, a fund that will provide benefits to approximately 2,300 retirees and about 100 active employees who are eligible for coverage upon retirement.

The retiree health benefits are worth about \$158 million in today's dollars. According to the USW, Continental's payments to the fund will include:

- \$40 million immediately.
- \$3 million in compensation to class members for the portion of 2007 when the company's \$3,000 cap was in effect.
- \$21 million paid in seven annual installments.

• Retiree medical benefit liability payments paid over 20 years, with an approximate present value of \$94 million.

Continental Tire North America's parent, Frankfurt, Germany-based Continental A.G., is providing a corporate guarantee for \$65 million of the \$94 million in retiree medical benefit liability payments.

The settlement is waiting for approval from the court. If it becomes effective in 2008, retiree health benefits for this group will be provided through the new VEBA-funded retiree health care plan starting on Jan. 1, 2009. If the settlement becomes effective in 2009, the new plan will begin providing benefits on Jan. 1, 2010.

Continental is providing interim benefits for class members' households until the settlement is approved.

Milliman: Pension funding topped 100% last year

CONTINUED FROM PAGE 4

actuary in New York.

After the high point in 1999, funding levels began to slide, hurt first by lackluster investment results and then by investment losses. The low point came in 2002, when the average funded ratio slumped to 82.3%. Since then, funding levels have improved each year.

But the survey illustrates the volatility of funding levels. In just the first quarter of this year, nearly all of the gain racked up last year was lost due to falling interest rates and subpar investment results. Milliman estimates that plans were just less than 100% funded on average at the end of the first quarter.

Among survey employers, Detroit-based General Motors Corp. has the biggest defined benefit pension program as measured by assets. Last year, GM had \$117.4 billion in

plan assets and its defined benefit plans were 107.7% funded, up from 104.6% in 2006.

Runner-up IBM Corp. of Armonk, N.Y., had \$98.3 billion in plan assets in 2007, up from \$90.5 billion 2006. Its funded ratio improved to 112.8% from 105.3% the year earlier.

FPL Group Inc., a Juno Beach, Fla.-based energy and utility company, had the highest funded ratio in 2007 at 216.5%, up from 200.1% in 2006. Atlanta-based Delta Air Lines Inc. had the lowest ratio:

The financially troubled airline's plans were 66.1% funded, up from 60.8% in 2006, according to the Milliman survey.

Pension programs of the surveyed employers include qualified and nonqualified U.S. plans and foreign plans.

The survey, "Milliman 2008 Pension Funding Study," is available at www.milliman.com.

\$117.4 B

IN PLAN ASSETS:

General Motors Corp. had the biggest defined benefit pension program among employers surveyed.

Marsh: Broker revamps large risk unit

CONTINUED FROM PAGE 4

ly a senior executive within Marsh's global property practice, has been selected to lead that new practice.

In addition, Marsh is placing under Global Risk Management its global Industry Practice group, which comprises its construction, health care, transportation and power expertise, among other areas.

James M. Enelow, current head of the Industry Practice group, will continue to lead that operation, Marsh said.

Marsh's online client interface, MarshConnect, also will be part of Global Risk Management, Marsh said.

In addition, William D. Irle II, a senior client relations manager for Marsh, will now oversee product

management within the global division and will be responsible for developing new consultative and transactional products and services, Marsh said.

The broker also is creating a new regulatory and tax practice within the division that will provide clients with real-time information on evaluating risk and regulations around the world, Marsh said.

Quality index: Willis system focuses on insurer service

CONTINUED FROM PAGE 4

Lance J. Ewing, vp of risk management at Harrah's Entertainment Inc. in Cordova, Tenn., said Willis' effort goes beyond what he has seen from other brokers. Mr. Ewing has used a variety of brokers over the years and is a current Willis client.

"It's maybe a little spin on an old record, but not entirely" when it comes to measuring insurers, he said. The Willis Quality Index "rolls up the most important things: contract certainty, who's offering good products and helps answer the question, 'Am I going to get my claim paid?'" Mr. Ewing said.

"As a buyer, I'd rather have it (Willis' index) in my pocket than not. The more arrows in my quiver, the better my decision making," he said.

The Willis Quality Index was designed to complement, not replace, assessments by insurance rating agencies and to enhance Willis' role as a broker in helping clients make the best choices, said Ms. Bramall.

Jim Auden, managing director at Fitch Ratings in Chicago, said Willis' index may actually help Fitch and other agencies understand qualitative factors in insurer performance.

"Lots of qualitative factors go into (financial strength) ratings," he said. Willis' tool "can give us a handle from an analytical and service standpoint" as to which companies are performing well. "Companies that are financially successful do a good job of underwriting, paying claims and delivering service," Mr. Auden said.

Willis' index combines quantitative data from its internal client service systems, such as policy placement and claims data, with qualitative assessments from nearly 4,000 Willis associates worldwide, Ms. Bramall said.

Based on analysis and integration of results, a five-star rating system is applied to insurers, and Willis' Client Advocates will use the tool to create customized reports for clients, she said.

Updates

Going forward, the Willis Quality Index will be updated monthly with quantitative data and biannual qualitative surveys within Willis, and will become "more granular" in terms of performance in specific product lines, for example, she said. Results of the biannual surveys are shared with the insurers as well.

To ensure transparency and consistent collection, analysis and sharing of data, Willis has engaged a third-party firm to audit its processes, Ms. Bramall said.

Insurers have responded positively to Willis' initiative, she said.

"Markets want to sell on service excellence and quality; they don't just want to sell on price," Ms. Bramall said. "They're very positive and enthusiastic about any initiative that encourages decisions based on service quality."

Mr. Ewing said insurers will pay heed to the Willis Quality Index. "Carriers will take notice, especially now that we're in a soft market," he said. "When they're all competing to attract and retain business, they pay attention to any rating information out there."



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Business Insurance OPINIONS

Insurance legislation would fill major void

THERE'S A LOT TO LIKE about the Insurance Information Act of 2008 that Rep. Paul Kanjorski, D-Pa., introduced last week.

If it were to become law, the bill would fill a void of insurance knowledge and expertise that currently exists at the federal level. In addition, the Office of Insurance Information that the bill would create within the Treasury Department could give insurers—and their customers—a federal advocate that they currently lack.

As he announced the planned bill introduction last week during a hearing on insurance regulation, Rep. Kanjorski noted that it has been apparent to him since the aftermath of the Sept. 11., 2001, terrorist attacks “that the federal government lacks the expertise it needs on insurance policy.” Events since then have only reinforced his belief, he said.

When lawmakers need expertise on securities, they can summon the chairman of the Securities and Exchange Commission or one of his deputies to discuss issues affecting that industry. Other agencies oversee other industries, but there is nothing comparable for the insurance industry.

Creating an Office of Insurance Information also would allow Treasury and other federal officials dealing with trade issues to tap the knowledge of in-house experts. In addition, one of the powers of the OII would be to establish federal policies for international insurance issues and ensure that state insurance laws remain consistent with federal policy in coordinating international trade agreements.

When it comes to insurance issues, ignorance is not bliss. Swift enactment of the Insurance Information Act would help assure that such ignorance is replaced with knowledge and expertise at the federal level.

When it comes to insurance issues, ignorance is not bliss.

Parking lot gun rule ignores real safety issue

A FLORIDA LAW prohibiting employers from banning guns locked in employees' vehicles in employer's parking lots has triggered widespread concern.

As we report on page 4, employer groups, risk managers and safety organizations oppose the law, saying it could increase workplace violence. The National Rifle Assn., which is promoting similar statutes in other states, says employers should not be able to micro-manage “the lawful contents of privately owned” vehicles, even on a business' property.

We see logic in the arguments of both sides. Easy access to weapons could make violent attacks more likely. But employees who have been victims of crimes or threats have a right to protect themselves, too.

Florida's law requires gun owners to have permits to carry concealed weapons, and the guns must be locked in vehicles. Obtaining such a gun permit has more stringent requirements than many believe. Training, criminal background checks and waiting periods are required. Laws bar the issuance of permits to anyone convicted of a felony or who has been treated at a mental health care facility.

Risk, in the workplace or outside it, cannot be eliminated. Personal responsibility is the only way to ensure public safety. We think Florida and the NRA should focus more on enforcing existing gun laws and promoting responsible gun ownership than adding to public fears.



Letter to the Editor

HSA debit cards differ from those for FSAs

TO THE EDITOR: In the April 14 editorial “HSA Proposal Lacks Basic Common Sense,” an untrue statement was made about health savings account debit cards. It says, “After all, HSA-linked debit cards that employees receive to pay expenses typically are programmed so they can’t be used to pay bills not related to health care.” This is only true for flexible spending account debit cards—not HSA debit cards. In fact, HSAs operate similarly to an individual retirement account.

A withdrawal can be made for any nonmedical reason or expense as long as the money is put back into the account within 60 days. It’s called the “playing with fire” rule for obvious reasons.

We see rampant misuse of HSA debit cards for nonmedical expenses, especially when there is an employer contribution to the HSA.

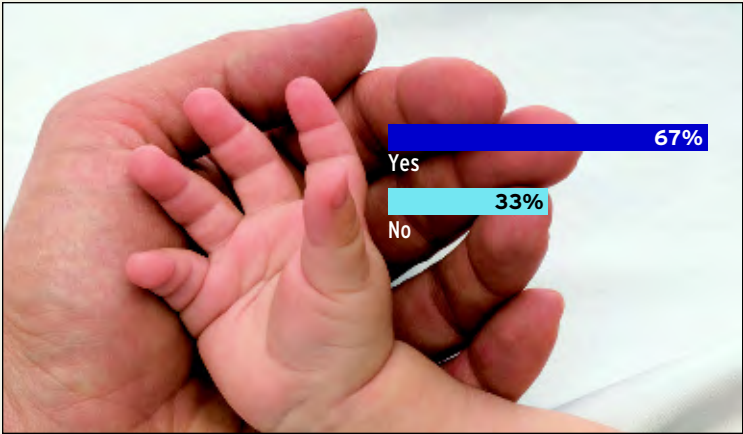
Jack Morris
C&J Consulting & Administration Inc.
Chattanooga, Tenn.

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Online Poll at www.businessinsurance.com

Do you think new state laws creating employee-funded programs that give employees paid time off after childbirth or to take care of ill family members are good public policy?



NEXT WEEK'S POLL: Who should determine whether a chief executive officer under investigation for wrongdoing but not indicted should leave his or her job?

B/I Online Poll tool sponsored by Wausau Insurance Cos.

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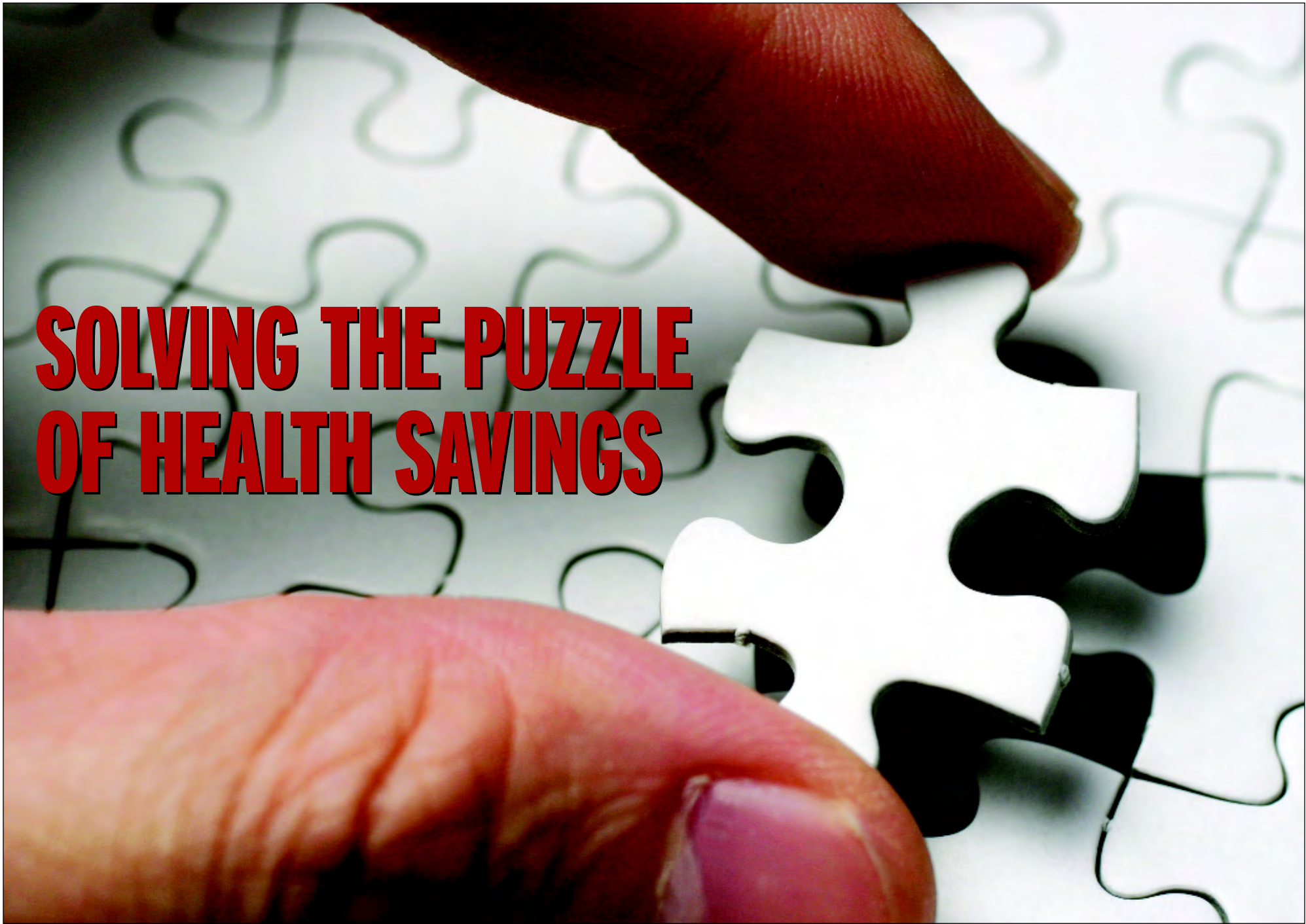
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Largest disease
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remains elusive**
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BENEFITS MANAGEMENT



SOLVING THE PUZZLE OF HEALTH SAVINGS

Lines blurring in wellness, disease management services

Proponents say integrated approaches will lower administrative costs, improve employee health status

By **JOANNE WOJCIK**

With wide acceptance of a link between lifestyle and the onset of chronic illness, disease management firms are incorporating wellness and health promotion into their traditional service model.

Unlike a more fragmented approach in which wellness and disease management services are provided by separate companies, usually to different groups of plan members, an integrated approach puts all plan members together so they can access both services

regardless of health status.

The objective is to keep healthy people healthy, reduce the risk factors among at-risk members and improve the health of those who already have chronic conditions by encouraging them to make lifestyle changes that wellness programs promote.

Some experts also say bundling wellness and disease management programs will save employers money, both through lower administrative costs and lower health care costs made possible by improvements in employee health status.

"I think that wellness is being focused almost exclusively on the well. People are missing the fact that for somebody who's already manifestly ill with a chronic disease, there's insufficient emphasis" on wellness, said Dr. Lonny Reisman, chief executive officer of New York-based ActiveHealth Management Inc. "For example, a diabetic may not be learning about diet and exercise" in a traditional disease management program.

By managing patients holistically, rather than treating each disease separately, it may be possible to improve their health, he said.

"The wellness notion needs to extend from cradle to grave, helping you to get as well as you can possibly be given your underlying physiology and pathology," Dr. Reisman said. "You may not be able to cure your diabetes, but how can you become as well as you can given your limitations?"

This evolution toward an integrated approach is blurring the lines that once separated wellness from disease management providers. The Disease Management Assn. of

See **INTEGRATED** page 12

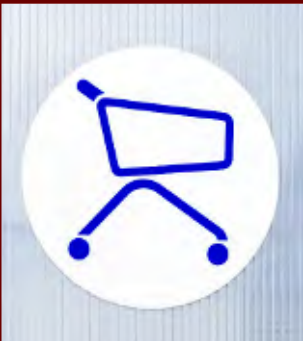
Largest disease management service providers

Ranked by total covered lives in 2007

Rank	Company/Address	Phone/Web site	2007 total covered lives*	2007 total clients	2007 total staff	Principal officer
1	OptumHealth 6300 Olson Memorial Highway, Golden Valley, Minn. 55427	888-262-4614 www.optumhealth.com	41,535,701	10,000	993	Dawn Owens, CEO
2	Alere Medical Inc. ¹ 595 Double Eagle Court, Suite 1000, Reno, Nev. 89521	888-802-5373 www.alere.com	32,000,000	55	727	Dr. Ron Geraty, president
3	CIGNA HealthCare 900 Cottage Grove Road, Hartford, Conn. 06152	860-226-6000 www.cigna.com	6,600,000 ²	6,300	670	Keith Dixon, president-Health Solutions unit
4	ActiveHealth Management 102 Madison Ave., New York, N.Y. 10016	212-651-8200 www.activehealth.net	2,500,000	36	173	Dr. Greg Steinberg, executive vp/ chief medical officer
5	Avidyn Health 1 Hanover Park, Suite 500, 16633 Dallas Parkway, Addison, Texas 75001	214-920-9076 www.avidynhealth.com	806,048	375	68	Chris Thomas, senior vp/COO
6	Qualis Health 10700 Meridian Ave. N., Suite 100, Seattle, Wash. 98133	206-364-9700 www.qualishealth.com	401,449	34	31	Dr. Jonathan R. Sugarman, president/CEO
7	American Health Holding Inc. 100 W. Old Wilson Bridge Road, Worthington, Ohio 43085	866-614-4244 www.americanhealthholding.com	375,000	351	25	Michael Reidelbach, president/CEO
8	Managed Care Concepts Inc. 7250 N. Cicero Ave., Lincolnwood, Ill. 60712	800-732-1299 www.managedcareconcepts.com	50,000	45	25	Karen Andelman McIntyre, president
9	U.S. Preventive Medicine Inc. ³ 3030 Hartley Road, Suite 290, Jacksonville, Fla. 32257	866-713-1167 www.uspreventivemedicine.com	11,400	10	40	Frederic S. Goldstein, president/COO

*Includes all eligible lives. 1 Includes ParadigmHealth Inc., which was purchased by Alere Medical's parent, Inverness Medical Innovations Inc., in December 2007. 2 Estimated. 3 Formerly Specialty Disease Management Services Inc.
Researched by Kevin Edison and Karen Tucker
Source: BI survey

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Integrated: Companies blend wellness, disease management services

CONTINUED FROM PAGE 9

America, saying it was reflecting that market direction, changed its name last fall to DMAA: The Care Continuum Alliance.

"We've gone from the siloed approach to the multidisease approach to expansion into the wellness area with the recognition that people don't just suddenly one day get diagnosed with diabetes," said Tracey Moorhead, president and CEO of the Washington-based DMAA. "There are a lot of things that happen in their lives that lead up to a diagnosis of diabetes or another chronic condition."

"We changed the name of the organization to better represent this full set of services ranging from wellness and prevention all the way through to chronic disease management to palliative end-of-life care and complex case management, which is at the other end of the spectrum," Ms. Moorhead said.

To provide integrated wellness and disease management services, disease management providers have either built their own integrated platforms, acquired them or partnered with wellness providers, said Patricia Curran, director, national health management at Buck Consultants L.L.C. in Washington.

'It's five times more cost-effective to keep the healthy people healthy than to just focus on managing the diseases of those who are already sick.'

Dr. Robert Jacqmin,
Hewitt Associates Inc.

Major insurers, such as Aetna Inc., have been working internally on integration.

"When we developed the disease management program, it was developed so that it could be integrated," said Sherry Brodeur, McLean, Va.-based head of program design and sales support for medical operations for Aetna. "We also launched a new wellness program on April 1 that is also focused on integration."

Louisville, Ky.-based disease management provider SHPS Inc. recently unveiled a "person-centric" delivery model dubbed Carewise that assesses the health status of an entire employee population

through health risk assessments and biometric screenings and then works to mitigate the risk factors that it identifies in each individual on a one-on-one basis.

"If you are trying to engage a member who has a clinical condition, smokes and is overweight, you can't be asking the person to participate in three separate programs. You're going to overwhelm the member," said Krishnan Sastry, executive vp, strategic product development at SHPS.

"SHPS starts with the member and looks at the risk holistically. We have an ability in our platform and processes to adjust how we reach out to the member to yield best possible outcome," he said. This is done by "prioritizing the risks, using a consistent method of communicating with the member and by being able to address both clinical and lifestyle risks in a tightly co-managed process."

Bob Queyrouze, internal consultant-compensation/benefits/health and productivity management at the Federal Reserve Bank of Dallas, likened the merging of disease management and wellness to the evolution that has occurred in employee assistance programs.

"They historically addressed psychological problems. But today, EAPs have branched out into work/life. In fact, the most used part (of EAP services) is work/life benefits, not psych, such as elder care, day care, tuition assistance. There's a very similar evolution occurring in wellness and disease management. They've combined to become a holistic program," Mr. Queyrouze said. In fact, "our EAP is also combined with our wellness and disease management programs."

Combining disease management with wellness has a twofold benefit for employers, said Bill Reed, president and CEO of Wilkes-Barre, Pa.-based AllOne Health Group Inc., a disease management provider formed in 2002 to provide integrated health and information services.

Because combining the programs generally lowers administrative fees, "the cost is more economical than the individual siloed approach," Mr. Reed said. "But the bigger issue is the outcome impact. The integrated approach produces better outcomes."

"One of the mistakes that have been made heretofore is focusing on the high-cost population, ignoring the majority of the population who are either healthy or at-risk and who will become high-cost claimants in the future," said Dr. Robert Jacqmin, Eagle, Colo.-based senior clinical consultant at Hewitt Associates Inc.

However, "it's five times more cost-effective to keep the healthy people healthy than to just focus on managing the diseases of those who are already sick," Dr. Jacqmin said, citing research by Dr. Dee Eddington, director of the Health Management Research Center at the University of Michigan.

Therefore, combining wellness with disease management should reap even greater savings for employers, Dr. Jacqmin said.

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Wellness, disease management converging

Leading-edge employers about four years ago began asking their disease management program providers to apply the same approach used for chronic conditions to the rest of the workforce, becoming a major factor in the integration with wellness programs, said Chris Coloian, vp, health advocacy products, at CIGNA Healthcare, a division of CIGNA Corp. based in Bloomfield, Conn.

"As they looked at what was working in the positive engagement of folks with chronic conditions, they realized that that same kind of approach, but less clinical and more behavioral and educational, could benefit the at-risk or healthy," Mr. Coloian said.

At U.S. Preventive Medicine Inc. in McKinney, Texas, "many clients were asking for a prediabetes and a prehypertension program," said Fred Goldstein, president and chief operating officer.

To fulfill this need, Mr. Goldstein's company, Specialty Disease Management Services, merged with U.S. Preventive Medicine last October. Then the combined company launched its

Prevention Plan pilot program in March using one large and one midsize employer as test subjects, he said.

The program will be expanded nationwide in the second quarter of this year, he said.

"We consider prevention both primary and secondary: first, to

'It's really about prevention for everyone, no matter where they are on the continuum of health.'

Andrew Scibelli, FPL Group Inc.

keep somebody from getting a preventable condition and, secondarily, to keep someone who has a chronic condition from getting worse," Mr. Goldstein said. "It's really about prevention for everyone, no matter where they are on the continuum of health."

Juno Beach, Fla.-based FPL

Group Inc. became one of the first employers to adopt an integrated approach to wellness and disease management back in 2000, said Andrew Scibelli, manager-employee health and well-being at the parent company of Florida Power & Light.

"We have based our program philosophy on a continuum of care," he said. "At one end of the spectrum, you have the apparently healthy individuals; at the other, end you have more of the catastrophic illness, your accidents, your cancer and things like that."

Between the extremes "are those with chronic diseases and the high-risk population that has exhibited those risk factors that indicate a high probability of future illness," Mr. Scibelli said.

"Natural flow suggests that, during your lifetime, you are going to go back and forth on that continuum," he said. "So we developed the model to provide services, resources and programs to individuals no matter where they fell on the continuum. It's really a total concept of total health and well-being."

—By Joanne Wojcik

Health coaches tackle both risks and goals

Programs, expertise and cost vary widely

By KAREN PALLARITO

Legendary Green Bay Packers Coach Vince Lombardi once described winning coaches as the ones who "get inside their player and motivate." That's good advice for the gridiron, but does it play in the workplace?

You bet, say providers of health coaching, a field that has blossomed as employers grapple with the impact of preventable health conditions on health care costs and productivity.

Health coaching is becoming a mainstay of employer wellness initiatives.

"We become the little voice on your shoulder that's saying, 'Now, we know what we're supposed to do. Let's set some goals,'" said Roger Reed, executive vp at Gordian Health Solutions Inc. in Franklin, Tenn. "It's almost a personal trainer approach."

IASIS Healthcare L.L.C., an owner and operator of acute-care hospitals also headquartered in Franklin, joined the health coaching bandwagon when it hired Gordian to counsel its medical plan partici-

pants beginning in 2006.

Russ Follis, the hospital system's vp of human resources, said the rationale was twofold. "If we can get less claims coming in by having healthier employees, it'll end up saving us money in the long run in terms of our health plan benefit costs," he said. Secondly, "we are a health care company, and promoting healthy lifestyles just seems the appropriate thing to do."

A growing number of employers are joining the fray. A joint National Business Group on Health/Watson Wyatt Worldwide annual survey of employer-sponsored health programs found that 60% of large U.S. employers offered health coaching in 2007, a 7% increase from 2006.

"Employers are concentrating more on how to keep their healthy people healthy," said Diane Murphy, senior health and productivity consultant in Watson Wyatt's Minneapolis office.

Health coaching has gained traction as employers ramp up efforts to tackle workers' multiple health

See **COACHING** page 16

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Coaching: Enhances wellness offerings

CONTINUED FROM PAGE 14

risks, including physical inactivity, stress, tobacco use and obesity. The concept builds on research led by Dee Eddington, director of the University of Michigan Health Management Research Center in Ann Arbor, and others linking reduction of health risks to reduced health care costs.

"A lot of folks put their big toe in the pool of wellness" by starting a health risk assessment program, "and then they realize, 'Oh, wait. All I'm doing is finding out how sick my employees are,'" said Michele Dodds, vp of health and wellness at the Chicago-based employee assistance program provider ComPsych Corp., which offers health coaching.

Many health care providers are adding coaching to their mix of services. New York-based WebMD Health Corp. added a health coaching capability when it purchased Indianapolis-based Summex Corp. in 2006. Louisville, Ky.-based Humana Inc. launched a new wellness program, including a coaching component, last June through its Fort Worth, Texas-based CorpHealth Inc. subsidiary. The British United Provident Assn., a London-based provider of health care services, entered the coaching business with its acquisition last December of Boston-based Health Dialog Inc.

There is tremendous variability among health coaching programs (see sidebar). The better ones hire highly trained health professionals, such as physician assistants, nurse practitioners, exercise physiologists

and registered dietitians, wellness experts say. A health education or coaching credential often is required, since the coach's main role is to help employees assess their risks and set achievable goals for improvement. The frequency of health coaching typically depends on the number and severity of a person's health risks. A higher-risk individual may need monthly sessions.

To create a seamless experience for employees, a health coaching company must coordinate with an employer's health plan, disease

'Anything you can do for the health of your employees is a win for everyone.'

Russ Follis, IASIS Healthcare L.L.C.

management company and other wellness providers. It's common for these companies to physically sit around a table and craft a plan to refer employees to the appropriate service.

Coaching often is conducted over the phone to cater to an employee's schedule. "It's more convenient, more accessible and it's actually less costly to provide the service via telephone," said Dr. Neil Gordon, chief medical and science officer for Nationwide Better Health in Columbus, Ohio.

In contrast, Marathon Health, a Colchester, Vt.-based health ser-

vices company, has its coaches counsel employees face-to-face at the worksite. Having a physical presence boosts employee engagement, with participation rates of 70% to 75%, said Chuck Reuter, the company's president.

Fees vary widely, depending on an employer's size and the mix of health coaching services offered.

- ComPsych said its programs cost 65 cents to \$1.25 per employee per month.

- Nationwide Better Health said an employer can spend an average of \$100 to \$250 per participant per year, or roughly \$8 to \$21 per employee per month.

- Marathon Health charges approximately \$10 to \$15 per employee per month.

As for return on investment, there is limited data so far on the efficacy and cost effectiveness of health coaching, said Susan Butterworth, director of health management services of Oregon Health & Science University in Portland, based on a comprehensive review of research to date.

At Fiserv Inc., a large financial services company, the jury is still out on health coaching. In two small pilot projects—one that lasted 12 weeks and another that lasted five months—obese employees lost an average of just seven pounds in each test. Because of the weight loss, "I'm not going to say this wasn't successful," said Linda Schuessler, manager of wellness promotion in Brookfield, Wis., for Fiserv. For now, though, the company is focusing on increasing opportunities for physical activity, she said.

In the meantime, IASIS saw \$1.1 million in health savings from reduced claims frequency and costs in 2007 vs. the prior year, due largely to the company's Healthy Steps wellness program along with health coaching, Mr. Follis said.

"Anything you can do for the health of your employees is a win for everyone," Mr. Follis said.

Successful wellness plans require advance analysis

By KAREN PALLARITO

As someone who evaluates health improvement programs for a living, Ariel Linden, president of Linden Consulting Group in Hillsboro, Ore., has seen many missteps.

One client threw in the towel after it could not prove that employee behavior had changed. The company did not determine whether the health coaches were properly trained, and it wasn't motivating employees to participate, Mr. Linden said. What's more, union leaders failed to recognize the value to employees and were discouraging workers from participating.

Before hiring a company to provide health coaching to employees, wellness experts recommend thoroughly evaluating the program and the provider.

Assess the potential savings. Ask a provider how it plans to save you money. If the answer is through reduced hospital admissions, find out how many admissions your company currently has, Mr. Linden said.

Look into the exact categories of savings, the number of employees who will generate that savings and the time frame for achieving a return—all of which should be measured against health care spending before implementing a coaching program.

If a provider promises a steep or speedy return on investment, be skeptical. There aren't enough large-scale studies to demonstrate such savings. In seeking a health coaching provider, Blue Shield of California identified six serious contenders.

Of those, "only one really tried to show that they had established direct, claims-based savings," said Dr. Andrew Halpert, senior medical director of the 3.2 million-member plan. Blue Shield did not choose that vendor and instead selected WebMD L.L.C. in which the primary focus was improving consumers' health over time, which could result in future claims savings, he said.

Evaluate the coaches and methodology. Find out how health coaches are trained, credentialed and supervised. Know what techniques they will use. "Motivational interviewing" is the only scientifically validated coaching method to facilitate behavioral change, said Susan Butterworth, director of health management services at Oregon Health & Science University in Portland. Many providers are

becoming interested in integrating the approach into their interventions, but few have provided the training and follow-up necessary to bring their coaches to a truly proficient level, she said.

Communicate it. Ohio State University's wellness program is widely recognized and well-received among employees. The university spent "a considerable amount of time" communicating it, said Gretchen Feldmann, communications manager in OSU's Office of Human Resources in Columbus.

Yet the health coaching component that was launched in August 2006 has garnered mixed reviews. One group of OSU employees uses, understands and enjoys the program; the other group doesn't quite understand that it is voluntary, and some see it as invasive, she said. The remedy: a targeted communications campaign to be rolled out before open enrollment this fall.

OSU will solicit employee "testimonial champions" who are willing to share personal stories of success with a health coach, Ms. Feldmann said.

Engage employees. Start by giving employees incentives to take a health risk assessment, Mr. Linden said. Once health risks are identified, the coaching provider can help determine who needs such help and how often. Incentives can boost participation in health coaching.

At OSU, employees can earn \$120 in premium reductions a year for undergoing a health risk assessment, plus up \$125 a year in cash for participating in preventive-care services, including \$25 for participating in sessions with a health coach.

Collect and analyze data. Larry Chapman, senior vp at WebMD Health Services in Seattle, said employers should use quantitative and qualitative measures for "lifting up the hood" and "seeing exactly what's going on in the engine" of their health coaching provider. Questions to ask include: Has there been a reduction in the number of risk factors or in the severity of risk per employee? Is there a difference over time in per capita claims costs of employees involved in coaching vs. non-participants? How do the costs of low-, medium- and high-risk employees compare?

"That change in growth rate is really one of the primary success parameters that tells you you're making a difference in the rate of growth of these people's health care costs," Mr. Chapman said.



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Wellness program incentives must comply with federal rules

By COLLEEN MCCARTHY

Companies that have been using financial incentives or other inducements as part of their wellness programs must reconsider those incentives in light of recent federal guidelines clarifying what constitutes health-related discrimination in employee benefit plans. In particular, group health plan sponsors must review wellness programs that offer rewards based on health standards to ensure they fit within legal and regulatory boundaries, benefits lawyers and consultants say.

"The minute you ask an employee to step on a scale or take a blood pressure test to be eligible for a health plan reward, you need to make sure the program is within legal limits," said Alison Earls, lawyer and chief executive officer of Atlanta-based ACE Ideas L.L.C.

In an annual survey conducted by the Washington-based National Business Group on Health and Watson Wyatt Worldwide (see box), a majority of participating companies now use incentives to motivate employees to take charge of their health, with more than half of employers tying incentives to health improvement activities while another 24% plan to do so in 2009.

While most incentives feature positive reinforcement, a growing number of companies are penalizing employees with unhealthy habits. Currently, 31% of employers offer rewards for health status factors while 6% penalize employees for poorly managing their health conditions, the survey found.

In January, Chicago-based Tribune Co. began adding a \$100 smoking surcharge to the monthly premiums of employees who smoke. That additional fee also covers any dependents of the employee who smoke.

At Marysville, Ohio-based Scotts Miracle-Gro Co., employees are charged an additional \$40 per month in premiums if they fail to take a health risk appraisal upon enrollment. Dependents covered under the plan also must take health risk assessments.

"It's definitely a growing trend among companies looking to influence behavior," said Sharon Cohen, a benefits attorney with Watson Wyatt in Arlington, Va.

The challenge for employers is to design wellness program incentives that comply with the nondiscrimination rules of the Health Insurance Portability Act as well as other federal and state antidiscrimination laws.

HIPAA prohibits group health plans and health insurers from discriminating against enrollees on the basis of health. The federal government recently issued final rules on how wellness programs could comply with HIPAA, clarifying how much employers can reward or penalize employees based on specific health results.

Wellness programs that offer rewards tied to group health premiums, contributions or benefits for meeting health standards must satisfy HIPAA nondiscrimination laws.

For example, a program that requires individuals to have a cholesterol level under 200 in order to receive a premium reduction is subject to HIPAA regulations, said Kelly Traw, an attorney with Mercer L.L.C. in Washington. However, a program that requires employees complete a health risk assessment to enroll in a plan does not discriminate based on health factors and is not subject to the regulations, she said.

To avoid violating HIPAA rules, total program rewards must not exceed 20% of the annual cost of coverage under the group health

plan and be reasonably designed to promote health and prevent disease, according to the regulations.

If a health factor makes it medically inadvisable or difficult for someone to reach a program goal, employers must offer a reasonable alternative standard or waive the standard and still provide the reward, according to the regulations. For example, a wellness program that gives a 5% premium discount to employees who have a body mass index of 24 or less must also relax the standard or substitute a different

See **INCENTIVES** next page

THE CARROT

Employers that use incentives to encourage wellness program participation:

	Cash or gift reward	Reduction in out-of-pocket expenses
For completing a health risk appraisal	32%	3%
For participating in health improvement or disease management programs	22%	7%
Participation in smoking cessation programs	18%	5%
Participation in weight management programs	19%	2%
For managing risk factors such as blood pressure, cholesterol and weight	9%	3%

Source: National Business Group on Health/Watson Wyatt Worldwide Employer Survey on Purchasing Value in Health Care

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Incentives: Rules tightened

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standard—such as walking three times a week—for a member whose doctor says meeting that standard is medically inadvisable.

"This is the kicker," Ms. Cohen said. "The guidelines say there has to be another way for members to earn the reward. Employers who are not offering reasonable alternatives are not complying with the law."

The Labor Department tightened the guidelines in December by effectively closing a loophole that some companies used to structure wellness programs to avoid HIPAA compliance. The companies developed so-called "supplemental" benefits that rewarded employees for meeting certain health standards. The Labor Department, though, clarified the rules for supplemental programs to specify that these benefits also cannot discriminate on the basis of health factors.

Employers should use caution when designing a wellness program because even if a program complies with HIPAA, it may run afoul of other federal and state laws, benefits lawyers say.

For example, a program that requires employees complete a health risk assessment to qualify for a reduction that is less than 20% of the cost of the coverage effectively complies with HIPAA but may vio-

late the Americans with Disabilities Act, which requires that participation in such programs be voluntary.

"Just satisfying HIPAA is not enough. There are a lot of other legal responsibilities," said Amy Gordon, employee benefits lawyer and partner at Chicago-based McDermott Will & Emery L.L.P.

Unless the Equal Employment Opportunity Commission publishes guidance as to what type of wellness incentive would be considered voluntary, employers and insurers should consider this area a possible red flag, she said.

In addition to federal law considerations, some state labor laws prohibit employers from providing cash incentives to change unhealthy but otherwise legal behavior, such as smoking, said Cathy Stamm, a senior associate with Mercer in Washington. A potentially unlawful program is one that offers a cash reward to employees who sign a waiver saying they have not smoked in 12 months.

"Even if the rewards are unrelated to a health plan, there is still a potential legal risk," Ms. Stamm said.

In an effort to answer employer questions about HIPAA compliance, the Labor Department has issued a wellness program checklist that is available at www.dol.gov/ebsa/pdf/fab2008-2.pdf.

Return on investment calculations for wellness programs remain elusive

Despite vague data, employers see savings in their programs

By LOUISE ESOLA

As comprehensive and sometimes costly wellness programs' popularity grows in the workplace, mainly to slow the rise in health care premiums, more companies are asking just how much they are saving in the long term.

The answer isn't easy to decipher, experts say. While many methods exist to calculate the return on investment, companies shouldn't expect precise figures and the results often enough do not translate into dollar signs.

"The ROI for wellness programs is often elusive," said Dr. Ron Leopold, New York-based national medical director and vp for Metropolitan Life Insurance Co.'s institutional business division. "Most employers today have to make the decision to invest in some wellness initiative and they shouldn't expect hard numbers to demonstrate the ROI."

Numerous studies have shown that wellness perks such as corporate fitness centers, onsite nutritionists, health counseling and disease management can positively affect health insurance claims and costs. But experts say businesses want to see the difference in their corporate bottom line.

"To expect a vendor a year later to prove they've had an impact is completely unrealistic," said Bruce Kelly, Minneapolis-based senior consultant and national leader for health data solutions with Watson Wyatt Worldwide.

It's not uncommon to help a company set up a wellness program and have the chief financial officer request an annual, or even quarterly, report on ROI almost immediately. "The expectations are set really high," Mr. Kelly said.

While many wellness consultants sell their services based on promises of return on investment, experts say most of these promises are based on studies and not actual data from the companies they serve.

Companies that create disease management programs to focus on chronic employee conditions such as high cholesterol, diabetes

or high blood pressure often expect immediate results in the form of fewer claims, he said.

"If you are talking about a program that aims to improve someone's cholesterol, it would take 15 years to see whether this improvement will prevent a heart attack," Mr. Kelly said.

Other experts say it easily could take five to 10 years from the time a company begins a wellness program before it caps or even lowers insurance premiums.

"The ROI might be out there; it's just not jumping out at you," said Mike Miele, president of Princeton, N.J.-based Apex Management Group, a division of Gallagher Benefits Services Inc. "There is no agreed-upon way to compute dollars from all these (wellness) activities."

While common practices—gathering participation figures, charting absenteeism, tracking changes in the size of medical insurance claims, to name a few—do exist to estimate how much a particular wellness program generates in overall savings, experts say many of the

Continued on next page



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practices are flawed.

For example, examining employee absenteeism may not be accurate because workers sometimes take sick days when they are not ill.

Tom Lerche, Chicago-based senior vp and practice leader for Aon Consulting's health and benefits practice, said many companies do not accurately track absenteeism among salaried employees, thus skewing any data collected on overall absenteeism.

Tracking medical claims data appears to be among the most popular ways for companies to calculate their ROI because it appears to be the most common-sense, bottom-line way to decipher a wellness program's effect on health costs, experts say.

While full of holes, the method could be reliable if companies focus on a specific set of employees and track them using data warehouses and other research methods, experts say. Among the main limitations in this approach are resources, both financial and manpower.

"What employers are going to have to do is large-scale, longer-scale studies of their programs that are based on rigorous research methods," Mr. Kelly said.

Tracking medical claims data could prove tedious, and, in some cases, may require help from an outside firm, Mr. Lerche said. "It's a matter of investment and resources," and a company would have to spend thousands of dollars over the original cost of a wellness program to calculate savings.

"To evaluate your program over a few years, you need to devote the resources," Mr. Lerche said. "There needs to be a commitment within the company over the long term. Who is going to own the responsibility of tracking data? (Human resource departments) are overstressed and have a lot to do already."

Companies also need to devote the time to track medical claims, which over time could get muddled amid employee turnover, experts say.

But that doesn't stop companies such as Pittsburgh-based health insurer Highmark Inc. and Kansas City, Mo.-based St. Luke's Health System from starting wellness programs that they say produced measurable savings even though their methodologies were less than perfect (see story, page 20).

Employees who gravitate toward wellness programs generally are healthy and "are seeking validation for what they are already doing," said Apex Management's Mr. Miele. "The people we often want to talk to are the people who hang up on us."

Many wellness programs include health risk assessments, but employees are increasingly timid in providing information regarding their health risks, experts say.

"There's such a plethora of things in the news about employers trying to keep health care costs low (and) people don't want their employers to know they are taking part in unhealthy behavior," said Don Powell, chief executive officer and president of the Farmington Hills, Mich.-based American Institute for Preventative Medicine.

To make this easier, companies can rely on tools such as the Wellness Wizard, a calculator developed by the institute. The calculator provides companies with a cost breakdown of eight common risk factors, from smoking to high blood pressure, that can affect health costs.

By plugging in the number of company employees, the Wellness Wizard uses data from seven studies and the U.S. government's National Center for Chronic Disease Prevention and Health Promotion to aggregate risks and costs.

The reports provide companies with a list of ailments and risk factors, along with the money it costs to treat individuals with such issues.

Mr. Powell said the Wellness Wizard is not entirely accurate for a company's specific population, but it does provide a glimpse of how health risks affect costs.

For example, a company with 2,000 employees spends an extra \$1.1 million in medical costs for employees who have diabetes,

according to a sample report. That same company is estimated to spend an extra \$566,031 on overweight individuals and \$187,462 on smokers.

Some companies, however, may forgo such a report and rely on common sense, say some experts who note that wellness programs have been around long enough to prove their worth beyond dollars and cents. Wellness programs have a reputation for boosting employee moral, improving absenteeism and

keeping a company competitive, they add.

"We already know that risky behaviors cost more, and if we know from literature that if we get people to change their lifestyles, change risk, then you can deduce that you have a return on investment," said Jack Bastable, Leawood-Kan.-based practice leader for health and productivity with CBIZ Benefits & Insurance Group. "In a lot of ways it's common sense: risk decrease, cost decrease."

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Employers find challenge in measuring wellness program return on investment

Highmark Inc., a Pittsburgh-based health insurer, plunged into a comprehensive wellness program for its own employees in 2002 and studied medical claims of two sets of participants for four years.

Using a sophisticated approach that tracked medical claims data and employees' own health risk assessments, it saw a \$1.65 return on investment—a total of \$1.3 million over four years—for every \$1 it spent on corporate wellness, according to a February article in the *Journal of Occupational & Environmental Medicine*.

Dr. Brian Day, Highmark's director of advanced analysis who helped oversee the study, acknowledged that the research had limits. Participation bias is among the study's possible

flaws, according to the report, in that wellness program participants may have been more motivated to manage their health than nonparticipants. The study also found some employees may have participated in wellness activities outside the workplace program.

The limitations of Highmark's study reveal another flaw in employers' efforts to calculate return on investment. The "worried well" is a term touted by consultants to describe the employee group most likely to participate in a wellness program: those who are healthy.

People who are healthy also are more likely to participate in employer-sponsored health risk assessments, another major tool

used by employers to estimate ROI.

Health assessments come in many forms and often include biometric screenings, such as weight and cholesterol readings, and employee questionnaires that aim to reveal risky behaviors. Even with an incentive such as cash or a reduced health insurance premium, experts again say the least healthy employees also are less likely to participate.

For Kansas City, Mo.-based St. Luke's Health System, health risk "appraisals" track employees' medical risks and health problems, said Gayle O'Connell, the hospital system's health enhancement program manager.

The appraisals, which included questionnaires covering exercise

habits to stress management, were used to calculate how much the hospital system avoided in medical costs with its wellness program that cost \$250,000 per year.

From 2001 to 2003, the hospital system avoided spending \$8.50 in medical costs for every \$1 it spent on wellness; from 2003 to 2005, the savings figure was \$3.50, Ms. O'Connell said.

While acknowledging that the system is not the most accurate way to calculate savings, Ms. O'Connell said it did allow the hospital system to track how employees changed behavior and how those changes helped the hospital system avoid higher medical costs.

Mike Miele, president of Princeton, N.J.-based Apex Management

Group, an employee benefits consulting and insurance services unit of Gallagher Benefits Services Inc., said this popular way of calculating possible ROI fails to track whether the wellness program caused the reduced health risk.

"This main method that people do is cohort tracking. They say, 'We surveyed 3,000 people and 1,000 people were high-risk and 600 people actually talked to us, and we monitored them, and we tracked their costs over time and it got better, so it's working,'" he said. "The problem is there are a lot of statistical errors in that approach. Maybe those people were getting better anyway."

—By Louise Esola

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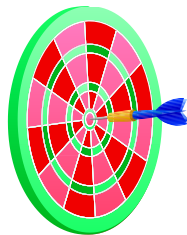
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International NEWS

ERM grows in Poland

Governance rules promote risk management

By RICHARD MILLER

WARSAW, Poland—Changes to corporate governance guidelines for publicly listed companies have helped raise the profile of risk management in Poland, said members of the country's risk management association.

Corporate governance best practices rules issued by the Warsaw Stock Exchange stipulate that company supervisory boards should monitor the implementation of risk management, which has increased board-level interest in enterprise risk management, said risk managers at last week's conference of the Polish Risk Management Assn.

"The whole market is talking about risk management and enterprise risk management as the most integrated way of managing risks," said Tomasz Miazek, head of group enterprise risk management and the insurance department at Telekomunikacja Polska S.A., Poland's largest telecommunications company.

Several major companies in Poland are implementing ERM.

Aside from Telekomunikacja, which is in its first year of implementing ERM, PKN Orlen S.A. in Plock, Poland, one of the largest oil refineries in Central Europe, is beginning to move from its traditional silo approach to ERM.

While the stock exchange rules are an external motivation, Piotr Szpakowski, director of Orlen's department of regulatory risk management, said there are internal reasons as well.

"It is a way to improve the management within the company," said Mr. Szpakowski.

"Enterprise or integrated risk management should also be the platform for the exchange of infor-

mation between managers, because in many cases—especially in complex companies—managers do not speak to each other," he added.

The topic of ERM dominated the agenda of the second annual Pol-Risk conference in Warsaw.

This year's event was meant to show risk, audit and control managers how to implement ERM, said Rafal Rudnicki, president of the Pol-Risk board.

"We wanted to show them that they can already think about risk

management at a strategic level—not only insurance, not only engineering, technical and security (risks), but all of that combined together and elevated one step further can bring much more value," said Mr. Rudnicki, who serves as risk and insurance manager at Raben Group, a logistics company in Poznan, Poland.

One conference discussion topic was a proposal by Standard & Poor's Corp. to "score" the quality of a company's ERM effort as part of its corporate credit rating process. S&P, like other rating agencies, already considers ERM when rating banks and insurers, but decided last year to extend the concept to nonfinancial companies.

Polish risk managers were generally keen on developing ways to measure the benefits of ERM.

"From a risk manager's point of view, it is critical," said Mr. Rudnicki.

At the conference, Paul Hopkin, technical director at the London-based Assn. of Insurance and Risk Managers, presented preliminary research by AIRMIC showing how ERM reduces risk exposure at companies. Mr. Hopkin said it would be a "much broader approach to quantify the benefits" of ERM than what S&P has undertaken.



MEDIA CONNECT
PolRisk's Rafal Rudnicki says measuring ERM benefits "is critical" for risk managers.

Europe considers class action law

Proposal for antitrust breaches seeks to avoid "excesses of U.S. system"

By SARAH VEYSEY

BRUSSELS, Belgium—The European Commission is seeking feedback on its latest proposals on so-called collective redress mechanisms for businesses and consumers that fall victim to breaches of E.U. competition law.

The commission's recent white paper on damages for breaches of antitrust rules outlines a model to compensate businesses and individuals that would allow them to join together to bring claims.

The proposals include safeguards to prevent "unfounded claims" and the "excesses" of the U.S. class action system. Comments on the white paper are due by July 15.

Those safeguards would include allowing only representative actions—claims led by, for example, recognized consumer groups. In addition, only actions in which claimants choose to participate, rather than actions brought by law firms for an unidentified number of claimants, would be permissible, the commission proposed.

Among other suggestions, the commission recommends that "to avoid the time and cost of relitigation," the final decision of a member state's competition authority should be considered sufficient proof of an infringement in any subsequent damages actions.

Currently, the commission said there are serious obstacles in most E.U. member nations that discourage companies and individuals from bringing antitrust damages actions.

"The suggestions in this white paper are about justice for consumers and businesses, which lose

billions of euros each and every year as a result of companies breaking E.U. antitrust rules," said Neelie Kroes, European commissioner for competition, in launching the white paper.

"These people have a right to compensation through an effective system that complements public enforcement, whilst avoiding the potential excesses of the U.S. system," she added.



AP PHOTOS

'These people have a right to compensation through an effective system that complements public enforcement.'

Neelie Kroes, European Commission

seen in a community instrument. We hope that this will be just the beginning of a wider reflection at the European level, which would pave the way for the principle of collective redress for consumers to be extended," she added.

Andy Holroyd, president of the Law Society in the United Kingdom, also welcomed the proposals.

"We need to stop obsessing about what happened in the United States.

Nobody wants that here or elsewhere in Europe," he said. "There are plenty of other, moderate models of class action systems to study that are geared more towards ensuring proportionality," he added.

The commission's proposals may heighten liability risk for companies in Europe, but they seem likely to fall short of altering the system to mirror that of the United States, experts say.

Tom Sheffield, technical director at Aon Ltd. in London, said U.S. class actions tend to be "opt-in"—whereby potential claimants automatically become part of a class unless they expressly opt-out. This can result in very large classes, he said.

Typically, the risk of class actions in the United States from a compa-

See **CLASS ACTION** next page

Brazil approves Lloyd's as reinsurer

By SARAH VEYSEY

RIO DE JANEIRO, Brazil—Lloyd's of London has received approval to become an admitted reinsurer in Brazil.

Lloyd's, which has a representative office in Rio de Janeiro, said it had received authorization from the Superintendencia de Seguros Privados, which last week opened the country's reinsurance market to overseas players.

Lloyd's said it would seek to enhance its presence further in Brazil.

Meanwhile, PartnerRe Ltd. last week established a representative office in São Paulo and has applied for a license to become an admitted reinsurer in Brazil.

Many of the world's largest reinsurers in recent weeks have announced plans to enter the Brazilian market since the country last year passed a long-awaited law that called for opening the sector to foreign companies.

Three categories of foreign reinsurers are allowed to operate in Brazil. They are:

- "Local reinsurers" maintaining

a registered office in Brazil. Local reinsurers have preferential access to 60% of Brazil's property/casualty reinsurance business for three years.

That will decrease to 40% the following three years, with the potential of a future law entirely eliminating the preferential treatment.

- "Admitted" reinsurers that are located abroad but maintain a representative office in Brazil.

- "Occasional" reinsurers that operate in Brazil without a local office.

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Commentary

Missing an opportunity by taking too little risk

When the suits in the C-suites realize they have missed a very big financial opportunity, the finger-pointing and head-rolling may not extend to risk management departments. But risk managers also clearly have missed a chance to boost their organizations' earnings and their own careers.

The missed opportunity: sponsoring the \$168 billion economic stimulus program.

Look around the big-city downtown district where you work and the small outlying community you call home. Corporations sponsor professional ballparks by paying millions of dollars for naming rights; they sponsor a variety of small-town celebrations and events.

Sponsoring the economic stimulus package would have resulted in a much broader splash of the corporate name, and it would have generated a much greater and quicker return on investment compared with other sponsorships.

In addition, it would have shored up the U.S. Treasury and, perhaps most importantly, given the stimulus package a better shot at working.

The concept is simple.

For every tax refund a company sponsored, it would have paid the government a sponsorship fee of one-third of the refund. In return, the government would have issued a tax refund voucher redeemable only with that sponsor.

The plan likely would have paid off for most sponsors, because many taxpayers would have calculated they could afford goods priced well beyond their tax refunds. For example, with his \$1,200 refund voucher for Big Box Electronics, John Q. Public could have more readily afforded that \$2,000 big screen TV, because his actual out-of-pocket expense would have been only \$800.

With \$168 billion of refunds, there would have been enough sponsorships available for big and small companies across America.

Sponsorships also would have aided the government, because sponsorship fees would have trimmed the net cost of refunds more than one-third after factoring in the float the government would have earned on the fees.

And, rather than squirreling away their refunds in savings accounts or using them to pay down debt—a real possibility during these scary economic times—taxpayers would have had to pour their refunds back into the economy. That was the idea behind the stimulus package.

How could risk managers have promoted this idea? Through



DAVE LENCKUS

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their enterprise risk management programs. One way to define ERM is to identify where an organization is missing financial opportunities because it is not taking enough risk. Sponsoring the stimulus program fits neatly into that definition.

The risk for sponsors would have been that taxpayers would not have spent more than their tax refund. But, c'mon! How could you pass up a \$2,000 big screen for \$800?

How could you pass up a \$2,000 big screen for \$800?

Of course, no plan is perfect. The biggest hitch in this plan would have been that some taxpayers would not have wanted to patronize their refund sponsors.

That's where good ol' American bartering comes in.

I can just envision how it would have worked with my neighbor.

"Mrs. Brown, you look beside yourself."

"Well, Bill, I got this @#/?*&%!!! refund, and it's a @#/?*&%!!! airline voucher! What am I going to do with this piece of @#/?*&%!!!? I haven't flown in my life, Bill, and I'm sure as shootin' not going to start now. @#/?*&%!!!"

"Wow. I don't know what sure as shootin' means, but you're obviously upset. I can understand that, because I don't like my refund sponsor, either. It's a day spa. I'd rather fly off to the coast for a getaway. Hey, want to sign over our vouchers to each other, since they're for the same amount? By the way, the name is Dave."

"Well, I have been a little tense lately. @#/?*&%!!! Let's do it, Dan!"

"Great! The name's Dave."

"Tell someone who cares. Get your @#/?*&%!!! voucher."

Market Moves

Flagstone buys stake in Imperial Re

BEDFORDVIEW, South Africa—Flagstone Reinsurance Holdings Ltd. said it has reached an agreement to acquire a 65% stake in Imperial Reinsurance Co. Ltd. in Bedfordview, South Africa.

Flagstone Re Chairman Mark Byrne will become chairman of Imperial Re, which is licensed for all classes of short-term coverage and writes proportional and nonproportional business on both a treaty and facultative basis.

Hamilton, Bermuda-based Flagstone said the deal is expected to close in the second quarter of this year.

Madison assumes broker responsibilities

TORRANCE, Calif.—In an agreement with Torrance, Calif.-based Keenan HealthCare, Madison Healthcare Insurance Services Inc. will assume brokerage services for all medical malpractice insurance coverage of Keenan's physician and medical group clients.

Huntington Beach, Calif.-based Madison also will assume responsibility for certain ancillary insurance coverage for Keenan, which provides employee benefits and services to its medical group clients.

Hanover completes Verlan acquisition

SILVER SPRING, Md.—Hanover Insurance Group Inc. of Worcester, Mass., said it has completed the \$29 million acquisition of Verlan Holdings Inc.

The acquisition of the Silver Spring, Md.-based holding company includes Verlan Fire Insurance Co. of Silver Spring, Md., and Coatings Industry Services Inc. of Owings Mills, Md.

Hanover is the holding company for a group of insurers including

Hanover Insurance Co. based in Worcester, Mass., Citizens Insurance Co. of America based in Howell, Mich., and their various affiliates.

Unum launches benefits package

CHATTANOOGA, Tenn.—Unum Group, an employee benefits provider based in Chattanooga, Tenn., has launched a benefits package that provides a database of group disability and life insurance coupled with voluntary benefits. The package, called Simply Unum, was designed for small to midsize businesses and makes more than 28,000 product combinations available to clients on a single technology platform.

Law firm expands New Jersey headquarters

BASKING RIDGE, N.J.—Carroll, McNulty & Kull L.L.C., a law firm with practice areas that include insurance coverage, insurance defense and employment, has expanded its headquarters in Basking Ridge, N.J., by more than 10,000 square feet to accommodate the growing firm.

The 10-year-old firm employs 38 attorneys and said in a statement that it plans to continue expanding. CMK said it is seeking to acquire smaller law firms in New York, Pennsylvania and New Jersey as part of its growth strategy.

Five earn workers comp best practices certification

LITTLE ROCK, Ark.—The Certification Institute in Little Rock, Ark., has awarded five professional employer organizations with its Workers' Compensation Risk Management Best Practices Certification. Obtaining the certification suggests a professional employer organization's risk management program is meeting proven insurance industry risk management best practices to reduce work-related accidents and health exposures and control workers compensation insurance losses.

Certificate recipients include A-Plus Benefits in American Fork, Utah; Employer Flexible HR Inc. in Houston; Extensis Group Inc. in Woodbridge, N.J.; Syndeo Out-

sourcing L.L.C. in Wichita, Kan.; and Team Link Corp. in Flemington, N.J. All are members of the National Assn. of Professional Employer Organizations.



An aerial view of the Three Gorges Dam on the Yangtze River in China.

Willis wins China contract; expands services in Poland

LONDON—Brokerage Willis Group Holdings Ltd. said it has won a two-year contract as the insurance consultant for operational assets of the Three Gorges Project, one of the biggest hydropower complex projects in the world located in Sandouping, China. The project is expected to be fully operational by 2011. The dam is the world's largest concrete structure and is projected to generate enough electricity to power a city four times the size of Los Angeles.

Additionally, the International Mergers and Acquisition Practice of Willis Group Holdings has launched a new team with headquarters in Warsaw, Poland, expanding its services into Central and Eastern Europe. Marius Stolarski has been named the new practice's regional manager for Central and Eastern Europe, M&A. The practice will focus on services arising from mergers, acquisitions, divestments, reconstruction and insolvencies.

TO SUBMIT ITEMS

BI's Market Moves column reports on activities by insurance industry companies and related entities. Personnel changes appear in Comings & Goings, while new product offerings appear in Products & Services. Please send Market Moves news to: Kristin Hunt, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; khunt@businessinsurance.com.

Class action: E.C. seeks balanced approach

CONTINUED FROM PAGE 21

ny's insurance perspective is that directors and officers coverage can be eroded by a large claim, he said.

Until now, the biggest risk to D&O coverage in Europe has been from regulatory actions, Mr. Sheffield said.

A greater focus on antitrust actions in Europe could cause underwriters to perceive greater risk and increase prices for insurance policies, he said. But the effect of such changes on terms and conditions and prices of policies are not likely to be felt widely until there are claims, he added.

Currently, the scope of collective

redress in Europe remains undefined, said Guy Soussan, a Brussels-based partner at law firm Steptoe & Johnson L.L.P.

"The commission wants not only plaintiffs but also 'other related entities' to be able to benefit from the new claims procedure. The true scope of who would benefit remains vague and wide open," Mr. Soussan said.

The commission has said, however, that it does not want the proposals to place a disproportionate burden on industry, Mr. Soussan said.

"Industry must hold the commission to these commitments if it is to emerge unscathed by the forthcom-

ing regulatory framework," he added.

The commission's proposals follow a green paper on antitrust collective redress, and a series of initiatives at the E.U. level.

Among other moves, Consumer Commissioner Meglena Kuneva has started a debate on collective redress for breaches of E.U. consumer law.

Many E.U. member states already have mechanisms in place for group legal actions.

The European Commission's white paper can be viewed at <http://E.C.europa.eu/comm/competition/anti-trust/actionsdamages/index.html>.

Guns: Florida law relaxes workplace ban

CONTINUED FROM PAGE 4

condition of employment, terminating or discriminating against an employee for storing a gun in their car, and from searching employee vehicles.

The NRA argues that a business owner's private property rights are not affected by "a law preventing the micromanagement of the lawful contents of a person's privately-owned automobile." Allowing employers to ban firearms in their parking lots interferes with employees' right to protect themselves during their daily commute, according to an NRA position paper.

"Customers and workers should not have to choose between protecting themselves or following the political policies of an anti-gun business," NRA past President Marion P. Hammer said in a statement.

But the Florida Chamber of Commerce and the Florida Retail Federation plan to sue to stop the law's implementation, said Adam Babington, director of coalitions and initiatives for the Tallahassee-based Chamber.

"This is an attack on business," said Mr. Babington, who added that concealed weapons permits are easy to obtain in Florida.

The law provides two new legal actions that workers can pursue for claims that their right to pack guns

in their cars has been violated, Mr. Babington said.

They complain to state authorities who can then seek an injunction or damages and fines. Simultaneously, employees can file a civil lawsuit claiming discrimination, he said. "Right now you have employment discrimination for gender, race, religion, now you would add gun ownership to that list," Mr. Babington said.

'You have employment discrimination for gender, race, religion, now you can add gun ownership.'

Adam Babington,
Florida Chamber of Commerce

The chamber also is concerned about third-party liability from guns brought onto business property and the potential for workers compensation losses, Mr. Babington said.

The new law states that employers have immunity from liability while complying with its mandates, but an employee's gun could be used in a way that does not comply with the law, Mr. Babington said.

The "immunity is so weak, and we all know that even if you have immunity you are still going to get sued," Mr. Babington said. "You might get a summary judgment, but you are still going to incur legal costs."

Such gun laws increase insureds' potential liability while restricting safety measures, said Bruce C. Wood, assistant general counsel for the American Insurance Assn. in Washington.

The American Society of Safety Engineers opposes government interference with employers' efforts to protect workers, a spokeswoman said.

ASSE recently filed an amicus brief urging the 10th U.S. Circuit Court of Appeals in Denver to affirm a judge's 2007 permanent injunction of an Oklahoma law that would have stopped employers prohibiting guns inside of locked cars on their property. The district court judge sided with employers and found the law conflicted with the 1970 Occupational Health and Safety Act requiring employers to lessen work-place hazards.

In Georgia, legislators earlier this month adopted a law that would restrict a company's ability to ban guns from parking lots accessible by the public. The legislation is pending action by Georgia's Gov. Sonny Perdue.

RRG: House measure seeks to include property cover

CONTINUED FROM PAGE 3

support, but enactment will be an uphill battle. Observers, though, are optimistic that such support will develop over time.

"This is still in its infancy. These things take time to develop," said Jon Harkavy, vp and general counsel for captive manager Risk Services L.L.C. in Washington. As a lobbyist for the Risk & Insurance Management Society Inc. in New York, Mr. Harkavy played a key role in helping to win passage of the 1986 Risk Retention Act expansion.

And the latest expansion—is was the case with original risk retention group legislation and the 1986 expansion—is opposed by many state insurance regulators, who view it as unnecessary, according to National Assn. of Insurance Commissioners President Sandy Praeger, who also is the commissioner of the Kansas Insurance Department.

"There are more than 800 companies writing commercial property coverage in the admitted market, so it is unclear whether there is a capacity problem that needs to be addressed. Some states are more comfortable with this expansion than others, but the majority of states think that the risk of unin-

tended consequences is not worth the risk of expanding RRGs' authority," Ms. Praeger said in a statement.

The current bill does more than just expand the coverages RRGs are allowed to write. The bill also includes certain corporate governance recommendations for RRGs that the Government Accountability Office suggested in a 2005 report. For example, RRGs would have to maintain a majority of independent directors on their boards and create independent audit committees.

The bill also would reduce the likelihood of state regulators illegally interfering with RRGs licensed in other states. For example, the measure would bar state regulators from issuing cease and desist orders for RRGs licensed in other states.

That provision is a response to an attempt by the California Insurance Department to shut down a Montana-chartered RRG that is providing medical stop-loss coverage to a group of California auto dealers. While the case is in litigation, a federal judge last month issued a preliminary injunction blocking the cease and desist order.

RRG advocates say the pre-emption provision in the Moore-Pryce bill should significantly reduce the likelihood of future legal tangles.



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401(k): House committee advances measure mandating fee disclosure

CONTINUED FROM PAGE 1

the U.S. Labor Department secretary.

In addition, administrators would have to disclose any financial relationships among service providers that could lead to potential conflicts of interest as well as information about investment options and risks, among other information (see box).

While most plan sponsors have welcomed better disclosure of 401(k) fees, many are concerned that the greater transparency required in both H.R. 3185 and the Labor Department's forthcoming regulations could increase lawsuits against plan sponsors. More than 30 such lawsuits already are pending, according to the American Benefits Council in Washington.

"Any time you have a new law and a new requirement, you have new opportunities to fail to meet those requirements. That, obviously, gives opportunities for more lawsuits," said Pam Hess, director of retirement research at Hewitt Associates Inc. in Lincolnshire, Ill.

Some defined contribution plan experts also say the additional disclosure requirements could increase administrative costs paid by plan participants, while at the same time overwhelming them with new information.

"It will cost money, and the participants will pay the cost of this," said David Wray, president of the Profit Sharing 401(k) Council of America in Chicago.

"Investors need the right information, not information overload. Unbundling 401(k) plans will flood employers and participants with reams of unnecessary and confusing data that won't add any useful information and may actually dissuade some employers from even offering plans," said a spokesman for the Investment Co. Institute in Washington.

"Unfortunately for America's workers, retirees and their families, the committee-passed bill would make 401(k) fee disclosure more complex and expensive than it needs to be," Bradford P. Campbell, assistant secretary for the Labor Department's Employee Benefits Security Administration, said in a statement.

However, the American Society of Pension Professionals & Actuaries

and the Council of Independent 401(k) Recordkeepers sent a letter to committee Chairman George Miller, D-Calif., supporting the specific allocation of fees. "These categories will permit plan fiduciaries to assess the reasonableness of fees by allowing an 'apples-to-apples' comparison to other providers, and will allow plan fiduciaries to determine whether or not certain services are needed, leading to potentially even lower fees," said Tommy Thomasson, chairman of the council, in a joint statement by both organizations.

'The amount of money and the number of people in the system is so large that it follows that there is going to be greater scrutiny.'

David Wray, Profit Sharing 401(k) Council of America

"Rather than mandating a particular business model, the amended legislation treats all business models equally and fairly," Brian H. Graff, ASPPA executive director and chief executive officer, said in a statement.

By contrast, Mr. Campbell said the Labor Department's own disclosure regulations "will empower workers, retirees and families by giving them the information they need to make informed retirement savings decisions."

One major difference is that Labor regulations do not require bundled providers to break out pricing for the components of their bundled services, but the House bill would.

Many retirement benefit experts are especially concerned that a requirement in H.R. 3185 mandating that plans offer at least one low-cost index fund could open the door to greater government involvement in fund selection, something that has been the purview of plan sponsors.

Though an earlier version of the bill, also sponsored Rep. Miller, would have required all 401(k) plans to offer one low-cost index

fund, an amendment added last week gave plan sponsors additional protection from fiduciary lawsuits under the Employee Retirement Income Security Act if they do so.

"The index fund requirement is a big issue," said Ann Marie Breheny, legislative associate at Watson Wyatt Worldwide in Arlington, Va. "The way it was put forth made it seem like...you get this option of liability protection if you offer it. But now it's a de facto mandate; it's a condition. To be protected, you have to offer this index fund."

"It is important that the government not be in the investment business," asserted Mr. Wray. "Would you, by extension, require an index fund in every IRA? Some future Congress might feel something else should be the investment in the plans. Some future Congress might think this should not be in the plans. Is the government going to begin superimposing the will of whatever Congress is in session over how the money should be managed?"

Regardless of whether the bill has sufficient votes to make it out of the House this year, it likely won't get out of the Senate, observers say.

"Chances are very slim considering the fact that this is a short legislative year because of the election," said Ms. Breheny. "The expectation is we will see further action in the House but not any meaningful action in the Senate."

Aside from the ASPPA and CIR, the legislation also has the support of the Pension Rights Center, AARP and organized labor.

But even if the 401(k) measure dies, the fee disclosure issue is not going away, experts warn.

"We're going to have to do more whether the bill passes or not," said Anne Waidmann, a director in PricewaterhouseCoopers L.L.P.'s human resources division in Washington, noting that the first phase of the Labor Department's regulations is already in place. Under the government's revisions to Form 5500, plan sponsors will be required to report more detailed information on fees beginning in 2009, she said.

"Then there will be other regulations on what the service providers are required to tell plan sponsors. The third step will be regulations on disclosure to participants," Ms. Waidmann said.

"The pressure for this has been building for a long time," said Mr. Wray. "The amount of money and the number of people in the system is so large that it follows that there is going to be greater scrutiny."

Rep. Miller said approximately 50 million U.S. workers currently are enrolled in some type of 401(k)-style retirement plan. According to 2007 Labor Department data, there were more than 635,000 401(k) plans covering nearly 64 million individuals, 52 million of whom are still working.

401(K) LEGISLATION

The 401(k) Fair Disclosure for Retirement Security Act would:

- Require service providers and plan administrators to disclose, in the form of a dollar amount or as a percentage of assets, all fees charged on 401(k) plans broken down into four categories: administrative fees, investment management fees, transaction fees and other fees.
- Require service providers to disclose financial relationships so that employers that sponsor 401(k) plans can make sure there are no conflicts of interest.
- Require that plan participants be given basic information about the investment objectives and strategies of each option, their risk levels, how the option is being managed and where they can obtain additional information regarding specific options.
- Require plan administrators to provide a history of the returns generated by each option, net of fees and expenses, for the previous year, five years and 10 years, or since inception, if later.
- Give the U.S. Department of Labor the authority to enforce the new disclosure rules and fine service providers that violate them.

Results: 2007 strong for managed care

CONTINUED FROM PAGE 3

Other insurers reported stable medical cost trend projections.

Aetna Inc. reiterated that its 2008 medical cost increase was projected at 7.5%, plus or minus 0.5%.

"I don't see anything pointing to an overall dramatic spike in trend, either in cost or utilization," said Stephen Zaharuk, vp and senior analyst for Moody's Investors Service Inc. in New York.

Although WellPoint plans to utilize its revised projections during renewals for the rest of the year, it is unclear if it will be able to raise rates in response to its revised trends, particularly if its cost trends are higher than its competitors, analysts say.

"That's the \$64,000 question," Mr. Zaharuk said. "The key is not only to price to trend but to make sure your trend is no higher than the competitors'."

Given tremendous competition in the health insurance market, attempts to increase pricing will encounter buyer resistance, analysts say.

"I think there will be more push-back from buyers of health insurance," Fitch's Mr. Ellis said.

Humana Inc. also scaled back earnings projections for the year, although it attributed the reduction to problems with its actuarial assumptions for its Medicare Prescription Drug Plan segment rather than a change in cost trends.

Humana is correcting assumptions that produced a "domino effect on results," although the financial impact will be confined to this year's results, Mike McCallister, president and CEO of the Louisville, Ky.-based insurer, said in a recent conference call.

Humana's problems were not symptomatic of broader problems in the sector, amounting to "just a major miscue in the pricing of their Part D product," Mr. Zaharuk said.

Although some of these problems may persist into the second quarter of this year, analysts do not expect that they will have a major effect on health insurer earnings going forward.

"They're still going to have good earnings, it's just not what they thought it was going to be," said Sally Rosen, managing senior financial analyst with Oldwick, N.J.-based A.M. Best Co. Inc.

The health insurers generally reported solid earnings in 2007 (see chart, page 3).

"Results were fairly strong for '07 and more or less in line with expectations," said Joseph Marinucci, credit analyst with New York-based Standard & Poor's Corp. "There has obviously been some noise in Q1, but I think that was company-specific rather than industry-specific."

Humana posted the strongest earnings, reporting a 71% rise in profit during 2007 due primarily to its surging government sector. "Medicare continues to be a strong

growth driver for us," Mr. McCallister said.

Among the top five health insurers, Aetna achieved both strong earnings growth and solid membership gains. Aetna posted 2007 profit that was 8% above 2006 while also demonstrating strong membership growth, both organically and through acquisitions. The Hartford, Conn.-based insurer projects commercial membership growth of 4% to 5% for 2008.

"When we put our products alongside the competitors in accounts in which we participate, we are seeing more success in companies taking up Aetna," Joe Zubretsky, executive vp and chief financial officer, said during a conference call last month.

Commercial membership growth will be challenging this year due to the weak economy and additional layoffs in a number of industry sectors, analysts say.

"Enrollment in the commercial sector still appears to be challenged and that does not seem to be letting up," Best's Ms. Rosen said.

When companies have difficulty growing organically, they often attempt to grow via acquisitions, but no major transactions are expected for the health insurance sector due to antitrust concerns.

"The overall tone of the marketplace is that you're unlikely to see anything major emerging," S&P's Mr. Marinucci said.

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Gen Re: Brandon's resignation likely marks end of criminal probe

CONTINUED FROM PAGE 1

After the verdict, federal prosecutors suggested they might "go up the ladder" against others involved in the deal, sparking speculation that criminal charges might be filed against Mr. Brandon.

"Generally what happens is the clear message is sent that 'We won't go after the company...if you meet our demands, and our demands are that you remove anyone at a high level in connection with this,'" said Joel M. Androphy,

a white-collar criminal defense attorney with Berg & Androphy in Houston.

"That's just common practice, especially...based upon what happened to Arthur Andersen," he said. The accounting firm was convicted in 2002 of obstruction of justice for shredding audit documents related to Enron Corp. Arthur Andersen went out of business even though the Supreme Court overturned that conviction in 2005.

Mr. Androphy said he doesn't believe the government would

indict Gen Re or Berkshire Hathaway "so they could have probably called their bluff." But that's a hard decision to make because "if you bet the wrong way, your shareholders are going to wonder why the company thought the services of its CEO were more important than the survival of the corporation."

"I think (Mr. Brandon's departure) clearly was initiated and pushed by the federal prosecutors to try to get this done simply because they didn't want to have an unindicted co-conspirator...running a significant part of the Berkshire empire," said Chuck Hamilton, a Berkshire equity analyst with FTN Midwest Securities Corp. in Nashville, Tenn.

Legal experts say federal prosecutors most likely did not have enough evidence to charge Gen Re or Mr. Brandon, so his departure concluded the government's investigation.

Peter J. Henning, a criminal law professor at Wayne State University in Detroit and a former SEC prosecutor, said he doesn't see criminal charges being filed against Mr. Brandon unless one of the five convicted defendants "does a complete 180" and comes forward with new incriminating information. And that's "hard to imagine because it would torpedo their appeal," he said, noting the difficulty in maintaining innocence and then coming forward with incriminating information.

"So as far as the criminal case goes, I would suspect it's pretty much over," he said.

"While every case is different, historically, when you have people on that level who are prosecuted, the government, if it is going to go after the company, is going to charge the company in the same indictment because the basis against the company is the acts and conduct of those individuals who were indicted," said Michael B. Himmel, chairman of Lowenstein, Sandler P.C.'s white-collar criminal defense practice group in New York.

"One would conclude that as a consequence of the CEO stepping down, that's probably the last thing to close the books on General Re," Mr. Himmel said.

At the same time, if there was sufficient evidence against Mr. Brandon, it is likely that he would have

NEW LEADERSHIP

Franklin Montross IV, who goes by "Tad," joined General Re Corp. in 1978 as a casualty facultative underwriter. Since then he has held a number of positions of increasing responsibilities both in the United States and internationally. Among his most recent promotions:

1992: Named senior vp of General Reinsurance Corp., the company's North American operating unit. Later that year he was named chief underwriting officer North America treaty and manager of the Underwriting Services Division.

1995: Named a director of General Reinsurance and a member of the executive committee of the board. Later that year he was elected to the board of management of Cologne Re.



GEN RE

2000: Named executive vp and vice chairman of General Reinsurance and executive vp and chief underwriting officer of Gen Re.

2001: Named president and chief underwriting officer of Gen Re.

2008: Named chairman and chief executive officer of Gen Re.

Industry sees no problem with change in leadership

STAMFORD, Conn.—The leadership change at General Re Corp. should go smoothly, as new Chief Executive Officer Franklin Montross IV has significant experience and a long history with the reinsurer, observers say.

Mr. Montross, who goes by "Tad," previously was Stamford, Conn.-based Gen Re's president. Last week he was named to the top spot the departure of former CEO Joseph P. Brandon, who has headed the company since 2001.

"We have not changed our rating, and that reflects the fact that (Mr.) Brandon's successor in this job, Tad Montross, is a very capable individual," said Thomas Upton, a managing director with Standard & Poor's Corp. in New York. "We've known (Mr. Montross) for a number of years, and we don't expect that this departure will have any material effect on the business of the organization."

"They're going to miss Joe Brandon, I think, but...not to the extent it would be a ratings issue," said Mark Rouck, a senior director at Fitch Ratings in Chicago. In Mr. Montross, "you've got a guy with experience who knows the company and knows the industry. That's a positive from a ratings perspective."

"I have known Tad for a number of years and feel he is very qualified to lead General Re going forward," said William H. Eyre Jr., managing director and CEO of Philadelphia-based Towers Perrin Reinsurance. "It's an unfortunate situation for Joe, but it's a positive spin" for Gen Re with Mr. Montross now at the helm, he said.

Chuck Hamilton, senior equity analyst with FTN Midwest Securities Corp. in Nashville, Tenn., noted that Mr. Montross "spent some time on the underwriting side as a facultative casualty underwriter...so he clearly understands the business itself. And he's a long-time 30-year insider to Gen Re, so he clearly knows how the company operates. So to me, I think...we've got somebody who knows the organization and should be capable of leading this company."

In a statement, A.M. Best Co. Inc. said: "Under the leadership of Mr. Brandon, the underwriting culture of Gen Re was vastly improved, and stringent underwriting standards and controls were established globally." Mr. Montross "has the necessary experience and capabilities to ensure a smooth transition and maintain the group's underwriting culture."

—By Sally Roberts

'I think (Mr. Brandon's departure) clearly was initiated and pushed by the federal prosecutors.'

Chuck Hamilton,
FTN Midwest Securities Corp.

resignation."

"My feeling is they did not have sufficient evidence to go after (Mr. Brandon) on a criminal basis, but he still is in peril with the SEC," Mr. Zamansky said.

Mr. Henning said that rather than filing civil charges in federal court, the SEC is more likely to file administrative proceedings against Mr. Brandon.

"It wouldn't surprise me if they were negotiating a settlement with him without filing anything," Mr. Henning said, adding that he expects the SEC will reach a settlement with Gen Re as well.

In October 2005, Mr. Brandon was served with a Wells notice informing him that the SEC was considering filing civil charges against him for violating securities laws (*BI*, Sept. 12, 2005).

SEC attorney Andrew M. Calamari last week said that the agency intends to file a motion to lift the stay on its civil suit, which has been in place pending the Gen Re/AIG criminal case, and pursue its litigation.

Mr. Calamari would not comment on the investigation or whether the SEC intended to file any new charges.

been among the indicted executives from Gen Re and AIG, Mr. Androphy said.

"It's never a good idea to charge someone separately. You want them charged together so they can point the fingers at each other," he said.

"Federal prosecutors got four convictions of Gen Re people at trial and they said they were going to work their way up the ladder," said Jacob H. Zamansky, a former federal prosecutor who is now a securities attorney with Zamansky & Associates in New York. "Rather than continue the case against (Mr. Brandon) and the company, it appears they asked for his

Regulation: Insurance information office proposed

CONTINUED FROM PAGE 3

tory issue and that is precisely" what has been done.

"The most important thing about this is that it actually has a chance of enactment," Mr. Wood said. "Whereas opponents of the OFC raise some legitimate concerns about broad federal regulation, it's almost impossible to make the substantive case that the OII is unnecessary."

Leigh Ann Pusey, chief operating officer of the American Insurance Assn., which also supports the OFC, agreed that the measure could be enacted.

'We have a need to have someone at the federal level to develop some insurance knowledge and expertise and to help develop policy.'

Leigh Ann Pusey, American Insurance Assn.

"I think it's possible," she said. "Obviously, we don't have much

time. Hopefully people will see it for its merits and separate it from whatever politics swirl around the blueprint and broader financial debate and seriously consider it."

"I think it stands on its own merit, and we think it is important to do," said Ms. Pusey. "We have a need to have someone at the federal level to develop some insurance knowledge and expertise and to help develop policy where there is none in respect to international agreements. It's designed to address an

immediate need."

But Justin Roth, senior federal affairs director for the National Assn. of Mutual Insurance Cos. in Washington, took a different view, noting that congressional supporters of the OFC praised Rep. Kanjorski's approach when he first broached the idea last week.

"They view it as a first step," said Mr. Roth. "And if you go by the Treasury blueprint, this is step No. 1 toward an OFC. It's obvious to us that this is step No. 1, and we strongly oppose federal regulation and we have concerns that this will lead to federal regulation."

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News
In Brief

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HSA rule permits
faster contributions

Final Internal Revenue Service regulations issued last week allow employers contributing to employees' health savings accounts to accelerate contributions for employees whose medical care expenses are greater than the amounts the employer has already contributed to the HSA. The rule goes

into effect immediately and applies to HSAs that are not part of Section 125 programs, in which employees make pretax contributions to their accounts. Accelerated employer contributions to HSAs that are part of Section 125 programs already were permitted.

Oklahoma lawmakers
expand comp fund

Legislation allowing Oklahoma's state fund to sell workers compensation policies outside of the state has been sent to Oklahoma Gov. Brad Henry for his signature. CompSource Oklahoma is a nonprofit insurer created by the state in 1933. House Bill 1959 would allow CompSource to compete with private insurers outside of the state. The American Insurance Assn. said it

opposes CompSource's expansion because the insurer enjoys competitive advantages over private insurers.

Florida Senate OKs
Citizens surplus shift

The Florida Senate approved a measure last week that would require state-run Citizens Property Insurance to transfer \$250 million of its surplus to the state's general revenue fund. The money would be used to provide capital for startup property insurers. The state House approved a similar surplus transfer the previous week and now must deal with the Senate measure, which proposes that insurers be subject to new regulations. The House version of the proposal does not include such a provision.

Atlanta RIMS chapter
endows scholarship

The Atlanta chapter of the Risk & Insurance Management Society Inc. has pledged \$100,000 for a scholarship honoring the founder of the University of Georgia risk management program. The donation to the Spencer Educational Foundation will be distributed over the next three years. The RIMS Atlanta Chapter/Dr. E.J. Leverett Memorial Scholarship is a merit-based award of \$5,000 to students from Georgia who are pursuing an undergraduate degree in risk management or insurance. The scholarship was created in memory of Edgar J. Leverett, the founder of the University of Georgia risk management and insurance program.

HSA: Transaction reporting rule faces uphill struggle

CONTINUED FROM PAGE 1

Pomeroy, D-N.D.

The legislation would require HSA trustees—typically banks—to substantiate that distributions from the accounts are for health care-related expenses.

Unsubstantiated expenses would have to be reported by trustees on tax forms and would be automatically subject to income taxes and penalty taxes. HSA distributions now can be taken tax-free if used to pay for health care expenses. Distributions taken for other purposes are taxed, with an additional 10% penalty tax imposed.

To substantiate expenses, banks would have to change the way that distributions are made from employees' HSAs. In the current low-overhead HSA administration world, employees with HSAs often pay uncovered health care expenses, such as prescription drug copayments, with a debit card. In other cases, employees may go online and have funds transferred electronically from their HSA to the provider.

With a health care substantiation requirement, account holders in some cases would have to file a claims form and provide a receipt to the bank where they established their HSAs to receive reimbursement.

To handle that, banks would have to acquire new administrative systems and the costs would be passed onto account holders. Benefit experts earlier said that account fees, now roughly \$3 a month, likely would double if the substantia-

tion requirement were to become law.

While a substantiation requirement would not be a "death knell" for HSAs, it would add costs and complexity, with some banks withdrawing from what is already a low-profit business, said Jay Savan, a principal with Towers Perrin in St. Louis.

But the narrow House passage of the proposal and the threatened presidential veto, along with other factors, decrease the likelihood that the plan will win final congressional approval. Most significantly, Washington observers say, the proposal likely would get a cool reception in the Senate.

"It would be an uphill fight in the Senate. There is no evidence at the moment that the Senate would want to follow the House's approach," said Kathryn Wilber, senior counsel-health policy at the American Benefits Council in Washington.

"It is difficult to see how Senate Republicans would accept the HSA provisions," said Frank McArdle, a consultant with Hewitt Associates Inc. in Washington.

And if Senate Republicans unite against the measure, they have enough votes to filibuster the proposal.

While its likely that the HSA provision won't go further in the current congressional session, observers aren't completely counting it out.

House proponents, for example, could try to fold it into a broader "must pass" bill, such as legislation to extend certain expiring tax

HSA VERIFICATION RULES DEBATED



'We ask that there be some verification to show the money withdrawn was spent for health care. That's all. What drives us to this is a report that we had from one account manager that shows these funds being withdrawn for everything from body shop repair to fast food restaurants.'

Rep. Earl Pomeroy, D-N.D.

'Health savings accounts were created to reduce the growth of health care costs. And they have achieved some noteworthy successes. But this bill is going to increase health care costs for individuals by crippling HSAs.'

Rep. Ed Royce, R-Calif.



breaks.

"The issue still bears watching," Mr. McArdle said. "It could re-emerge as part of another bill as a revenue-raiser," he added.

"Anything can happen when something is labeled a revenue-raiser," said Jon Kessler, a board member and former chief executive officer of WageWorks Inc., a San Mateo, Calif.-based debit card provider.

According to the congressional Joint Committee on Taxation, the HSA substantiation provision would raise just more than \$300 million in tax revenue between 2011, the first year it would go into effect, and 2018.

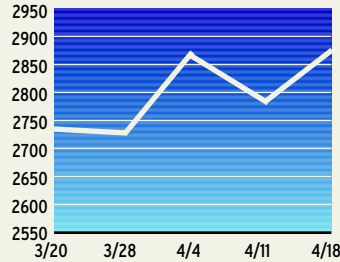
Presumably, the provision would raise revenue because HSA trustees would have to report unsubstantiated expenses on tax forms sent to the government. Under current law, individuals report HSA distributions on an Internal Revenue Service tax form and indicate the amount of distributions that were for health care expenses and the amount that were not. Only through audits, though, can the IRS uncover whether HSA enrollees truthfully reported whether or not the distributions were for payment or reimbursement of health care expenses.

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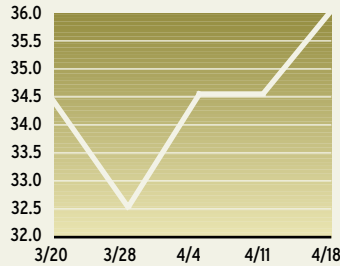
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Up-to-the-minute data for all 82 companies that comprise the BI Stock Index can be found at www.IndustryFocus.com.

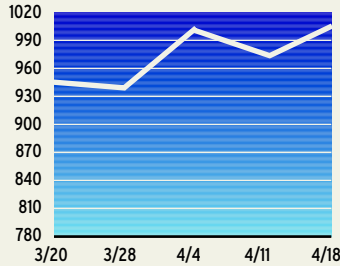
BI STOCK INDEX



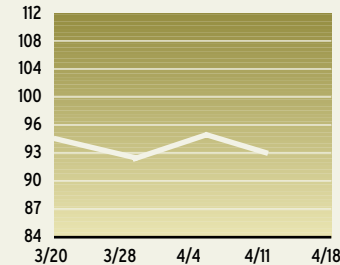
BI BROKERS INDEX



BI INSURER/REINSURERS INDEX



BI MANAGED CARE ORGANIZATIONS INDEX



Percentage change of BI Stock Index vs. key indicators

BI STOCK INDEX	2887.99	▲ 3.91%
DOW JONES	12849.36	▲ 4.25%
S&P 500	1390.33	▲ 4.31%

LARGEST GAINS

Ambac Financial Group Inc. . .	12.20%
MBIA Inc.	10.51%
PMA Capital Corp.	10.41%
EMC Insurance Group Inc. . . .	9.65%
AIG	9.49%

LARGEST LOSSES

RLI Corp.	-3.73%
Navigators Group Inc.	-3.41%
Endurance Specialty	-2.04%
Fairfax Financial Holdings . . .	-1.80%
Berkshire Hathaway	-1.30%

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Colleen McCarthy

Defamed in posting or was it a 'spoof?'

Sympathetic judges sometimes aren't enough for a defendant to escape a defamation lawsuit—even when the plaintiff is an attorney.

In a federal appeals court ruling triggered by a posting on a union Web site bulletin board, an attorney who represents truckers in tort cases accused American International Group Inc. of defaming him in a personal comment that was posted with a story from a local newspaper.

The June 2002 story related that attorney Brian M. Wendler of Wendler & Ezra P.C. in Edwardsville, Ill., had been arrested for alleged domestic battery. Mr. Wendler later explained in a deposition that, after arguing with his wife at a party, she fell and scraped her hand as he attempted to prevent her from entering their house. His wife later dropped the charges.

Someone posted the story in July 2002 on the International Brotherhood of Teamsters' online bulletin board with a note that said, "Don't make the same mistake me and my husband did—it's a waste of time and money."

Mr. Wendler charged that the personal note defamed him and was an attempt to steer potential clients away. The note implied that a client was unhappy with his professional services, but the Internet Protocol address used to post the note belonged to an AIG-owned computer, he alleges.

A trial court dismissed Mr. Wendler's lawsuit, however, because he did not specify how the IP address was traced to AIG. In addition, no evidence examined whether the IP address had been hijacked, or "spoofed," to hide the true address of the computer used to post the material.

A two-judge panel for 7th U.S. Circuit Court of Appeals had the same concerns but still overturned the lower court's decision on April 9. AIG's mistake was that it did not respond appropriately during discovery to a request for information about the source of the post, the appeals panel said.

"It may be that AIG has nothing more to disclose—though that is no reason to ignore a motion to compel," the ruling said. The panel ordered the lower court to rule on Mr. Wendler's motion to compel AIG to respond to his request for information.

Business Insurance END PAGE



Suburb wants to shine legal light on outages

Deerfield, Ill., usually a tranquil suburb of Chicago, is tired of being left in the dark by energy giant Commonwealth Edison.

Last week, the village filed a class action lawsuit in Lake County, Ill., on behalf of its 18,000 residents as well as businesses, claiming it has suffered enough power outages—1,377 from 2000 to 2007—and that the electric company has violated the Illinois Public Utilities Act. The complaint asks for ComEd to provide reliable and adequate power to the village.

Though 13% of the power outages were weather-related, Deerfield Mayor Steve Harris said his patience with the Chicago-based Exelon Corp. subsidiary has run out. "ComEd has given us no other option than to seek a legal remedy to their gross and willful dereliction of duty," Mr. Harris said in a statement.

The complaint includes several letters from Deerfield residents complaining about outages and "low amperage" in their homes. Many residents were told by ComEd employees that infrastructure in the area needs to be upgraded. According to the

complaint, Deerfield has been included in the top 1% worst-performing circuits for ComEd's Northeast service area in every year from 2001 to 2006.

In response to the suit on which a hearing is set for August, ComEd said it was disappointed with Deerfield's decision to sue over power supply reliability in the community, adding that, to date, the company has "worked cooperatively with village officials" on the issues.

"We recently presented the village with a reliability program for 2008 that addresses pockets within the community where reliability has not met the expectations of our customers and the company alike," a spokesman for ComEd said in a statement. "Until today, the village had only expressed satisfaction with this approach."

ComEd added that the term "electrical failures" used throughout the village's complaint is invalid. "A car can hit a pole, damaging ComEd equipment (and) resulting in a power outage," a ComEd spokesman said in a statement. "The cause of the outage is not failure of a ComEd component."



NYT PHOTOS

In 2006, Eliot Spitzer and running mate David Paterson celebrated winning New York's Democratic gubernatorial primary. Mr. Paterson succeeded Mr. Spitzer, who resigned in March.

Domino effect for ex-Marsh execs from Spitzer exit

The wheels of justice continue to revolve in New York given the exit of former Gov. Eliot Spitzer.

Five former Marsh Inc. executives still awaiting trial on fraud, antitrust and various larceny charges stemming from the 2005 big-rigging investigation by Mr. Spitzer, then New York attorney general, will be getting a new judge.

That's because New York Supreme Court Judge James A. Yates has resigned from the bench to serve as counsel to new Gov. David Paterson.

Effective April 28, Judge Yates will fill the position currently held by David Nocenti, whom Mr. Spitzer appointed as his counsel in 2006, bringing Mr. Nocenti with him from Mr. Spitzer's time as attorney general.

Mr. Spitzer's resignation as governor in March following his identification as a patron of a prostitution ring left his staffers vulnerable to the chopping block.

While the five ex-Marsh executives will get a new judge, Judge Yates last week sentenced two of their onetime peers—William Gilman and Edward J. McNenny. The pair were sentenced to 16 weekends in jail plus five years probation and 250 hours of community service.

In February, Judge Yates found Messrs. Gilman and McNenny guilty of restraint of trade under New York's Donnelly Act.

Bush bashers won't need special cover

Talk is cheap.

But under an ordinance suggested back in November, would-be protestors wishing to air their grievances in Kennebunkport, Maine, would have had to pay for otherwise free speech.

Kennebunkport, which is where the first President Bush owns a summer residence that is sometimes visited by his son, the current President Bush, said that groups wishing to demonstrate would have to purchase insurance.

The Maine Civil Liberties Union protested, holding that making demonstrators take out insurance

presented an unconstitutional breach of civil liberties and a financial burden that might force some who wished to have their voices heard to remain silent.

Kennebunkport officials heeded that complaint and revised the ordinance, which had never been implemented.

When residents vote on the ordinance in June, they will be approving or rejecting a document that contains no insurance requirement.

No matter how the vote goes, free speech will remain free in more ways than one in Kennebunkport.



REUTERS

More than 1,000 anti-war and pro-impeachment protesters, including Dan DeWolf of Vermont and Chris Elliott of New Hampshire, rallied last July in Kennebunkport, Maine, outside the Bush family compound.

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SPECIALTY MARKETS



Built to order

A downturn in new single-family housing construction has hurt demand for some construction-related lines of coverage, though insurance markets for other building sectors remain strong. **Page 10**

To server and protect

Reports of computer security breaches and the exposure of consumers' personal information are heightening interest in cyber risk coverages. **Page 14**

Everyone into the (talent) pool

With the demand for top talent outstripping supply, specialty markets companies must find ways to recruit and develop skilled professionals. **Page 16**

FEATURES

Bearing up in crisis

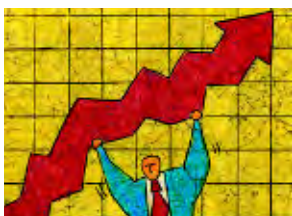
In addition to the impact on their investment portfolios, many insurers may face a subprime mortgage hit through claims on policies held by the various players in the mortgage process. **Page 18**

A favorable diagnosis

A panel of top executives at the PLUS Medical PL Symposium discussed medical professional liability insurers' improved fortunes since 2005 as well as what might be ahead. **Page 20**

Coordinated efforts

IBM's Jamie Bisker on creating the integrated insurance enterprise and how true integration can enhance a company's business vision and heighten its performance. **Page 21**



Super-sized

Our annual ranking of the largest MGAs in the U.S. **Page 22**



THREE QUESTIONS

Judith Klugman of Swiss Re Capital Markets in New York offers her thoughts about developments in the cat bond market. **Page 5**

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Silver lining amid economic crises?

For all the bad business news of the past several months in the United States—the economic downturn, the housing crisis and the subprime mortgage disaster—for proponents of federal regulation of insurance, at least, the dark cloud showed the slightest glimpse of a silver lining late last month.

That break in the clouds came in the Bush administration's formal support of an optional federal charter for insurance companies and producers. That support emerged March 31 as part of a broad financial regulatory modernization plan presented by U.S. Treasury Secretary Henry Paulson.

For OFC supporters, the secretary's announcement was welcome news. While OFC bills have already been introduced in Congress, having the administration's formal support for the concept can't hurt.

Will an OFC become law this year? Unlikely. The remaining Bush administration can be measured now in months, rather than years, limiting the president's clout. Perhaps there's merit in trying to get the three senators seeking his office—Hillary Clinton, John McCain and Barack Obama—on the record on the subject.

And in Congress? Political reality again comes to the fore. This is an election year, with members seeking re-election soon to turn their attentions full-time to keeping their seats in the Capitol. History shows one shouldn't expect too much legislative heavy lifting in that sort of environment.

But there are other realities that must be taken into account: globalization of business and capital, emerging risks and a convergence of financial services.

In Europe, the insurance industry's moving forward with a common regulatory framework under the European Union, and elsewhere around the world there's a push for harmonization of financial standards.

Meanwhile, as many see it, in the United States the industry is attempting to confront 21st century issues and opportunities, hamstrung by a creaky 19th century regulatory apparatus. Did those who shaped the current U.S. system of state-based insurance regulation contemplate such issues as globalization? The Internet? Climate change? Probably not.

Would a federal regulatory system in and of itself be better than the current state-based

system? Of course not. It would take a commitment to shaping a system that will truly provide the efficiency and uniformity needed to allow the industry to flourish and best serve its customers over the next 100 years.

Over the years, our government has given OFC opponents plenty of ammunition to challenge suggestions that federal regulation is the path to greater efficiency. They can point to bloated bureaucracies and a convoluted U.S. tax code for starters, and it's hard to argue.

The issue of an optional federal charter has been one that's divided various participants in the industry for some time. Not surprisingly, industry trade groups differed in their responses to the Bush administration proposal.

The American Insurance Assn., the Council of Insurance Agents & Brokers, the Reinsurance Assn. of America and, on the commercial buyers' side, the Risk & Insurance Management Society Inc. all praised the measure.

Among those opposing the OFC proposal—and largely acknowledging the need for

'IN THE UNITED STATES the industry is attempting to confront 21st century issues and opportunities, hamstrung by a creaky 19th century regulatory apparatus.'

reforms but looking for them within the existing state-based regulatory structure—were the Property Casualty Insurers Assn. of America, the National Assn. of Mutual Insurance Cos. and the Independent Insurance Agents & Brokers of America.

Those differing views could be a strength, leading to the soundest possible solution to the issues facing the U.S. insurance regulatory system, if those holding them can come together and work toward the best interests of the industry and insurance buyers.

How the OFC issue plays out remains to be seen. The one certainty facing the U.S. insurance industry, though, is change, and it's in the industry's best interests that everyone involved works together to shape a regulatory framework to meet it.

It's a tractor. It's a bug. It's a...what the heck is it?

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RMS launches fire risk model

NEWARK, Calif.—Risk modeling firm Risk Management Solutions Inc. has launched a new probabilistic model that assesses commercial fire risks.

The RMS Account Fire Model is aimed at primary commercial and specialty insurers and reinsurers. Newark, Calif.-based RMS said it provides a link between engineering best practices and the account underwriting process, and supplies previously unavailable comprehensive data at the account level.

Armed with that comprehensive data, underwriters can more confidently assess

the profitability of business they're taking on, RMS said.

The model simulates the behavior of fires as they spread through buildings' open doors and breached firewalls, and actively demonstrates the effects of sprinkler systems in containing damage. The effect of fire department activity is modeled by simulating response and control times based on actual U.S. fire incident statistics.

The Account Fire Model also provides an engineering assessment of the vulnerability of buildings, contents and business interruption to fire. **IF**

PCI joins nine others as newest member of IRC

MALVERN, Pa.—The Property Casualty Insurers Assn. has joined nine other insurance organizations as a member of the Insurance Research Council, a public policy research organization offering analysis on various issues of interest to insurers, consumers and public policymakers.

In a statement announcing the Des Plaines, Ill.-based PCI's IRC membership, David A. Sampson, PCI's president and chief executive officer, said, "The IRC has a proven track record in bringing factual information to public policy debates on a wide variety of insurance issues, such as natural catastrophes, auto injury compensation and highway safety."

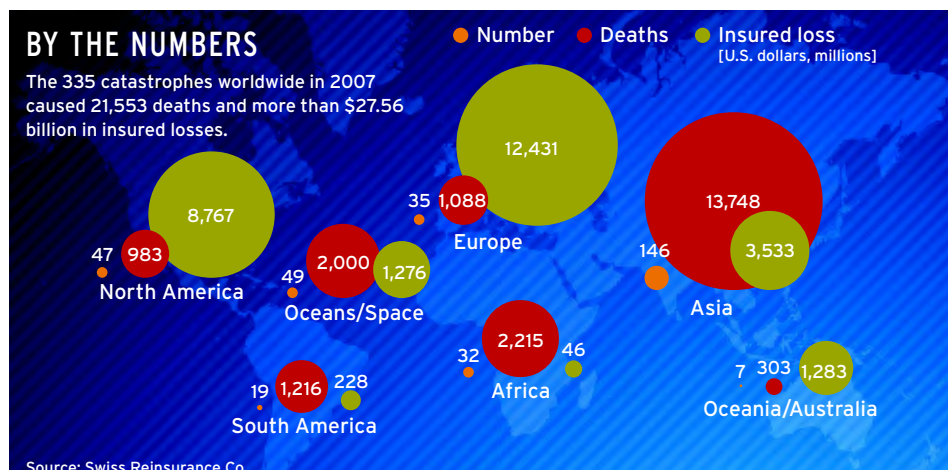
Founded in 1977, the IRC is an independent nonprofit research organization supported by property/casualty insurance organizations.

The IRC is dedicated solely to research and communicating its research findings.

The IRC is a division of the Malvern, Pa.-based American Institute for Chartered Property Casualty Underwriters and the Insurance Institute of America.

Other IRC members include Allstate Insurance Co., American Family Insurance, Farmers Insurance Group, Hartford Financial Services Group Inc., Liberty Mutual Group, the National Assn. of Mutual Insurance Cos., Safeco Insurance Cos., State Farm Insurance Cos. and United Services Automobile Assn.

More information about the IRC can be found online at www.ircweb.org. **IF**





Even in the face of softening insurance and reinsurance markets, the catastrophe bond market continues to grow both in terms of the volume of cat bonds brought to market and the number of issues, with 2007 the most active year yet in the market's history. Recently, Judith Klugman, managing director at Swiss Re Capital Markets in New York, offered her thoughts about developments in the cat bond market.

Does the fact that the catastrophe bond market continues to grow even as traditional markets soften suggest that cat bonds have become established with many insurers and reinsurers as simply one more tool for transferring risk?

That is a very fair assessment. The way that cat bonds really came into being, the genesis, was constraints in capacity, whether it was Hurricane Andrew or when we really saw it with Katrina. I think what we're seeing now is that if you're a primary insurance company or a reinsurer, it's just part of the normal way you do risk transfer along with reinsurance. It really makes sense to have them side by side. They really are complementary.

We certainly would envision continued growth. We see tremendous interest among sponsors and we see more interest from investors than we have supply, and I think what's driving investors to our market is the lack of correlation with financial markets. We've been saying that for some time, but I think it's really bearing fruit.

What are some of the benefits insurers and reinsurers perceive in using cat bonds to transfer risk?

I think companies are seeing several benefits that are responsible for their interest in cat bonds. One is that you can lock in coverage for more than one year. Reinsurance contracts are typically annual contracts, but a cat bond can be structured over multiple years.

Another is the "mechanistic" nature of a catastrophe bond. For example, if you have a trigger that's based on underwriting losses that would trigger if a U.S. hurricane was \$40 billion or greater, if (the Insurance Services

Office Inc.'s Property Claim Services) comes out and says the event was \$40 billion, that is what it takes, you get a payment. In traditional reinsurance, it's my understanding it can take a while for claims to develop, so it can take longer to get a payment with traditional reinsurance.

But I think the biggest benefit of the capital markets, of a cat bond, is that it's fully cash collateralized. If you know your coverage is fully cash collateralized, there are tremendous benefits to that.

When you look at these benefits, I think primary and reinsurance companies are looking at the cat bond market as a permanent part of their risk transfer strategy. So I think cat bonds have moved beyond being for capacity shortfalls. They really have a place at the table of and for themselves.

Early on in the market's history, common criticisms of using cat bonds vs. reinsurance were the inefficiencies and costs associated with bringing a catastrophe bond to market. Has that situation changed?

I think that as the market has matured, and with the explosion and the growth there has been a lot of paring down of the documents. They're being streamlined.

Across the board there are a lot more efficiencies in the process, and what that ultimately results in is the all-in costs are lower because you're not paying so much to lawyers. **IF**

Zurich's ZPass allows real-time agent quotes

SCHAUMBURG, ILL.—Zurich Financial Services Group is providing its small commercial business agents in the United States access to real-time quoting through the insurer's new ZPass interface platform.

The Swiss-based insurer, whose North American business is based in Schaumburg, Ill., said ZPass allows agents to conduct commercial lines business more efficiently without

duplicate data entry.

Agents using the system can process quotes and proposals directly from their agency management systems without needing to rekey data into point-of-sale systems.

The system lets agents electronically upload client data, obtain quotes, generate proposals and issue policies in real time for customers purchasing business owner's policies, commercial auto,

commercial umbrella and workers compensation coverages.

ZPass, which is delivered by the SeaPass Hub technology platform, is available now to Zurich-appointed agents who subscribe to the SeaPass Hub.

Agents using TransactNow or IVANS Transformation Station will gain access to Zpass during this year's second quarter, and will be notified by their Zurich representatives. **IF**

IMA launches wholesale broker and MGA

DALLAS—IMA Financial Group Inc. has formed Towerstone Inc., a Texas-based wholesale insurance broker and managing general agency with experience in a wide range of industries and expertise in energy and construction.

Towerstone is the result of the merger of Energy Risk Associates Inc. and R.A. Stough L.L.C., which did business as PWIB Texas, following the acquisition of PWIB Texas by Wichita, Kan.-based IMA Financial Group earlier this year. IMA formed Energy Risk Associates in Dallas in 1997.

Since its formation, wholesale broker



Mr. Stough



Mr. Ashcraft

ERA has specialized in the energy industry. PWIB Texas conducted wholesale brokerage and MGA business since 2004, specializing in placing property/casualty insurance with a par-

ticular focus on construction.

Robin A. Stough was named president of Towerstone. Mr. Stough, who has more than 30 years of insurance industry experience, was president of PWIB Texas. He also is a director of the Texas Surplus Lines Assn.

Steven "Pat" Ashcraft, executive vp and energy practice director, will lead Towerstone's energy division. Mr. Ashcraft has specialized in placing insurance for the energy industry since 1980.

Towerstone is based in Dallas with an office in San Antonio. **IF**



THE QUOTE

'UNDERWRITING IS KEY right now. You have to find the diamonds in the rough.'

DETLEF STEINER
CHAIRMAN, DELOS INSURANCE CO.

Zywave courts smaller agencies with BrokerageBuilder Express

MILWAUKEE—Employee benefits and property/casualty broker software solution provider Zywave Inc. is offering a new insurance-specific prospecting and benefits account management application that is designed to address the needs of smaller insurance agencies looking for a shorter implementation time and requiring fewer users on the system.

The application, BrokerageBuilder Express, is an addition to the Milwaukee-based Zywave's BrokerageBuilder Web-based agency management system.

The application allows BrokerageBuilder to be scalable to an agency's needs, Zywave said, allowing agencies to make their businesses more efficient,

accurate and profitable by keeping account data in a single place.

BrokerageBuilder can generate automated client-ready proposals and is designed to allow agencies to conduct in-depth prospecting as well as tracking accounts from lead to sale.

The application can also manage workflows through accounts, insurers or basic activities assigned to agency staffs.

Zywave provides a line of Web-based employee benefits and P/C communication, administration and claims data analysis systems that are designed to help insurance brokers do business more profitably.

The company's tools are employed by nearly 1,000 agency partners. **IF**

Ironshore enters health care liability market with IronHealth

SIMSBURY, Conn.—Ironshore Inc. has moved into the health care liability market with its launch of a dedicated facility, IronHealth.

IronHealth, based in Simsbury, Conn, initially will offer hospital professional liability, managed care errors and omissions liability, and long-term care professional liability coverage.

Matt Dolan has been named president of the new Ironshore unit, with Josh Stein as chief underwriting officer, Randy Oates as chief operating officer and Tammi Dulberger as chief actuary.

IronHealth's leadership team most recently ran OneBeacon Professional Partners, which they formed in 2002.

Ironshore Inc. is a Cayman Islands company formed in 2006 to provide property/casualty insurance worldwide. **IF**

Errors & Omissions

In the story titled "Data-enabled decisions" that ran in the March issue of Industry Focus, the name of Erie Insurance Group and its location in Erie, Pa., were misspelled.

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Mr. McGavick

Hamilton, Bermuda-based XL Capital Ltd. has named **Michael S. McGavick** chief executive officer. Mr. McGavick, who is to join the company May 1, will replace **Brian M. O'Hara**, who announced last year that he would retire as CEO in mid-2008. Mr. O'Hara will serve as chairman of XL's board during the final year of his board term, which expires in April 2009. Mr. McGavick was president and CEO of Seattle-based Safeco Corp. from 2001 through 2005, before leaving to make an unsuccessful run for one of Washington state's seats in the U.S. Senate.

Peter Zaffino has been named CEO of New York-based Guy Carpenter & Co. L.L.C. Mr. Zaffino, who previously was executive vp and head of U.S. treaty operations at Guy Carpenter, replaces David Spiller, who left the company.

Willis Group Holdings Ltd. has promoted **Graham Millwater** to the new post of president of Willis Group Holdings. Mr. Millwater previously was chief operating officer. At the same time, London-based Willis created two group COO positions. **Tim**

Wright will join Willis in September as group COO, assuming day-to-day responsibility for executing the broker's Shaping our Future initiatives and overseeing operational processes, service centers and information technology. Mr. Wright will join Willis from Bain & Co., where he is head of U.K. financial services. **Patrick Regan**, who has been chief financial officer, was also named group COO, overseeing the company's finance and administrative activities.

Novato, Calif.-based Fireman's Fund Insurance Co. has appointed **Michael LaRocco** as president and CEO. Mr. LaRocco, who had been president and COO of Safeco Corp. until 2006, assumes the CEO post from Chuck Kavitsky, CEO and president of Fireman's Fund parent Allianz of America, who had been serving as interim CEO.

New York Life Insurance Co. has named **Ted Mathas** CEO-elect. Mr. Mathas will succeed **Sy Sternberg** on Mr. Sternberg's June 30 retirement. Starting July 1, Mr. Sternberg will remain nonexecutive chairman of the New York-based company's board for a transition period. Mr. Mathas has been New York Life's president since last June and will retain that title upon assuming the CEO's role.

Dwight Evans has been named president and CEO of New York-based Folks-

america Reinsurance Co., a unit of White Mountains Insurance Group Ltd. Mr. Evans had been executive vp-global reinsurance of Hamilton, Bermuda-based White Mountains Re Ltd. and president and CEO of White Mountains Re Underwriting Services Ltd. **Warren Trace** was named to succeed Mr. Evans as president of White Mountains Re's Bermuda-based reinsurance operations.

Edmund Kelly has been appointed CEO of Paris Re America Insurance Co. He joins Paris Re from ICAT Holdings, where he was president and COO. Mr. Kelly will be based in Miami. Paris Re America is a subsidiary of Zug, Switzerland-based Paris Re Holdings Ltd.

Lexington Insurance Co. has named **Steve England** president of Landmark Insurance Co. in Atlanta. Previously, he was a regional vp.

Kerry Drake has been named president and CEO of Wright & Percy Insurance in Baton Rouge, La. Before his promotion, Mr. Drake was senior vp in Wright & Percy's life,

health and corporate benefits division.

Julian Cusack has been promoted to COO of Hamilton, Bermuda-based Aspen Insurance Holdings

Ltd. Mr. Cusack will continue in his roles as chairman and CEO of the company's Aspen Insurance Ltd. unit.

San Francisco-based Woodruff-Sawyer & Co. has promoted **Charlie Rosson** to CEO. Previously, he was a senior vp and employee benefits practice leader.

Los Angeles-based Farmers Group Inc. has named **Kevin Kelso** executive vp and chief marketing officer. Mr. Kelso previously was executive vp and president of personal insurance. Farmers Group is a subsidiary of Zurich Financial Services.

Indianapolis-based Well-Point Inc. has named **Brian A. Sassi** president and CEO of the company's consumer business unit. Mr. Sassi, who previously was president of Blue Cross of California, replaces Joan Herman, who retired.

Marsh & McLennan Cos. Inc. has appointed **Ben Allen** president and CEO of Kroll Inc., the New York-based company's risk consulting and technology group. Mr. Allen, who had been Kroll's COO, succeeds **Simon V. Freakley**, who was named CEO of a newly formed MMC corporate advisory and restructuring unit.

Michael R. Elia has been named CFO of Dublin, Ohio-based Frank Gates Cos./Attenta. Previously, he was senior vp and CFO at FastenTech Inc. **IF**



Mr. Kelso



Mr. Drake



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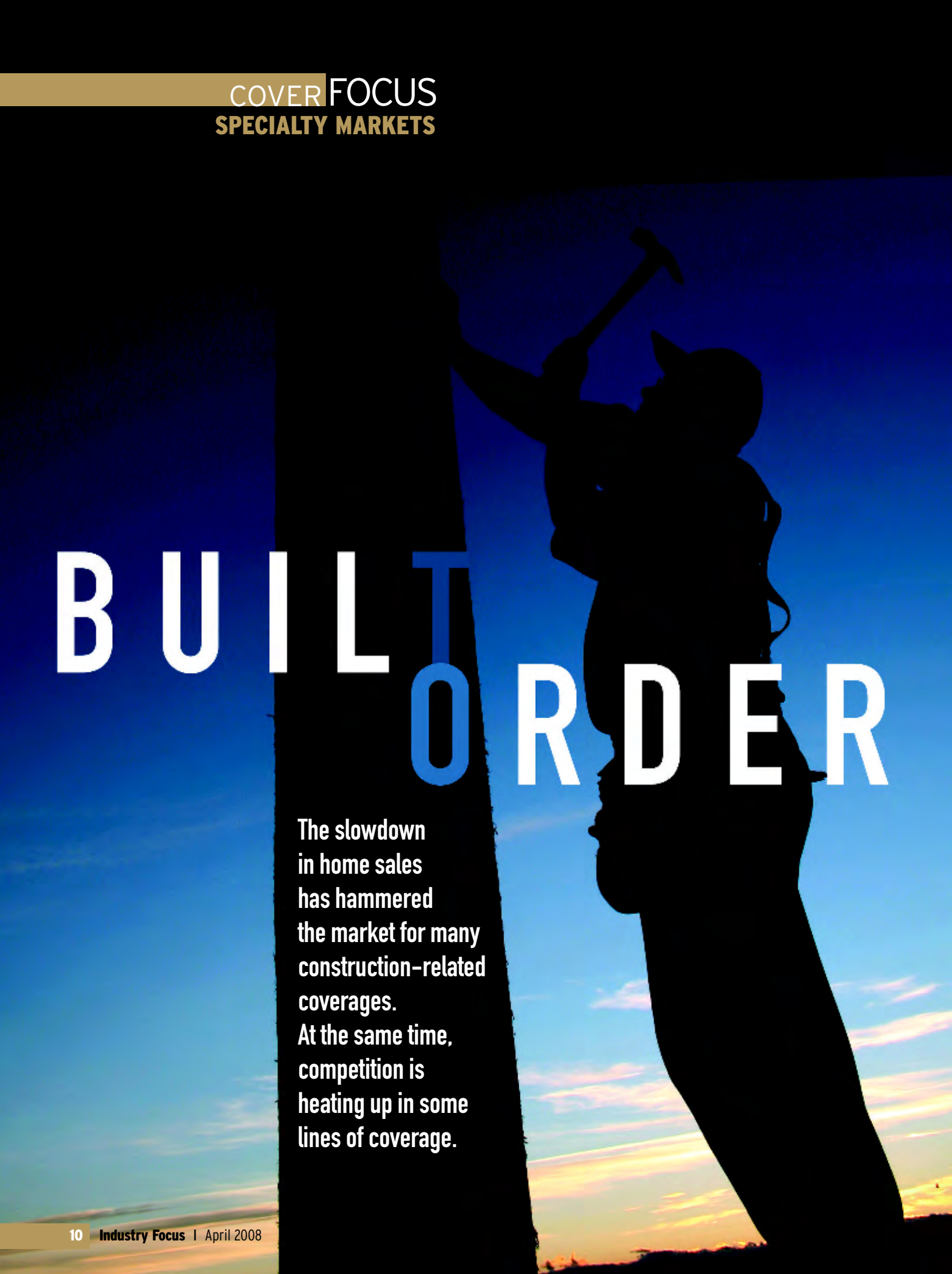
Alex Letts, CEO of RI3k

Joseph Plumeri, CEO of Willis, Inc.

Mario Vitale, CEO of Zurich

Bill Hartnett, Microsoft

BUILT ORDER

A silhouette of a construction worker wearing a hard hat and using a hammer to drive a nail into a vertical wooden post. The worker is positioned on the right side of the frame, with their arm extended upwards. The background is a vibrant sunset sky with horizontal clouds, transitioning from a deep blue at the top to a bright orange and yellow near the horizon. The overall mood is one of industry and construction.

The slowdown in home sales has hammered the market for many construction-related coverages. At the same time, competition is heating up in some lines of coverage.

By Meg Fletcher

The credit crunch has reduced the demand for construction-related insurance for single-family home developers, but competition is increasing among insurers that cover financially stable developers of multifamily dwellings and most commercial projects, most observers say.

Yet, questions remain about how long the credit crunch will last and how far it will spread.

The decline in single-family home construction projects has been "moderate to devastating," nationwide said Rick Girden, the Chicago-based managing director of the construction practice of Mercator Risk Services Inc., a national wholesale broker and managing general agent.

Mortgage lenders have tightened their underwriting standards. That is creating problems for homeowners, especially those with subprime loans, to renegotiate their mortgages. It also makes it more difficult for developers to borrow money to continue building and leaves them discounting their existing inventory of houses, Mr. Girden said.

For example, before loaning money to a condominium developer in the current market, mortgage lenders may require that 70% of the units be sold rather than the previous standard of 50% or less, he said.

"People are tight with money right now," said John Buckley,

president of NIF Services of New York Inc., which acts as an MGA and broker for construction-related risks primarily in New York, New Jersey and Connecticut. Hardest hit is the developer that typically builds three to eight houses a year, who is trying to sell a backlog of inventory and not start any new projects, Mr. Buckley said.

There has been a reduction in underwriting builders risk and general liability cover for single-family dwelling builders west of the Mississippi, especially in California, said David J. Price, executive vp and chief underwriting officer for Burns & Wilcox Ltd. in Farmington Hills, Mich., which underwrites builders risk and general liability insurance and acts as a managing general agent.

"States heavily affected by subprime lending are feeling the pain—Arizona, California and Florida," said Carole Fleischman, president of the managed insurance programs division of Arrowhead General Insurance Agency Inc. in Pasadena, Calif. The MGA offers liability coverage for various phases of commercial contractors' operations and wrap-up programs for residential and commercial projects, with a heavy emphasis on loss control.

Hard-hit states include Florida while the Midwest has been less affected, other sources said.

Exceptions in the depressed residential construction market include builders of high-end residential properties valued at more

than \$3 million each, which usually take about three years to complete, Mr. Buckley said. Artisan contractors, such as cabinetmakers, also are an exception.

COMMERCIAL RISKS

Subprime problems have had limited effect on commercial risks, most experts said.

There has been an upswing in building multifamily dwellings, as the people leaving single-family homes need a place to go, Mr. Girden said.

"We still see some apartment houses and a fair amount of rehab from contractor clients," who are "very resilient," said Mr. Price and others.

Lorna Parsons, president and chief underwriting officer for Chevy Chase, Md.-based Victor O. Schinnerer & Co. Inc., said: "I've remained bullish on the (commercial) marketplace," because most of her clients for professional liability coverages—architects, engineers and consultants—work on commercial projects.

She also cited U.S. government data to support her position. The U.S. construction market is a \$1.2 trillion annual market overall, with \$825 billion in private projects and \$295 billion in public projects including infrastructure repairs. Of the \$825 billion in private construction, the \$460 billion residential segment single and multifamily housing is down 20% this year compared with last year, while the \$360 billion commercial segment is flat. Companies that can will move into the commercial segment, she said.

"The downturn really hasn't hurt us yet," said Edwin van Zijll, a vp-technical underwriting for Allianz Global Corporate & Specialty North America, a unit of the Allianz Global Risk U.S. Insurance in Burbank, Calif. The company, which can offer \$200 million in property limits, focuses on large construction projects.

Even so, a few experts say commercial building also has suffered.

There has been some slowdown in general commercial construction, Mr. Girden said.

Allianz is not getting as many new submissions from southern California, Florida and Las Vegas as it used to,

Mr. Zijll said.

"Projects are smaller," and wrap-ups take more time because "insurers are taking longer to respond," Ms. Fleishman said.

Beyond the concern about some builders, Ms. Parsons said current market conditions have caused her to question how the subprime woes may affect the financial strength of insurers with whom she deals.

She also wonders whether economic conditions may spur an increase in professional liability claims against her clients. For example, builders or developers might be inclined to allege a design flaw as a way to obtain extra money or time to complete projects, although that typically happens during a period of high interest rates, Ms. Parsons said.

Sometimes, "desperate people do desperate things" in an attempt to recover insurance proceeds to help keep businesses afloat, Ms. Parsons said.

INSURERS' RESPONSE

Construction-related coverages generally are readily available for financially secure developers and owners during the current soft market, most experts said.

There is a wide variety of complex

construction-related coverages that insurers underwrite to protect contractors, developers and owners from mostly liability and sometimes property damages. The policies include builders risk, owners interest, and some wrap-up and completed operations programs. The coverage is specific to a project, whether it is a new subdivision or rehabilitating an existing building, which may be written as inland marine coverage.

"There is a glut of insurers willing to write this business," Mr. Girden said.

"The soft market has hit," said Mr. Buckley, whose company writes general liability and commercial property for general and artisan contractors as well as some builders risk and owners interest coverages.

"Because of the competitive nature of the marketplace, many of the underwriting requirements have been eased quite a bit," Mr. Price said. For example, restrictions on coverage for claims against the policyholder's prior work have been softened by underwriters generally. "That's a major departure and may bring fruit that you don't want to eat," he said.

Underwriting guidelines "seem to be loosening a bit," said Ms. Fleishman. For example, underwriters will consider an applicant's request to delete an exclusion, such as a specific type of pipe, so it can be used in the project.

In Connecticut, New Jersey and New York, there have been no significant changes in major terms and conditions, Mr. Buckley said. However, some insurers have extended completed operations coverage to two or three years, a coverage that previously was harder to obtain, he said.

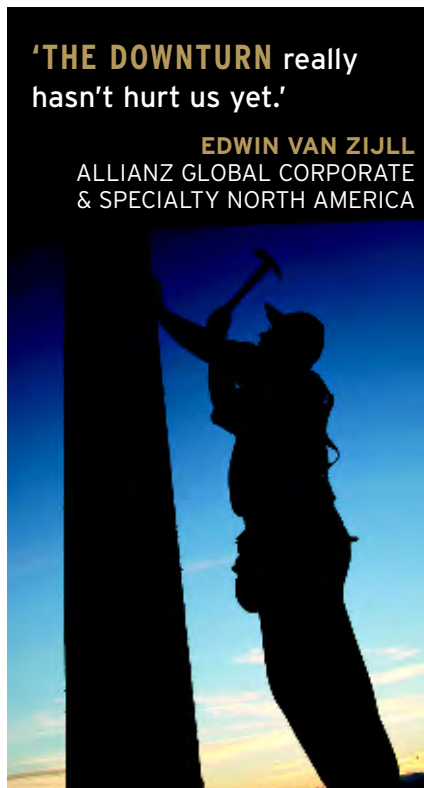
In addition, an insurer may throw in additional coverage for owners seeking to be named as additional policyholders on a contractor's policy, he said.

A typical deductible for builders risk coverage is \$5,000 to \$25,000 while a deductible may range from \$10,000 to \$25,000 for developers liability coverage, Mr. Girden said.

It's possible to get lower deductibles on some construction-related policies, Mr. Buckley said. For example, the average deductible in the Connecticut, New

'THE DOWNTURN really
hasn't hurt us yet.'

EDWIN VAN ZIJLL
ALLIANZ GLOBAL CORPORATE
& SPECIALTY NORTH AMERICA



Jersey and New York area now is \$10,000 to \$15,000, compared with \$15,000 to \$20,000 last year, he said.

A year ago, self-insured retentions on wrap-ups for small projects were a minimum of \$50,000 and now they are half that, Ms. Fleishman said.

PRICING

Pricing for construction-related coverage is "unreasonably affordable," Mr. Price said.

"A few years ago, all of this business was booming," he said. That attracted new insurers that would give discounts to attract business, which put pressure on established markets to keep rates lower than they otherwise would be.

In the past two years, coverage for general contractors declined as much as 40%, while premiums for small artisans—such as flooring installers—has declined 10% to 15%, Mr. Price said.

Mr. Buckley said rates are 25% lower for contractors general liability or owners interest policies compared with last year.

In addition, average minimum premiums went down "quite a bit" just since last November for limits of \$2 million per occurrence, \$2 million general aggregate, and \$2 million products and completed operations, Ms. Fleishman said. For example, a \$250,000 minimum premium then for a wrap-up policy is \$125,000 now, she said.

Arrowhead's target client is a "paper contractor" with \$100 million to \$200 million in annual revenues that subcontracts all or most of a project, she said. The company stresses the need for clients to follow sophisticated risk management protocols, such as professional reviews before and during construction, to reduce losses, she said.

Rates are going down for professional liability coverage, Ms. Parsons said. "It definitely went down about 5% in 2007 and I expect that it will go down about 5% this year."

Yet some insurers want to be sure they are dealing with stable applicants and scrutinize builders' and developers' financial statements before writing coverage, Mr. Girden said. For example, one major national insurer requires that a senior vp sign off on the financial

review before coverage is written, he said.

In addition, insurers are seeking more warranties to protect developments from vandalism, Mr. Girden said. For example, they are requiring developers to have periodic security patrols nightly.

If the construction is located in an area that's being redeveloped, Mr. Price said his company would check crime statistics to determine the potential exposure. If deemed significant, then the company may require fencing or security guards, he said.

SURETY

"There is a real concern" about surety bonds, Mr. Girden said.

Developers buy surety protection to guarantee that they complete their work. Such coverage is required by entities such as municipalities that want to ensure that subdivision projects are completed. If a developer fails to com-

plete a project, the municipality can collect on the surety bond.

Surety companies are monitoring customers "a lot more" and asking a lot more questions, and may limit the dollar amount of construction projects in which a developer can participate, Mr. Girden said.

"Surety providers are being more careful because of the financial stress on contractors," some of which are cutting back or going out of business, said Lynn Schubert, president of the Washington-based Surety & Fidelity Assn. of America.

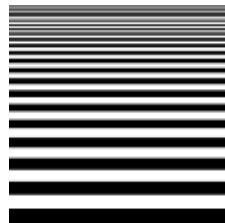
Surety companies are concerned about the fate of so-called "subdivision bonds," which municipalities often require to guarantee installation of roads and utilities in a new subdivision, Ms. Schubert said.

"As of yet they are not a serious problem, but they are something that we are watching," she said. **IF**

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Data breaches spark interest in cyber coverages

By Meg Fletcher

Upscale grocer Hannaford Bros. Co. reported that millions of customers' credit and debit card information had been compromised and, within days, four groups of plaintiffs' attorneys filed suit against the Scarborough, Maine-based company.

The plaintiffs allege that the supermarket chain was negligent for failing to provide adequate security for 4.2 million credit and debit card numbers, including 1,800 that were actually subject to fraud.

Hannaford was the victim of "a novel and sophisticated attack on our computer network" that resulted in the theft of some credit and debit card numbers during the card verification and transmission process in transactions from Dec. 7, 2007, to March 10, 2008, according to statements by Ronald C. Hodge, president and CEO. The grocery store chain is owned by food retailer Delhaize Group of Brussels, Belgium.

This latest data breach underscores the nature of the exposures that computer-related insurance—cyber risk and technology errors and omissions coverage—is designed to meet.

"People become more interested" in cyber insurance every time there is such a breach, but it is too soon to say whether that will result in more policies being sold, said Nicholas Economidis, a Philadelphia-based vp-technology, media and network security for AIG Executive Liability, a unit of American International Group Inc.

The speed with which class actions in the Hannaford case were filed indicates that plaintiffs' attorneys think they can demonstrate that damages occurred, said Tracey Vispoli, vp and manager for the financial fidelity and cyber solutions unit of the Chubb Group of Insurance Cos. in Warren, N.J.

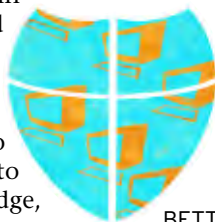
Cyber risk "is no longer just an IT

issue," Ms. Vispoli said "Now, C-level executives have to be involved in best practices."

It amazes me that we are not getting more inquiries" about Internet risk-related coverages generally, said Deborah Dioguardi, assistant vp for professional liability, employment practices and directors and officers coverages at NIF Group Inc. in Manhasset, N.Y.

If history is a guide, reports of recent data breaches may spur interest in computer-related coverages, but it will happen only gradually.

Too many businesses still think they don't need it and consider insurers'



'THERE HAS BEEN a lot of new interest in privacy and data protection coverages.'

RICHARD S. BETTERLEY
BETTERLEY RISK CONSULTANTS INC.

products too confusing and expensive to buy, several sources say.

SIGNS OF MATURITY

Yet there are signs of growing maturity in the market and, as the number of class action lawsuits grow, computer-related liability coverages should have more chances to show their value.

"There has been a lot of new interest in privacy and data protection coverages," said Richard S. Betterley, president of Betterley Risk Consultants Inc. in Sterling, Mass.

The cyber risk market "offers property and theft (first-party) coverage and liability (third-party) coverage; some carriers offer liability only, while others offer all," he said in a 2007 cyber risk market survey of 10 insurers and three wholesalers.

Most first-party property coverage protects a company against hacker attacks that can cause denial of Web

services, he said.

U.S. premium volume for cyber insurance was in the \$400 million range during 2007, up from \$300 million to \$350 million in 2006, Mr. Betterley estimated. It's odd that there has not been more of a rush toward specially designed products, and he said the slow growth of most new products and the relatively low insurance limits available may contribute to that.

Even so, things are improving. Individual insurers reported growth ranging from nearly 10% to more than 50% in last year's report, he said.

"I think it's seen as a real strong business growth opportunity for insurers, but they are cautious" about whether they understand the risk sufficiently to underwrite it profitably, Mr. Betterley said.

Previously, the coverages "didn't sell all that well," he said.

The slow market growth is due to a lack of understanding and that some businesses say the coverage it is "a little expensive," Ms. Dioguardi said.

Companies with computer-related risks seemed to think a problem would not happen to them or that they could readily fix it, Mr. Betterley said. Now, however, they're seeing "their peers get very substantial data breaches," he said.

In addition, "the types of coverages offered by cyber risk insurers vary dramatically," Mr. Betterley said. "Some carriers offer coverage for a wide range of business activities, while others are more limited," so "choosing the right product is a challenge," he said.

His survey focuses on insurance products designed to protect against the unique risks of doing business. His focus is on coverage for organizations offering products and services over the Internet—excluding insurance—and content providers.

One particular concern is that substantial differences can exist in policies in defining "insured," "claim" and whether subcontractors are covered, Mr. Betterley said.

Currently, "the marketplace is very competitive, with a wide variety of coverages being offered," said Inga Goddijn, product manager for E&O and information technology risks at Deerfield, Ill.-

based Markel Shand Inc., an underwriting manager specializing in surplus lines coverages. It targets small to midsize companies with revenues up to \$25 million, and offers typical cyber liability limits of \$1 million to \$3 million, although it can offer \$5 million. Typical deductibles range from \$5,000 to \$25,000.

"When considering purchasing this coverage, I do think it's important for buyers to closely examine the terms being offered," Ms. Goddijn said. "There is little consistency in the forms from one market to the next, with each carrier using their own definitions, terms and conditions," she said.

"One of the drivers has been concerns for the liability exposure created by databases," she said. "It's important for businesses to think of the first-party costs to them" following a data breach, including the costs of resuming computer operations, bringing in experts to fix the problem and time lost in performing normal business functions.

PRICES VARY

Pricing for the coverage also varies.

"The marketplace for this coverage is very competitive with pricing down 5% to 10% from last year," Ms. Goddijn said.

"In the current soft market, it's staying flat because it is still quite new," Ms. Vispoli said. Chubb began offering its cyber security product to financial institutions in 2001, expanding to other businesses last year. A typical Chubb cyber risk customer has \$200 million or less in revenues and is seeking \$2 million to \$10 million in limits, with a deductible of \$25,000 to \$250,000.

Regardless of the price, some critics question the need for cyber coverage.

"I don't normally recommend cyber insurance since there are too many open questions on its value," said Rich Mogull, founder of Securosis L.L.C., an independent security consulting practice in Phoenix.

Insurers don't have adequate actuarial data to price the product, Mr. Mogull said. The only value insurance offers is that it may cover some of the financial costs of a data breach.

"The question of meaningful loss data is a fair one," Ms. Goddijn said.

Any insurance product takes time to mature and develop loss information.

It's a complicated coverage that "is difficult for underwriters to underwrite," in part because of the lack of good claims data, Ms. Vispoli said.

While insurers use assumptions to develop confidential pricing models, they also use concrete loss data.

For example, the Ponemon Institute L.L.C. in Traverse City, Mich. reported that data breaches cost companies \$197 per compromised customer record in 2007, up from \$182 in 2006. The findings were based on an analysis of 35 U.S. organizations experiencing breaches ranging from fewer than 4,000 records to more than 125,000 records, according to a company statement.

In addition, "there are a lot more claims out there than people realize," AIG's Mr. Economidis said.

Mr. Economidis said he also expects an increase in corporate liability exposure for damages resulting from the unintended release of personal data as a result of a decision last November by the 9th U.S. Circuit Court of Appeals in the case of *Stollenwerk vs. Tri-West Health Care*. That decision will make it easier for plaintiffs suffering identity theft to seek recoveries for damages.

Approximately 40 states require notifying consumers following a breach of private information such as credit or debit card numbers, Social Security numbers and health history.

Estimates of the cost of notifying each compromised customer vary from a few dollars to Ponemon's estimate of \$15 in 2007, which was down from \$25 per customer in 2006.

In addition, costs of monitoring a person's credit range from \$10 to \$20 per year, Mr. Economidis said. AIG offers up to \$25 million in limits for both cyber risks and technology E&O coverage, with varying retentions.

Technology E&O insurance "is coverage for the liability of organizations and individuals that provide products and services utilizing technology," Mr. Betterley said in his 2008 market survey of 18 insurers.

There are three major types of technology E&O coverage:

- Liability—defense and settlement

costs for the liability arising from the failure to properly handle private data.

- Remediation—costs to respond to a data breach, including investigation, customer notification and credit monitoring.

- Fines and/or penalties—costs to investigate, defend and settle fines and penalties that a regulator may assess.

The older technology E&O market is more established than the cyber risk market and much larger with annual gross written premium possibly as high as \$1.5 billion to \$2 billion, Mr. Betterley estimated.

BEWILDERING CHOICES

Yet the technology market still varies "wildly," he said. "With a wide variety of coverages available, each written on a nonstandard form, insureds and their advisers can be confused and bewildered at the choices," he said.

Policyholders can either buy individual policies that supplement their core general liability coverage or a policy that includes both general liability and technology E&O coverage, Mr. Betterley said. "Some carrier markets offer coordinated E&O and CGL coverage, whereas other markets may offer monoline E&O only," he said.

Pricing of technology E&O coverage is declining with the soft market.

Rates are softening "significantly," Mr. Betterley said. Several insurers reported plans to reduce rates 10% to 20% as needed, with a few planning reductions of 3% to 5%, he said.

Applying for computer-related coverages often includes some type of network security assessment.

"It's very important," Ms. Vispoli said. Chubb will decline to quote a risk if an applicant's security system does not meet its standards. If the security system is borderline, Chubb may require changes.

At AIG, the application process is "a lot easier to apply than it used to be," Mr. Economidis said. In the late 1990s, AIG would inspect the applicant's worksite. Now, underwriting primarily depends on the application, with a supplemental application for companies with more than \$250 million in sales. A conference call may be arranged to resolve any questions. ■



Star power

Specialty markets battle for top talent in competitive recruiting environment

By Rodd Zolkos

As in other areas of the insurance business, the need for top talent is a critical issue among specialty markets companies.

The talent need might be particularly acute for specialty market players as they confront competition from new entrants, a softening market drawing admitted market players to compete for business that had been the province of excess and surplus writers, as well as the fresh exposures and changing risk profiles of specialty clients.

"If there is one issue that our members have consistently been challenged with during the softening market, it's been recruiting and retaining quality talent and the intellectual capital that's needed," said Bernd G. Heinze, executive director of the King of Prussia, Pa.-based American Assn. of

Managing General Agents.

Among specialty insurers, "what I've observed, particularly with a lot of the Bermuda and London companies that are seeking diversity in their portfolios, they have come to the States to build specialty operations," said Peter Reed, partner with executive search firm CTPartners in New York.

Those new operations, he said, are competing with U.S. operations for talent. "Now there's a lot of new entrants and not enough talent on the bench to support those efforts."

In the current market, "you'd better know how to underwrite and follow your underwriting rules," said Detlef Steiner, chairman of New York-based program insurer Delos Insurance Co.

"Underwriting is key right now," Mr. Steiner said. "You have to find the diamonds in the rough."

In such an environment, talent is

critical, he said.

His company relies largely on "outsourcing," Mr. Steiner said, working through MGAs. "We are outsourcing a lot," he said. "We are outsourcing almost everything to our MGAs."

Because the company is working with MGAs, it doesn't need as large a staff, but it still requires at least "a few people who really understand the business," Mr. Steiner said. "You give your paper to somebody who is using it in the market, so you'd better control what they're doing," he said.

"Particularly in our business, program business, there are not many people doing this business. So it can be difficult to find what you need," he said. "Finding these talents is not easy. It's difficult because it's a different mindset. You can't just hire people from a traditional insurance company and expect them to understand outsourcing."

Mr. Steiner said he has been fortunate at Delos. He previously ran specialty insurer Clarendon Insurance Group, where he was president and chief executive officer, and was able to draw some professionals he worked with there to Delos.

Specialty companies looking for top talent need to recognize that demand often outstrips supply, CTPartners' Mr. Reed said.

"It's certainly a competitive market and companies that need talent are going to pay for it," he said.

'CHANCE TO BE TOP DOG'

Smaller companies might be able to meet their talent needs by giving someone a rung or two down the organizational ladder at a larger company a chance to step up, Mr. Reed said.

"Some of those smaller companies might give someone who's a layer or two down in a bigger organization the chance to be top dog," he said. "You might see some of those companies go a notch down and give somebody an opportunity to advance their career in a way that they otherwise might not have been able, maybe build equity in a new organization."

"The first look, of course, is to look at somebody who has a name, has credibility and perhaps can bring a team,"

Mr. Reed said.

He cited the recent example of Ironshore Inc. forming a health care liability operation, IronHealth. The operation is headed by Matt Dolan as president, who, along with the rest of its senior management, previously ran OneBeacon Professional Partners.

Recruiting an entire specialty market team is a way to get in the game quickly in a new market, Mr. Reed said. Another technique some companies are using is to temporarily assign leaders from one area of the company to lead the new specialty effort.

As they look to attract top executives, salary is obviously one way specialty insurance businesses are competing, but salary alone isn't enough, Mr. Reed said. "Where the winners pull away is total compensation."

Companies have to look for ways to lock individuals into the organization, which means "keeping them not just financially engaged but intellectually," Mr. Reed said. "There are people who are motivated by things other than money."

Nonmonetary motivations could include benefits, breadth of responsibilities and an opportunity to take an equity stake in a company.

There's another challenge facing smaller specialty insurance startup operations as they look for top talent. "Where they're going to struggle in a market like this...is they don't have the resources and the servicing capabilities that the bigger companies bring," Mr. Reed said.

Whether it's with technology-based tools or other services, larger companies are increasingly looking for ways to add value to their relationships with clients; insurance buyers, in turn, are expecting to receive those benefits in their insurance relationships.

The ability to provide those sorts of resources might make it difficult to lure some individuals from larger companies.

"It will be a factor for someone who's been at a big company and who's become accustomed to and whose whole pitch in dealing with clients is those extra services," Mr. Reed said. "That's sort of an unintended but very real retention tool."

Among MGAs, the talent that's required extends beyond underwriting and comes into play in such areas as mar-

keting, the AAMGA's Mr. Heinze said.

Looking at new business opportunities, MGAs must be sure they're providing clients the appropriate forms and coverages, Mr. Heinze said. As clients' business situations change, MGAs need professionals on their staffs who can recognize the impact of those changes on the clients' insurance programs.

"It's an ongoing underwriting process that our members face," Mr. Heinze said. "The issue is to make sure that employees are giving clients what's appropriate and what they're looking for, and no less."

As a way to address some of those challenges, the managing general agents group formed AAMGA University 21 years ago.

The university's board of directors is made up of previous AAMGA presidents, and the association employs a full-time director of education and professional development responsible for the program's curriculum and keeping abreast of the educational needs of AAMGA members, as well as the retail agents they serve, "because they are the actual customers of our members," Mr. Heinze said.

SIDE-BY-SIDE RISK ED

In recent years, Mr. Heinze said, the association has increasingly focused on educating not just its members but also those retail agents, "because having them learn together is the best way to handle risk."

AAMGA University offers two designations for individuals, the Certified Insurance Wholesaler and Certified Wholesale Insurance Specialist, as well as a designation for agencies, the Certified Managing General Agency, that reflects the educational activities of an MGA's employees.

The designations are earned by completing educational requirements through AAMGA University and nonuniversity courses and, for the individual designations, completion of a project.

Mr. Heinze said a key benefit for an agency getting the CMGA designation is it demonstrates to insurance markets and retail agents that the MGA is committed to staying current with market issues as well as preparing itself to deal with changing conditions and emerging exposures.

The AAMGA has also begun working to reach the next generation of insurance professionals, hoping to attract them to

and prepare them for the specialty markets.

"We've formed a partnership with Georgia State University," Mr. Heinze said. The association pledged \$1 million to fund an endowment to establish a distinguished chair in GSU's J. Mack Robinson College of Business, Department of Risk Management and Insurance.

"We thought this would be a great opportunity for the AAMGA to talk to the professors and tap their expertise," Mr. Heinze said. "Not only will research be done but white papers will be written, so the AAMGA can continue its leadership in the specialty markets area."

The AAMGA also is reaching out to other university business schools and insurance and risk management programs, and is expanding its internship program. The internships are designed to give participants exposure to various aspects of the business. The association is designing the internships to meet the various needs of students interested in them.

"We need to change our way of thinking, because what we see in many of the young people today is they don't have the same sort of work thought process that we've had in the past," Mr. Heinze said. To that end, rather than offering only semester-long internships, the AAMGA is designing its internships to fit the student's schedule—whether it's a week, a month, a holiday break, etc., and creating syllabuses that are appropriate to the time frame.

"It would be foolish of us and we could not expect to be all that we could be if we ignored some of these young people who've chosen this as a career," the AAMGA's executive director said.

"As there's been more convergence in the business with the capital markets, as underwriting companies have become more sophisticated, there's a case to be made to a young person to build a career in insurance," Mr. Reed said, and companies that do the best job of crafting a message to college students making that case "will have a leg up."

"Companies that can offer a young person a training program and, perhaps, a rotational program that can give them an exposure to various lines of business, I would think would be very attractive to young people," Mr. Reed said. ■

Subprime fallout could cost billions

By Meg Fletcher

NEW YORK—The insurance industry faces billions of dollars in litigation losses related to the U.S. subprime mortgage crisis, including a wider variety of claims than analysts predicted initially.

The property/casualty insurance industry's main loss exposure will be from financial institutions' claims to recover losses under their directors and officers and errors and omissions coverages, industry experts say.

Insurers also may face claims under other potentially applicable coverage including fiduciary liability and comprehensive general liability, said Robert Jacobs, one of three policyholders' attorneys with Washington-based Howrey L.L.P. who discussed the topic with an economist during a webinar last month sponsored by the New York-based Risk & Insurance Management Society Inc.

Plaintiffs also may seek recoveries under partnership liability and credit risk insurance, according to New York-based research firm Advisen Ltd.

"Among the potentially groundbreaking suits...are those filed by the NAACP and the cities of Cleveland and Baltimore alleging predatory and discriminatory lending" for selling higher-interest subprime mortgages to blacks more frequently than to whites, according to a special Advisen report.

Several factors may limit insurance recoveries, some observers say.

For example, it remains to be seen whether financial institutions' coverage responds to suits such as one filed by the Baltimore-based National Assn. for the Advancement of Colored People, which the courts may find involved willful acts that could preclude recoveries, observers said.

In addition, plaintiffs seeking recoveries under federal securities laws face a higher burden of proof than they did previously, experts say.

"A tidal wave of defaults by U.S. homeowners with tarnished credit histories under adjustable-rate mortgages sparked the present crisis in the global financial

markets," wrote David Bradford, co-founder of Advisen and editor-in-chief.

It has also sparked interest among some U.S. corporate policyholders affected by such financial dealings to explore the possibility of litigating to recover damages or to protect their firms from such claims. For example, the recent webinar drew nearly 500 people—auditors, banks, brokers, fund managers, insurers and lawyers—representing 341 companies, a RIMS spokeswoman said.

Although subprime litigation is in its early stages, all financial institutions will have exposure to the crisis, said William R. Berkley, chairman and chief executive officer of W.R. Berkley Corp.

Lawsuits related to subprime fallout are being filed daily, though estimates of total insured or uninsured losses vary.

■ New York-based Guy Carpenter & Co. L.L.C. estimated in January that the insured D&O impact will be \$3 billion, mainly for primary insurers, from a total \$400 billion in insured and uninsured losses.

■ Advisen Ltd. estimated in February that D&O liability insurers are likely to face as much as \$3.6 billion in claims and defense costs stemming from shareholder lawsuits over write-downs for subprime-related investments.

■ Yet Bear, Stearns & Cos. Inc. in January estimated industry D&O losses at \$9 billion—a number that D&O experts have referred to as extremely high—before the investment firm collapsed and was sold for \$10 a share last month.

■ Overall, total losses "could total \$400 billion to \$500 billion," Faten Sabry, vp of Washington-based NERA Economic Consulting, said during the webinar.

ROOT OF THE PROBLEM

"Subprime loans accounted for more than 20% of U.S. mortgages in 2005 and 2006, up from 9% in preceding years," Mr. Bradford said.

Lenders "significantly relaxed" their underwriting and frequently wrote loans with a low initial fixed rate that resets to a higher adjustable loan for the duration of the mortgage. "When falling real estate prices made it difficult for subprime homeowners to refinance before higher monthly payments kicked in, many defaulted," Mr. Bradford said.

That pain spread to those who participated in securitizing the subprime loans, which seemingly turned "the illiquid asset into a security," Ms. Sabry said. Sometimes, insurance and letters of credit made the securitized packages attractive to investors.

Securitization expanded the number and type of defendants potentially liable for policyholders' losses.

Mr. Bradford said a key participant in the process was mortgage lenders, who followed their usual practice of selling loans to investors and keeping only an origination fee.

"Lenders nonetheless found themselves in deepening trouble as the result of buyback provisions that permit investors to sell back loans that go bad within a specified period of time," he said. Investors forced lenders to buy back hundreds of millions of dollars in bad loans, causing dozens of them to go out of business or seek a buyer.

The loans acquired from mortgage lenders often were pooled in mortgage trusts, and investment banks created residential mortgage-backed securities from

SUBPRIME TARGETS

Breakdown of 236 subprime lawsuits filed as of March 17

Securities class action and securities fraud	74
Underwriting malpractice	50
Fraudulent practices including predatory lending	44
Shareholder derivative suits	22
ERISA	16
Breach of contract	13
Auditor malpractice	5
Breach of fiduciary duties	5
Banking malpractice	1
Legal malpractice	1
Other	5

Source: Advisen Ltd.

these trusts and sold them to financial institutions and investors, he said.

"As defaults mounted, (collateralized debt obligations) plummeted in value and investors were forced to write down the value of the assets on their balance sheets," Mr. Bradford said. Advisen identified 130 companies that reported \$257 billion in subprime-related write-downs by early February. In addition, "bond insurers that guarantee the interest and principle payments on some of these securities have come under intense pressure and more write-downs will come if these insurers collapse," he said.

With the subprime woes, banks have significantly restricted credit availability.

U.K. mortgage bank Northern Rock was an early casualty. The bank was rescued by the Bank of England earlier this year. "This sort of 'collateral damage' from the subprime crisis is expected to spread more broadly through the global economy," Mr. Bradford said.

In the year since the first subprime-related write-downs, defaults reached record levels and companies were forced to re-evaluate the value of mortgage-backed CDOs and other securities and report write-downs, he said.

Some analysts say that write-downs globally could top \$450 billion.

EVERYONE'S A TARGET

"Almost every party in the loan origination and securitization machine that financed the housing boom of the recent past is a target for lawsuits," Mr. Bradford said. That includes mortgage brokers, lenders, underwriters, rating agencies and bond insurers. Other potential targets include banks and real estate investment trusts that provided capital to subprime lenders, financial institutions that failed to disclose their risky investments and homebuilders.

As of mid-March, 236 subprime-related lawsuits were filed in 11 categories, Advisen reported (see chart, page 18).

The report said that the most popular cause of action alleges securities laws violations. One common claim is that lenders lacked internal controls and based projections and results on incorrect assumptions or manipulated facts. Another is that financial statements were misstated because of the failure to



Workers leave the New York headquarters of financially ailing investment firm Bear, Stearns & Cos. Inc.

properly account for loan repurchases or write-down deteriorating assets.

Other frequent claims are underwriting malpractice and fraudulent trade practices, Advisen said. Some of the subprime mortgage-related lawsuits include derivative shareholder actions while others are class actions brought under the Employee Retirement Income Security Act.

The Howrey attorneys said the trusts and trustees of the underwriter or placement agent, as well as the rating agency, could face breach of contract allegations and challenges to valuation of residuals, servicing rights and loan loss reserves.

In addition, buyers of the mortgage- and asset-backed securities—including pension funds, insurers and hedge funds—may face allegations related to investment suitability and misrepresentation, as well as violations of investment and risk management guidelines.

Many policyholders with subprime-related grievances should be able to legitimately file claims with their insur-

ers for defense and indemnity coverage under terms of their claims-made policies, said attorney Andrew Reidy of the Howrey law firm. Claims related to investigations by various federal and state agencies are more difficult because they depend on a state's laws as well as the terms of the policy, he said.

D&O, E&O COVER

Analysts generally agree that the plaintiffs most likely hope to recover from D&O coverage. E&O coverage for financial institutions, real estate appraisers, auditors and lawyers also may be tapped, Mr. Bradford said.

Citing Guy Carpenter's research, Mr. Bradford said there is at least \$16 billion in mortgage broker E&O limits at risk.

Some specialized forms of bankers professional liability "may be called on fairly often," Mr. Jacobs said.

"However, most of the predatory and discriminatory lending suits filed to date have targeted lenders rather than brokers," Mr. Bradford said. Also, "insurers may have grounds for denying coverage for many predatory lending claims since it is a deliberate and illegal act."

D&O insurers may be helped by the fact that "many large banks have eliminated corporate reimbursement and entity coverage...leaving only coverage for derivative suits and other nonindemnifiable situations as well as suits with the entity in bankruptcy," Mr. Bradford said.

Also, it is likely that courts will dismiss many subprime-related securities lawsuits, according to Advisen and Guy Carpenter research, because recent U.S. Supreme Court decisions have raised pleading standards in securities cases.

Also, it will be more difficult for a plaintiff to argue "that the conduct of any one company and its directors and officers was egregious or fraudulent" because the losses are related to the collapse of residential real estate prices, a large-scale event, Mr. Bradford said.

The fact that many hedge funds and some financial institutions did not purchase coverage or have large retentions also will limit recoveries, observers say.

"The overall financial impact on insurers is likely to be painful, but not cataclysmic," Mr. Bradford said. ■

'Perfect storm in reverse'

Medical professional liability sees fortunes turn due to variety of improvements

By Rodd Zolkos

CHICAGO—After losing money from 2001 to 2004, medical professional liability insurers' fortunes have turned positive since 2005, though some factors that contributed to their financial improvement may be subject to change.

"The industry is probably in a position that is better than it's ever been in before," said Robert D. Francis, chief operating officer at the Doctors Co. in Napa, Calif. Mr. Francis moderated a panel offering an overview on the medical professional liability industry last month at the Professional Liability Underwriting Society's Medical Professional Liability Symposium in Chicago.

One key to the improved financial performance of medical professional liability insurers in recent years has been a downturn in claims frequency, according to the panel.

In discussing factors behind that frequency decrease, Janet R. Fort, vp at Lexington Insurance Co.'s AIG Healthcare unit in Southfield, Mich., said, "Most people would put their finger on...tort reform."

Other "softer reasons" also are contributing to the decrease in frequency, she said, including patient safety initiatives at hospitals and clinics.

"There is an improved judiciary in many states," said Todd R. Mockler, senior vp at John B. Collins Associates Inc. in Minneapolis. "There are risk management initiatives taking place"

leading to improvements in loss frequency.

"I don't think you can put your finger on any one thing," Mr. Mockler said. "You might say it's kind of a perfect storm in reverse, where a lot of things come together to lead to improvements over the past five or six years."

Donald W. Bahr, senior vp at Max Bermuda Ltd. in Hamilton, Bermuda, said he thinks societal pressures against frivolous lawsuits have been a factor in reduced frequency, along with the fact that lawsuits have become less lucrative.

"We've been trying to ascertain whether this loss-cost decrease is across the board or just in frivolous lawsuits," said Mr. Bahr, who expects a "gradual uptick" in frequency over the next few years, driven in part by pressures from the current economy leading to an increase in lawsuits.

Ms. Fort also expects frequency to turn upward, noting that more people are entering the health care system at the same time that the number of health care

providers is declining. Both features "put stressors on the systems," she said.

Asked whether there are ways to predict changes in frequency, James D. Hurley, consulting actuary with Tillinghast in Atlanta, said, "One thing you don't want to do is overlearn from what you're seeing in the data."

"Sometimes early on in the process, what you see is not what you get," he said.

Medical professional liability insurers have also benefited from a decline in

claim severity, according to some panelists.

"We're seeing a decline in frequency in the eight-figure claims," Ms. Fort said. She attributed that trend in part to third-party administrators and insurers doing a better job of identifying cases that might lead to large awards and resolving them before they get to trial.

A softening market is another factor that could affect medical professional liability insurers going forward.

"Anybody I talk to, the phone calls I get in a given week, there are probably a half dozen that have to do with someone being irrational" in pricing, Mr. Hurley said, and the frequency of those calls is increasing.

This year "is a year that's already in the book, if you will," Mr. Hurley said. But looking towards 2009, "I know people are getting more aggressive, he said.

"It's bloody," Ms. Fort said of market competition. "I think we're in the competitive stage right now."

Underwriters believe they are cutting prices on profitable accounts, she said. "When we get to the bottom of the slippery slope, you'll see people cutting prices on unprofitable business," Ms. Fort said. "That's when you know that we've hit bottom." That point is perhaps two years off, she said.

"As we hit 2008 we're continuing to see falling rates on the primary side and we're seeing a lot more pressure to decrease reinsurance costs," Mr. Bahr said. Ceding companies are buying less reinsurance as their own positions have strengthened, he said.

Looking at the potential effect of this fall's U.S. presidential election, Ms. Fort said, "If there's universal health care of some sort, there's going to be more people pushed through the system and no mechanism for training more physicians, so there's going to be a collision."

Mr. Mockler, though, described the U.S. health care system as an "aircraft carrier" that isn't subject to rapid turns one way or the other. "Nothing will happen overnight in terms of health care," he said. **IF**



Members of the Professional Liability Underwriting Society gathered in Chicago last month for the group's annual Medical Professional Liability Symposium.

'WE'RE SEEING a decline in frequency in the eight-figure claims.'

JANET R. FORT, LEXINGTON INSURANCE CO.'S AIG HEALTHCARE

Integration breeds flexibility to withstand uncertainties

By **Jamie Bisker**

It is clear that the insurance industry needs to embrace the concepts and capabilities derived from applying innovation to a large proportion of its activities.

The challenge of late is that even though the message and the power of its execution are as viable as ever, those that promote the idea (including this author) are in danger of wearing out the attention span of the intended audience.

This should not be surprising, given the consistency of human nature and how quickly we habituate to stimuli, but it is more dangerous than merely growing weary of various TLAs (three-letter acronyms) and the fads that often accompany them.

To lessen the likelihood of “idea fatigue,” I think it is very important that industry mavens turn their attention to some of the critical elements necessary to create value in the near future for insurers and their stakeholders. One of the critical elements of the insurance equation is integration.

This should not be confused with various concepts of “business alignment,” a concept most IT and business professionals equate with water being wet—it’s a given. Yes, there are companies out there that do need to focus on some of these straightforward and essentially assumed aspects of our current insurance environment, but we need to look forward when possible.

Integration, in the sense that I use it, means “coordinating business processes into an effective business environment,” a slight modification to one of its traditional definitions. Today’s business environment is growing less tolerant of insurers trying to move forward with established and aging modes of operation. Integration is a point of focus that can drive the insurance industry forward.

In light of the available tools and technology, insurers need to improve the coordination of business between lines of business and operational areas. This is true whether it’s across existing or planned divisions, between floors, across town or around the country. However, for insurers with global strategies, integration takes on boardroom importance to ensure that benefits derived from emerging markets are not consumed by inefficient operations.

There are two basic variables in achieving integration in an insurance company. First, a company must



Jamie Bisker is global insurance industry leader at the IBM Institute for Business Value in Cambridge, Mass.

invest in understanding, controlling and ultimately delivering on its data resources. Generally, this means understanding master data management, working with industry standards for data and knowledge transfer, and having consistent systems architecture.

The second variable is achieving the systems flexibility necessary to respond to the demands of the financial services marketplace in addition to the traditional needs of risk management. It is no secret that the current and near-term future state of the art for this aspect of integration

revolve around component-based methodologies and services-oriented architecture. Both of these variables drive the ability to be flexible enough to respond to whatever business, competitors or nature throws at us.

Another important aspect of an integrated insurance enterprise (I²E) is establishing the holistic approach to our industry that is a key to breaking out of the old models constraining our success.

At the risk of diving too deeply into the metaphor bin, I want to posit that insurance integration as discussed here can be thought of in terms of a well-run restaurant.

It’s not about how much the meal costs or even the quality of the food—again, those are givens today in a world where we can spend our dining-out dollars in hundreds of venues. What often distinguishes the best from the rest is the feeling that you, the diner, matter to everyone in the operation.

You are everyone’s table. The manager checks during every visit to make sure you are satisfied and fixes things if you are not. The extra item is slipped into the order because they know you like it, and all the other little touches that make a difference to each client. These restaurants are holistic and know that operating with an understanding of the entire business is critical to their success and critical to their culture. Holistic operations and management style are key elements of an I²E as well. Flexibility is needed by both the business and IT sides of the equation.

Integration is a key element in developing a vision for your company, because without a vision, there is less reason to exceed current attributes. And that, unfortunately, is what locks so many companies into pitched battles for optimization of the current squeaky wheel.

The goal of achieving higher performance through integration will require investment in the variables that companies can control. Steadfast execution of an integration strategy will allow companies to better deal with the variables they can’t control. ■

LARGEST MANAGING GENERAL AGENTS, RANKED BY 2007 PREMIUM VOLUME*

RANK

1

Burns & Wilcox Ltd.

220 Kaufman Financial Center
30833 Northwestern Highway
Farmington Hills, Mich. 48334
800-521-1918
www.burnsandwilcox.com

2007 premium volume \$750,000,000

% change	7.1%
2007 gross revenue	\$185,000,000
% change	5.7%
% MGA	58.0%
% wholesale broker	30.0%
% Lloyd's of London coverholder	12.0%
Total employees	891

Principal officer:
Alan J. Kaufman
chairman/president/CEO



RANK

2

Eastern America Insurance Agency Inc.

Metro Office Park
Street One, Lot 10, P.O. Box 193900
San Juan, Puerto Rico, 00919-3900
787-273-1288
www.universalpr.com

2007 premium volume \$224,463,335

% change	-6.3%
2007 gross revenue	\$11,359,439
% change	8.8%
% MGA	100.0%
% wholesale broker	0.0%
% Lloyd's of London coverholder	0.0%
Total employees	159

Principal officer:
Luis Miranda Casanas
president

RANK

3

K&K Insurance Group Inc.

1712 Magnavox Way
Fort Wayne, Ind. 46804
260-459-5000
www.kandkinsurance.com

2007 premium volume \$213,316,406

% change	-3.5%
2007 gross revenue	\$42,902,000
% change	-10.1%
% MGA	96.0%
% wholesale broker	4.0%
% Lloyd's of London coverholder	0.0%
Total employees	276

Principal officer:
Ross T. Smith
president/CEO

RANK

4

NIF Group Inc.

30 Park Ave.
Manhasset, N.Y. 11030
516-365-7440
www.nifgroup.com

2007 premium volume \$205,000,000

% change	-2.5%
2007 gross revenue	\$21,000,000
% change	4.5%
% MGA	62.0%
% wholesale broker	35.0%
% Lloyd's of London coverholder	3.0%
Total employees	128

Principal officer:
Mark P. Maher
president

Source: Business Insurance survey. Researched by Kevin Edison and Karen Tucker.

RANK

5

WK&C Agency Inc.

1 Huntington Quadrangle
Suite 4N20
Melville, N.Y. 11747
631-756-3000
www.wkfc.com

2007 premium volume
\$200,000,000

% change	23.5%
2007 gross revenue	\$28,400,000**
% change	20.1%
% MGA	95.0%
% wholesale broker	0.0%
% Lloyd's of London coverholder	5.0%
Total employees	88

Principal officer:
Thomas J. Kennedy
chairman/CEO

RANK

6

**Sullivan Group-
Wholesale Operations**

800 W. Sixth St.
Suite 1800
Los Angeles, Calif. 90017
213-626-1000
www.gjs.com

2007 premium volume
\$197,265,797

% change	-6.7%
2007 gross revenue	\$22,932,679
% change	5.0%
% MGA	50.0%
% wholesale broker	47.0%
% Lloyd's of London coverholder	3.0%
Total employees	149

Principal officer:
Gerald J. Sullivan
chairman

RANK

7

**LoVullo Associates
Inc.**

6450 Transit Road
Depew, N.Y. 14043
716-856-3065
www.lovullo.com

2007 premium volume
\$141,984,000

% change	6.4%
2007 gross revenue	\$39,000,000
% change	11.1%
% MGA	65.0%
% wholesale broker	30.0%
% Lloyd's of London coverholder	5.0%
Total employees	78

Principal officer:
Leonard T. LoVullo
president

RANK

8

Insurance House

1904 Leland Drive
Marietta, Ga. 30067
770-952-0080
www.insurancehouse.com

2007 premium volume
\$114,000,000

% change	2.7%
2007 gross revenue	\$17,816,000
% change	25.3%
% MGA	65.0%
% wholesale broker	30.0%
% Lloyd's of London coverholder	5.0%
Total employees	200

Principal officer:
Jill Jinks
CEO

RANK

9

**Arlington/Roe
& Co. Inc**

8900 Keystone Crossing
Suite 800, P.O. Box 80803
Indianapolis, Ind. 46280
800-878-9891
www.arlingtonroe.com

2007 premium volume
106,544,098

% change	1.5%
2007 gross revenue	\$11,950,945
% change	3.9%
% MGA	56.0%
% wholesale broker	44.0%
% Lloyd's of London coverholder	2.0%
Total employees	127

Principal officer:
James A. Roe
president

RANK

10

**Midlands
Management Corp.**

3503 N.W. 63rd St.
Suite 305
Oklahoma City, Okla. 73116
405-840-0074
www.midlandsmgt.com

2007 premium volume
\$88,500,000

% change	27.0%
2007 gross revenue	\$20,350,000***
% change	28.8%
% MGA	70.0%
% wholesale broker	20.0%
% Lloyd's of London coverholder	0.0%
Total employees	165

Principal officer:
Charles C. Caldwell
president/CEO

*Companies deriving more than 50% of their wholesale premium volume from acting as a managing general agent **Business Insurance estimate ***10% of total wholesale revenue comes from acting as an underwriting manager



SCOTT G. STEPHENSON
is an executive vp of the
Jersey City, N.J.-based
Insurance Services Office
Inc.

Sophisticated analysis changing the game

Advanced analytics are creating a significant disruption in the insurance marketplace. Indeed, the proliferation of analytics is more than just introducing a new player. It's unleashing a true "game changer."

Avoiding this transition is not an option—doing so can only be detrimental and, ultimately, self-defeating for insurers.

We have seen it before: the introduction of catastrophe modeling, medical bill review and predictions for cost containment and reserving in workers compensation, granular estimation for rebuilding properties, risk-based pricing in personal auto, predictive models for fraud mitigation and other operational processes. And the list continues.

Applying advanced analytics to ever-larger and more detailed databases is transforming business processes and improving decision-making. From product development and marketing, to underwriting and rating, to claims and reinsurance, predictive analytics offer limitless opportunities for better strategic and tactical decisions across the insurance enterprise and in distribution channels.

Effective predictive analytics combine two essential elements. First is the discipline of data analysis and rigorous parsing of disparate data sources to arrive at practical conclusions. Second is the skill to construct intricate algorithms and models to validate the likelihood of specific outcomes.

Beneficial predictive models depend on quality data. The quality and availability of data determine the effectiveness and reliability of predictive models, especially at highly granular levels of variables, where analyses can produce direct and fundamental value.

For example, sophisticated predictive models for personal auto rating and underwriting already are in development. The focus is on identifying new ways to segment and evaluate risk using geospatial information at and around specific locations where customers live and drive. In addition, innovative practitioners are making next-generation personal auto models even more powerful by adding variables based on the characteristics of individual vehicles (horsepower, for example) with the necessary data obtained by decoding vehicle identification numbers.

Solution providers at the forefront of data, analytics and decision support products are

extending analytic innovation beyond personal auto and into homeowners insurance. They also are rapidly improving their understanding of risks in commercial auto, workers compensation, general liability and commercial property.

Predictive modeling enables workers comp insurers to accurately identify the variables affecting losses and build rating plans that attract good risks. Another promising direction in workers comp is using advanced analytics to stem premium leakage, improve premium audit efficiency and manage claims.

Predictive models enable pricing each risk on its own merits. But even when insurers cannot deviate from bureau rating plans and loss costs, the same models may enhance underwriting or marketing decisions.

The value creation chains for all insurance lines have much in common. In particular, fraud is a problem for all lines. Today, leading-edge insurers are using predictive analytics and data-visualization tools to deter

WE ARE AT the start of an intellectual and technological age that will remake the insurance business.

fraud, settle meritorious claims more quickly and increase customer satisfaction.

More advances are on the way. Text mining is an example of new technology poised to unlock the deep and highly informative but unstructured data in claim adjusters' notes—valuable information previously beyond the reach of investigators looking to detect potential fraud. Better access to that data will trigger further refinements to predictive models that already are transforming marketing, rating, claim operations and underwriting.

The game is definitely changing. Art and science are coming together in new ways all along the insurance value chain. We are at the start of an intellectual and technological age that will remake the insurance business.

Insurers that succeed in deploying advanced analytics are the "game changers" that can look forward to a long and prosperous future. Those insurers that don't invest in new and better data—or fail to deploy enhanced analytic tools and expert human resources—face a far different outlook.

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