

CONGRESS SAYS RESERVISTS SHOULD GET FUNDS IN FSAS WHEN CALLED TO DUTY / PAGE 3

MENTAL HEALTH PARITY BILL OVERCOMES KEY OBSTACLE IN COMPROMISE TALKS / PAGE 3

JUDGE SAYS FRAUD LAWSUIT RELATED TO RUNOFF DISPUTE MUST BE HEARD IN U.K. / PAGE 3

In Brief

Chubb exec Motamed to become CNA chief

CNA Financial Corp. said last week that Thomas F. Motamed will be the insurer's next chairman and chief executive officer. Mr. Motamed will succeed Stephen Lilienthal on June 8, 2009. Mr. Motamed joins CNA from Warren, N.J.-based Chubb Corp., where he serves as vice chairman and chief operating officer. Mr. Lilienthal, who is retiring, joined Chicago-based CNA in July 2001 as CEO of its property/casualty operation.

Aon paying \$4 million to settle Florida probe

Aon Corp. has reached a \$4 million settlement with Florida officials over undisclosed compensation the insurance broker allegedly received for the placement of insurance coverage on behalf of Florida

See **IN BRIEF** page 21

BENEFITS MANAGEMENT

BENEFITS TECHNOLOGY AND COMMUNICATIONS

Health insurers providing information in various



languages to serve broader consumer base; employers increasingly turning to e-

learning tools to help get out the message on benefits offerings; automated phone systems help keep patients on track with prescriptions and other treatments.

Page 10



A shot in the arm for health records?

Google, Microsoft tools could give booster to PHR movement

By **KRISTIN GUNDERSON HUNT**

Use of electronic personal health records could increase substantially if Google Inc.'s consumer-driven model launched last week is successful, benefit experts say.

Many employers have been skeptical about the value of PHRs, saying employees are concerned about privacy and likely won't take the time to maintain the records. But with companies such as Google rolling out its Google Health PHR and Microsoft Corp. launching a similar product, which so far is limited to its business partners, experts say the concept may take off.

"Products like (Google's and Microsoft's) will increase awareness and, therefore, use," said Barbara Cox, a senior principal and national practice leader for information management systems at Noblis Inc.'s Center for Health Innovation in Falls Church, Va.

Electronic PHRs, already offered by several major insurers and employers, allow individuals to input their health and medical information via software or online

portals. Patients own the data and determine who may access the records, such as family members, health care providers and medical plans.

Proponents say PHRs can make the system more productive and efficient. Doctors could follow patients' health histories more easily and review them more thoroughly, improving diagnoses and reducing mistakes.

Promoting employee use of PHRs is in line with the trend toward engaging employees in their health care, Ms. Cox said. "If individuals are more engaged in their health, then they're going to take steps to improve it, which lessens the health care cost," she said.

Electronic PHRs most commonly are offered by health plans for a fee paid by the employer, said Cathy Tripp, Watson Wyatt Worldwide's national leader for consumerism in Minneapolis. Some employer groups have purchased stand-alone PHRs from providers such as WebMd or Mayo Clinic. Most current models, though, aren't interoperable or portable, she said. If users change health plans, they may have to set up a new record.

Additionally, some employers have formed coalitions to sponsor

See **RECORDS** page 6

Greenberg may face civil charges by SEC

Gets Wells notice over Gen Re finite deal

By **SALLY ROBERTS**

NEW YORK—Maurice R. Greenberg will likely fight any further civil charges that might be brought against him in connection with his alleged role in helping his former firm inflate its loss reserves with two sham reinsurance deals with General Re Corp., attorneys say.

The 83-year-old embattled former American International Group Inc. chief was served a "Wells" notice by the Securities and Exchange Commission on May 16, indicating he may face civil charges related to the \$500 million loss portfolio transfer he initiated with Gen Re in 2000 as AIG's chairman and chief executive.

Securities regulators charged in a previous suit that the deal, which

New York-based AIG admitted should not have been accounted for as reinsurance, was made to allay analysts' qualms about loss reserves and transferred no risk.



Mr. Greenberg

In February, a jury found five executives from Gen Re and AIG, including former Gen Re CEO Ronald E. Ferguson, guilty of conspiracy and fraud over their alleged roles in the deal.

Although Mr. Greenberg was identified as an unindicted co-conspirator in court filings, he has never been criminally charged in the case and maintains his innocence.

Legal observers say prosecutors likely lacked evidence to bring criminal charges, so they passed the case

See **GREENBERG** page 21

Subprime losses grow for some P/C insurers

But softening market bigger challenge for sector

By **JUDY GREENWALD**

Several commercial property/casualty insurers have been hit by the subprime credit crisis and related investment troubles, and some observers expect more bad news on the investment front.

But the situation will not have a major impact on the commercial property/casualty industry and may even help maintain underwriting discipline, they say. Another area of concern, though, is the likelihood of increased directors and officers liability claims over the next several years.

Meanwhile, aside from New York-based American International Group Inc.—the insurer hardest hit

by the subprime-related write-downs—most major property/casualty insurers reported a good first quarter, though results are expected to continue to deteriorate in a softening market.

Subprime impact

AIG reported a \$7.81 billion loss for the first quarter, which reflects a \$9.11 billion pretax charge for a net unrealized market valuation loss related to AIG Financial Product Corp.'s super senior credit default swap portfolio.

The subprime crisis is at the root of other property/casualty insurers' investment losses or declines, said

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FSA distributions for reservists OK'd

Employees called up for active duty won't have to forfeit balances

By JERRY GEISEL

WASHINGTON—Employees no longer will have to forfeit unused balances in their health care flexible spending accounts when called up from the reserves for active military duty under legislation on its way to President Bush.

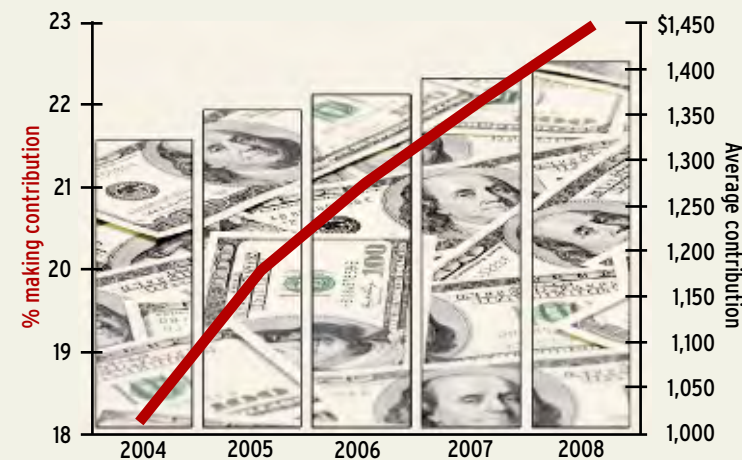
Instead of forfeiting balances, which now can happen in such situations, the legislation will allow employers to amend their FSAs to permit reservists called up for at least six months of active duty to take FSA balances as a taxable cash distribution. The bill cleared the House and Senate last week with no opposition.

The legislation, H.R. 6081, which includes numerous other provisions to aid reservists, deals with a problem that has significantly increased in recent years as more reservists are called up for active service due to the conflicts in Iraq and Afghanistan. Currently, about 100,000 individuals from reserve and National Guard units are on active duty, according to the Department of Defense.

It isn't known how many reservists will benefit from the proposed change to amend a more than two-decade-old Internal Revenue Service "use it or lose it" rule governing FSA balances, though the number is thought to be small.

Still, "for a handful of employees, it may be a very big deal," said Andy Anderson, of counsel with Morgan,

EMPLOYEE PARTICIPATION IN FLEXIBLE SPENDING ACCOUNTS



Source: Hewitt Associates Inc.

Lewis & Bockius L.L.P. in Chicago.

The legislation deals with situations in which employees have a balance in their FSAs at the time they are called for active duty. While federal laws allow employees to tap those balances after being called up, to do so employees have to continue to pay—with after-tax dollars—a premium that is 102% of the amount employees paid to the FSA while working. For example, if an employee agreed to contribute \$1,200 a year to the FSA with monthly contributions of \$100, federal law would permit the employee, after being called up, to contin-

ue FSA coverage through monthly contributions of \$102.

Few employees, though, tap this option and the balances typically are forfeited. One reason is activated employees and their families are entitled to enroll in TriCare, a Department of Defense health care program that provides generous benefits with no premium contributions. As a result, employees have a vastly reduced need for FSAs since they are used for reimbursement of uncovered benefit expenses.

Additionally, employees called

See **RESERVIST** page 7

Barrier to mental parity bill dropped

House kills requirement that all conditions in APA manual be covered

By JERRY GEISEL

WASHINGTON—House conferees last week dropped a contentious provision from legislation that would mandate parity for mental health care benefits, significantly increasing chances that a final agreement will be reached, though key obstacles remain, observers say.

In an offer to the Senate, House conferees deleted the provision, which was included as part of the parity bill the House passed last year, that would have required group health plans cover all mental health care conditions listed in the most recent edition of a diagnostic treatment manual of the American Psychiatric Assn.

That provision was vigorously opposed by employer groups, which said such a requirement would have delegated to a third party—the psychiatric industry—decisions about the services for which they would have to provide coverage. The requirement is not part of mental health benefits parity legislation passed by the Senate last year.

Some House members, such as Rep. Joe Barton, R-Texas, had

warned earlier that the Senate would not accept having covered mental health conditions determined by the APA manual. Other observers said business support for mental health parity would vanish if the provision remained, eliminating any chance of the House and Senate agreeing on a compromise bill.

"It was a deal-breaker," said Frank McArdle, a consultant with Hewitt Associates Inc. in Washington.

With the provision removed from the House version, the likelihood of a compromise is greater.

"It is an important progress point towards enactment," said Neil Trautwein, vp and employee benefits counsel with the National Retail Federation in Washington.

"It absolutely increases the chances that a compromise will be reached," Mr. McArdle said.

Still, a final agreement on a compromise bill is by no means certain, observers say.

"There are still some contentious issues out there," said James Gelfand, senior health policy manager at the U.S. Chamber of Commerce in Washington.

For example, under the House bill, the legislation would go into effect on Jan. 1, 2009, which business groups say is too short a time for employers to make the changes needed in their mental health care coverage. Under the Senate bill, the effective date for compliance would be the plan year that begins on or after Jan. 1 of the first calendar year after the date of enactment.

Other objectionable provisions in the House bill, business groups say, could make it more difficult for employers to ensure that only medically necessary mental health care services are provided.

Additionally, the Bush administration is concerned about language—not directly related to mental health care parity—that would impose new restrictions on physician-owned hospitals, which it believes could restrict patient choice of providers.

That House conferees agreed to drop mandating coverage for any mental condition in the APA disorder manual bodes well for resolution of other significant differences

See **PARITY** page 7

Runoff fight must move to U.K.: Judge

Insurers charge fraud

By DAVE LENCKUS

NEW YORK—Two U.S. insurers in runoff plan to appeal a federal judge's ruling that they must press their fraud claims against former runoff manager Cavell USA Inc. in an English court, according to the insurers' attorney.

The insurers, Seaton Insurance Co. and Stonewall Insurance Co., both of Providence, R.I., want to press their fraud claims in a U.S. court. But Cavell is trying to move the case to the United Kingdom, where parent company Randall & Quilter Investment Holdings P.L.C. is based.

The case is part of more extensive litigation over control of Seaton and Stonewall 10 years after the solvent companies went into runoff because of their heavy exposure to asbestos and pollution losses in underwriting insurance and reinsurance.

Cavell originally managed the runoff in partnership with hedge fund Greenwich Street Capital Partners II L.P., backed by \$590 million of loss portfolio reinsurance from Berkshire Hathaway Inc.'s National Indemnity Co. (*BI*, May 12).

The two insurers claim that Cavell damaged their value by abdicating its claims-servicing duties to National Indemnity.

Cavell denied the allegations.

According to court documents, a paragraph in the term sheet of the contract between the insurers and Cavell releases Ken Randall, chairman and chief executive officer of London-based Randall & Quilter, from various types of claims. But then the paragraph lists exceptions to that release. Among those exceptions are fraud claims.

Another page in the contract states that any disputes arising under the term sheet must be heard in a U.K. court. The insurers argue that the fraud claim exception in the term sheet's claim release section means they are not bound to the contract's U.K. court provision.

In his May 14 decision dismissing the insurers' claims against Cavell, U.S. District Court Judge Richard M. Berman in New York ruled that the contracts between the insurers and Cavell required that all disputes must be resolved in England.

Judge Berman ruled the insurers' tort claims stem from a contractual relationship between them and Cavell. Those claims "ultimately hinge on rights and duties" established in the provision outlining where contract disputes will be resolved, Judge Berman ruled.

The ruling "definitely will be appealed," said Shawn Kelly, an attorney for the insurers. "The fraud happened in the U.S.," said Mr. Kelly, a partner with Riker Danzig Scherer Hyland & Perretti L.L.C. in Morristown, N.J.

NOAA forecasts 12-16 named storms in hurricane season

Government agency puts odds of above-normal activity at 60%

WASHINGTON—This year's Atlantic hurricane season could see above-normal activity, the National Oceanic and Atmospheric Administration's Climate Prediction Center said last week.

The center said there is a 60% chance of above-normal activity and a 25% chance of what it called near-normal activity during the 2008 hurricane season, which begins June 1 and runs through Nov. 30.

"The climate patterns expected during this year's hurricane season have in past seasons produced a wide range of activity and have been associated with both near-normal and above-normal seasons," NOAA said in a statement.

This year's outlook, the center said, suggests a 60% to 70% chance of 12 to 16 named storms. The projection calls for six to nine hurricanes, two to five of which would grow into major hurricanes packing sustained winds of at least 111 mph.

"The main factors influencing this year's seasonal outlook are the continuing multidecadal signal—the combination of ocean and atmospheric conditions that have spawned increased hurricane activity since 1995—and the anticipated lingering effects of La Niña," Gerry Bell, the lead seasonal hurricane forecaster at NOAA's Climate Prediction Center, said in the statement. "One of the expected oceanic

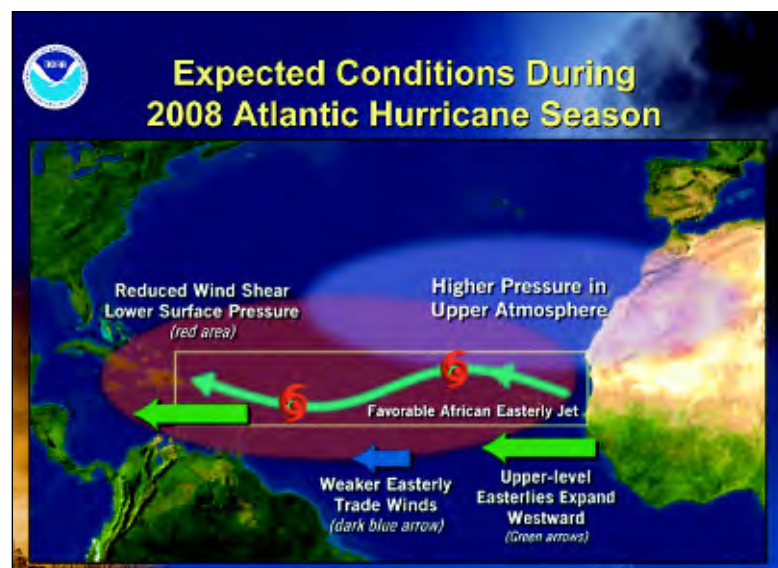
conditions is a continuation since 1995 of warmer-than-normal temperatures in the eastern tropical Atlantic."

According to NOAA, La Niña involves "cooler-than-normal sea-surface temperatures in the central and eastern tropical Pacific Ocean that impact global weather patterns."

NOAA plans to update its Atlantic hurricane season outlook on Aug. 7, just before what has proven historically to be the peak period for hurricane activity.

According to NOAA, an average season has 11 named storms, including six hurricanes, two of which reach major status.

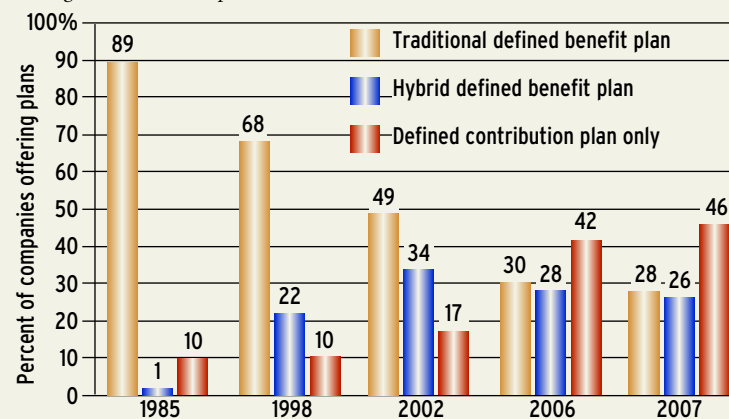
—By Mark A. Hofmann



NOAA's Atlantic hurricane forecast combines the influence of several factors.

RISE AND FALL

How defined benefit pension plans are declining and defined contribution plans growing among Fortune 100 companies*



*Plans offered to newly hired salaried employees
Source: Watson Wyatt Worldwide

Fewer large firms offer defined benefit plans

Hybrids also losing ground to DC alternatives

By JERRY GEISEL

The nation's largest employers continue to move away from defined benefit pension plans and toward defined contribution plans, according to a new survey.

Last year, 54% of Fortune 100 companies offered a defined benefit plan to new salaried employees, down from 58% in 2006 and 63% in 2005, Watson Wyatt Worldwide said in an analysis released last week.

The numbers affirm the two-decade fall from favor of traditional defined benefit plans. In 1985, 89% of the Fortune 100 offered a traditional defined benefit plan to new employees compared with just 28% in 2007, according to Arlington, Va.-based Watson Wyatt.

Pension plan hybrids—so named because they combine elements of defined benefit and defined contribution plans but legally are defined benefit plans—also have been declining after rapid growth in the

1990s, when many large employers converted traditional plans to cash balance plans, the most widespread hybrid.

In 1985, just one Fortune 100 company offered a hybrid plan to new employees; by 2002, 34% did. But last year, only 26% of large companies offered hybrids, down from 28% in 2006.

The popularity of cash balance plans began to wane after the 2002 high point amid a wave of lawsuits that charged the plans' design discriminated against older employees.

But Alan Glickstein, a senior retirement consultant in Watson Wyatt's Dallas office, said he believes more employers will adopt cash balance plans as legal uncertainties have eased. Among other things, several appeals courts have ruled that the plans are not age discriminatory, starting with a landmark August 2006 decision involving IBM Corp.'s cash balance plan.

See **SURVEY** page 19

CDHP myths hinder implementation

Employers, insurers, consultants face communication challenges

By GLORIA GONZALEZ

NEW YORK—Health insurers and benefit consultants face the same challenges as their customers when implementing consumer-driven health plans, including alleviating concerns and dispelling myths, benefit managers say.

Numerous myths are associated with consumer-driven health plans, including that they are much less generous than traditional plans offered by employers, Roland McDevitt, director of health research for Watson Wyatt Worldwide in Arlington, Va., told attendees of the New York Business Group on Health's May 14 Consumerism in Healthcare Conference in New York.

Employer premium contributions and account contributions are substantial when compared to other plans, he said. The contributions for individuals average about \$4,192 for health reimbursement account plans, \$3,840 for health savings account plans and \$3,810 for all other plans, according to a Kaiser Family Foundation survey.

"I don't think you can characterize this as cost shift-

See **MYTHS** page 18

MYTH VS. REALITY

Several myths associated with consumer-driven health plans have been dispelled by research:

MYTH	REALITY
CDHPs not gaining traction with employers	47% of large employers offered a CDHP in 2008
CDHP members with chronic conditions will face very high out-of-pocket costs every year	Median out-of-pocket maximums for CDHPs are \$3,000 vs. \$2,000 for preferred provider organization plans
Employees very unhappy with CDHPs	Satisfaction rate of 85% vs. 92% for other plans

Source: Rand Corp./Watson Wyatt Worldwide, Kaiser Family Foundation, Employee Benefit Research Institute

Wellness incentives need oversight

Some workers join programs, but don't take on lifestyle changes

By GLORIA GONZALEZ

NEW YORK—Employers using incentives to promote participation in their wellness programs have found the inducements do not always result in the desired change in employees' behavior, benefit managers say.

Sometimes, employees take the money or gifts but fail to fully participate in wellness initiatives. In other cases, employees participate in programs for which they are ineligible simply to receive the incentive, employers say. In response, benefit managers must constantly tweak their incentive programs to utilize them effectively.

Humana Inc., for example, gave incentives to employees to sign up for health coaches, but it found that

some employees ignored their coaches' advice, said Elona DeGooyer, senior consultant, health and wellness, for the Louisville, Ky.-based insurer.

Some childless employees signed up for Webcasts on parenting just to receive the incentives, she told attendees of the New York Business Group on Health's May 14 Consumerism in Healthcare Conference in New York.

"Incentives are good and bad things," Ms. DeGooyer said. "You have to be careful what you're incenting."

Humana advises its employees that benefit plan incentives will change every year. "Don't get accustomed to them because we're changing them according to feedback and according to how our pro-

grams change and what we really want to drive participation in," Ms. DeGooyer said.

Campbell's Soup Co. has offered a health risk assessment for four years, but participation was poor the first year because the company gave towels as incentives, said Jan Kelly, director of health and welfare programs for Campbell's in Camden, N.J. The company then offered \$25 gift cards as incentives, boosting participation to more than 52%.

"Participation has been a real roller coaster," Ms. Kelly said.

For Fidelity Investments, initial participation in its health risk assessment program was "great" with reduced premium contribu-

See **INCENTIVES** page 18



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Records: Online offerings may get boost

CONTINUED FROM PAGE 1

their own models, such as Dossia, a platform supported by eight large employers, that is intended to be a lifelong PHR when it does launch (BI, April 28).

In Kansas City, Mo., 24 area employers have formed CareEntrust, which works with insurers to set up an electronic community health record that collects medical records, laboratory test data and pharmaceutical information for consumers, physicians, insurers, benefit managers and employers. Employees at participating companies can use the information to build their own PHR. If they change jobs within the consortium, they can move their PHRs between participating companies. If an employee moves outside the employer network, though, the PHR is lost.

Still, it's a worthwhile effort, said Stephen Best, assistant vp and director of compensation and benefits for JE Dunn Construction Group in Kansas City, Mo., a founding member of CareEntrust. "This is an investment in something we think is going to provide a return," he said.

Computer retailer Dell in Round Rock, Texas, has offered employees access to PHRs since 2004, said a company spokesman. In 2006, it began working with WebMD to provide automatic, secure claims-import capabilities to its PHR. Employees can track and manage data on procedures, conditions and medications. "We pursue this as we believe arming employees with easily accessible information will help make them better consumers of health care and information that helps them manage their own wellness," the spokesman said in an e-mail.

For PHRs' advantages to play out, however, people have to use them.

Speculation has surrounded whether Google Health and Microsoft HealthVault will increase PHR utilization because of their brand names and ability to access the PHRs anywhere at any time at no cost to the consumer. HealthVault has yet to set a date to go live among individuals.

Both offerings have similar capabilities. Individuals can store information such as lab test results and family health histories, provide health care-related search features and wellness regimens, and refill prescriptions and schedule doctor appointments (see related story).

However, the Google and Microsoft PHRs are portable and interoperable—qualities the private

'I don't mean to be a skeptic, but I just don't see people taking the initiative.'

Ray Brusca, Black & Decker Corp.

models are missing, Ms. Tripp said. They are the first products with national reach that can follow patients regardless of where they work or the health plan they use, Ms. Cox said.

Throw in the companies' trusted brand identities with user accessibility, and it seems likely they will prevail in the PHR market, Ms. Cox said.

On the flip side, Ms. Tripp said neither model is connected to a major health plan and may never be since health plans are developing their own PHRs. Health plans have access to patient data and can put that into members' records, requiring members to do less.

For any PHR model to dominate

or even work at all, the user experience must become less burdensome and more secure, experts said.

Ray Brusca, vp of benefits for Black & Decker Corp., said the Towson, Md., power tool maker isn't promoting any electronic PHRs to employees, who do not want the responsibility of gathering and maintaining the data. "I don't mean to be a skeptic," he said, "but I just don't see people taking the initiative."

Additionally, Ms. Cox said security and privacy issues are a concern due to personal information being stored online. Employers don't want to be liable for breached information, and employees don't want their information to be misused.

Because health care is outside the core business models of Google and Microsoft, JE Dunn Construction's Mr. Best said individuals may feel more comfortable using platforms from companies focusing solely on electronic PHRs or health care services such as CareEntrust or Dossia. Alternatively, Ms. Tripp said individuals might feel more comfortable using public platform models because they are independent from their employers and insurers, organizations they trust very little when it comes to private information.

Ultimately, no model is complete and no one solution is recognized as the best, Ms. Tripp said. But a more competitive marketplace likely will improve PHR applications and drive utilization, she said, which is a good thing for employers.

"The good news is that all of these emerging players are pushing the industry to focus on data security, privacy, portability and interoperability," Ms. Tripp said. "These four principles are critical components for all of the solutions and will drive the next-generation functionality."

Commentary

More reasons to get out from behind the wheel

It's getting so that I don't like to drive anymore.

The reason for this owes only partly to the high cost of gasoline in Chicago, which one day last week had the dubious honor of the highest gas price in the country. That hurts, but it really only means an additional \$12 at the pump per tank, which is still far less than a week's worth of the high-octane coffee I put in my system.

And it's only partly due to having a 15-year-old with a learner's permit who constantly wants to practice her ulcer-inducing driving skills, or else constantly critique my driving skills.

Rather, it's because I'm starting to wonder if I'm taking an unacceptable risk on the roads due to the increasingly well-documented deterioration of driving skills of my fellow drivers.

I must have missed the announcement, but May appears to be Insurer Survey of Reckless Driving Habits Month. There have been multiple polls released by insurers that show safe and responsible drivers are becoming an endangered species.

It's curious why insurers conduct these kinds of surveys—asking respondents to display their lack of knowledge of the rules of the road, or to disclose their poor or just plain crazy habits behind the wheel. But it's even more curious why people willingly reveal to insurers that they ought to have their auto insurance premiums trebled. I have yet to see insurers pursue these incautious respondents with the same zeal as those with poor credit ratings, but time will tell.

One survey, the GMAC Insurance National Drivers Test, found that one in six drivers on the road would not pass their written DMV exam if taken today. If you ever find yourself approaching an intersection with a blinking red light, you'll find a large concentration of these drivers demonstrating their ignorance and putting you at risk. I'm concerned that Illinois was among the states with one of the worst scores nationwide, though I only missed one question: What should you do if approaching an intersection with a steady yellow light? The correct answer was stop, if safe to do so, but we all know the answer depends on whether the intersection is clear enough to allow one to put the pedal to the metal and squeak through before it turns red, right?

A survey by South African insurer AAMI found that about 25% of drivers ignore warnings on their prescription or over-the-counter medication when they get behind the wheel. Those are the warnings that caution about



PAUL WINSTON

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appears monthly. E-mail:
pwinston@crain.com

medication causing drowsiness, affecting reaction times and so on. AAMI also found about 14% admitting to driving under the influence of alcohol, marijuana, speed and other not-over-the-counter drugs.

Nationwide Insurance released a survey that found nearly 40% of teenagers and young adults surveyed send and receive text messages while driving. OMG. Another 40% said they have been hit or

May appears to be the Insurer Survey of Reckless Driving Habits Month.

almost hit by another car whose driver was talking on a cell phone.

In the United Kingdom, Sainsbury's Car Insurance reported that its survey found 1.15 million people admitted to driving a car in the past 12 months without having any insurance. Sign them up! Nearly 40% of these uninsured motorists were aged 17 to 24 and another 22% were aged 25 to 34.

Another U.K. survey, conducted on behalf of Zurich Insurance, found that 10 million British motorists had been the victim of road rage over the past three years. Granted, that number of California drivers is probably similarly victimized on a daily basis.

State Farm Insurance and the Children's Hospital of Philadelphia partnered on a survey of teen drivers and found a big gap between perception and reality when it comes to safety on the road. For example, 60% believe inexperience influences driving safety, but only 15% regard themselves and their peers as inexperienced drivers. Or, 79% allow that text messaging can be very dangerous while driving, but only 25% said the same about cell phone use.

So, for now, the car sits in the garage, my bike is by the back door and I'm keeping a low profile so my daughter doesn't wave the keys in my face and ask "Want to go for a drive?"

Google Health aims for simplicity of use

Google Inc.'s personal health record within Google Health allows individuals to collect, store and manage their own health-related records online. Its purpose is to organize patient information and make it accessible and useful, according to the company.

Google Health allows users to automatically import their medical records, prescription histories and test results into an online profile that can be accessed from anywhere at any time for free.

Eventually, Google intends to allow users to have access to tools and services such as scheduling appointments, refilling prescriptions and utilizing wellness tools, Marissa Mayer, vp of search and user products, said in a statement.

For example, a blood pressure device manufacturer could integrate its devices with the platform. As a result, Google Health users could take their blood pressure with the device and then upload the reading into the online portal using a USB device.

Google has already partnered with several companies, including CVS Caremark Group's MinuteClinic in Minneapolis; Walgreen Co. in Deerfield, Ill.; Cleveland Clinic in Cleveland; and Quest Diagnostics Inc. in Madison, N.J., to integrate their information into the platform. Users can link their records from those organizations to their Google Health account.

Google Health records are portable and users can



Google Health includes personal health records that are intended to make it easy to manage health information, a Google official says.

access and control them from anywhere. They can import information from any health plan or medical provider, manually entering the data or uploading it depending on whether the information comes from a Google Health partner.

"We aren't doctors or health care experts," Ms. Mayer said in a statement, "but one thing Google can create is a clean, easy-to-use user experience that makes managing your health information straightforward and easy."

—By Kristin Gunderson Hunt

Reservists: Call-up won't force employees to forfeit FSA balances

CONTINUED FROM PAGE 3

up for active duty may be deployed in parts of the world, such as Iraq, where they would have limited opportunities to use health care services eligible for FSA reimbursement.

By allowing employees to receive a taxable distribution from their FSAs when they are called up for military service, "individuals won't lose money that was contributed to their FSA but that they are now unable to spend," Mr. Anderson said.

The legislation does not require employers to amend their plans to permit the distributions of FSA balances to called up employees.

Still, while not required to do so, "I suspect many employers" will amend their plans, said Scott Sims, a legal consultant in the Falls Church, Va., office of Hewitt Associates Inc.

Parity: Key provision removed

CONTINUED FROM PAGE 3

in the two bills.

"This shows that they (House conferees) want a bill, not an issue," Mr. Trautwein said.

While significant differences remain, the core of the House and Senate bills is identical: requiring group health care plans to provide the same coverage for mental disorders as is provided for other medical conditions.

That would be a big change from current law enacted in 1996 that bars only discriminatory annual and lifetime dollar limits on coverage of mental disorders. Discrimination, though, is permitted in other ways. For example, it is legal for a health plan to limit how many annual outpatient visits for treatment of mental disorders it will cover, while imposing no comparable limit on other medical conditions.

Additionally, current law allows health plans to impose higher cost-sharing requirements for mental health care services than for other medical services.

The drive for parity legislation began soon after the limited 1996 bill was passed. But the effort didn't get serious until Senate backers, most notably Sen. Edward Kennedy, D-Mass., of parity legislation began to work with business groups to develop a measure that they could support.

That effort bore fruit when several key business groups, including the American Benefits Council, the National Retail Federation and the U.S. Chamber of Commerce, announced their backing of the Senate bill.

Those groups, recognizing that Congress eventually was going to pass a bill, decided, following the 2006 congressional elections, to work with Senate advocates to make the legislation more to their liking.

Few employers, experts say, would want to incur a potential public relations black eye if they failed to permit the distributions and employees then forfeited account balances.

"Public opinion will persuade employers to implement this provision," said Sharon Cohen, an attorney with Watson Wyatt Worldwide in Arlington, Va.

Adding a cash distribution feature, though, will require work. Employers will have to amend their FSA plans, communicate the change to employees and later distribute the money to employees.

Because of the work involved,

'This is a way for legislators to show support for those called up for military service.'

Sharon Cohen, Watson Wyatt Worldwide

some employers may wait to implement the change until the start of the next plan, said Rich Stover, a principal with Buck Consultants L.L.C. in Secaucus, N.J.

The legislation would allow

employers to immediately change their FSA distribution rules.

Passage of the FSA distribution legislation is the second time this year Congress has passed a measure that gives new benefit rights for reservist employees and their families.

Earlier this year, Congress approved legislation that expanded the Family and Medical Leave Act to allow employees to take up to 12 weeks of leave when a spouse, child or parent is on active duty in the armed forces or is called up for active duty. Leave could be for "exigency," as defined by regulations now being drafted by the Labor Department.

That measure also gives employees who are the spouses, children, parents or next of kin of servicemember up to 26 weeks of leave under the FMLA to care for a servicemember injured during military service when that injury results in the servicemember being unable to perform his or her duties.

Congressional receptivity, especially in an election year, to such measures is not surprising. "Legislators are responding to real and perceived inequities incurred by those called to duty," Mr. Anderson said.

"This is a way for legislators to show support for those called up for military service," Ms. Cohen said.

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Business Insurance OPINIONS

Sen. Kennedy's style deserves emulation

WITH SEN. EDWARD KENNEDY having what we hope is many months, if not years, remaining in the Senate, this is not the time for a eulogy.

Still, the stunning diagnosis last week that Sen. Kennedy has a malignant brain tumor is an appropriate time to note not only some of his legislative accomplishments in the employee benefits arena that the Massachusetts Democrat has had in 45 years in the Senate, but the chief reason for those accomplishments.

In health care, his most significant success was passage of legislation in 1996 that curbed the use of exclusions of pre-existing medical conditions in health plans. That law makes it easier for employees to change jobs without fear of losing coverage for current medical problems.

He also was a driving force behind legislation passed three decades ago that requires health plans to provide the same coverage for maternity and childbirth as other medical conditions, a change

that has benefited millions of women. Currently, Sen. Kennedy is leading the effort to enact comprehensive but reasonable parity legislation for mental health care. What is striking about his accomplishments—and these are only a few—is the way he has operated as a lawmaker.

So often, and Democrats and Republicans are equally guilty, the style on Capitol Hill is a take it or leave it approach. Bipartisanship and negotiations in good faith at times seem to have gone out the window.

But Sen. Kennedy is different. He understands good politics is as much about negotiation and compromise as it is good ideas. Take the health care portability bill. He very much wanted the bill, but to do so he had to accept a provision—opposed by the Clinton administration and no doubt disliked by Sen. Kennedy—advanced by Senate Republicans to allow employers to offer medical savings accounts, the predecessor to health savings accounts. Much negotiation followed, a fair compromise was reached on MSAs and in the end the American public benefited from passage of the portability bill.

We hope Sen. Kennedy's style is one other lawmakers will learn to follow.

Lloyd's broker changes warrant careful scrutiny

THE VOTE by members of Lloyd's of London to approve governance changes that would ease access to the market generally should be welcomed by policyholders.

The decision last week to allow brokers other than official Lloyd's brokers to place risks in the market is another step in the journey started decades ago of turning Lloyd's from a not-so-exclusive club into a modern insurance market.

Policyholders and brokers outside of London may still want to tap the local expertise of Lloyd's brokers to place risks in what is still a unique market, but to force them to do so smacked of protectionism.

Other aspects of the proposals, however, may need more consideration to avoid jeopardizing the market's integrity. Lifting the ban on brokers taking ownership stakes in managing agencies, for example, may lead to efficiencies for the companies involved, but that should not be the overriding factor in the decision.

While U.K. insurance regulation and the business environment for insurers and brokers has changed markedly since the cross-ownership ban was put in place more than 25 years ago, the rules were implemented for good reason. Scandals of the 1970s and 1980s that involved market insiders pushing profitable business to certain syndicates harmed Lloyd's reputation, and moves to withdraw the regulations should not go through without careful consideration.

He understands good politics is as much about negotiation and compromise as it is good ideas.



BI beats list

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

Agents/brokers:

Sally Roberts.

Benefits—health care and ancillary benefits: Joanne Wojcik.

Benefits—retirement savings/pensions: Jerry Geisel.

Canada—risk management and benefits: Gloria Gonzalez.

Commercial auto: Jeff Casale

Employment practices: Judy Greenwald.

Environmental risk management: Sally Roberts.

Federal regulation/legislation—benefits: Jerry Geisel.

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

Health care industry operations: Gloria Gonzalez.

Industry Focus: Rodd Zolkos, Meg Fletcher.

Insurance coverage litigation: Douglas McLeod.

Insurance fraud: Douglas McLeod.

Latin American markets: Roberto Cenicerros.

Marine: Gloria Gonzalez

Property/casualty industry operations: Judy Greenwald.

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Property loss control/

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Tort reform: Mark A. Hofmann.

Work/life benefits and EAPs: Sally Roberts.

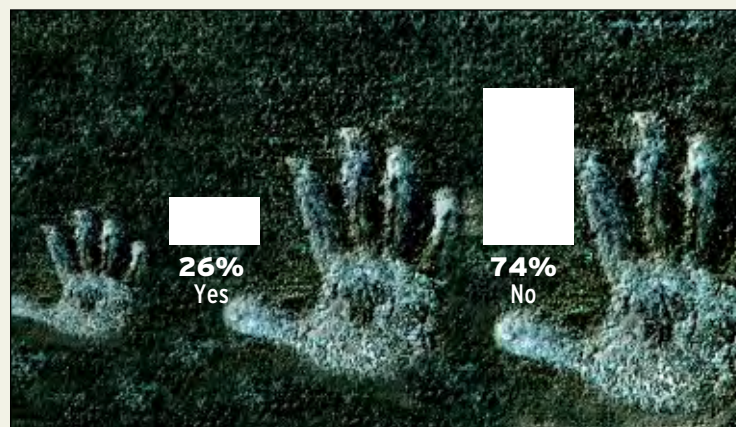
Workers compensation: Roberto Cenicerros.

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Online Poll at www.businessinsurance.com

Are mandates extending the age that employer health plans must cover dependent children too burdensome?



NEXT WEEK'S POLL: Are AIG's recent financial results a sign of more trouble ahead?

BI Online Poll tool sponsored by Wausau Insurance Cos.

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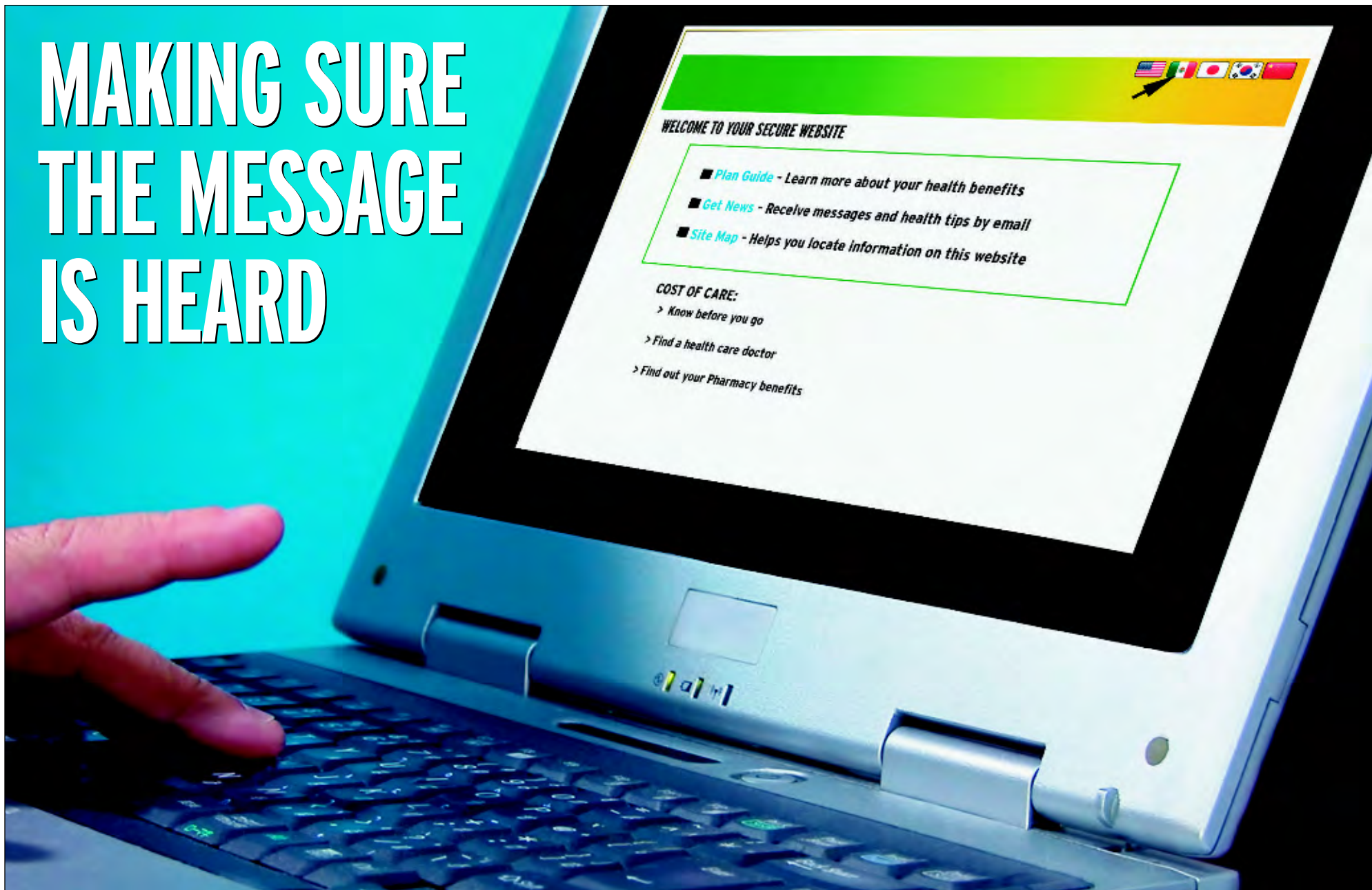
BENEFITS TECHNOLOGY AND COMMUNICATIONS

More employers use e-learning to improve benefits education, but keeping workers engaged seen as key challenge / **Page 14**

Some health care companies replace people with computers to keep members on track with treatment / **Page 15**

BENEFITS MANAGEMENT

MAKING SURE THE MESSAGE IS HEARD



Health insurers expand multilingual capabilities

Consumer-driven health plans, growing competition drive efforts to provide information in various languages

By **LOUISE ESOLA**

Health insurers are finding that they need to provide information in more than English and Spanish for the many ethnic groups they serve.

Hartford, Conn.-based Aetna Inc. and Minnetonka, Minn.-based UnitedHealth Group Inc. are developing and promoting health insurance tools in several Asian languages, for example, and experts say providing information and services in members' native languages helps some consumers navigate the complicated world of health insurance.

Most insurers began providing tools, brochures and directories in Spanish, the second-most common language spoken in the United States (see chart, page 11), years ago. Insurers say such programs—a business necessity in border states such as Arizona, California and Texas—are models for expanding into other languages.

Oakland, Calif.-based Kaiser Permanente now offers members access to an online health dictionary in English, Spanish, Chinese, Vietnamese, Korean, Armenian and Russian.

For other insurers, it appears that the Asian languages—after Spanish—are leading the way in the trend to improve communication with nonnative English speakers, based on a review of current offerings and products in the works at several major insurers.

Experts say consumer-driven health care plans, fast becoming a mainstay among employers nationwide, force insured individuals to take a more active role in selecting and managing their health care, which in turn pushes insurers to offer their products in languages

other than English.

"There is this obvious need to have the information in a language (the insured) can understand," said Rita Carreon, senior manager for clinical strategies with Washington-based America's Health Insurance Plans, a health insurer trade group. "I think we will continue to see this trend to address the needs of members and allow members to make better decisions."

Employers and employees requested tools in other languages and insurers complied not only to help serve existing members but to

increase business and remain competitive, Ms. Carreon said. Currently, most if not all insurers have expanded their language offerings, she said.

Russell Bennett, Cypress, Calif.-based vp for UnitedHealthcare's Latino Health Solutions, which introduced interactive health insurance tools in Spanish six years ago, said insurers will seek ways to make programs more user-friendly as health care becomes more complicated.

Continued on next page

CONTINUED FROM PREVIOUS PAGE

“Even if (nonnative English speakers) speak English at work, you find that when they want to understand something more complicated, they want to resort to their home language because they have a greater vocabulary and understanding,” Mr. Bennett said.

UnitedHealthcare, which inherited Asian and Spanish programs when it bought PacifiCare Inc. in 2005, already provides California clients with a searchable database of doctors who speak the Mandarin and Cantonese dialects of Chinese, Japanese, Vietnamese and Korean. The insurer provides PDF directories in those same languages for members in Texas and Illinois and is developing searchable databases for those states and elsewhere, said Amber Jia, Phoenix-based director of UnitedHealthcare’s Asian American Markets.

“Rather than translate doctor materials, we are working to lead

(members) to doctors who speak their language,” Ms. Jia said.

UnitedHealthcare also provides online health insurance dictionaries and plan explanations in Chinese, Korean and Vietnamese, and Ms. Jia said it will continue improving its Asian programs.

Aetna, which provides brochures in Korean and Chinese and is gearing up to launch a Chinese-language Web site later this year, also is riding the trend.

“As a health care company, we have to connect with people and I can’t see any other way of doing this than communicating in a language they understand,” said Rachel Vorobyev, Hartford, Conn.-based head of local marketing improvement and targeted growth

management for Aetna.

Among those benefiting from these changes are the companies insurers hire to develop and translate materials.

Shawn Jenkins, chief executive officer of Benefitfocus.com Inc., a Charleston, S.C.-based software and Internet services company that designs online tools for more than 25 Blue Cross Blue Shield insurance plans nationwide, said his company is working to perfect its Spanish-language program and develop programs in Vietnamese, French and German, mostly at the request of clients.

“Now that companies are requiring (members) to make more decisions about their health care, there is more of a demand for these kinds

of products,” Mr. Jenkins said. “The notion of choice and empowering the employee is creating the need for translations.”

For now, however, the newest programs are nowhere near as complete as what’s been provided for Spanish speakers, insurers quickly admit. Spanish-language programs, which have been around more than a decade in some states, include directories, interactive videos, questionnaires, enrollment information and health care glossaries.

Some in the industry are concerned that translating health insurance tools may still leave gaps in insurance understanding.

Valerie Wedin, a Minneapolis-based national health care communications champion with Watson

Wyatt Worldwide Inc., said health care literacy will continue to be a problem even with materials translated in other languages. Even with word-for-word translations, she said, people may still have difficulty understanding their health insurance.

“I think what insurers are also trying to do is beef up their customer service (and) telephonic aspects as better way(s) to reach people,” Ms. Wedin said.

Another area of concern is the legality of some insurance documents and tools, which often are crafted with the help of attorneys, said Mr. Jenkins of Benefitfocus.com, which has hired bilingual attorneys to help with the company’s Spanish translations.

HOME LANGUAGES

Top 10 most-spoken languages in U.S. homes among those age 5 and older

Language	No. of speakers
1. English	216,176,111
2. Spanish ¹	32,184,293
3. Chinese	2,300,467
4. French ²	1,932,418
5. Tagalog	1,376,632
6. Vietnamese	1,142,328
7. German	1,120,256
8. Korean	983,954
9. Russian	812,404
10. Italian	802,436

1 Includes Spanish Creole; 2 Includes Patois, Cajun and French Creole

Source: Languages Spoken at Home by Language: 2005 from American Community Survey 2005, U.S. Census Bureau. Total respondents 268,110,961



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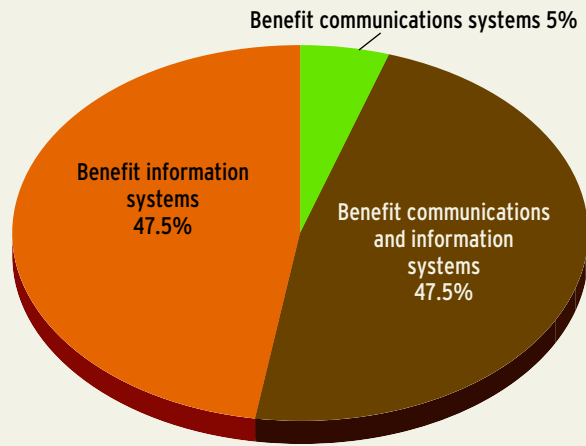
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TYPE OF SYSTEMS

Based on the system's primary purpose for all companies listed.



Source: BI survey

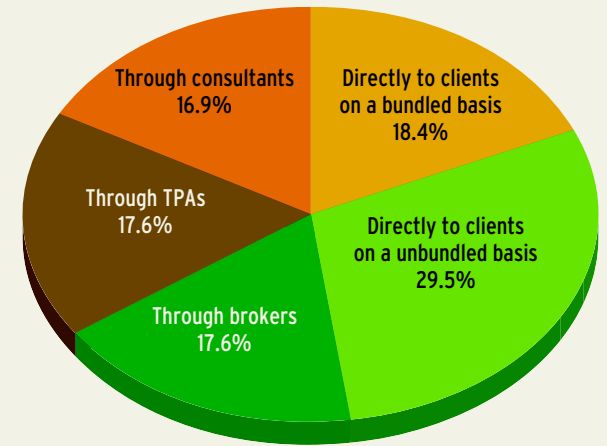
BENEFIT COMMUNICATIONS AND INFORMATION SYSTEMS

Ranked by number of installations in benefit departments

System	Company	Number of installations
FlexComp 9.0 Taxdemo	HR Consulting Group Inc.	5,250
BeneTrac	Paychex Benefit Technologies Inc.*	1,000
Benelogic	Benelogic	638
FlexComp 9.0 FSA	HR Consulting Group Inc.	353
FlexComp 9.0 Cafeteria/FSA/Premiums	HR Consulting Group Inc.	341

*Paychex Inc. acquired Hawthorne Benefit Technologies Inc. and its BeneTrac system September 2007.
Source: BI survey

HOW EMPLOYEE BENEFIT SYSTEMS ARE SOLD



Source: BI survey

Largest employee benefit information systems

Ranked by number of installations in benefit departments

Rank	System name	Company/Address	Phone/Web site	Number of installations	Price	First installation	Principal officer
1	ADP HR/Benefits Solution	Automatic Data Processing Inc. 1 ADP Blvd., Roseland, N.J. 07068	800-225-5237 www.adp.com	4,200	N/A	1997	Rich Watson, vp-ADP major account services
2	My Benefit Express	Benefit Express 441 S. Fernandez Ave., Arlington Heights, Ill. 60005	847-637-1551 www.benefitexpress.info	3,845	N/A	2000	Maria Bradley, president
3	bswift	bswift 224 N. Des Plaines, Sixth Floor, Chicago, Ill. 60661	312-261-5750 www.bswift.com	3,500	N/A	2000	Richard Gallun, CEO
4	My Premium Accountant	Benefit Express 441 S. Fernandez Ave., Arlington Heights, Ill. 60005	847-637-1551 www.benefitexpress.info	645	N/A	2001	Maria Bradley, president
5	TravisCobra	Travis Software Corp. 1155 Dairy Ashford Road, Suite 500, Houston, Texas 77079	281-496-3737 www.travisoft.com	481	\$2,595 to \$7,995	1986	Alan H. Williams, president
6	TravisBilling (TBILL)	Travis Software Corp. 1155 Dairy Ashford Road, Suite 500, Houston, Texas 77079	281-496-3737 www.travisoft.com	421	\$2,295 to \$8,995	1988	Alan H. Williams, president
7	WebCOBRA.com	Travis Software Corp. 1155 Dairy Ashford Road, Suite 500, Houston, Texas 77079	281-496-3737 www.travisoft.com	274	N/A	2004	Alan H. Williams, president
8	VisualHCS Benefit Administration Software	Byrne Software Technologies Inc. 1819 Clarkson Road, Suite 200, Chesterfield, Mo. 63017	636-537-2505 www.byrnesoftware.com	80	\$15,000 to \$500,000	1986	Bill Byrne, president
9	FlexAdmin	Flex Compensation Inc. P.O. Box 220, Minneapolis, Minn. 55440-0220	800-333-5597 www.flexcompensation.com	75	\$1,495 to \$4,995	1986	Gary Bohline, president
10	TravisFlex	Travis Software Corp. 1155 Dairy Ashford Road, Suite 500, Houston, Texas 77079	281-496-3737 www.travisoft.com	51	\$2,495 to \$9,995	1987	Alan H. Williams, president

N/A=Not available

Source: BI survey

Researched by Kevin Edison and Karen Tucker

Visit www.businessinsurance.com/directories for more information and to access the full searchable Directory of Employee Benefit Information Systems. Business Insurance now offers the option to purchase the entire online directory as an Excel file or as a PDF.

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Employers use e-learning tools to improve benefits education

Internet-based communications reduce costs, but care needed to ensure workers stay engaged for duration of process

By KAREN PALLARITO

With a worldwide workforce of more than 11,000, including military bases with no access to its intranet, government contractor L-3 Communications Vertex Aerospace L.L.C. needed to communicate benefits more efficiently. It also wanted to know if employees actually looked at the information.

Beginning with open enrollment last October, Madison, Miss.-based L-3 Vertex rolled out a password-protected Internet site, available to roughly 90% of its workers. Employees can log on wherever they are and download the benefits plan, including a PowerPoint presentation explaining the benefits. The company, in turn, tracks page views and downloads.

"We have changes in our benefits, some years more subtle than others, but we usually have changes every year," said Robert James, the company's vp of human resources. "The PowerPoint with the voice-over allowed us to get the communication out on those changes without having to send a rep to every site."

Electronic learning has gained popularity among U.S. companies. On average, 30% to 35% of the information delivered in most companies today is electronic, said Edward Trolley, vp of learning outsourcing at ACS Learning Services in Chicago. That's up from 20% to 22% four to five years ago, he said.

Benefits, and communication about them, are important to employers and employees alike, according to Metropolitan Life Insurance Co.'s Sixth Annual Employee Benefits Trends Study. For employers, employee retention was the top objective of offering benefits. For employees, health benefits ranked behind salary, and retirement benefits tied for the third-highest factor in retention and workplace loyalty, according to the April study.

In its simplest form, e-learning is conducted via e-mail, CDs and DVDs. More sophisticated formats include videos and Web conferences. Using online or other electronic means to train employees is convenient because workers can do it on their own schedule. It eliminates the need to travel and allows employers to deliver a consistent message, Mr. Trolley said.

"So if I've got an hour right now on a four-hour training program, I can do an hour, I can log off, I can come back tomorrow, next week, next month, and start up again where I was," Mr. Trolley said. "And if I don't remember what I did in the first hour, I can go back and do it again, and then when it's all done...I can go back and do a refresher."

There's a financial imperative as well. With e-learning, there's no need to book a space and send an instructor. After the upfront invest-

ment to create an electronic program, it can be tweaked with little expense, Mr. Trolley said.

By minimizing printing and mailing costs, L-3 Vertex expects to save thousands a year. For those that prefer paper, the company will distribute CDs from which employees can print out copies of enrollment materials.

'The next frontier for managing costs is engagement and education.'

Donald R. Sanford,
Buck Consultants L.L.C.

Electronic learning is still rather new to the benefits arena, so its usage is "on the low end" compared with other company departments, Mr. Trolley added.

But Donald R. Sanford, managing director in the St. Louis office of Buck Consultants L.L.C., expects increased demand for sophisticated communication tools as many employers move to consumer-driven health care plans.

"The next frontier for managing costs is engagement and education," Mr. Sanford said. "By educating

employees and engaging them in the process, they can better take charge of their own health and lifestyle and have a positive long-term impact on health care costs."

However, it is unclear if e-learning achieves better results than traditional teaching methods.

In a sweeping review of the literature, U.K. researchers at the University of Sussex found "weak, positive but not yet compelling evidence of the effectiveness" of e-learning in higher education, medical education and the workplace. In the workplace, easy-to-use technology positively affected learners' satisfaction with e-learning, and flexibility in when and where the learning takes place influenced the quality of the experience.

Even as the use of e-learning is growing, Nnette Kress, senior vp and national practice leader for communications at Segal Co. in New York, sees a resurgence of face-to-face meetings and health fairs.

As employees are forced to make more decisions about their health and retirement, they want every piece of information they can get, Ms. Kress said.

"They also want to be in a place where they can perhaps hear somebody else's questions that they themselves might not have thought of." It's not a backlash against technology, Ms. Kress said. "I just think that people need both."

For L-3 Vertex, feedback from its

benefits e-learning effort found that employees on average stayed for only one-third to one-half of the PowerPoint presentation. So this year it will put all the important changes at the beginning.

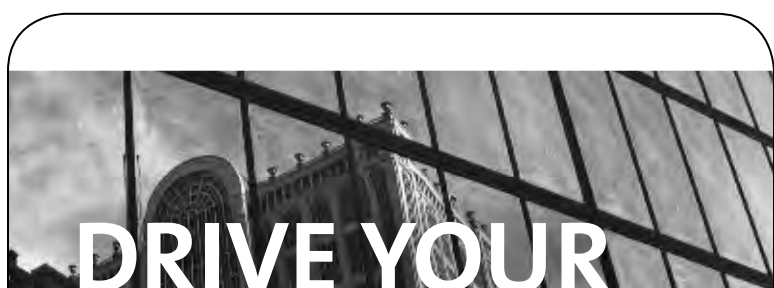
"People, we found out, are in such a hurry when they go to the Internet, they want a data dump upfront," Mr. James said.

Maureen Robbins, vp of benefits at Realogy Corp. in Parsippany, N.J., sees great potential in electronic benefits communication. Beginning with last October's open enrollment, the real estate services company began doing all of its benefits communication electronically for a global workforce of 13,000.

Looking ahead to the next open enrollment, Ms. Robbins said she hopes to record and post a video on benefits changes for the next year. Eventually, she would like to have an entire video library to help employees navigate their benefits, including mental, dental and disability.

"When you go to your carriers, they'll say, 'You know what? We have a great Web site, but your employees aren't using it,'" Ms. Robbins said. "Well, that's because they're not aware of it, so we need to educate more on what's out there, what's available to make them better consumers."

That could be as simple as creating a video demonstration for employees to click on, she said.



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Employees expect consumer-grade sites

Selecting an employer-sponsored health plan may never be as effortless as shopping on Amazon.com, but that hasn't deterred human resource managers from contemplating ways to make corporate Web sites more user-friendly and interactive.

"What I hear from clients all the time is their employees (want) a consumer-grade experience," said Michael Rudnick, global practice leader for intranets and portals at Watson Wyatt Worldwide in Stamford, Conn. "They're very used to the way Web sites behave on the Internet, and they want that same level of...feature functionality."

Amazon embodies many traits that employers desire for their own Web sites. A click of a button yields product information, customer reviews, comparable products and more. At this point, though, there's more thinking going on than large-scale implementation, Mr. Rudnick said.

One obstacle is that HR departments traditionally have not had to woo customers.

"My belief is that's what been the driver of why you see all this innovation in customer service on the Internet: because you're fight-

ing for customers every day," Mr. Rudnick said. "But you don't see that same level of customer-focused innovation on intranets because employees are a captive audience and the business model is not as clear-cut."

Coordinating with multiple vendors complicates the task. While it's technically feasible to have employees connect with the corporate health plan through a single sign-on via the company's Web site, it's administratively and technologically complex.

"Ask five vendors (and) you're going to get five different ways to do it," Mr. Rudnick said, because there is no single standard for data integration.

Nevertheless, employers are enhancing their Web sites with tools and information, said Donald R. Sanford, managing director and national practice leader for communication at Buck Consultants L.L.C. in St. Louis.

Some companies are putting wellness information online. Others are giving employees access to their claims history, for example, so they can decide which health plan is the best buy for them.

While these Web-based innovations are "still evolving," Mr. San-

ford said he expects activity to ramp up as employers seek to retain talented employees. "You're going to have to build tools that are going to make it easier for them to work there and make them more efficient," he said.

When Plano, Texas-based Perot Systems Corp. switched from a traditional health maintenance organization/preferred provider organization model to high-deductible health plans in 2006, the technology services company added a Web-based tool to help its 11,000 U.S. employees sort their options and enroll online.

The following year, through an agreement with Medstat, a unit of Ann Arbor, Mich.-based, Thomson Reuters, Perot Systems added two years of utilization history for every employee.

That feature was helpful because it automatically calculated an employee's out-of-pocket costs, said Kay Pendleton, Perot Systems' senior benefits manager. While employees weren't pleased about having a deductible and coinsurance, "they were very pleased at the user-friendly format and how easy it was to navigate through the enrollment process."

—By Karen Pallarito

Computers replace people for some health care reminder calls

Interactive systems keep members on track for treatment schedule

By LEIGH PAGE

An increasing number of health insurers are using computer-based phone systems to interact with plan members.

The insurers and pharmacy benefits managers that use interactive voice response systems hope they will improve compliance with medication regimens and ensure that members take preventive tests.

Some large insurers, though, have not embraced the technology. And several of those that do, make only limited use of the available technology.

Loaded with specific claims information on each individual, the systems call members and carry on a "conversation" through a series of decision trees that ask questions or provide advice based on what the recipient says.

For example, an IVR may call members who have not refilled their medications as prescribed, based on claims data. It would then ask a series of questions to determine why and help find ways to deal with the problem. A member who has difficulty paying for the drug, for instance, may be asked to consider a generic drug.

IVR vendors say the systems greatly reduce the unit cost of calls and markedly expand the number of people reached, compared with fully-staffed phone banks. Since reaching more people can lead to savings through measures to prevent or control illnesses, PBMs and insurers usually provide the technology to employers at little or no extra cost.

The systems have been available since the beginning of the decade, but many PBMs and insurers are not embracing the full range of services offered. For example, St. Louis-based Express Scripts Inc. and Franklin Lakes, N.J.-based Medco Health Solutions Inc. report use of IVR just as an initial step before handing members over to a patient care coordinator.

Medco uses Seattle-based Varolii Corp. and Express Scripts uses Beverly, Mass.-based Eliza Corp. CVS Caremark Corp., based in Woonsocket R.I., said it uses an "automated message delivery process" for refills and other uses but would not detail the process or disclose vendors.

Some big insurers don't use the systems at all. A spokesperson for Aetna Inc., said the Hartford, Conn.-based insurer uses live phone calls but not automated ones, but would not discuss the reasons why.

Even IVR vendors say their product will not replace live calls for sophisticated disease management, where one-on-one care is necessary. But some insurers have deeper concerns about the product—that it may lack the personal touch and annoy members with calls.

These were the concerns of Linda B. Lyle, vp for operations at Cariten Healthcare Inc., a Knoxville, Tenn.-based managed care company with more than 200,000 members. When

Cariten first tested an IVR from Silverlink Communications Inc. in Burlington, Mass., to alert members about flu shots in 2006, "I didn't want us to be perceived as the company you cannot touch," she said.

However, most members commenting on the new system said they appreciated the alerts. Ms. Lyle said the calls actually put a more human face on Cariten. "They were glad that we were reaching out to them," she said. "People don't usually get calls from us." What criticisms there were centered on the voice's "corny" Southern accent, which was replaced with a more realistic-sound-

ing one, Ms. Lyle said.

She said the calls significantly increased the number of members getting flu shots. Now the system also is used to get patient feedback after elective surgery and contact members in need of colonoscopies.

Highmark Inc., in Pittsburgh, uses Eliza to contact diabetic members who have fallen behind in getting preventive exams as well as members who need mammograms, cervical cancer checkups and colonoscopies, according to claims data.

"Due to this program, we have seen big improvements in screening

rates," said Anna Silberman, vp for preventive health services at Highmark.

Eliza reports that its colonoscopy calls increased colon cancer screening rates by 66% to 137%.

Eliza President Alexandra Drane said her company puts a great deal of thought into creating scripts to draw in recipients. "We present things in a way that is fresh and unusual and that hopefully is somewhat fun," she said.

Some employers are skeptical about the systems. Mark Kitchen, benefits manager at Marsh Supermarkets Inc. in Indianapolis, with

12,800 employees at 72 stores, said such calls would be intrusive. "It's not appropriate for the employer to be involved in telephone calls about an employee's use of medications," he said.

Most IVR vendors say they keep employers at arm's length from any individual employee's data, and the calls use security questions to make sure they are talking to the right person.

Don Sanford, a principal at Buck Consultants L.L.C. in St. Louis, said IVRs have a bright future. "It's like having a call center, but with a computer," he said.

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For more information, contact Mitchell Schmidt, senior vp, ACE Casualty Risk, at 215-640-1816 or Clint Johnson, executive vp global underwriters-foreign casualty, at 212-209-2218.

AIG unit enhances real estate coverage

NEW YORK—AIG Excess Casualty, a unit of American International Group Inc., has announced Real Estate Advantage, a collection of coverage enhancements aimed at the real estate industry's evolving exposures.

The enhancements provide coverage for claims asserting discrimination, as well as extended coverage for professional liability claims for services such as onsite spas and beauty salons.

Real Estate Advantage also enhances coverage for environmental liabilities with an extended pollution endorsement for additional named perils including pesticides, herbicides and carbon monoxide. The pollution endorsement also allows policyholders more time to report a claim and offers policy limits up to \$50 million.

For more information, contact Joseph Cellura, senior vp, real estate and financial institutions, AIG Excess Casualty, at 212-458-1315 or visit www.aig.com/aigexcesscasualty.

Cambridge expands litigation services

GREENWICH, Conn.—Cambridge Integrated Services Inc., a subsidiary of Cambridge Solutions Ltd., has enhanced its litigation management services with two advancements to address litigation fees.

Legal bill review and deposition services are intended to provide Cambridge customers with cost-saving measures during the claims process.

Legal bill review services are intended to help Cambridge clients avoid inappropriate fees and unnecessary expenses associated with claims management, according to the company.

Additionally, the service allows for every line item on a client's bill to be checked against company-specific business rules. If a line item is not in compliance, the service identifies the item and returns it for adjustment.

The legal bill review services team also can integrate litigation management information with claims management data to pinpoint areas for overall process improvement and cost savings.

Cambridge's deposition services

will offer clients to access a wide range of deposition services in more than 60 cities nationwide. Some of the services include online deposition scheduling, court reporting, calendar management, video deposition, online transcripts and document retrieval services.

For more information contact Kevin Turner, executive vp, business development, at 586-864-1291 or kevin.turner@cambridge-na.com.

RMS database measures accuracy of catastrophe data

NEWARK, Calif.—Risk Management Solutions Inc. has launched ExposureRefine, which it claims will enhance exposure data quality within the insurance industry and improve the accuracy of modeling capabilities for catastrophe risks.

ExposureRefine is designed to help insurers and reinsurers improve the accuracy of their catastrophe loss analysis by assessing portfolio exposure data quality.

The service also measures and benchmarks data quality and uses a combination of RMS analytics and databases to assess, measure and improve the completeness and accuracy of exposure data, according to the modeling firm.

The ExposureRefine service also uses various analytics that quantify the completeness and resolution of data and predictions by identifying suspicious or illogical combinations and inconsistent patterns.

The product is based on an RMS database, ExposureSource, which includes high-resolution information on buildings in the United States derived from a range of third-party sources, as well as data developed from field surveys, consultations with local planning departments and interpretations of satellite imagery and building photographs, RMS said.

For more information, contact Jackie Barber, global public relations manager, at jackie.barber@rms.com.

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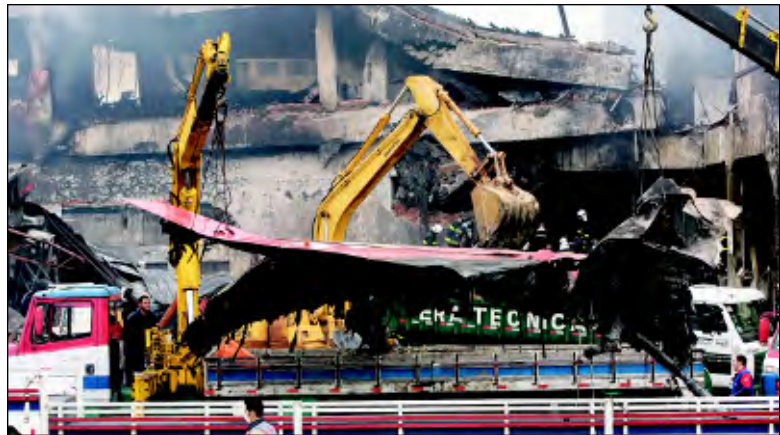
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International NEWS



The International Civil Aviation Organization is considering proposals that would supersede the 1952 Rome Convention on liability for ground losses from aviation accidents and terrorism.

Aviation organization considers liability caps

Accidents, terrorist attacks subject of proposals

By STACY SHAPIRO

MONTREAL—Two draft conventions that deal with liability and compensation for third parties on the ground following a terrorist attack and an airline accident will be presented in June to the full council of the International Civil Aviation Organization.

Wording of the two draft conventions—the Convention on Compensation for Damage Caused by Aircraft to Third Parties and the Convention on Compensation for Damage Caused by Aircraft to Third Parties in Case of Unlawful Interference—was approved at the end of the ICAO's 33rd Legal Committee meeting that was held April 21-May 2 in Montreal. Representatives included 48 nations, airlines, their insurers, aircraft manufacturers and airports.

Should the ICAO council approve the proposals at its June meeting, a diplomatic conference then would be called to consider the conventions, said Carole Gates, director of industry risk management and insurance for the International Air Transport Assn. in Montreal.

The earliest such a conference would be called is December, Ms. Gates said.

The so-called "general risks" convention had been set aside during previous meetings of the ICAO's Special Group, which worked on the wording of both conventions before ICAO's Legal Committee meeting.

The ICAO's Legal Committee agreed that airline operators' strict liability be capped in the general risks convention at the same level as the unlawful interference convention, delegates said.

Under a three-tier system, the airline operator's liability would be capped at 700 million special drawing rights, a multicurrency measure set up by the International Monetary Fund, based on mass of the craft. The second layer would be capped at 3 billion SDRs collected through a levy on passengers and freight. The third layer would be tapped when damages exceed the first two layers in cases where airline operators were proven to have intentional or reckless knowledge that damage would result.

Together, the conventions would supersede international agreements on ground losses that were implemented in the 1952 Rome Convention, long before the Sept. 11, 2001,

See **AVIATION** next page

Canadian firm wins pensions case

But key issue over control of surplus to be decided by highest court

By GLORIA GONZALEZ

TORONTO—In another favorable ruling for pension plan sponsors, the Ontario Court of Appeal ruled last week that a Canadian employer does not have to share a portion of its pension surplus with employees of a unit it sold two decades ago.

The full impact of the decision in *Burke vs. Hudson's Bay Co.*, though, in large part will depend on the outcome of an appeal to the Supreme Court of Canada on another critical pension ruling from the Court of Appeal that centered on control of pension fund assets.

If the Supreme Court overturns the decision in *Kerry (Canada) Inc. vs. DCA Employees Pension Committee*—also seen as a positive ruling for employers—it may limit the influence of the *Burke* decision, pension lawyers say.

"I think (*Burke*) is a kind of companion decision to the *Kerry* case," said David Vincent, senior partner and co-chair of the pensions and benefits group of Ogilvy Renault L.L.P. in Toronto. "If the *Kerry* case gets overturned by the Supreme Court of Canada, then this one is also in jeopardy."

In the latest case, the Court of Appeal last week overturned a lower court ruling that Toronto-based retailer Hudson's Bay had to transfer a share of a \$94 million Canadi-



RULING HIGHLIGHTS

The appeals court, which ruled on several issues, decided:

- The company had no obligation to transfer any of the surplus under its plan documentation and no legislation mandates such a transfer upon selling an asset.
- The starting point for any determination of the rights and obligations of the parties to a pension plan is the plan documentation.
- Pension plan text and trust agreements should be read as an "integrated whole" rather than stand-alone documents.
- The employer was entitled to pay plan expenses from the fund and take contribution holidays.
- The company clearly stated that booklets provided to plan members were merely summary documents, directed readers to the official plan documentation and properly retained the right to change the plan terms in disclaimer language featured in written communications.

Source: Ontario Court of Appeal

an (\$93.9 million) surplus to a pension plan created for the Northern Stores Division it sold in 1987. As part of the sale agreement, the division, which became Winnipeg-based North West Co., agreed to employ 1,200 Hudson's Bay workers and to establish a new plan comparable with the Hudson's Bay plan. Hudson's Bay agreed to transfer cash assets equal to the pension liabilities of the transferred employees, but would have no further obligation for their benefits.

The former employees filed a complaint in 1994 asking for a court order that Hudson's Bay transfer a share of the surplus to the new plan or to a trust. A lower court judge concluded that some employees had a reasonable expectation, based on written communications, that part of the surplus would be used to improve their pensions and that the company did not own the surplus. The failure to transfer surplus assets to the new plan constituted a breach of trust, according to the lower court judge.

The Court of Appeal, though, ruled that the company had no obligation to transfer any portion of the surplus under the terms of its pension plan documentation and the absence of legislation mandating such transfers.

See **PENSION** next page

Lloyd's approves proposed reforms

Changes would widen access to market, lift ownership restrictions

By STUART COLLINS

LONDON—Lloyd's of London has voted in favor of reform proposals that would allow Lloyd's insurers to accept business from intermediaries other than registered Lloyd's brokers.

At an extraordinary general meeting last week, the membership of Lloyd's approved a resolution to consent to the proposals to amend the Lloyd's Act 1982—the statutory legislation that provides for governance at Lloyd's. More than 99% of Lloyd's membership voted in favor of the proposals.

"This is an overwhelming endorsement from our membership in support of the Treasury's proposals to reform Lloyd's governance arrangements and improve access to the market," Lloyd's Chairman Lord Peter Levene said.

Last year, the U.K. government proposed modernizing the corporate governance arrangements at Lloyd's through a legislative reform order to amend the Lloyd's Act. In March of this year, the U.K. Treasury set out its proposals in a consultation document, "Proposals for Legislative Reform Order to Amend Lloyd's Act 1982." Under the Treasury proposals, the market would remove a requirement that business be placed by Lloyd's brokers, opening the market to other regulated brokers in the United Kingdom and even individual insurance buyers (*BI*, March 17).

The move, made in response to competitive pressures from other insurance markets in the United States, Bermuda and Dublin, Ireland, seeks to remove costs and help Lloyd's underwriters find new

routes to reach clients round the world, Treasury said in its consultation document.

The government also proposed eliminating restrictions on associations between managing agents and brokers. Those rules would be repealed and replaced with disclosure requirements that would allow Lloyd's to monitor associations to avoid conflicts of interest.

The consultation document also outlined plans to relax rules regarding the appointment of Lloyd's chairman and deputy chairman, including the removal of the requirement for the governor of the Bank of England to approve nominations to Lloyd's Council, the market's governing body.

The consultation can be viewed at www.hm-treasury.gov.uk/consultations_and_legislation/lloydsact/consult_lloyds_act.cfm

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Myths: CDHP implementation battles

CONTINUED FROM PAGE 4

ing," Mr. McDevitt said.

The perception that CDHPs are not gaining traction with employers is another myth, he said. Although only 5% of employees with employer coverage are in CDHPs, a National Business Group on Health/Watson Wyatt study found that 47% of large employers offered a CDHP this year while 54% will offer a CDHP next year.

One criticism of account-based plans is that enrollees will forgo preventive care, but several major health insurers have reported that preventive service usage in the plans is generally comparable to preferred provider organization plans, Mr. McDevitt said.

In addition, a RAND Corp./Watson Wyatt study found that all but one of the 46 account-based plans offered by large employers in the study provided at least some coverage for preventive services before the deductible is satisfied, while 89% paid for the full cost of preventive services.

When UnitedHealth Group Inc. replaced its traditional plans in 2005, its employees wanted to "cherry pick" what they viewed as the best features of their clients' benefit plans, said Craig Mitchell, director of total compensation for UnitedHealth in Minnetonka, Minn.

"Worst of all for our company, our employees thought because we were a health care company, we should give away health care free," Mr. Mitchell said. "This is health care. This is serious cost."

The insurer had to share information on the cost pressures associated with providing a health care benefit to help employees understand the need for change, Mr. Mitchell said. "They assume the worst and that

becomes a barrier for us," he said.

Getting employees to accurately compare the costs of the old and new plans was an issue for both UnitedHealth and Watson Wyatt, their benefit managers said.

When UnitedHealth employees calculated the costs of the new HSA and HRA options, they focused on the out-of-pocket maximums or deductible levels and overlooked costs such as copayments under the old plans. "You have to have them think about the total package," Mr. Mitchell said.

Watson Wyatt replaced its tradi-

'I think it's better to err on the over-communication side because there are a lot of different components to these plans.'

John Bowe, Watson Wyatt Worldwide

tional plans with an HSA-linked plan on Jan. 1, 2007. When a company transitions from a health care plan that features a \$15 copayment to a plan with a \$3,000 family deductible, "that's all the population sees," said John Bowe, director of benefits for Watson Wyatt in Arlington, Va. "Take the focus off of the deductible."

The first year of the full replacement process is the toughest, as employees experience "a lot of anxiety," but the transition to a CDHP is a long-term strategy and not a short-term fix, Mr. Bowe said. "There's a lot of education that needs to take place in that first year," he said.

Watson Wyatt provides its

employer contributions at the beginning of the year, so employees who manage their accounts are more comfortable about the plans, Mr. Bowe said. "While it's not great for everyone, particularly for the high utilizers—they still have some anxiety—the majority of people are in a much better" position, he said.

Despite the perception that employees will forgo necessary care, UnitedHealth found that usage of preventive services increased because it provides preventive care free to its employees, Mr. Mitchell said. "We're more than willing to assume that cost."

Benefit managers considering a transition to CDHPs need to spend a great deal of time communicating a large amount of information, so they should release information in a staggered manner, Mr. Bowe said.

"You cannot over-communicate these plans," Mr. Bowe said. "Everybody's different and I think it's better to err on the over-communication side because there are a lot of different components to these plans. There are a lot of tricky things, particularly if you introduce a health savings account."

UnitedHealth decided late in the process to proceed with a full replacement. It had 10 weeks to get all employees educated and had to use all of its resources to meet the challenge. Mr. Mitchell advised benefit managers at the conference to make such a decision as early as possible to ease the process. "Don't underestimate it," he said.

Companies implementing CDHPs must have strong partnerships with their vendors, which will be responsible for implementing a substantial portion of the new benefits program, Mr. Bowe said. "If they fail to deliver, it will appear as if the plan has failed," he said.

Incentives: Wellness oversight required

CONTINUED FROM PAGE 4

tions of \$20 per month as an incentive, said Tracey Crowell, director of benefits, human resources in Boston. The program eventually was modified to require employees to participate in other activities to receive the same reduced premium contribution, but providing more choices and trying to communicate them proved challenging.

"We got a little too tricky with the activities," Ms. Crowell said, adding that Fidelity Investments is soliciting feedback directly from

employees that will be used in developing a new incentive strategy. "We're trying to figure out what the right thing to do is there."

The benefits staff used the health risk assessment data to make a business case to management of the need for a smoking cessation program that launched last year and plans to implement other wellness programs such as weight management, Ms. Crowell said.

Health risk assessments alone are insufficient to determine if employee wellness has been achieved, but the assessments can be a gateway to

disease management programs, Ms. Kelly said. Health risk assessments "are an important component, but you need to have all the other programs to complement that," she said.

Benefit managers say employers need to find ways other than incentives to promote wellness among their employees.

Both Humana and Campbell's recently won awards from the National Business Group on Health in Washington for their efforts to encourage their employees to live healthier lifestyles. Despite the time-consuming process of applying for such recognition, the awards can be used as communication tools to encourage employees to participate in wellness initiatives and to secure senior management buy-in for future wellness programs, the benefit managers said.

"Here's an award we won, but we wouldn't have won it without you, and we won't win it again if you don't continue to participate," Ms. DeGooyer said of her future messages to Humana employees.

"It really does help promote it with employees," Campbell's Ms. Kelly said.

Pension: Canadian firm not required to share surplus

CONTINUED FROM PREVIOUS PAGE

The trial judge's decision was surprising because trust law does not typically give much weight to expectations, but the Court of Appeal reaffirmed that plan documentation should determine issues such as surplus entitlement, said Christopher Naudie, a partner in the litigation department of Osler Hoskin & Harcourt L.L.P. in Toronto, who represented Hudson's Bay in the dispute.

"The nice thing about the Court of Appeal decision is that we view it as a return to settled law," he said.

Plan sponsors must still carefully analyze their pension trust and plan documentation to determine surplus ownership, pension experts say, but the Court of Appeal ruled the employer did not have an obligation to share the surplus with its former employees.

"While it's a good decision for employers, the plan documentation is still going to be relevant in determining a particular employer's obligation," said Stephen Pibworth, legal consultant for Hewitt Associates Canada in Toronto. "Generally speaking, most employers would not have voluntarily transferred a pro-rata share of surplus."

Since many Canadian pension plans are in deficit positions, the decision may be a "moot point" for companies considering similar asset sales, but the ruling may limit the legal exposure of companies that previously sold assets while their plans were in surplus positions, Mr. Vincent said.

Many employers, though, will not be affected by the *Burke* decision because their plan documents do not give them rights over the surplus or have language specifying that the fund must be used for the exclusive benefit of the plan members, said Bethune Whiston, a partner and manager of the Toronto pension legal team of consulting firm Morneau Sobeco. The *Burke*

case is "a very, very important decision, but it is, as they all are, limited in its application," she said.

Pension experts also say that the *Burke* decision is inherently linked to the *Kerry* case because the Court of Appeal used similar reasoning on pension issues in both cases.

The Supreme Court is expected to hear an appeal of the *Kerry* decision in November. In the June 2007 decision, the Court of Appeal ruled that a divisional court erred in finding that the company was not allowed to pay pension plan expenses from the pension fund after taking into account the fund's surplus. The court ruled that there was no statutory requirement the employer pay the expenses and the language of the plan documentation did not prohibit the payment of most expenses from the fund (*BI*, June 11, 2007).

"I think the fact that the Supreme Court agreed to hear the appeal does create some uncertainty for plan sponsors," Mr. Pibworth said. "On the other hand, hopefully a decision from the Supreme Court of Canada will provide even greater certainty for plan sponsors."

In the *Burke* decision, the Court of Appeal reiterated the plan sponsor was entitled to pay expenses from the fund, a central tenet in the *Kerry* decision, said Mitch Frazer, chair of the strategic communications committee of the Toronto-based Assn. of Canadian Pension Management, which represents plan sponsors in Canada.

"If *Kerry* gets overturned, it removes the underpinning of a lot of the argument the Court of Appeal brings forward on the plan expenses issue," said Mr. Frazer, who is also a partner in the pension and employment practice of Torys L.L.P. in Toronto, which has represented Hudson's Bay in other legal matters.

Burke vs. Hudson's Bay Co., Court of Appeal for Ontario, 2008 ONCA 394, May 20, 2008.

Aviation: Proposals address terrorism-related losses

CONTINUED FROM PREVIOUS PAGE

terrorist attacks in the United States. The original 1952 Rome Convention on Damage Caused by Foreign Aircraft to Third Parties on the Surface, which went into effect in 1958, was designed to address ground damage caused by an aircraft accident.

But the Rome Convention did not deal with ground damage caused by acts of terrorism, nor was it widely accepted around the world because the liability limits were viewed as inadequate. Moves to amend or replace the Rome Convention have been in the works for years, but efforts intensified following the 2001 terrorist attacks.

During the recent ICAO Legal

Committee meeting, compromises were agreed upon to achieve broad approval for the new wording on unlawful interference. Most nations represented at the meeting, including the United States, approved the proposal, which some say is not as favorable to airline operators as originally intended, delegates of the meeting said.

The unlawful interference draft convention would continue to channel liability for third-party ground damage to airline operators. The liabilities also continue to be exclusive—so apart from the terrorists themselves, no other person or organization other than the aircraft operator would have any liability for damage caused by a terrorist attack.

NYBGH benefits event draws 200

NEW YORK—About 200 people attended the third and final meeting in the New York Business Group on Health's series on Consumerism in Healthcare: Reality or Wishful Thinking.

The May 14 conference in New York featured sessions that discussed topics such as

the myths vs. realities of account-based health care plans and consumerism in pharmacy benefit and wellness strategies.

The next NYBGH event, Workplace Responses to Employees with Cancer: What Employers Can Do, will take place June 18 in New York.

—By Gloria Gonzalez

Ariz. enacts captive expansion law

By JERRY GEISEL

PHOENIX—Arizona Gov. Janet Napolitano signed legislation last week that allows employers with captive insurance companies in the state to expand their use.

Under the law, a branch captive can be established to cover any risk a traditional single-parent captive could write. That expansion would appeal to parents of offshore captives that want to retain those captives but also, for example, want to cover risks that state regulators and

others want covered through an insurer licensed in the United States.

The new law, in part, builds on an expansion measure approved last year. The 2007 measure included a provision that gives employers with captives in other domiciles the ability to set up branch captives in Arizona to fund employee benefit risks.

That provision was geared to employers that want to fund benefit risks through captives but also want to continue to sponsor captives out-

side the United States. U.S. Department of Labor rules stipulate that captives used to fund benefit risks of U.S. employees must be licensed domestically.

Other provisions in the measure make clear that Arizona captives can write coverage for employment practices risks, and that a single-parent captive can be organized as a limited liability corporation.

Arizona in recent years has been one of the nation's fastest-growing domiciles. It currently has 99 captives.

Survey: Fewer large firms offer defined benefit plans

CONTINUED FROM PAGE 4

In addition, Congress made clear that new plans are protected from such suits as part of 2006 pension funding reform legislation.

"There now is a lot more discussion out there about these plans," Mr. Glickstein said.

'There now is a lot more discussion out there about these (cash balance) plans.'

Alan Glickstein, Watson Wyatt Worldwide

before they catch up with defined contribution plans. Last year, 46% of Fortune 100 companies offered only a defined contribution plan to new salaried employees. That's up from 42% in 2006 and sharply higher than 1985, when only 10% of the companies only offered a defined contribution plan.

Employers that have gravitated to defined contribution plans have cited several reasons, most notably their predictable cost.

As this shift has occurred, employers have added defined benefit plan-like features to their defined contribution plans, Mr. Glickstein said.

For example, more employers are automatically enrolling employees in their defined contribution plans—unless they specifically object. Additionally, many employers that have made 401(k)s or other defined contribution plans their sole retirement option are making contributions on behalf of employees instead of only matching employees' salary deferrals.

Such designs increase the likelihood that employees will have adequate funds available at retirement.

Copies of the Watson Wyatt survey are available at www.watsonwyatt.com.

FORENSIC ACCOUNTANT DIRECTORY

Business Insurance will publish an online Directory of Forensic Accounting Firms in conjunction with the August 4 issue. The issue will include a Spotlight report on Catastrophe Management and a ranking of the largest forensic accounting firms. If your firm provides forensic accounting services and would like to be included in the directory, please contact Kevin Edison, research director, at kedison@businessinsurance.com

Florida law mandates coverage for autism

By COLLEEN MCCARTHY

TALLAHASSEE, Fla.—Florida Gov. Charlie Crist signed legislation last week that will require insurance companies to pay for diagnosis and treatment costs for autistic children up to \$36,000 annually with a lifetime cap of \$200,000.

Under the Window of Opportunity Act, S.B. 2654, major insurance companies that operate in the state of Florida, and companies

with more than 50 employees, will be required to offer coverage for autism-related disorders.

The legislation gives insurance companies until January 2009 to negotiate a compact with the state to develop autism-coverage plans, before the mandate takes effect in 2010.

The legislation also calls on insurance companies to enhance consumer awareness of the benefits.

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Rating firms look at AIG

NEW YORK—American International Group Inc.'s capital-raising efforts have led to its removal from Standard & Poor's Rating Services' CreditWatch list, but Moody's Investors Service has downgraded the insurance financial strength ratings of several of its subsidiaries.

In addition, Fitch Ratings affirmed AIG's insurer financial strength ratings.

And the insurer now faces a class action suit stemming from its \$7.81 billion first-quarter loss.

AIG announced last week it had raised about \$20 billion through the sale of common stock, equity units and fixed-income securities. The insurer had originally planned to raise \$12.5 billion.

New York-based S&P affirmed its AA+ counterparty credit and financial strength ratings on AIG's core operating subsidiaries, following its capital raising efforts. The outlook on the ratings is negative, S&P said. The rating agency affirmed the New York-based insurer's AA- counterparty credit and senior debt ratings.

S&P said the total issuance replaces essentially all of the capital lost in the past two quarters because of market valuation losses and "other-than-temporary" impairments on mortgage-related securities, and restores the firm to a very strong consolidated capital position.

However, New York-based Moody's downgraded the financial strength rating of AIG's commercial insurance group subsidiaries to Aa3 from Aa2, among other ratings changes.

Fitch Ratings affirmed the AIG's AA+ insurer financial strength ratings, among others, although the outlook is negative.

Meanwhile, the Jacksonville Police and Fire Pension Fund in Florida filed a lawsuit May 21 in federal district court in New York seeking class action status against AIG and current and former officers in connection with the first-quarter loss.

The suit seeks compensatory damages, and claims defendants issued "a series of false and misleading statements relating to the company's finances that artificially inflated the price of AIG securities." The pension fund has more than \$1 billion in total assets.

The AIG spokesman had no comment.

—By Judy Greenwald

Property/casualty insurers' 2008 first quarter results

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

	Corporate		Corporate		Property/casualty operations		Property/casualty operations		
	Net income	Percent increase (decrease) 2008-2007	Consolidated revenues 2008	Combined ratio 2008 ¹	Combined ratio 2007 ¹	Net premiums written 2008	Percent increase (decrease) 2008-2007	Policyholder surplus 2008	Percent increase (decrease) 2008-2007
The Travelers Cos. Inc.	\$967,000	(11.0) %	\$6,232,000	87.6 %	89.2 %	\$5,188,000	0.9 %	\$22,353,000	5.4 %
Chubb Corp.	664,000	(6.5)	3,489,000	83.9	83.4	2,936,000	2.4	13,300,000	11.3
ACE Ltd.	377,000	(46.2)	3,076,000	84.6	87.1	3,049,000	(4.2)	16,735,000	11.9
Liberty Mutual Insurance Co.	360,000	2.9	6,885,000	100.7	101.1	6,256,000	10.0	14,099,000	16.7
CNA Financial Corp.	187,000	(36.8)	2,282,000	98.1	95.1	1,619,000	(6.5)	8,110,000	(1.5)
Hartford Financial Services Group Inc.	145,000	(83.5)	1,544,000	87.8	88.8	2,584,000 ²	(1.5)	8,300,000	-
SAFECO Corp.	141,800	(22.3)	1,501,600	93.0	89.8	1,360,900	(2.1)	2,849,800	(27.7)
American Financial Group	76,000	(33.1)	1,014,200	80.8	84.0	658,000	0.2	2,014,000	(21.8)
Argo Group International Holdings Ltd.	36,900	47.0	258,100	95.9	94.2	237,500	18.5	1,260,000	65.8
RLI Corp.	25,459	(21.7)	158,964	89.2	81.4	120,889	1.2	747,570	(3.5)
Old Republic International	(19,057)	N/M	951,681	94.3	91.4	493,852	(0.6)	2,438,941	1.5
Cincinnati Financial Corp.	(42,000)	N/M	780,000	98.6	89.6	776,000	(8.3)	4,027,000	(15.1)
American International Group Inc.	(7,805,000)	N/M	14,031,000	96.9	87.5	12,080,000	(0.2)	N/A	N/A
Cumulative	\$(4,885,898)	N/M	\$42,203,545	93.2 %	90.1 %	\$37,359,141	1.0 %	\$96,234,311	3.3 %

¹ Includes dividends. ² Statutory. N/M - Not Meaningful
Source: BI survey, company reports

Insurers: Some P/C companies hit by subprime crisis

CONTINUED FROM PAGE 1

Joseph R. Lebens, a consultant with the Tillinghast insurance consulting business of Towers Perrin in Hartford, Conn. Even if insurers have invested in derivatives and other vehicles not labeled subprime investments, "if they dug deep enough, they'd find that subprime is at the bottom of the food chain, so to speak," he said.

However, "the industry is well positioned to weather the current storm," said Jeff Berg, senior vp with New York-based Moody's Investors Service, who said another factor that has affected insurers' investment returns is widening credit spreads, which lowers the value of their portfolios.

Mark Charron, a principal and national actuarial and insurance solutions leader for Deloitte Consulting L.L.P. in Hartford, Conn., said he is not sure the subprime crisis is "going to cause property/casualty carriers to really see significantly more financial trouble. The declining real estate market and the declining economy have broader implications for the industry."

John L. Ward, chief executive officer of Cincinnati-based Cincinnati Partners L.L.C., said, "I think the lower investment gains have encouraged companies to emphasize underwriting discipline to a greater extent, so those two components tend to keep each other in check."

Other companies reported lower investment income or losses as well:

- Bermuda-based XL Capital Ltd. reported \$1.4 billion in net unrealized losses, net of tax, for the quarter. It said the losses were primarily due to continuing widening credit spreads on corporate and structured credit investments and unfavorable foreign exchange rate movements, partly offset by interest rate declines. It also reported \$102.3 million in net realized losses.

- Chicago-based CNA Financial Corp. reported a \$714 million decrease in its pretax net investment

income, reflecting in part a \$91 million decline in limited partnership results.

- Cincinnati Financial Corp. reported \$232 million in net realized losses.

- The Hartford Financial Services Group Inc. reported \$2.02 billion of total unrealized losses and \$1.37 billion in net realized capital losses.

- Chicago-based Old Republic Corp. reported \$900,000 in realized investment gains but \$167.5 million in unrealized losses for the first quarter.

A Fitch Ratings report last month concluded subprime mortgage exposure represented less than 4% of all cash and investments last year, or about 14% of stockholders' equity for the 51 property/casualty companies studied. The report says, however, AIG "represents a disproportionate three-quarters share of the subprime exposure."

The report says also many property/casualty insurers have significant exposure to insured municipal bonds, which have experienced declining prices because of deterioration in financial guarantors' financial strength. However, "the risk is somewhat mitigated by the strong investment-grade credit position of the municipalities," says the report.

It remains unclear how the situation will develop.

"I expect the worst is not over," said Mr. Lebens. "I think that there's much more fallout to be had. I think the government has stemmed the tide for the time being, but I don't think we're done by any means."

James Auden, Chicago-based Fitch senior director, noted, however, that insurers with subprime exposure are not "in a position where they're forced to sell assets, so they have the ability to wait it out."

"I don't know if you can say that the problem's over, though," he said. "There could be further investment losses as the year progresses. It's encouraging the bond market recovered a little bit and access to capital has improved for the insurers," Mr. Auden said.

D&O losses stemming from the credit crisis also are expected, say observers. Mr. Lebens said he has seen estimates ranging from \$3 billion to \$10 billion, noting that as the subprime crisis fuels an overall economic crisis and stock prices drop, D&O claims will be filed against companies not directly involved in subprime mortgages, he said.

However, Matt Nellans, an analyst with Morningstar Inc. in Chicago, said it is a "little bit harder than you think to get a claims payment for some of these things."

Results good overall

Meanwhile, property/casualty results were good overall despite the softening market, say observers.

With AIG's \$7.81 billion loss, the 13 major property/casualty insurers surveyed by *Business Insurance* reported a \$4.89 billion loss vs. \$8.8 billion in profit for the comparable period a year ago. Among other results:

- Net premiums written increased 1%, to \$37.36 billion.

- Insurers reported a 93.2% combined ratio vs. a 90.1% for the comparable period a year ago.

- Policyholder surplus increased 3.3% for the 12 insurers reporting that result, to \$96.32 billion.

"Results remain solid," said Adam Klauber, director of equity research for Cochran Caronia Waller Securities L.L.C., a Chicago-based insurance industry banking firm.

"Growth, as expected, is weak," he said. Accident year results were "surprisingly good," while good reserve development continues to boost results. "Premiums are weak, but they're not going down dramatically and you're not seeing the impact of pricing in the loss ratios yet," Mr. Klauber said.

Results "were actually a little bit better than I expected," although "there were a fair amount of weather catastrophes in the quarter, so it wasn't a spectacular first quarter," said Paul Newsome, an analyst with Sandler O'Neill & Partners L.P.

in Chicago.

Rate cuts are "starting to have more of an impact" on net premiums written, though "some of the larger companies seem to be holding up much better than some of the smaller companies," said John Iten, a director at Standard & Poor's Corp. in New York.

But, he added, in "terms of combined ratios and underwriting performance, the story is pretty good. I think with few exceptions, the combined ratios held up pretty well in the first quarter" and overall are still under 100%.

Cliff Gallant, an analyst with Keefe, Bruyette & Woods Inc. in New York, said that while "it's easy to be negative right now because of the direction of pricing," the "absolute levels of pricing is not so bad, reserves are still good and loss trends are manageable."

The outlook is for continued rate softening, say observers. With commercial lines rate declines seeming to pick up steam in most lines of business, "this obviously will lead to poor prospects for earnings for growth in 2008 and 2009," said John D. Gwynn, managing director at Memphis, Tenn.-based investment firm Morgan Keegan & Co. Inc.

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policyholders, including several public entities. The officials charged that Chicago-based Aon improperly collected undisclosed compensation when it placed various coverages with insurers. Aon agreed to pay \$2.6 million to Florida to reimburse affected policyholders and to reimburse state officials for \$1.4 million in fees and costs. In 2005, Aon and other large brokerages struck

settlements various with states over compensation arrangements and the use of contingent commissions.

Bush signs measure to bar genetic bias

President Bush has signed the Genetic Information Nondiscrimination Act, which prohibits employers from firing, refusing to hire or otherwise discriminating against workers on the basis of genetic information. It also bans health insurers or group health plans from basing eligibility determinations or adjusting premiums or contributions on the basis of genetic information, and it forbids the disclosure of genetic information.

Mass. to refine health cover rules

Massachusetts regulators plan to clarify final rules on the design requirements of health plans state residents must be enrolled in to avoid financial penalties. On Jan. 1, 2009, under the state's health care reform law, most state residents will have to be covered in plans that meet minimum "creditable coverage criteria." Under rules finalized last June, plans considered offering minimum coverage can't, among other things, have annual deductibles greater than \$2,000 for individual coverage or \$4,000 for family coverage. Additionally, in order for the enrollees to have creditable coverage, a plan cannot impose an overall annual benefit limit or a per illness annual maximum

benefit for covered core services. The bulletin will provide more clarification of what are considered covered core services.

Texas storm claims put at \$50 million

A storm that struck Austin, Texas, earlier this month caused about \$50 million in insured losses according to the Insurance Council of Texas. Up to 20,000 insurance claims are expected from the May 14 wind and hail storm, the Austin-based council said. The storm, which packed 65 mph winds, knocked out power to thousands of homes. According to the council, the last Texas storm to cause more insured losses than this storm was on March 24, 2005, which resulted in \$100 million in losses.

Greenberg: AIG's former chief receives Wells notice

CONTINUED FROM PAGE 1

to the SEC to bring civil charges, which require a lower standard of proof. Securities regulators will use evidence presented at the criminal trial, observers say. If the SEC is successful, it likely will seek to bar Mr. Greenberg from acting as a director or officer of a public company. C.V. Starr & Co. Inc., of which he is chairman and CEO, is a private company.

Although a Wells notice generally signals that securities regulators believe they have enough evidence to warrant an enforcement action, the recipient may respond to the allegations.

"We remain confident of our position on the merits" and when the SEC has the opportunity to consider all the facts, "we believe that they will agree," Robert Morvillo, Mr. Greenberg's attorney, said in a statement. Mr. Morvillo is a partner at Morvillo, Abramowitz, Grand, Iason, Anello & Bohrer P.C. in New York.

Mr. Greenberg has always acknowledged that he initiated the deal, a spokesman for Mr. Greenberg said last week. "He doesn't know what happened. But there was a federal case up in Hartford where four General Re and one AIG employee

were found guilty. The supposition from Greenberg's side is that he asked for a legitimate deal, the General Re people got together and couldn't come up with one that met the requirements, so they came up with a fraudulent one. But they didn't call (Mr. Greenberg) up and say 'Hey, I came up with a fraudulent one for you.'"

Legal experts say Mr. Greenberg likely will face civil charges.

"A lot of evidence came out in the criminal trial that (Mr. Greenberg) was probably involved in the activities in which these five executives were convicted, but there may not be enough hard evidence like e-mails to show the key element in the criminal case, which is intent," said Jacob H. Zamansky, a securities attorney with Zamansky & Associates in New York.

"When you have a situation where you think somebody knew or should have known, that's more of a civil case that the SEC brings. Because in a criminal case, it's got to be proven beyond a reasonable doubt on all the elements, including intent, and they may be lacking in that one area, which is why they are going civilly rather than criminally," he added.

While the preponderance-of-evidence burden in a civil case is easier

to prove, "it does not mean it's an easy case," noted Peter J. Henning, a criminal law professor at Wayne State University in Detroit. "They still have to prove that (Mr. Greenberg) intended to defraud, and that can be hard to do," he said. "The SEC has to show more than just he initiated a transaction, but that he was involved in the accounting for it and understood what was going on."

In upholding the convictions of the former Gen Re and AIG executives, U.S. District Court Judge Christopher Droney earlier this month said there was enough evidence to show the conspiracy to artificially inflate AIG's loss reserves and deceive investors started with Mr. Greenberg's call to Gen Re.

Robert Heim, a former SEC prosecutor now with Meyers & Heim L.L.P. in New York, said that because Mr. Greenberg "admits he initiated the call and says other people carried out the transaction, Judge Droney's reference to (Mr. Greenberg) may not carry as much weight as the SEC would like."

Attorneys agree any civil action the SEC may bring will be contentious.

Most people facing an SEC enforcement action will "roll over" with some consent order and a fine, Mr.

Zamansky said. "I don't see (Mr. Greenberg) doing that. He's been fighting the last five years. It seems like he relishes the fight. He's unlike a lot of SEC defendants. He's got the stomach and the finances for a fight."

"It's a legacy issue with him," said Joel M. Androphy, a white-collar criminal defense attorney with Berg & Androphy in Houston, noting Mr. Greenberg is 83. The question is, "does he want to spend the next couple of years in court or does he want to spend it on the beach? It's not a money issue, it's a legacy issue."

In addition to potential SEC charges, Mr. Greenberg still faces a civil suit filed by former New York Attorney General Eliot Spitzer in 2005, which he has vowed to fight. Mr. Spitzer charged AIG, Mr. Greenberg and former AIG Chief Financial Officer Howard I. Smith with using the Gen Re deal and other transactions to falsify AIG's financial statements. AIG agreed to pay \$1.64 billion in February 2006 to settle those charges.

Mr. Greenberg was forced to resign from AIG in 2005 amid the growing investigation (see related story).

It is unknown whether Mr. Smith, who also has never been criminally charged in connection with the deal, also received a Wells notice. Calls to his attorney were not returned, and the SEC would not comment.

Joseph P. Brandon, former CEO of Gen Re who resigned from the reinsurer in April, was served a Wells notice in October 2005 in connection with the deal. His departure last month was largely seen as a deal with federal prosecutors in return for closing the criminal case against him. Like Mr. Greenberg, Mr. Brandon was identified as an "unindicted co-conspirator" in court papers.

Whether the SEC adds Messrs. Brandon and Greenberg to its civil case against the five convicted former executives or files separate actions remains to be seen. The SEC's existing civil case has been stayed pending completion of the criminal trial. The defendants have requested a further stay of the SEC's action until completion of their appeal, but a federal judge indicated she was inclined to lift the stay following sentencing.

The original May 15 sentencing date has been postponed and no new date has been set.

Debate erupts over why Greenberg left AIG

NEW YORK—A public spat has erupted over the circumstances surrounding former American International Group Inc. Chairman Maurice R. Greenberg's 2005 departure from the insurer he built.

In a May 16 letter to the editor of the Wall Street Journal, Richard I. Beattie, an attorney representing AIG's independent directors, disputed claims in an earlier editorial that then-New York Attorney General Eliot Spitzer had threatened to bring criminal charges against the company if AIG's board didn't oust Mr. Greenberg.

Rather, Mr. Greenberg was asked to step down after AIG's auditors determined that they could no longer rely on his certification of the company's financial

statements and for violating company policy by refusing to cooperate with government investigators, wrote Mr. Beattie, chairman of New York-based Simpson Thacher & Bartlett L.L.P.

As part of an investigation by the Securities and Exchange Commission and Mr. Spitzer's office, "more than 15 AIG employees voluntarily submitted to questioning by the authorities and did not invoke their Fifth Amendment rights not to testify for fear of self-incrimination," Mr. Beattie wrote. "Mr. Greenberg refused to do so."

In a letter that appeared in last Friday's Wall Street Journal, however, Mr. Greenberg's attorney, David Boies of New York-based Boies, Schiller & Flexner L.L.P., contested Mr. Beattie's assertions.

"The historical record is clear that AIG's directors caved in to demands from Mr. Spitzer to remove Mr. Greenberg without basis—and without even permitting Mr. Greenberg to be heard by the board," Mr. Boies wrote.

In addition, Mr. Boies said Mr. Greenberg did not invoke his Fifth Amendment rights until after he left AIG. Mr. Boies added that Mr. Greenberg also had no choice but to do so until he had an opportunity to review documents relating to events Mr. Spitzer said he intended to examine—documents AIG has refused to turn over.

A spokesman for AIG, who confirmed the information in Mr. Beattie's letter, declined to comment.

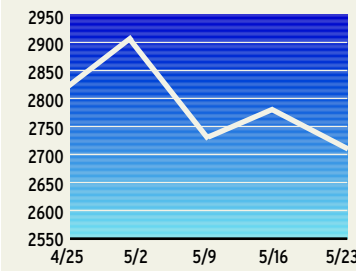
—By Sally Roberts

Stock Index

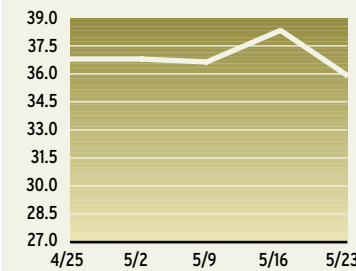
[5/19-5/23]

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

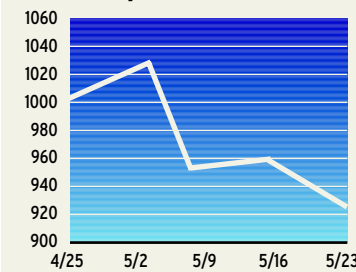
BI STOCK INDEX



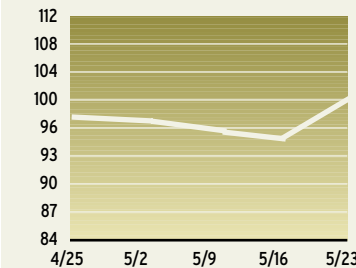
BI BROKERS INDEX



BI INSURER/REINSURERS INDEX



BI MANAGED CARE ORGANIZATIONS INDEX



Percentage change of BI Stock Index vs. key indicators

BI STOCK INDEX	2712.06	↓ -1.86%
DOW JONES	12479.63	↓ -3.91%
S&P 500	1375.93	↓ -3.47%

LARGEST GAINS

Health Net Inc.	12.77%
Humana Inc.	10.61%
UnitedHealth Group Inc.	7.52%
Aetna Inc.	4.71%
WellPoint Health Networks ...	4.68%

LARGEST LOSSES

MBA Inc.	-22.67%
Ambac Financial Group Inc. ...	-16.36%
Citigroup Inc.	-8.65%
Unitrin Inc.	-7.62%
Marsh & McLennan ...	-6.65%

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

Contributing: Mark A. Hofmann,
Sally Roberts, Joanne Wojcik

Ky. city caught between rock and wet place

Talk about a Catch-22.

The Federal Emergency Management Agency has ordered the city of Hawesville, Ky., to have a flood wall that protects the municipality from the Ohio River inspected and certified. The city is more than willing to do so, because if the flood wall isn't certified, residents will have to pay more for flood insurance. The city is even willing to pay for the inspection.

But, as Hawesville Mayor Charles King told a reporter for a local TV station, WFIE-14 in Evansville, Ind., the federal government won't allow the city to pay for the inspection. Under federal law, only federal funds can be used to conduct the inspection.

Mayor King found out to his dismay that federal funding isn't available. If Hawesville doesn't get the flood wall certified within a year, "then FEMA will look at our flood wall like it's nonexistent," he told WFIE-14. "Consequently all of downtown Hawesville and the residents therein will be in the 100-year flood plain."

So far, the city hasn't found a way out of its dilemma. The flood wall exists, and the city's willing to certify it exists solidly enough to protect Hawesville from the Ohio. The only thing that appears nonexistent in the government's insistence that non-available federal funds be used to pay for the certification may be common sense.

Business Insurance END PAGE



Chickens used as guinea pigs in bug battle

Why did the chickens cross the road?

To help protect residents of Utah from West Nile virus, of course.

About 450 so-called sentinel chickens have been distributed in Provo, Utah, to more than a dozen mosquito abatement agencies in the area.

Health officials soon will begin testing the chickens for West Nile virus as the first indication of where infected mosquitoes are most prevalent in the state, said a spokeswoman for the Utah County Department of Health.

"The chickens will pick up the virus, but they won't get sick and they won't die," she said.

The chickens will be placed in pens in undisclosed areas of Utah where the virus is expected to show up and will have blood drawn weekly from early June through September, the spokeswoman said.

Utah officials are unsure where infected mosquitoes will be the most concentrated this summer. Although last year was drier than normal, this year has

been much wetter, providing better breeding conditions for mosquitoes that also can infect humans.

West Nile infections have already been reported this year in Arizona and California, the Centers for Disease Control and Prevention said.

Pioneer in cat modeling honored for climate work

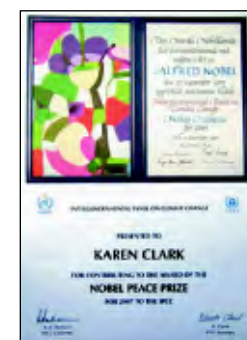
Economic models have long played a role in the determining the Nobel Prize in economics.

Now a catastrophe modeler has been recognized for work that played a role in the joint award of the Nobel Peace Prize to the Intergovernmental Panel on Climate Change and former U.S. Vice President Al Gore in 2007.

Karen Clark, president and chief executive officer of Boston-based Karen Clark & Co., received

an award certificate last week from the IPCC. According to a letter from IPCC Chairman Rajendra Pachauri, "We are providing a copy of this award only to those who have contributed substantially to the work of the IPCC over the years since the inception of the organization."

"The IPCC produces key scientific material that is of the highest relevance to policy-making, and is agreed word-by-word by all governments, from the most skeptical to the most confident," said Mr. Pachauri in his Nobel acceptance speech. "This difficult process is made possible by the tremendous strength of the underlying scientific and technical material included in the IPCC reports."



Karen Clark, president and chief executive officer of Boston-based Karen Clark & Co., received an award certificate (above) last week from the IPCC.

The IPCC last week honored the contributions of Ms. Clark, who founded the first catastrophe modeling company—Applied Insurance Research, now AIR Worldwide Corp.—in 1987. She has worked with the IPCC for more than a decade, first serving as a co-lead author for the Second Assessment Report published in 1995.

Since then, she's sponsored and supported scientific research on climate change and its potential severe weather impacts, which she described as "one of the most critical issues of our time and an area of vital ongoing scientific investigation."



An HMO decided to use a specimen cup as a mascot in its drive to attract more traffic to its Web site.

Cup lures stream of visitors

The new mascots for Minneapolis-based HealthPartners are certain to turn some heads, and maybe a few stomachs: Petey P. Cup is a 7-foot urine specimen cup, while Pokey the Syringe is a 10-foot syringe.

The characters are part of a larger marketing campaign aimed at persuading existing members of HealthPartners, a nonprofit health maintenance organization, to use its Internet resources, said Larissa Rodriguez, director of marketing.

Currently, only about 14% of the health plan's members access its Web site, www.healthpartners.com, where members can make appointments, e-mail their doctors and even

check their test results, she said.

But the campaign also is likely to attract new patients, given the reaction HealthPartners has already received, Ms. Rodriguez said. Within two days of the advertising campaign's May 19 start, a video of Petey posted on YouTube had already gotten 3,000 hits, she said. Several Internet blogs also picked up on the unconventional choice of mascots.

The idea for the off-the-wall campaign came from a Minneapolis ad agency. After finding that most health care advertising was unremarkable, "we decided to do something unique and fun that

would create a buzz and get people talking," Ms. Rodriguez said.

So the creatives at Kerker & Associates Inc. devised the idea of using so-called "spectaculars"—giant props of common health care items such as tongue depressors, cotton swabs, pill capsules as well as syringes and specimen cups, placing them at locations throughout the Twin Cities, Ms. Rodriguez said.

After seeing the proposal, however, "the medical group got so excited about it they decided they needed a mascot," Ms. Rodriguez said. "We're just having fun with it."



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