June 20, 2005
$5

Boehner urged to revise pension funding reform bill / 3

Brokerage execs discuss changes to business / 3

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COMPENSATION CRISIS

Secret provisions ensured Marsh commissions on fee-based deals

By DOUGLAS McLEOD

NEW YORK—As Marsh & McLennan Cos. Inc. awaits responses to its client restitution offers in the bid-rigging and client-steering scandal, a new wrinkle has emerged in the workings of the broker's now-discontinued contingent commission agreements: the "true-up" provision.

Starting in the late 1990s, Marsh's Global Broking unit added the provision to placement service agreements with a handful of insurers, enabling it to extract commission revenue from insurers on business where clients were paying Marsh fees, sources familiar with the practice say.

Under the true-up arrangements, Marsh would calculate its average commission on a book of business with an insurer quarterly; if the average commission fell below the level called for in the PSA, the insurer would have to make up the difference, these sources say.

Fees were not counted in the quarterly true-up calculations—though the associated premium volume was—and this had the effect of holding down average commission levels and increasing insurers' payments to Marsh, people knowledgeable about the practice say.

"Having fee-based business helped you get a bigger bite of the apple on the back end," one person familiar with the agreements said.

A sizable chunk of Marsh's excess casualty PSA revenue flowed from true-up agreements, one source said. Clients—and most Marsh employees—were unaware of the deals, and the insurers involved went along with them only grudgingly, several sources agree.

"Ultimately, there was no benefit for the client and no benefit for the insurance carrier. There was only a benefit for Marsh," a person familiar with the PSAs said.

Marsh representatives declined to comment specifically on true-up provisions but noted that Marsh discontinued all of its contingent compensation arrangements last year, after New York Attorney General Eliot Spitzer filed

See TRUE-UPS / page 38

Truing up

How sources describe Marsh's true-up calculations:

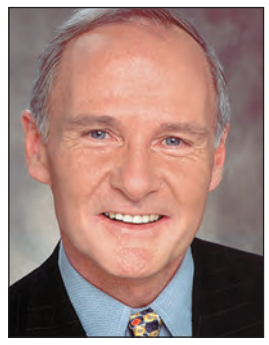
- On a quarterly basis, Marsh determined its average commission and premium volume on a book of business with an insurer.
- The calculations included premiums on fee-based business, but not fees themselves, effectively pushing down the average commission level.
- The insurer then paid Marsh the difference between its average commission and the commission level called for in Marsh's placement service agreement with the insurer.

HRH, Unum settle with Mass. over barred payments

$1.3M deal admits no guilt

By SALLY ROBERTS

BOSTON—Another state insurance industry investigation culminated last week, as one of the world's biggest brokerages and an insurer agreed to pay $1.3 million to settle allegations involving undisclosed commissions that violated procurement contracts.



Mr. Reilly

Hilb Rogal & Hobbs Co. and Unum Life Insurance Co. of America each agreed to pay $650,000 to settle a suit, filed by Massachusetts Attorney General Tom Reilly, charging that Unum paid, and an HRH subsidiary accepted, hundreds of thousands of dollars in undisclosed commissions in violation of procurement contracts with the Commonwealth of Massachusetts.

In his complaint, filed in Suffolk Superior

See HRH / page 38

CalPERS sees payoff from health cost cuts

By ROBERTO CENICEROS

SACRAMENTO, Calif.—The California Public Employees' Retirement System said last week that its strategy for attacking cost drivers has paid off, with health plan premium increases that averaged just 8.9% for its 2006 purchases.

The Sacramento-based retirement system also said it negotiated health maintenance organization rate hikes averaging 8.7% for 2006—the smallest HMO increase for CalPERS since 1999. The 2006 rates, though, include a 9.5% increase for self-funded preferred provider organization plans, up from a 6.4% increase for 2005 coverage.

Those single-digit increases are a dramatic contrast to just a few years ago, when CalPERS, like most other health care purchasers, was hit with dramatic rate increases. Those increases peaked in 2003, when premium rates leaped 24.1%.

CalPERS, which spends $4 billion annually to provide retirement and health benefits to more than 1.4 million public employees, retirees and their families, obtained its 2006 rates without raising employee co-pays or cutting benefits.

Several factors helped win rates below those of past years, a CalPERS spokesman said. Those factors included measures for addressing cost drivers implemented for plans purchased for 2005 and carried through for 2006, a general slowing in health plan cost increases and improved claims data. The improved claims data allowed CalPERS to compare insurer bids against claim costs.

The rates obtained by CalPERS represent a "good deal," acknowledged Linda Bergthold, senior consultant for Watson Wyatt Worldwide in Los Angeles, but she said that they are not surprising. The rates are in line, she noted, with

See CALPERS/ page 36

Late News

U.S. attorney issues finite risk subpoenas

Several insurers and reinsurers last week reported receiving subpoenas from the U.S. attorney for the Southern District of New York relating to finite reinsurance. The companies—ACE Ltd., Assurant Inc., auto insurer Bristol West Holdings Inc., PartnerRe Ltd., Platinum Underwriters Holdings Ltd., RenaissanceRe Holdings Ltd., St. Paul Travelers Cos. Inc. and XL Capital Ltd.—all said they would cooperate with the requests for information.

IRS clarifies tax rules on premiums

An organization that is the sole purchaser of coverage from an insurer cannot take a tax deduction for the premiums it pays, the Internal Revenue Service ruled last week. To be eligible for a tax deduction, insurance must involve risk distribution involving numerous parties, so that one insured is not "in significant part paying for its own risks," the IRS said in Revenue Ruling 2005-40. The IRS also said no risk distribution exists if the insurer covered a second policyholder whose business accounted for 10% of the insurer's premiums.

Calif. amusement parks face higher safety duty

Operators of California amusement park rides must meet higher safety standards under a California Supreme Court ruling that the rides be treated as "common carriers," in the same way as public transportation. The ruling means that operators must use "the utmost care and diligence"—the standard that applies to operators of buses and other types of public transportation—rather than the old standard of "reasonable care" in seeking to ensure the safety of rides. The ruling stems from a lawsuit filed by the family of a

See LATE NEWS/page 39

NEWSPAPER

BENEFITS MANAGEMENT

Work/Life Benefits
PAGE 11

BI RANKS

Employee Assistance Program Providers
PAGE 18

Inside

Top court rules against Quebec ban on health cover
Supreme Court of Canada ruling is not expected to impact benefits plans.
Page 4

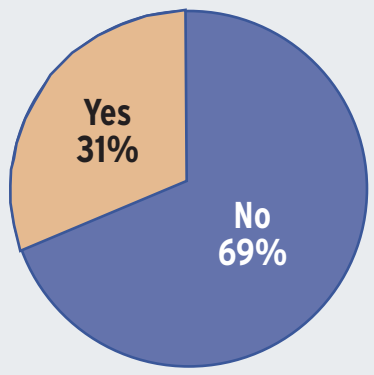
Lowering the costs of health care
Former Bush administration official says technology, prevention can help.
Page 4

Flirting with risk of harassment suits
Wal-Mart is stifled in its efforts to export workplace rules, Paul Winston writes.
Page 6

Risk managers urged to lobby for TRIA extension
Congressman says expiration of TRIA will not be pleasant.
Page 6

Online poll - [6/13 - 6/17]

Are you aware that employers must notify all their Medicare-eligible employees of whether their group prescription drug coverage is equal to what Medicare will provide?



Participate in *BI*'s online polls at *www.businessinsurance.com.*

Departments

Advertiser Index 38
Business Resources 32
Commentary 32
International 33
Opinions 8
Paul Winston 6
Perspectives 10
Products & Services 31
Professional MarketPlace 34
Ticker 39
World Updates 33

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Boehner urged to change pension bill

Suggestions include scrapping premium increase for PBGC, protecting cash balance plans

By JERRY GEISEL

WASHINGTON—As the first committee vote nears on recently introduced pension funding reform legislation, the bill's chief sponsor is being urged to change the measure significantly.

The suggested changes, voiced last week at a hearing by the House Education and the Workforce Committee, include rolling back a proposed big hike in premiums that employers would pay the U.S. Pension Benefit Guaranty Corp., scrapping a new way of valuing pension liabilities and incorporating in the legislation legal protection for cash balance plans.

While recognizing that opposition exists to aspects of his bill, Rep. John Boehner, R-Ohio, who also chairs the Education and the Workforce Committee, said the legislation will improve the security of pension benefits without discouraging employers from offering defined benefit plans. He said his measure, unlike one proposed earlier by the Bush administration, does not focus exclusively on shoring up the PBGC, which by itself will not bring stability to the defined benefit plan system.


Rep. Boehner

Rep. Boehner, who expects his committee to vote on his bill by the end of the month, said he is willing to listen to the concerns of interest groups. "We are at the beginning of this process, and we plan to work with all interested parties, including the (Bush) administration, employers and labor groups as we move forward," he said.

But Rep. Boehner cautioned that quick action is vital, referring to the failure of United Airlines' pension plans and the possibility, without congressional action, of more multi-billion-dollar pension failures and the resulting prospect of a costly taxpayer bailout of the PBGC.

One change recommended at last week's hearing involves PBGC premiums. The legislation would increase the base PBGC premium, which Congress has kept steady since 1991, to $30 a year per plan participant from $19. The increase would be phased in over

See PENSIONS / page 39

BI launches benefit manager award

Business Insurance is pleased to announce the launch of its first Benefit Manager of the Year™ award to recognize excellence and innovation in employee benefits management.

The inaugural award in benefits follows in the tradition of the magazine's long-standing Risk Manager of the Year™ competition. *Business Insurance* invites readers to nominate outstanding benefit managers for this award, the winner of which will be announced in the Dec. 5 issue of the magazine.

Any full-time employee of a corporation, nonprofit organization or government entity who oversees or administers employee benefit functions is eligible for the award. A nominee need not manage benefit programs as his or her sole responsibility but must be a full-time employee of his or her organization.

An independent panel of judges will score each nominee on how well he or she:

- Solved one or more major problems for his or her employer.
- Innovatively applies benefit programs to his or her organization's needs.
- Effectively uses benefit programs to help control costs.
- Exhibits leadership in achieving change within his or her organization.
- Established an effective system for communicating benefit programs to employees.
- Skillfully administers benefit programs through the application of technology.
- Develops in his or her career and promotes the advancement of the benefits management profession.

The value or generosity of specific benefits will not be judged; the award is intended to honor outstanding performance in managing and administering benefit programs overall. The highest-scoring candidate will be named Benefit Manager of the Year™. Judges will include representatives of employee benefit consulting firms, brokerage firms, health insurers/managed care organizations and benefits industry vendors.

"At a time when benefit programs are becoming a strategic challenge for employers, and with *Business Insurance* covering benefit issues closely since the magazine's inception, we think it's a great moment to give special recognition to leaders in the benefits field," said *BI* Editor Regis Coccia. "We invite all our readers to help us identify the top benefit managers by submitting nominations."

Candidates may nominate themselves or be nominated by a supervisor, colleague, broker, consultant or service provider, but the nomination must be accompanied by a letter from a superior who is familiar with the candidate's work. The deadline is Aug. 26.

To nominate a candidate, please download a nomination form at *www.businessinsurance.com/BMOY* or request one from Regis Coccia at 360 N. Michigan Ave., Chicago, Ill. 60601; *rcoccia@businessinsurance.com.*

Execs predict future brokerage models

By RUPAL PAREKH

NEW YORK—Now that major brokerages in the insurance industry have ended the practice of accepting contingent commissions, brokers going forward will adjust their business model to raise premium commissions, enhance transparency and improve client relationships, executives say.

Participating in the discussion about the future of the broker business model at Standard & Poor's insurance conference, "Insurance 2005: Under the Microscope," held last week in New York, were Patrick G. Ryan, executive chairman of Chicago-based Aon Corp. and David Eslick, chairman and chief executive officer of Briarcliff Manor, N.Y.-based USI Holdings Corp.

The panel was moderated by Tom Upton, managing director at S&P, and S&P Director Steven Ader also took part in the discussion.

Probes into industry practices by New York Attorney General Eliot Spitzer and others


David Eslick, left, and Patrick G. Ryan said that industry probes are a chance for brokerages to rebuild trust.

prompted most of the world's largest brokers to end contingent commissions. In addition several large brokerages have agreed to pay restitution to clients to settle probes by Mr. Spitzer and other authorities.

The investigations, while difficult for the brokerage community, have resulted in an opportunity to rebuild trust, and create better relationships with clients, Messrs. Ryan and Eslick both said.

Previously, many companies were not aware of exactly how much money was attributable to contingent commissions, Mr. Ryan said, and his company has "liked taking the mystery out of the business."

However, Mr. Ader noted, to regain lost contingent commission income, brokers will need to revise their business models.

Whether the contingency arrangements will cease to exist across the entire industry remains to be seen, but the emphasis for all brokers—whether global or local—must be on full disclosure, Mr. Ryan said. According to him, brokers cannot participate in the market in the absence of transparency.

"Those days are over," Mr. Ryan said in an interview after the discussion. "When you're fully transparent, contingent commissions will go away."

In order to improve bottom lines, brokers will raise premium commissions, Mr. Ryan

See S&P / page 36

Canadian high court rejects ban on private health coverage

But employers likely won't expand benefits despite pressure

By GLORIA GONZALEZ

Most Canadian employers are unlikely to expand their employee benefits programs, despite a recent Supreme Court of Canada decision that opened the door for the development of a private health care system that could exist alongside the country's single-payer health care system.

That's because Canadian employers are struggling with escalating health care costs, and current tax codes give them no incentives to cover health care services already provided by the government, consultants say.

In a June 9 decision, the court ruled in *Chaoulli vs. Quebec (Attorney General)* that Quebec's ban on private insurance for health care services that are already provided by the province is unconstitutional.

While the decision technically applies only to Quebec, observers say it will have widespread implications for the rest of the country. While five provinces—Alberta, British Columbia, Manitoba, Ontario and Prince Edward Island—have bans similar to Quebec's on private insurance, all Canadian provinces currently have restrictions on the ability of providers and clinics to collect payments directly from patients or third parties if they receive government funds. "The expectation is that the other provinces will follow suit, so all plan sponsors should be looking at this," said Greg Durant, group and health care Central Canada practice leader for Watson Wyatt in Toronto.

As a result of the ruling, unions and employees are expected to increase the pressure on Canadian employers to offer private care options for doctors, specialists and hospital visits normally covered by the government. Offering private health care options would enable employees to avoid the long waiting periods often associated with government-funded health care services, consultants say.

"The pressure will be to expand their benefit programs to allow employees to have private health care," said Larry Jackson, the Toronto-based health and welfare practice leader for Canada for Buck Consultants, an Affiliated Computer Services company.

The first step for employers is to examine their labor contracts to see whether these contracts require them to cover private health care services. Barring any contractual obligations, though, employers are unlikely to offer private health care options unless the federal income tax code is amended to allow them to deduct these expenses, consultants say. The current tax code does not allow employers to deduct expenses for private health care services already offered by the government, a fact that employers will cite

See HEALTH CARE / page 36

Insurers try to stop ACE from combining asbestos arbitrations

By DOUGLAS McLEOD

PHILADELPHIA—London insurers are seeking to block units of ACE Ltd. from consolidating arbitration proceedings on dozens of asbestos claim-exposed reinsurance contracts dating back to the 1950s.

ACE units last month filed 17 separate arbitration demands against Lloyd's of London underwriters and other London-market reinsurers, charging the reinsurers with a "pattern and practice of delay, obstruction and failure and refusal to timely pay" asbestos claims, according to court filings and a lawyer involved in the dispute.

Arbitration battle

Units of ACE want to consolidate arbitration proceedings for roughly 50 reinsurance contracts in force between the 1950s and 1980s, a move London reinsurers are trying to block.

The ACE units, which are running off business originally written by CIGNA Corp. and Aetna Property & Casualty operations that ACE acquired, seek "recovery of all outstanding amounts as well as future billings" on asbestos losses.

The ACE arbitration demands cover roughly 50 reinsurance contracts in force between the 1950s and 1980s and list roughly 100 policyholders with asbestos claims that ACE contends should be covered under the contracts, according to Jack B. Gordon, a lawyer with Fried, Frank, Harris, Shriver & Jacobson in Washington, representing the reinsurers.

Many of the claims are on losses for which ACE has not yet billed or given notice to the London reinsurers, Mr. Gordon said. London reinsurers have also demanded that ACE's asbestos claims be supported by adequate evidence, he said.

An ACE spokesman declined to comment on the dispute.

ACE has sought to consolidate arbitrations of the approximately 50 contracts into 17 proceedings, while the reinsurers argue that the contracts themselves contain no provisions for consolidated proceedings and that they should be arbitrated separately.

London reinsurers last week filed nine separate complaints against ACE units in federal courts in Pennsylvania, New Jersey and California. The suits seek court orders that ACE subsidiaries may not consolidate the arbitrations and must address disputes under each treaty separately.

London reinsurer plaintiffs include Lloyd's underwriters and London-based Excess Insurance Co. Ltd., a Hartford Financial Services Group Inc. unit that is in runoff.

ACE units named in the suits include ACE Property & Casualty Insurance Co., Century Indemnity Co. and Westchester Fire Insurance Co.

Many of the reinsurance contracts involve excess liability coverage written for public utility companies and oil and gas producers and distributors, court records show.

Errors & Omissions

• A story in the June 13 issue, "E.U. Cleanup Laws May Spur Demand for Stand-alone Pollution Coverage," misspelled the name of Dan Anderson, a professor of risk management and insurance at the University of Wisconsin-Madison.

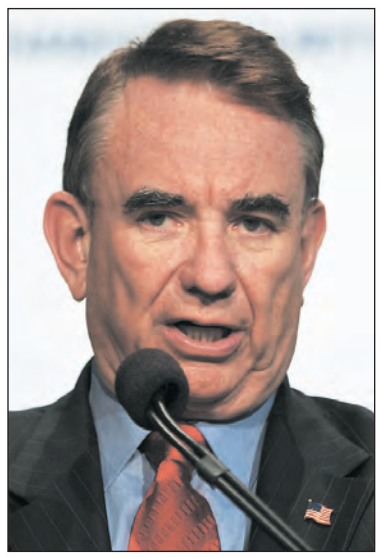
Ex-HHS head touts technology, prevention to lower health costs

By JERRY GEISEL

WHITE SULPHUR SPRINGS, W.Va.—The battle to control medical cost increases and improve health care quality must be fought on several fronts, says a former Bush administration health care official.

Those fronts, says Tommy Thompson, include prevention and disease management, technology and medical liability reform.

Speaking earlier this month at the Council of Insurance Agents & Brokers Employee Benefits Leadership Forum at The Greenbrier resort in White Sulphur Springs, W.Va., Mr. Thompson, the former secretary of the Department of Health and Human Services, said without a transformation, the current health care system will not survive.



Mr. Thompson

"Unless we do something about it...I don't think we will have a health care system that you will recognize," Mr. Thompson said, referring to a taxpayer financed, government controlled single-payer system, which he believes would be enacted if the current system fails.

But a shift to a single-payer system, which Mr. Thompson would dislike, is not inevitable, he said. Indeed, there is much in the control of employers, government and the medical community to restrain cost increases and improve quality.

One course of action, described by Mr. Thompson as "low-hanging

See THOMPSON / page 28

Documentation key to fighting employment practices claims

Start process early, expert advises

By DAVE LENCKUS

MILWAUKEE—Public entities could avoid many employment practices claims and losses by documenting their files better and implementing and following personnel policies and procedures, according to a risk control expert.

Providing employees due process to air their grievances also would help minimize employment practices claims, said Dennis Molenaar, national director-risk control in the public sector services unit of St. Paul Travelers Cos. Inc. in St. Paul, Minn.

Employment practices liability problems can begin as early as the job interview process, Mr. Molenaar warned during a session at the Public Risk Management Assn.'s annual conference in Milwaukee earlier this month.

To help avoid liability stemming from that process, Mr. Molenaar advised maintaining interview notes "forever," regardless of records destruction policies. If, for example, a class of claimants allege discrimination based on an entity's hiring practices over several years, interview notes could show that other candidates were more qualified, Mr. Molenaar explained.

"But be careful what you write down," he warned. Mr. Molenaar related an employment practices case in which an unsuccessful job applicant sued over the derogatory and profane notes one interviewer made in the applicant's file and shared with another interviewer.

The case settled "in the $90,000 range," Mr. Molenaar noted.

Every hiring should be made on a conditional basis, Mr. Molenaar emphasized. No job offer should be finalized until the applicant has cleared a background check, completed a written test and passed a drug and alcohol screening and a physical agility test, he said.

"There's nothing wrong with a drug screen, as long as it's related to a job," he said. As part of the screening, applicants should be asked whether they take prescription medication that could impair their job performance.

In addition, "if you don't have a drug and alcohol policy, you're in trouble." Employers need an estab-

See EPLI / page 35

Continued PRIMA coverage on page 35

Lawmaker urges risk managers to lobby now for TRIA extension

By MARK A. HOFMANN

WASHINGTON—Time is running out for the reauthorization of the Terrorism Risk Insurance Act, according to one of the law's chief backers.

And if TRIA—which provides a federal backstop for insurers facing losses from future catastrophic terrorist attacks—expires at the end of this year as slated, the impact on the economy will not be pleasant, Rep. Paul Kanjorski, D-Pa., told an audience of risk managers last week. "We'll be back where we were in 2002," before TRIA was enacted, said Rep. Kanjorski. He said that the lack of terrorism insurance during the year between the attacks of Sept 11, 2001, and the enactment of TRIA in late 2002 cost about $25 billion in delayed or canceled construction projects.

If risk managers want to see TRIA extended, they need to focus their efforts on Republican members of the U.S. Congress and avoid using extension legislation as a vehicle for tort reform, he warned.

Rep. Kanjorski, who is the ranking Democrat on the House of Representatives Financial Services Committee's Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises, made his comments during the Risk & Insurance Management Society Inc.'s seventh annual "RIMS on the Hill" federal legislative meeting in Washington last week.

PHOTO: PHOTOGRAPHER SHOWCASE

If TRIA expires at the end of this year as slated, "We'll be back where we were in 2002."

Rep. Paul Kanjorski, D-Pa.

Rep. Kanjorski said that supporters of TRIA extension should not be lulled into complacency by the fact that they have more than six months before TRIA expires on Dec. 31. The legislative calendar, which contains numerous recesses, does not coincide with the calendar most people use, he pointed out. Members of Congress "only have about 10 working weeks" left in the year, he said.

In addition, the Senate would have to approve any TRIA extension. But that chamber "could lock itself up" over judicial appointments or other matters, he said.

Rep. Kanjorski noted that he and several other Democratic members of the House have introduced legislation to extend TRIA through the end of 2007, as well as to broaden its coverage to include group life insurance as well as property/casualty lines. But the bill has not moved any further than a bipartisan Senate extension

See RIMS / page 32

PAUL WINSTON

Editorial Director

Wal-Mart is flirting with harassment risk

Wal-Mart managers in Germany have a flirting problem.

On the one hand, the stores have discovered that encouraging flirtatious shoppers is good for business. As reported in the Wall Street Journal in November, German Wal-Mart stores have begun an experiment to rival more traditional settings—such as speed-dating nights at bars, discos or Internet chat rooms—as a place for singles to meet and mingle.

Friday nights have been designated as the night for "Singles Shopping," and the discount retailer has even trademarked that catchy phrase to prevent others from copying its savvy marketing ploy. According to the Journal, the stores even have special shopping carts, marked with red bows, to let other singles know you are shopping for more than beer and bratwurst.

There's an old German saying that the shopping cart at a giant discount retailer is the window to the soul, and apparently shoppers are proving that to be true. What could be a more honest start to a lasting relationship than knowing your soul mate's preference for toilet tissue, motor oil or small electric appliances?

The phenomenon has spread from Dortmund to other locations, and managers from Germany have even made a presentation on the success of targeting lonely consumers to the honchos at Wal-Mart HQ in Arkansas, according to the Journal. As of the article's publication, about 30 couples have connected under the fluorescent lights.

So what's the problem?

Well, it appears that while Wal-Mart customers are encouraged to flirt between the aisles, its efforts to discourage employees from doing the same have been blocked. In the parlance of flirting, Wal-Mart is receiving mixed signals.

Last week, a court in Germany upheld the right of Wal-Mart workers to flirt at work, according to a report from Reuters. Apparently, workers went to court to challenge a corporate code of conduct that barred "any kind of communication that could be interpreted as sexual," as well as alcohol and drug use, and required employees to report violations to a company hotline.

According to Reuters, the court held that the clauses in the code were in violation of German labor laws, though the specific basis for the ruling was not available because the opinion has not yet been published.

It's also not clear from the report whether Wal-Mart employees were truly fighting for their right to romance their co-workers, or if they regarded the code of conduct as an unwelcome corporate intrusion into their personal affairs.

Wal-Mart's intention, on the other hand, is obvious: It was attempting to manage the risk of being held liable for a hostile workplace, and to protect its workers from inappropriate and unwelcome sexual advances. There's a clear connection between the cost of litigation and the price of goods and services—and Wal-Mart is nothing if not sensitive to any factor that can affect the price of the goods it offers shoppers.

U.S. employers, of course, are painfully familiar with the risk of being sued for harassment in the workplace, including worker-on-worker harassment. That is why codes of conduct, such as the one in the dispute in Germany, are common in the United States. While some regard such rules and codes as unnecessary and meddlesome, there is no denying that employers are routinely sued and held liable for not doing more to protect workers from more severe forms of harassment. Clearly, American workers would rather have the right to sue, than the right to flirt in the workplace.

Exporting a little American-style risk management to address an American-style risk—trying to hold an employer vicariously liable for the actions of employees—does not seem unreasonable, but the German court appears to have disagreed. As a result, barring an appeal, German workers are free to continue flirting on the job.

Maybe to avoid potential problems in the workplace, Wal-Mart stores in Germany can take a page from their marketing playbook: Workers who are receptive to flirting can place a red bow on their name tags, or maybe the company can even designate certain shifts for single employees on the prowl, just as it set aside Friday nights for single shoppers.

Unfortunately, I don't think it will have much luck getting a trademark for the name "swing shift."

Editorial Director Paul Winston's commentary appears fortnightly. He can be reached at pwinston@businessinsurance.com

Editorial

Cut fees for RRGs

DOES IMPOSING HIGH FEES and taxes on risk retention groups harm a state's economy and its business climate?

Nevada legislators evidently think so. When lawmakers in the state recently passed a fee- and tax-cutting measure, they accepted arguments by the state's Division of Insurance that keeping the level of fees and taxes that Nevada imposes on RRGs ultimately would drive out existing RRGs and discourage new formations.

And that, the Division of Insurance concluded, would cost the state a lot more in revenues than would a reduction in charges.

That analysis seems absolutely on the money. Consider, for example, the $2,450 initial and annual fee Nevada imposes on RRGs that are licensed in other states but write business for Nevada policyholders.

The fees, which are of questionable legality, are not imposed by many other states. Of those states that do charge fees, the typical amount is $100 to $300, a fraction of what Nevada had charged.

That difference made Nevada-licensed RRGs subject to retaliatory fees in many other states. Simply put, many states impose the same fees and taxes on out-of-state insurers that insurers they license pay in other states.

The result was Nevada-licensed RRGs got clobbered with retaliatory charges—something they could avoid by pulling up stakes and going to states with a lower-cost regulatory environment. Nevada wisely recognized the need to avoid losing such business and cut the fees to $250 and the premium taxes paid by out-of state RRGs to 2.0% from 3.5%.

We think Nevada's action is positive not just for RRG growth, but also to bolster its pro-captive reputation. Charging outlandish fees on RRGs clearly was a blot on that reputation.

We hope other states that have been imposing stiff fees on RRGs take note of Nevada's action. RRGs are a legitimate and a vital source of coverage for organizations in many business fields. They also, through the jobs they bring, aid economic growth. Smart state leaders should recognize that.

Get noisy on TRIA's behalf

ON MOST CALENDARS, six months might look like plenty of time to finish a task, particularly if you'd already successfully completed that task once before.

But when the calendar in question is a legislative calendar and the task is passing legislation that will keep the Terrorism Risk Insurance Act in place for another two years, six months isn't much time at all.

That's why risk managers and others who favor a TRIA extension would do well to heed the words of Rep. Paul Kanjorski. Speaking at the Risk & Insurance Management Society Inc.'s seventh annual "RIMS on the Hill" legislative conference in Washington last week, the Pennsylvania Democrat called for TRIA supporters to make some "noise" in favor of reauthorization.

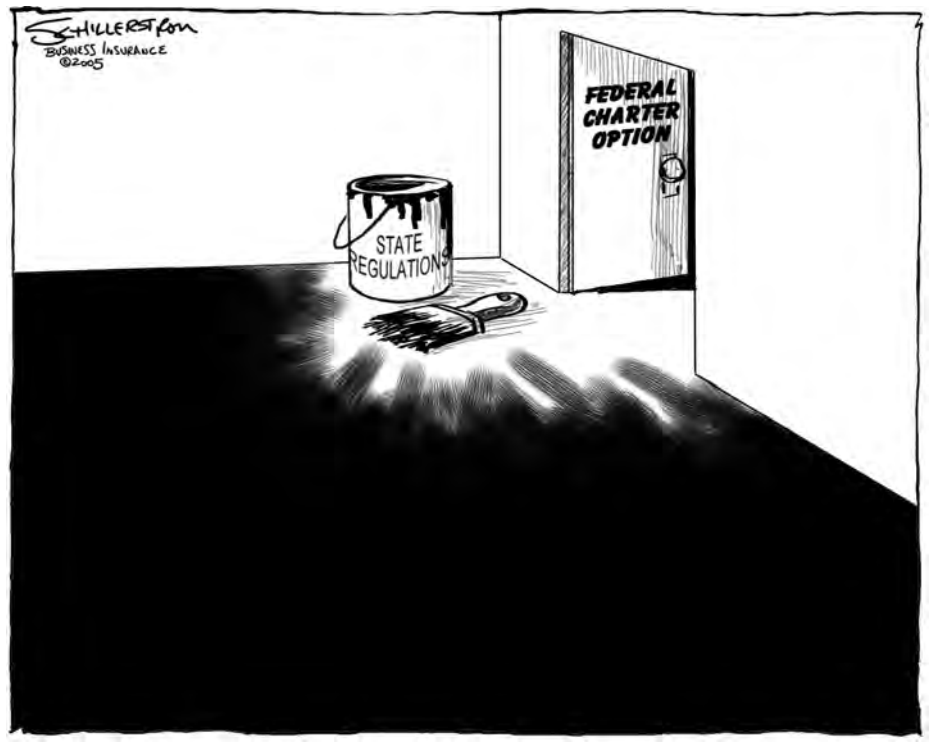
Rep. Kanjorski isn't the first TRIA supporter to call for other backers to make their voices heard, but his appeal underscores the urgency of the situation. As he pointed out, six months on a normal calendar represents only about 10 weeks on Congress' current legislative calendar for the remainder of this year. With TRIA slated to expire Dec. 31 and no reauthorization bill having won even committee approval yet, time is clearly of the essence.

For risk managers to make the best of the time available to them, they should also heed what RIMS President Ellen Vinck said at last week's conference when she stressed that extending TRIA is not an insurance industry issue but a business issue. Without the federal backstop provided by TRIA, terrorism insurance—which is absolutely critical for construction projects, financial institutions and numerous other enterprises—will suffer a capacity crunch.

Make no mistake, contrary to some misinformed critics, TRIA is no bailout for insurers. It's an insurance policy for the economy as a whole. Until there's an adequate private market for terrorism insurance—and we have our doubts that market will emerge any time soon—TRIA will be a necessary component of economic national security.

Buyers have to get that message across, and get it across now and until TRIA is reauthorized. Time isn't on their side, so they must seize every opportunity they can to make their voices heard.

Schillerstrom



Letters

AIG's asbestos reserve 'revelation' a long time coming

To the editor: American International Group Inc.'s 10-K analysis of their reserve increase for asbestos liabilities is unnecessarily complicated (*BI,* June 6), and Judy Greenwald's front-page article on the "revelation" overlooks, I think, a very important aspect of the story.

After acknowledging in its 10-K filing that reserves for asbestos and environmental claims cannot be estimated using "conventional reserving techniques," AIG states, "The market share method produces indicated asbestos and environmental reserve needs by applying the appropriate AIG market share to estimated potential industry ultimate loss and loss expenses based on the latest estimates from A.M. Best and Tillinghast." A discussion of multiple scenarios and various factors then ensues, but AIG concludes without any substantive quantitative analysis that asbestos reserves need to be increased by $1.2 billion gross and $650 million net.

Forgive me for being a simplistic claims guy, but the AIG-estimated market share of projected asbestos liabilities, as calculated by Best and published by them and other industry analysts since 1996, is and has been 2.9%. In May of 2001, Best revised their projected ultimate net asbestos loss to the U.S. insurance industry to $65 billion (from their 1994 projection of $40 billion). The following month Tillinghast released their study estimating the industry loss as $55 billion to $65 billion, and two months after that Milliman published their estimate of $70 billion. Applying the AIG market share to the Best estimate (the approximate midpoint of the three) yields an AIG ultimate net asbestos exposure of $1.89 billion.

According to published data, by the second quarter of 2004, AIG had recognized (all figures net) $1.25 billion of that exposure ($886 million paid, $361 million paid), indicating a deficiency of $638 million, which is pretty darn close to their net increase of $650 million.

Whether a "revelation" or not, AIG deserves recognition for the new realism utilized in estimating their ultimate asbestos liability. But because the industry estimates it was based upon were published over four years ago, one might reasonably wonder why it took so long. Considering that $650 million is being ceded to AIG reinsurers, I wonder if those reinsurers might not ask the same question.

Renny W. Hodgskin
Senior Vp
Cambridge Integrated Services Group Inc.
Cranbury, N.J.

Business Insurance

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Perspectives

Lay groundwork for HSA acceptance

By Wayne Page

Talk to an employee about health savings accounts and the first reaction you're likely to get is, "How high did you say my medical plan deductible is?"

Clearly, a successful HSA implementation must actively involve employees if they are to become empowered consumers and willing participants in a company's health care cost-containment strategy. Failure to conduct employee focus groups and invest in employee communications will probably result in only lukewarm acceptance of the qualifying high-deductible health plan required for HSA enrollment.

Employers may want to dust off some of the tools used during the 1980s for their first rollouts of "full flex." When flexible benefits were new, the early implementers learned the importance of educating employees on how to make intelligent choices. Employers' default and mandated levels of benefits became less stringent over time, as true flex took hold. The same level of employee education is now required, as employees round out their defined contribution retirement planning by creating their own vested and portable HSAs.

Many an employer has assumed that an HDHP will so limit enrollment that pursuing HSAs is not worth the effort. Early results from employee surveys, focus groups and actual early implementers are disproving this assumption.

It is true, though, that employee acceptance of an HDHP requires a shift in thinking. The nature of HSAs requires individuals to take responsibility for their own accounts and for the tax consequences of their distributions. Such employee empowerment is consistent with the current national discussions regarding "an ownership society," in which individuals take more responsibility for their own financial well-being.

In the benefits management arena, the decreased use of defined benefit retirement plans, the popularity of defined contribution 401(k) plans and employee choice via cafeteria plans are all part of this ownership trend. The decline of employer-provided post-retirement medical coverage reinforces the need for employees to create additional assets to cover pre-Medicare medical expenses or to supplement their Medicare coverage.

So, how do we get employees to buy into this concept?

The most important step in promoting the adoption of an HDHP actually comes in the beginning, when designing a plan. Companies should conduct actuarial analyses to position and price a qualifying HDHP that will meet the needs of a significant number of individuals. Not unlike early flexible benefit option pricing, with its concerns over adverse selection and plan utilization, an appropriate balance of employer subsidy and risk sharing will likely be required to maintain total program effectiveness.

"As the move toward individual empowerment continues, employers should take a long-term view of HSAs."

But even the best designed plan requires a communication initiative to gain employee buy-in. Significant investments in employee communications and Web-based tools and in empowering employees to become intelligent health care consumers have proven successful in focusing attention on the long-range savings opportunity available with HSAs.

As part of this communication effort, employees can benefit from education on some critical points:

- Consumerism: Web tools provided by the insurers active in this market are important in training employees to conduct research and become intelligent health care consumers.
- Carryover: There are no "use it or lose it" rules that require balances to be forfeited at year end.
- Investment features: Individuals select their own investment vehicles from those offered by the HSA vendor, similar to how they select investments in their 401(k) plans.
- Tax deduction: Up to certain limits, HSA contributions are deductible by the eligible taxpayer.

Employers that believe that establishing such a plan sounds like a lot of work are right. Because HSAs are administrative relationships between the individual and the HSA vendor, though, the actual logistics associated with HSAs—enrollment, plan administration and disbursements—are less than with other employee benefit programs such as flexible spending accounts. The employer's one-time involvement is upfront in plan design, pricing, employee communications and vendor screening (which can be optional).

Although some companies are providing modest HSA contributions to encourage enrollment in the HDHP, once the plan is in place, almost all HSA activity is between the individual and the selected vendor. The eligibility of the claim expense is a taxpayer/individual issue; the HSA vendor merely distributes funds, as requested. The employer only manages the qualifying HDHP.

As the move toward individual empowerment continues, employers should take a long-term view of HSAs. Increased investments in employee communication and education by employers today can result in lower medical costs and a more self-sufficient work force, with fewer entitlement expectations, in the future.

Wayne Page is a director in KPMG L.L.P.'s compensation and benefits practice in Atlanta. The views and opinions are those of the author and do not necessarily represent the views and opinions of KPMG L.L.P. (U.S.). The information contained is of a general nature and is not intended to address the circumstances of any particular individual or entity.

Web posting of manual constitutes advertising under policy

Activities of an insured under a commercial general liability insurance policy including referring potential customers to an installation manual posted on its Web site after receiving inquiries from them about its products constituted "advertising," thus triggering an insurer's duty to defend the insured in a copyright infringement suit, according to the U.S. Court of Appeals for the Fourth Circuit.

Teletronics International Inc. engaged in the manufacture, distribution and sale of high-technology wireless communications products. Teletronics was insured under a CGL policy issued by the Transportation Insurance Co. The policy contained an "advertising injury" provision in which the insurer agreed to indemnify and defend Teletronics against third-party claims for damages caused by Teletronics in the course of advertising its goods, products or services. Teletronics is a direct competitor of Young Design Inc., which also manufactures and sells radio amplifiers. Teletronics and Young Design explored a proposal for Teletronics to purchase Young Design amplifiers and resell them under its own name. Young Design provided Teletronics with an electronic copy of its user and installation manual. Subsequently, Young Design discovered Teletronics was distributing a user manual with its amplifiers that was nearly identical to Young Design's copyrighted installation manual. Young Design sued Teletronics, asserting several claims, including copyright infringement. Teletronics demanded that the insurer defend and indemnify it against Young Design's suit. The insurer refused on the ground that there was no advertising injury. The trial court ruled for the insurer. Teletronics appealed.

On appeal, Teletronics argued that posting the installation manual on its Web site brought the infringement suit within the policy's "advertising injury" provision. The appellate court said that the vast majority of jurisdictions have defined "advertising injury" as "the widespread distribution of promotional material to the public at large." According to the court, by posting the installation manual on the Internet, Teletronics distributed the document to a large audience of potential customers. Thus, the court concluded that Teletronic's activities here constituted advertising, and that the insurer was therefore obligated to defend Teletronics under the liability insurance policy. The trial court decision was reversed.

Teletronics International Inc. vs. CNA Insurance Co., U.S. Court of Appeals for the Fourth Circuit, Jan. 20, 2005 (BI/05/Ju.-$10)

Contract breach not property damage

A construction company's allegations that an insured had interfered with the company's contractual relationships were outside a commercial general liability insurance policy's property damage coverage, according to the U.S. Court of Appeals for the Fifth Circuit.

Legal Briefs

Lamar Advertising Co. provides advertising displays throughout the United States. Sometime in 1999, Continental Casualty Co. issued a CGL policy to Lamar. Coverage included damages because of property damage or personal injury. Subsequently, Lamar, in the process of expanding its advertising business, acquired two other companies. Lamar assumed all the obligations the two companies owed to RAL Construction Co. RAL had contracted with the two companies to be the exclusive provider of maintenance and construction services to bus shelters owned or leased by the two companies. RAL sued Lamar, alleging that Lamar breached the agreement by entering into municipal contracts without using RAL's services and by ceasing to use RAL's services on existing contracts after it acquired the two companies. Lamar sought coverage of the cost of defending itself from RAL's suit from its insurer. The insurer denied coverage. Lamar settled the RAL suit and then brought this suit against the insurer seeking to recover the costs of defending the RAL suit. The trial court ruled against Lamar. Lamar appealed.

On appeal, Lamar argued that RAL's loss of employees and consequential loss of money constituted damage of property, as defined under the CGL policy, and, thereby, it was covered under the policy's provision addressing property damage liability. The court said that, essentially, Lamar argued that RAL's employees should be considered property for purposes of the insuring agreement. "Because we flatly reject the remarkable notion that people are property," the court said, "this argument is to no avail." Accordingly, the court held that the loss of profits that do not flow from injury to tangible property was not a loss covered by the policy's property damage provision. The trial court decision was affirmed.

Lamar Advertising Co. vs. Continental Casualty Co., 5th U.S. Circuit Court of Appeals, Jan. 7, 2005 (BI/03/Ju.-$10)

Severance benefits denial upheld

An Employee Retirement Income Security Act plan administrator's decision to deny enhanced severance benefits under an employee severance pay plan to an employee who had resigned has been upheld by the 3rd U.S. Circuit Court of Appeals in Philadelphia.

Gary Bader was employed by Harbison-Walker as director of worldwide minerals processing. Mr. Bader was covered under an ERISA plan that provided that an employee who voluntarily terminated employment for "good reason" may qualify for enhanced severance benefits. RHI Refractories America Inc. then acquired Harbison-Walker. Following the acquisition, RHI offered Mr. Bader a position with the succeeding company as director of worldwide cement. Mr. Bader acknowledged that his former and proffered positions were the same. Mr. Bader resigned rather than accept the offered position, asserting personal perceptions that there would be adverse changes to his job responsibilities following the RHI acquisition. Mr. Bader applied for enhanced severance benefits. The plan administrator denied his claim. Mr. Bader sued the plan administrator but lost in the trial court. He appealed.

The appellate court said that the plan administrator's decision would be overturned only if the evidence in the record clearly did not support it or that the administrator had failed to comply with the procedures required by the plan. In this case, the court said, there was ample evidence to support the administrator's decision. According to the court, there was no evidence that indicated that Mr. Bader was at any time unable to or prevented from continuing his prior responsibilities due to RHI's acquisition of his former employer. The trial court decision was affirmed.

Bader vs. RHI Refractories America Inc., 3rd U.S. Circuit Court of Appeals for the Third Circuit, Oct. 1, 2004 (BI/04/M.-$10)

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available, at $10 each, by sending a check payable to Mayo H. Stiegler, to Business Insurance 360 N. Michigan Ave., Chicago, Ill. 60601-3806. Provide the listed number for each opinion ordered.

BENEFITS MANAGEMENT

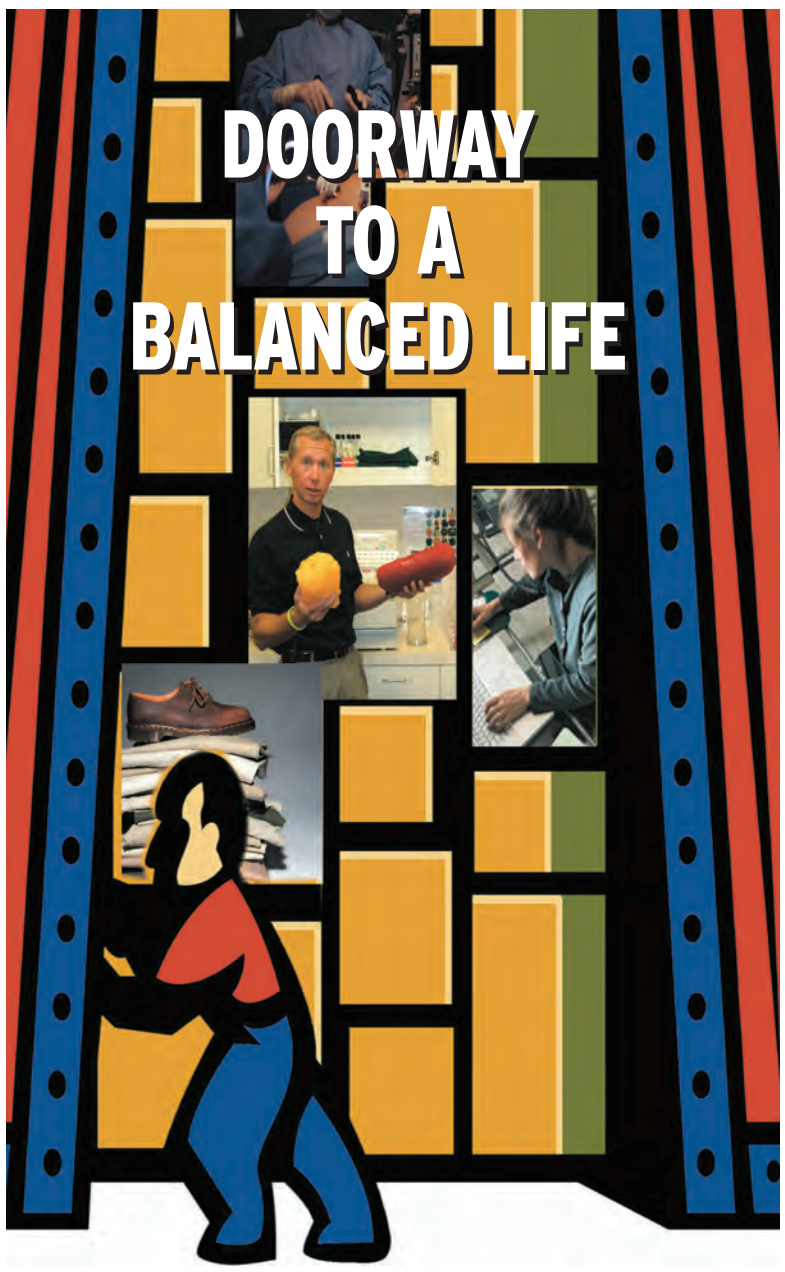
Work/Life Benefits

Should employers cover weight-loss surgery? / 22

Q&A tracks trends in work/life benefits / 24

Teaching dos and don'ts of corporate fashion / 28

Canadian EAPs make a comeback / 26



On-site health resource centers aim to prevent employee illness

By JOANNE WOJCIK

Recognizing the role that health education and easier access to preventive health care services can play in reducing employee medical costs, some progressive employers have begun building on-site health resource centers for their employees.

Unlike workplace clinics staffed by medical providers who treat minor illnesses and injuries, though, health resource centers, as their name suggests, provide tools that employees can use to take charge of their health.

In some cases, the resource centers are simple, such as a self-service health information library that employees can access in a room set aside for that purpose. In other cases, they are sophisticated facilities that also provide physical therapy, exercise equipment, psychiatric counseling and pharmacies so that employees can take care of their health care needs during work hours, reducing absenteeism and enhancing productivity.

"It's an inviting, welcoming place to go," said Gary L. Earl, former vp of benefits and corporate human resources at Caesars Entertainment Inc. Mr. Earl recently left his position when Caesars' merger with Harrah's Entertainment Inc. closed June 10.

"Everything in here is (centered) around health," he said while walking into the Total Resource Center he created in the Paris Hotel on the Las Vegas strip. It is one of 11 wellness centers the company has to serve its 55,000 employees nationwide.

The lobby resembles a doctor's waiting room, with a receptionist sitting behind a glass partition, a row of chairs lined up against the entry wall and even a plastic credit card logo plaque sitting on the counter alongside clipboards holding medical records release forms.

"There are three core things that happen here," Mr. Earl said. "Wellness and wellness education, which includes prevention. Secondly, there's rehabilitation, occupational and physical therapy; and third is behavioral health."

Adjacent to the reception area is a dimly lit room with a couch and two upholstered chairs where a CIGNA Behavioral Health psychologist meets with Caesars Entertainment employees four days a week.

There is also a lactation room for nursing mothers, several physical therapy treatment rooms, treadmills and other exercise machines, balance balls, free weights, three sizes of padded physical therapy tables to accommodate employees of all weights and sizes, and an information technology center with computers connected to the Internet.

"A lot of people have wellness centers. A lot of people have rehabilitation centers. A lot of people have a lot of this. But they have yet, for the most part, to figure out how to connect it," Mr. Earl said. "When Sara comes in with a bad knee, and who, by the way, may be obese and diabetic, we can treat her for her weight management, we can give her diabetes education, we can treat her knee problem and, chances are, 70% of the time, it came from an emotional issue. So why do I want to just treat her knee?" he asked.

After having taken a similar tour of Caesars Entertainment's Total Resource Center, Chris McSwain, manager of compensation and benefits at SCANA Services Inc., decided to open a health resource center in the utility's corporate headquarters in Columbia, S.C.

"It's called the LiveWell Resource Center," whose logo is "Live Well, Life Counts," Mr. McSwain said.

"We are setting our model up so that we have the pharmacy, wellness and life assistance…so that

See CENTERS / next page

Backup caregiver services help keep workers on the job

By SARA HARTY

Snow days, sick kids, babysitters with the flu, elderly parents who unexpectedly need some short-term assistance: it's not really a secret that situations like these lead to more than a few missed days of work.

Yet there are cost-effective steps that employers can take to reduce missed days of work, increase productivity and give a big boost to employee morale all at the same time, say proponents of employer-subsidized in-home backup care.

Both employers and employees like the flexibility of in-home backup care, which can meet the needs of any dependent, whether infant, teenager or elderly parent. Mildly ill children or elders can be cared for and the hours covered are unlimited, including overnight and weekends.

This is a benefit that balances business needs with employee needs, said Carol Sladek, a work/life consultant with Hewitt Associates in Lincolnshire, Ill. It is especially useful for health care providers or those in other industries where it is important that workers be on site in order to be productive, she noted.

Blue Cross/Blue Shield of Massachusetts recently decided to offer in-home backup care as a benefit, because "we really liked that combination of child care and elder care," said Catherine Devlin, director of associate relations for the Boston-based company.

"As we looked at how our demographics are changing and what we need now and what we'll need five years down the road, we saw a significant increase in the number of employees with elder care responsibilities," said Ms. Devlin. BC/BS of Massachusetts began contracting with Brookline, Mass.-based Parents in a Pinch Inc. about three months ago to help meet those needs.

PIP has provided backup care services since 1984. "From the moment we opened our doors, we knew there would always be a demand for our services," said Barbara Marcus, the company's chief executive officer. "Despite the reluctance to let a stranger into our homes–and I understand that reluctance very well–the issue for us has always been keeping up with the supply" of caregivers, said Ms. Marcus.

An employer pays PIP an annual fee ranging from $5,000 to $100,000, depending on the number of its employees, which entitles each employee to use the service 20 times a year. For their part, employees pay the caregivers the going hourly rate in their part of the country, ranging from $11 to $16 an hour. Some employers also choose to subsidize employee costs in part or in full, and PIP will tailor the program to the employer's specifications, said Lynne Satlof-Karas, director of PIP's corporate services.

When employees need backup care, they contact the PIP call-in center, which is open from 7 a.m.

See BACKUP / page 16

Ranking of employee assistance programs / 18

Next Employee Benefits section: Retiree benefits / July 11

Centers: Tools to take charge of one's health

PHOTO: JOANNE WOJCIK

Christina Mulloy, an orthopedic certified specialist with Memphis, Tenn.-based Physiotherapy Associates and the director of Caesars Entertainment Inc.'s health resource center located beneath the Paris Hotel in Las Vegas, demonstrates the use of a grid designed to measure mobility in physical therapy.

Continued from previous page

(the mental health) becomes more acceptable by our employee base. We really see a lot of our medical and pharmacy costs being rooted in behavioral issues," Mr. McSwain said.

The 2,000-square-foot center on the 11th floor of SCANA's headquarters building is scheduled to open for business July 11. It will include a lactation room; educational materials and computers linked to a benefits portal, Health Smart, that employees can use to make drug and plan comparisons and learn about specific health conditions; physicians' scales; a blood pressure monitor; and two televisions and one projector with streaming video of health programming. There will also be an on-site pharmacy staffed with a licensed pharmacist whom SCANA decided to put on its payroll.

After getting the green light for the project from SCANA's chairman, Mr. McSwain did research on "having an on-site doctor or on-site nurse, and that model really didn't fit our numbers. There's a critical mass of 2,000 to 3,000 people that you need. And when we started looking at our pharmacy data, we realized we had some real opportunity areas there. So our chairman said he basically wanted a pharmacy on site."

Consequently, Mr. McSwain approached the South Carolina Board of Pharmacy for help in hiring a licensed pharmacy manager and to work out additional logistics, including developing an interoffice prescription drug service for employees without immediate access to the LiveWell Resource Center.

SCANA has about 1,300 employees who work within walking distance of the headquarters, but the remaining group of 5,500 employees are at a variety of work loca-

See CENTERS / page 14

Independent vendors tapped to staff centers

Caesars Entertainment Inc.'s Total Resource Center, located beneath the Paris Hotel on the Las Vegas strip, is staffed entirely with independent contractors, according to Gary L. Earl, former vp of benefits and corporate human resources for the gaming, hotel and resort company.

Health care services at the one-year-old facility, one of 11 wellness centers Caesars developed to meet the needs of its 55,000 employees nationwide, are provided by a variety of vendors to the 5,500 employees who work at either Paris or the Bally's casino next door, which is connected underground.

"I have no interest in making anybody an employee. Why would I do that?" Then the company would "have liability, malpractice, all the other issues," said Mr. Earl, who recently left his position when Caesars' merger with Harrah's closed on June 10. "We were able to go out and get Physiotherapy Associates, CIGNA Behavioral Health, Health Education and Wellness—three partners" who understood his vision, he said.

Nor does Caesars pay anything extra for the convenience of having all of these health care providers on site, Mr. Earl said.

"I pay a claim," he cited as an example. "Harry got hurt on the job and has to go to a physical therapist. He has to get in his car and drive to some physical therapist and get his treatment and the claim gets submitted. The same thing. But it is more likely he will go, and less time will be lost, if he can get his physical therapy at work."

—By Joanne Wojcik

Dependent Care Resource and Referral Service Providers

Company/Address	Phone/Fax/Web site	Principal officer
Ann Clark Associates Inc. dba ACI 8910 University Center Lane, Suite 650 San Diego, Calif. 92122	858-452-1254 Fax: 858-452-7819 *www.acieap.com*	Dr. Ann D. Clark, CEO
Child & Elder Care Insights Inc. 19111 Detroit Road, Suite 104 Rocky River, Ohio 44116	800-234-6322 Fax: 440-356-2919 *www.carereports.com*	Elisabeth A. Bryenton, president/CEO
ComPsych Corp. NBC Tower, 455 Cityfront Plaza Drive Chicago, Ill. 60611	800-851-1714 Fax: 312-595-3125 *www.compsych.com*	Dr. Richard A. Chaifetz, chairman/CEO
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Work/Life Innovations 1025 Silas Deane Highway Wethersfield, Conn. 06109	800-568-7436 Fax: 860-563-6912 *www.worklifeinnovations.com*	Mary-Ellen Sposato Rogers, CEO
Workplace Benefits dba Work|Life Benefits 4020 Capital Blvd., Suite 100 Raleigh, N.C. 27604	919-834-6506 Fax: 919-833-9888 *www.wlb.com*	Dean Debnam, CEO

Source: *BI* Survey

PHOTO: JOANNE WOJCIK

Gary L. Earl, vp of benefits and corporate human resources at Caesars Entertainment Inc., holds up rubber replicas of fat and muscle that are used in weight management education at Caesars' health resource center. The center also features a model of "the food pyramid" that indicates appropriate portion sizes.

Centers: Promoting good health

Continued from page 12

tions, he said.

"In our feasibility study, we knew that to generate a meaningful penetration rate, we were going to have to be able to get medications out to our remote locations through intercompany mail," Mr. McSwain said. "We can reach 85% of our people in 24 or less hours. The other 15%, we can reach within 48 or less hours."

Portland, Maine-based UnumProvident Corp. is hoping its newly opened health resource centers will yield long-term savings by maintaining or improving the health status of its employee population, according to Sally H. Saunders, director of health and group insurance plans.

The financial services company recently converted its corporate health care clinics in Portland; Worcester, Mass.; Chattanooga, Tenn.; and Columbia, S.C., into health resource centers.

The centers "came out of our health care strategy," Ms. Saunders said. "The company is saying to people, 'Your health really matters to us.'"

All three of these employers are on the leading edge of an emerging trend in which companies increasingly are recognizing that keeping employees healthy will improve their bottom lines by lowering health care costs, reducing absenteeism and enhancing productivity.

"Many clients in the financial services industry have had these programs in place for years," said E. Stuart Clark, executive vp of on-site operations at CDH Meridian, a Nashville, Tenn.-based subsidiary of population management firm I-trax Inc. CDH Meridian operates health resource centers on behalf of employers.

But what had been what Mr. Clark called "a cottage industry" is starting to get a lot more attention as employee health care costs continue to rise.

"Employers are realizing they can no longer just design costs out of the system. What I mean by that is, you can't make the co-pay any higher than it is; you can't restrict the physician network any more than it is. They've engineered all they can out of it, and people are still getting sick," he said

The health resource center concept is to reduce costs by preventing illness, he said. "As simple as that sounds, it's not something that employers in this country have embraced until recently," he said.

"Many employers have places, especially in corporate headquarters, where there are on-site screenings, for example, for employees who travel outside the U.S. (and need) medical information, or (for) work comp, or injuries," said Helen Darling, president of the National Business Group on Health in Washington.

In addition, there is "usually a big open space with a lot of information, sometimes there's a receptionist or a physician under contract or on staff that do a combination of occupational health and primary care," she noted.

Having a corporate health resource center makes health promotion and wellness programs more visible to employees, which should increase utilization, said Bruce Kelley, a senior consultant at Watson Wyatt Worldwide in Minneapolis.

"The typical health plan has copayments for various services, while the wellness benefit usually has a fixed-dollar benefit without a copayment or deductible. Doctors don't ever access that benefit because they don't have to bill for it, and a member doesn't go to a doctor on a wellness basis except for physicals," said Jack London, senior consultant and executive director of patient advocacy at Apex Management Group in Las Vegas. Mr. London worked with Mr. Earl in developing Caesars Entertainment's health resource center.

As a result, "it's a nonused benefit that just sits there. So we went to employer groups and suggested they encourage use of the benefit," Mr. London said.

"A lot of it is cost-driven, but the more progressive employers are realizing that to get the cost down, they have to get at the root cause" of those costs and "drive behavioral changes and sustain them, like weight management," said Mr. Kelley.

Early reports indicate that on-site health resource centers may have the potential to help companies do just that. Since Caesars Entertainment opened its center last year, the trend rate for its global life and health budget has dropped to a negative 5.3%, compared with the national average for employers ranging between 9.6% and 12.0%, according to Mr. Earl.

Backup: Employers pay caregivers to help keep workers on the job

Continued from page 11

center, which is open from 7 a.m. to 7 p.m. Monday through Saturday and from 5 p.m. to 7 p.m. on Sunday. PIP can typically have a caregiver at the house within two hours of receiving a call, said Ms. Marcus.

Screening caregivers

A key part of PIP's service is its provider screening and vetting process. After caregivers have passed the interview process and background check, they take a short, interactive computer training course on safety and discipline and are taught how to handle choking emergencies. CPR classes are offered twice a month for any interested caregiver, Ms. Marcus said. After every placement, PIP follows up with users to make sure they were completely satisfied with the caregiver, culling any caregiver who receives even a mediocre report.

This prescreening makes it easier for employees to take the leap and allow "strangers" to care for their dependents, Ms. Marcus said.

Dr. Diane C. Greer, medical director of mental health/social services at MGH Chelsea HealthCare Center in Chelsea, Mass., used the service for the first time after her regular sitter caught the flu. "As a physician, I absolutely have to be at work. I was absolutely panicked. I really did not want to use them, but I did call them and they were so responsive and flexible. I've used them four times now and will definitely use them again. I don't have a need for it that often, but when I do, it is indispensable," said Dr. Greer.

PIP is one of the benefits offered by Cambridge, Mass.-based Harvard University, and "it allows me to run my organization more effectively," said Tiziana C. Dearing, executive director of the Hauser Center for Nonprofit Organizations at Harvard.

> "Not only does it allow my staff to be at work, but it allows them to be fully at work mentally. People are not forced to make bad choices between home and work."
>
> **Tiziana C. Dearing**
> **Hauser Center**
> **for Nonprofit Organizations**

"I consider this to be a true benefit. Not only does it allow my staff to be at work, but it allows them to be fully at work mentally. People are not forced to make bad choices between home and work," said Ms. Dearing, who has used the service herself several times.

PIP is not the only vendor offering backup dependent care. Wilmington, Del.-based Just in Time Care has also found a niche in the marketplace, using a slightly different model than does PIP.

Just in Time Care is the corporate services unit of The Family & Workplace Connection Inc., a nonprofit dependent care resource and referral organization.

Just in Time Care was founded after a particularly bad winter in 1994. "The roads were so icy and snowy that schools were closed for days on end," recalled Gerri Weagraff, business development director of Just in Time Care.

Wilmington-based E.I. DuPont de Nemours & Co. "was one of the companies that was seeing what was happening, which was that parents were staying home with their children or bringing them to work, where they were roaming the halls. Or they were leaving children or dependent elders at home, then coming to work and worrying about them. Absenteeism and distractions were up, and productivity was down," Ms. Weagraff said.

Comprehensive service

DuPont, which helped fund Just in Time Care's start-up and was one of its initial clients, envisioned a comprehensive service "that would allow employees to choose the backup care that they preferred for their own scenarios, whether that be school closings, business travel, children sick, elders just out of the hospital, every possible scenario where care would be unavailable and there would be gap time," Ms. Weagraff said.

At first, Just in Time Care referred employees to the typical day care providers for out-of-home placements for children and elders, as well as to nanny and home health agencies for in-home placements. But in 1998, the organization evolved at the request of Citigroup, which was using the service for its employees in the New York City area.

"Citigroup knew that many of its employees used family and friends for backup care and wanted to be supportive of those arrangements," Ms. Weagraff said.

"Much of this care is a day here and a day there," Ms. Weagraff said. "People want care they are familiar with." She said that people find it easier to ask a neighbor or even their own family members to help them if they can tell them that their company will pay them for their services. Now all Just in Time Care clients offer this option to their employees, and 75% of the care arranged by Just in Time Care is provided by friends and family members.

In its first year of operation, Just in Time Care arranged 1,473 days of backup care. In 2004, it arranged more than 28,000 days of backup care, according to Ms. Weagraff.

In 2004, JITC reported that it saved 19,861 workdays for the approximately 100,000 employees eligible to receive its services.

Employees are urged to enroll in the program "before they realize they need care" and to think through their potential backup care needs, Ms. Weagraff said. Just in Time Care helps them identify providers that meet their needs and urges employees to check them out ahead of time. Although Just in Time Care used to prescreen the providers that it recommended, it no longer offers that option, she said. Employees can use the program even if they haven't pre-enrolled by calling the Just in Time Care hotline, which operates 365 days a year from 5 a.m. to 10 p.m. In addition, an answering service will beep a customer service representative during the night when needed.

> "The expense of providing backup care is minimal, and the return on investment is almost immediate."
>
> **Barbara Marcus**
> **Parents in a Pinch Inc.**

Employees choose from the options that Just in Time Care identifies for them and fill out an invoice form so that Just in Time Care can reimburse the provider for the company portion of the care.

All of Just in Time Care's clients choose to subsidize at least 80%, and some 90%, of the cost of care, typically up to a per-employee cap of $300 a year.

Employers contracting with Just in Time Care pay an annual fee based on total employee population. This fee covers enrollment, employee publicity materials, the cost of referrals and comprehensive extensive monthly usage reports, said Ms. Weagraff. By multiplying the number of workdays saved by the cost of a missed employee workday, employers can determine their return on investment, which Ms. Weagraff said ranges from 2-to-1 to 4-to-1.

PIP's Ms. Marcus concurred, noting that "the expense of providing backup care is minimal, and the return on investment is almost immediate." She added that in-home backup care fills many gaps in a way that is "more responsive, more flexible and much less expensive" than on-site backup care centers.

Ceridian Corp., based in Minneapolis, soon will offer a more do-it-yourself approach to locating backup dependent care. Customers of Ceridian's employee assistance programs and work/life services will have access early next year to an online service that can identify caregiver resources across the country.

Employees will be able to access the data in the Backup Care Locator at any time, said Jean Holbrook, director of product management for Ceridian in Boston.

The database includes more than 20,000 entries nationwide, and, although it is "more robust in some areas than others, it is a pretty comprehensive service," Ms. Holbrook said.

Employers will pay no additional fees for the Backup Care Locator, which is integrated into Ceridian's EAP. Subscribers to Ceridian's EAP or to its work/life services pay an annual per-employee fee that ranges from about $8 to $32, depending on the size of the organization and the scope of services being provided, Ms. Holbrook said.

In addition to the Backup Care Locator, Ceridian offers another service called Just in Case, which reimburses employees for their backup care. "The Locator ties into the Just in Case service very nicely," said Ms. Holbrook. Just in Case is not included in the standard EAP package and does have a small management fee, she said.

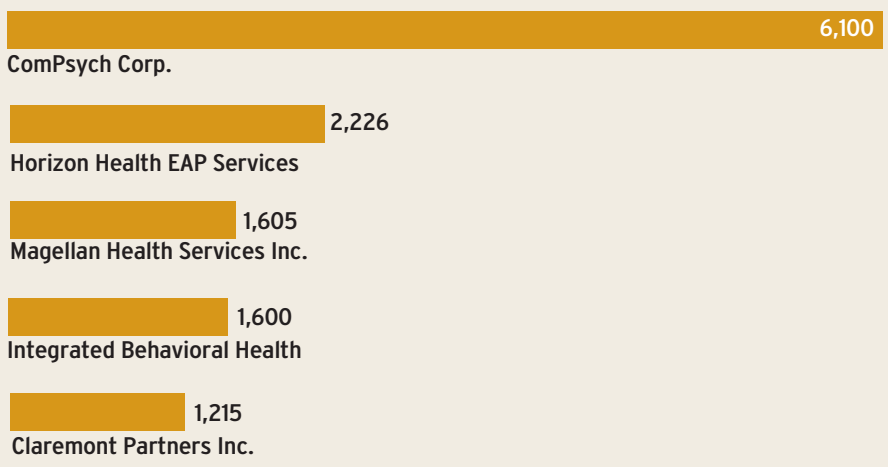
Ceridian worked with Just in Time Care to develop the Locator. "Just in Time Care owns the data; we own the Web platform that provides the access to the data," explained Ms. Holbrook.

The American Business Collaboration funded the program, which is already available to its member companies. The ABC works together to invest in dependent care programs and services and includes Abbott Laboratories Inc., Deloitte & Touche US L.L.P., Exxon Mobil Corp., General Electric Co., IBM Corp., Johnson & Johnson, PricewaterhouseCoopers L.L.P. and Texas Instruments Inc.

The Backup Care Locator currently is available to the funding companies. As of January 2006, it will be available to all Ceridian EAP and work/life customers.

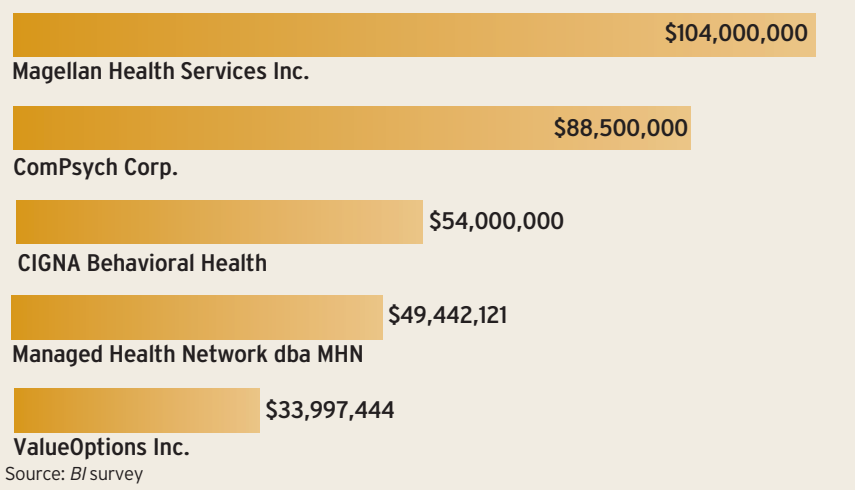
BI RANKS

Largest EAP providers by employer clients



Source: *BI* survey

Largest EAP providers by total revenues



Source: *BI* survey

Largest employee assistance program providers

Ranked by number of lives covered at year-end 2004

Rank	Company/Address	Phone/Fax/Web site	Lives covered	Employer clients	Total salaried employees	Total contracted employees	Principal officer
1	ComPsych Corp. NBC Tower, 455 Cityfront Plaza Drive Chicago, Ill. 60611	800-851-1714 Fax: 312-595-3125 *www.compsych.com*	23,400,000	6,100	327	28,021	Dr. Richard A. Chaifetz, chairman/CEO
2	Magellan Health Services Inc. 16 Munson Road Farmington, Conn. 06032	860-507-1900 Fax: 860-507-1990 *www.magellanhealth.com*	12,800,000	1,605	4,300	63,000	Steven Shulman, chairman/CEO
3	CIGNA Behavioral Health 11095 Viking Drive, Suite 350 Eden Prairie, Minn. 55344	952-996-2000 Fax: 952-996-2659 *www.cignabehavioral.com*	6,300,000	1,000	950	17,962	Keith Dixon, president/CEO
4	VMC Behavioral Healthcare Services 100 S. Greenleaf Gurnee, Ill. 60031	847-625-3500 Fax: 847-249-2772 *www.vmceap.com*	4,610,000	332	238	17,950	Mary Vasquez, president/CEO
5	Managed Health Network dba MHN 503 Canal Blvd. Point Richmond, Calif. 94804	800-488-8449 Fax: 510-620-6490 *www.mhn.com*	3,821,861	560	900	40,269	Jerry V. Coil, president/CEO
6	Horizon Health EAP Services 1500 Waters Ridge Drive Lewisville, Texas 75057	877-232-8172 Fax: 972-420-8247 *www.horizoncare.net*	3,339,000	2,226	327	23,209	Cindy Sheriff, president
7	Claremont Partners Inc. 1050 Marina Village Parkway, Suite 203 Alameda, Calif. 94501	800-834-3773 Fax: 510-337-8833 *www.claremonteap.com,* *www.claremontpartners.net*	3,152,100	1,215	200	18,215	Tom Bjornson, CEO
8	Bensinger, DuPont & Associates 20 N. Wacker Drive, Suite 920 Chicago, Ill. 60606	312-726-8620 Fax: 312-726-1061 *www.bensingerdupont.com*	1,800,000	250	55	8,100	Peter Bensinger, president/CEO
9	ValueOptions Inc. 240 Corporate Blvd. Norfolk, Va. 23502	757-459-5200 *www.valueoptions.com*	1,470,695	331	4,622	48,216	Ronald I. Dozoretz, chairman/president/CEO
10	Ann Clark Associates Inc. dba ACI 8910 University Center Lane, Suite 650 San Diego, Calif. 92122	800-932-0034 Fax: 858-452-1254 *www.acieap.com*	1,420,000	254	139	44,000	Dr. Ann D. Clark, CEO

Visit *www.businessinsurance.com* for the full searchable employee assistance program providers directory

Bariatric surgery can save more than it costs

By KAREN PALLARITO

Should health care purchasers and payers cover bariatric surgery, the popular stomach-reducing procedure credited for whittling the waistlines of Today Show weatherman Al Roker, American Idol judge Randy Jackson, singer Carnie Wilson and thousands of ordinary citizens?

A single surgery, without complications, can cost $25,000 to $30,000, consultants say. A difficult case might run upward of $100,000. Plus, the risks to patients can be significant. About 2% of patients experience a major complication in the first 30 days after surgery, according to a Milliman Research Report based on surgeries in 2000 and 2001.

But not covering tummy-trimming surgeries such as gastric bypass could prove even more expensive for employers and health plans in the long run, because desperately overweight people are much more likely to develop costly complications such as diabetes and cardiovascular disease.

"I think they have to look at it one way or another; either they're going to pay for it now or they're going to pay for it a lot later," said Stephanie Pronk, senior consultant and national practice director for health improvement with Watson Wyatt Worldwide in Minneapolis.

As insurers and employers weigh the costs and serious patient safety issues associated with the invasive treatment of morbid obesity, coverage decisions are a mixed bag, benefits experts say. Several insurers, including Blue Cross & Blue Shield plans in Florida and Nebraska, have dropped coverage. But Blue Cross & Blue Shield of North Carolina has moved aggressively into obesity management with a multipronged program that includes bariatric surgery coverage.

> "Some large insurers that dropped bariatric surgery over the last couple of years are now bringing it back into their plans."
>
> **Morgan Downey**
> **American Obesity Assn.**

Only four states—Georgia, Indiana, Virginia and Maryland—have laws that address the coverage of morbid obesity treatment, and these statutes differ in scope. Georgia's law states that heath insurers that provide major medical benefits "may offer coverage for the treatment of morbid obesity." Maryland is the only state that explicitly requires health plans to cover the surgical treatment of obesity.

Nationally, less than one-half of large employers pay for the surgery, according to survey data from the Washington-based National Business Group on Health.

A significant number of employers have either limited coverage or have instituted strict requirements around the surgery, noted Joe Marlowe, the Conshohocken, Pa.-based national health care practice leader at Aon Consulting. Common features include counseling to prepare patients for the surgery itself and the lifetime impact it will have on their eating habits. Some employers require candidates to shed five or 10 pounds before surgery to demonstrate that they will have the discipline to control their eating once the surgery is done.

While coverage remains spotty, Morgan Downey, executive director and chief executive officer of the American Obesity Assn. in Washington, is encouraged by recent developments. "Some large insurers that dropped bariatric surgery over the last couple of years are now bringing it back into their plans," he noted.

Aetna Inc. now offers bariatric surgery as a rider, instead of a standard benefit, for most groups, according to a spokeswoman for the Hartford, Conn.-based insurer.

CIGNA HealthCare says it is making bariatric surgery available beginning in January 2006 for an additional premium.

Recent studies documenting bariatric surgery's successes have sparked renewed interest. One analysis, a review of existing studies published Oct. 13, 2004, in the Journal of the American Medical Assn., found that people who had the surgery saw improvements or complete remediation of their co-morbidities. Diabetes, for example, vanished in more than three-quarters of patients and was resolved or improved in 86% of patients.

PHOTO: CORBIS

Employers and health insurers are increasingly willing to cover bariatric surgery as part of an effort to help workers become healthier.

The current body of evidence, however, still fails to resolve troubling questions about the long-term effects of the surgery. "No one knows whether people who have the surgery live longer or shorter and have fewer or more side effects than those who do not have the surgery," said Dr. W. Alan Schaffer, chief clinical officer at Bloomfield, Conn.-based CIGNA. Still, the new findings are compelling enough for the 11 million-member health insurer to begin recommending that its employer customers re-evaluate their coverage for bariatric surgery.

Most health plans that pay for bariatric surgery still use guidelines developed by a 1991 National Institutes of Health consensus panel to evaluate patients. Generally, candidates should have a body mass index of 40 or greater. However, people with less severe obesity may be considered if they have certain life-threatening conditions.

What is changing is how the surgery and related pre- and post-operative services are provided. Increasingly, health plans are directing care through "centers of excellence" to weed out poor providers and improve patient care.

The North Carolina Blues established one such center last August. "We wanted to make sure that our members are having these surgeries in centers where they have appropriate support before and after the surgery and where there's a good track record of quality," said a spokeswoman for the insurer.

CIGNA is in the process of contracting with members of its bariatric network. To be eligible for its centers of excellence designation, facilities must offer certain pre- and post-operative services, meet volume and surgeon experience thresholds and demonstrate a willingness to improve care by reporting outcomes.

The concept seems to have wide appeal, not only among health plans and employers but among providers of bariatric services, too.

Surgical Review Corp., an independent review organization launched in January 2004 by leaders of the American Society of Bariatric Surgery, administers the society's fledgling centers of excellence program. When Raleigh, N.C.-based SRC began accepting applications from hospitals and surgeons last October, the nonprofit organization expected about 100 hospitals and 350 surgeons to apply for approval in the first year. Instead, it received applications from about 330 hospitals and 700 surgeons in the first month alone.

The interest likely stems from "the fact that a lot of the hospitals and surgeons are so frantic to see that reimbursement is turned back on from the payers," said Gary M. Pratt, SRC's executive director.

One of SRC's big selling points: it intends to amass an exhaustive outcomes database using information gathered from centers of excellence participants. Over time, providers will be able to mine that data to glean best practices, Mr. Pratt said. Payers will be able to see how their providers stack up against other providers nationally, he added.

NBGH strongly endorses the centers of excellence approach. Helen Darling, president of the Washington-based organization, said, "These people need a lot of services, so you want to be sure they're getting (that care), because otherwise they're going to be back in there—back in the hospital." And that would add to the price tag, she said.

Tracking work/life benefit trends

Kathleen M. Lingle says programs have positive impact


Ms. Lingle

Kathleen M. Lingle is the director of the Alliance for Work-Life Progress, a Scottsdale, Ariz.-based professional association committed to the development and advancement of the field of work/life effectiveness. Prior to her current position, Ms. Lingle served as national work/life director at KPMG L.L.P., where she had primary responsibility for creating and implementing workplace strategies for KPMG's 18,000 U.S. firm members. Ms. Lingle is the former director of work/life training at the Families & Work Institute in New York, where she assisted in the design and delivery of work/life training for managers at both First Horizon National Bank and Chase Manhattan. She is a member of the Conference Board's Work/Life Leadership Council, a member of the Work/Life & Women's Initiatives Executive Committee of the American Institute of Certified Public Accountants and has served on the steering committee of the Boston College Work/Life Roundtable.

Q: What would you say is the biggest trend in the area of work/life benefits today?

A: I've just finished putting together a keynote speech that summarizes all of the trends going on within the work/life arena, and there turned out to be so many that it's hard to choose just one.

However, in terms of potential impact, I have to say the discernible uptick in interest among men in work/life effectiveness is the most significant trend to watch. Work/life professionals have maintained for years that the juggling act is not exclusively a woman's issue, since everyone who works is, in fact, managing a dual agenda—one personal and one professional.

But men are becoming more active consumers of work/life programs and policies on their own behalf and in support of their families. Gen X and Gen Y fathers are leading this trend, according to the 2002 National Study of the Changing Workforce conducted by the Families & Work Institute.

That same 25-year longitudinal study shows that men are doing more of the housework and taking on more of the child care, according to their wives—and who would know better? So it logically follows that men are directly experiencing more work/life conflict, feeling the pain and looking for relief.

Fortunately, they are in a much better situation than their wives were a decade ago, since today so many companies offer work/life support to both men and women in one or more of seven categories.

Q: What work/life benefit programs do workers value most?

A: Workplace flexibility is No.1, by a long shot. Parents value flexibility plus some or multiple support for child care. The workforce in general is aging and is turning its attention to elder care.

Q: What do you see as the biggest obstacle in getting more employers to embrace work/life programs?

A: The biggest obstacle resides in leadership's core beliefs about the nature of people.

Although almost all corporate mission statements say that people are their most important asset, in fact, the behavior of many employers and the work environments that they foster undermine this sentiment, however inadvertently. It is more common for senior leadership to actually perceive people as costs, not as valuable assets to be invested in, maintained and given the same level of attention as other organization capital. Costs are negative, to be squeezed out of the system.

Q: How, then, can human resources or benefit managers get their managers to buy into work/life programs?

A: There is now more than a decade's worth of increasingly robust empirical research that establishes the positive impact of support for each one of the seven categories of work/life support on business drivers such as attraction, retention, engagement and productivity.

Over 500 of these studies are summarized in Sandra Burud's new book, "Leveraging the New Human Capital" (co-authored by Marie Tumolo, Davies-Black Publishing, 2004).

Additionally, there is compelling evidence from multiple business and financial sources outside of the work/life field that "employers of choice" that do attempt to take better care of employees than some others are significantly more profitable, averaging about four times the stock value of companies that don't get it.

The business case for work/life effectiveness has been proven. The time has come to ask doubting employers to explain how withholding

Dental

Disability

Life

Critical Illness

Long-Term Care

Auto & Home

Retirement & Savings

Executive Benefits

workplace flexibility, dependent care, health and wellness promotion, lack of support for diversity, etc. …contributes to the attraction, retention and engagement of their workforce.

Q: What do the companies that are considered "employers of choice" have in common in terms of their work/life programs?

A: Virtually all of them offer workplace flexibility; that is foundational to being an employer of choice. A large percentage offers a variety of support for dependent care, most commonly child and elder care resource programs. They have more-generous parental leave programs, which increasingly include a week or two of paid leave for new fathers.

What they have in common that distinguishes them from other companies is the practice of opening dialogue with employees to continually check in to see how things are going and what could be better. They perceive their workforce to be trusted—a necessary requirement for flexibility to flourish—and they tend to partner with them, looking for mutually rewarding solutions to commonly shared challenges, such as innovation, solving work overload, process inefficiencies and identifying opportunities to eliminate low-value work.

As a result, another characteristic they share in common is uncommon profitability, which is the point of the whole exercise for all stakeholders.

Q: What is the first step toward implementing a work/life benefit program?

A: The first step is to understand what work/life effectiveness is and how it manifests itself organizationally. It is a business strategy that centers on creative, customized ways of making people feel successful both at work and at home as a powerful catalyst for engagement and retention.

Some of its body of knowledge is programmatic and focuses on a blend of traditional and nontraditional benefits; a lot of its content is deeply rooted in aspects of organizational culture and requires expertise in culture change management.

So the place to start is with a simple inventory of existing practices, policies and programs in the following seven categories of support for work/life effectiveness. Together they represent all of the intersections between the worker, the family, the community and the workplace: workplace flexibility; paid and unpaid time off; dependent care—both child care and elder care; health and wellness; community involvement; financial support; and culture change initiatives like diversity, women's advancement, work environment initiatives, etc.

Not every organization covers all of these bases at the onset, but all employers do have at least a smattering of offerings across several of them. The objective, over time, is to build and/or strengthen a broad-based portfolio that meets the needs of all key stakeholders—employees, managers, leadership, clients, men, women, parents, singles.

Once the inventory is complete and reviewed by leadership, a gap analysis is the next step, to identify any important elements that seem to be missing. Usually there is enough substance for the inventory to be turned into a simple communiqué or brochure that highlights how supportive the company is of employees today.

The next step is to touch base with employees via a survey, focus groups, action councils or some other means to ascertain their most important needs and priorities, since money and resources are finite. This will help eliminate initiatives of no perceived value to employees and clarify which policies and programs should come next.

After that, action planning is straightforward.

Canadian EAPs making a comeback

Employees value benefit, but national health care lessens need for programs

By GLORIA GONZALEZ

In light of the extreme stress that mergers can place on employees, Ivanhoe Inc. and Cambridge Shopping Centers Ltd. figured their 2001 merger was the perfect time to introduce an expanded employee assistance program.

As it happened, use of the merged entity's EAP reached a peak rate of 13.5% among the company's 800 eligible full-time employees in the year after the merger, a development David Smith, vp, human resources, at Montreal-based Ivanhoe Cambridge attributes partly due to the stress of the merger. "Stress is a buzzword, for sure, but you probably see more stress-related issues than anything else," he said.

The EAP—which covers an extensive range of issues, from family and parenting counseling, mental illness care, substance abuse assistance, career/vocational concerns and legal and financial difficulties—helped earn the real estate company a spot on the 2004 list of the 50 Best Employers in Canada, published by benefits consulting firm Hewitt Associates and Toronto-based newspaper The Globe and Mail. It also placed Ivanhoe Cambridge at the forefront of a growing trend among Canadian employers of adopting EAP programs. EAPs are now "becoming more prevalent and more popular," Mr. Smith said.

Many Canadian employers have implemented wellness and employee assistance programs in an effort to reduce absenteeism and health care costs, although some have justified the expense for purely altruistic purposes.

Program adoption

The adoption of wellness programs in Canada began in the 1980s and accelerated through most of the 1990s. They lost a bit of their luster in the late 1990s and early 2000, though, because the benefits of such programs had not been proven, said Ken Werker, a partner in consulting firm Morneau Sobeco's absence and disability management solutions practice. "Over the last two or three years, they've come back as part of a comprehensive strategy of absence and disability management," Mr. Werker said.

More than half of 180 surveyed employers have wellness programs in place, according to a February study by Morneau Sobeco. The study found that the percentage is higher for employers with at least 1,000 employees, with 75% reporting having wellness programs.

Although the consulting firm has not yet done a survey on the number of employers with EAPs, the vast majority of its clients now have sophisticated assistance programs, said Mr. Werker, who is based in Vancouver, British Columbia.

Wellness programs in Canada consist of seminars and workshops on physical and mental health topics, speakers discussing health topics during lunch or after work, exercise programs held either at work sites or contracted with off-site facilities, articles on various topics and online personal health assessments or diagnostic tools. EAPs, meanwhile, have become more highly developed, evolving from simple help lines to 24-hour, seven-day-a-week counseling and task management services.

Canadian employers will often use these two types of programs in conjunction to address key workplace issues, and then make changes to their wellness programs based on what their EAP providers say the employee population is using the programs for, Mr. Werker said. For example, if a company's EAP shows a high incidence of substance abuse, it can offer preventive courses and train supervisors to look for signs of abuse as part of its wellness program.

"Employers can use these summary reports as diagnostic tools to see if there are workplace issues that need to be addressed," Mr. Werker said. "You can take the reactive approach and turn it into a proactive approach."

Canadian EAPs differ slightly from those in the United States, because most are not limited to three counseling sessions as are many programs south of the border, said Judy Plotkin, national business leader for Toronto-based Warren-Shepell, which provides EAP and health and wellness programs in both Canada and the United States. These programs provide a similar range of services in the United States and Canada, though the rate of utilization tends to be higher in Canada, she said.

Employer goals

Canadian employers that have employee assistance and wellness programs have varied goals, said Barbara Jaworski, director, work/life and well-being for Toronto-based FGIworld, which provides employee assistance and wellness programs in Canada. "Some organizations are really only concerned with containing costs," she said. "If the main goal of an organization is to maintain costs, they're going to be focusing in on things like absenteeism and the drug costs."

"Absenteeism and presenteeism are big drivers for organizations who put EAPs in place," Ms. Plotkin said. "Employers in Canada definitely want to see improvements in terms of absenteeism and presenteeism."

Promoting a healthy lifestyle was a key reason Husky Injection Molding Systems Ltd. developed its wellness program more than 10 years ago, said David Doull, director, wellness, for the Bolton, Ontario-based company. Chief Executive Officer Robert Schad "believes healthier employees are more productive," Mr. Doull said.

The company has onsite wellness centers, with nurses, doctors, chiropractors, physiotherapists and massage therapists in several facilities, and its employees make about 9,000 visits a year to the various practitioners, Mr. Doull noted. Husky was also named to the 50 Best Employers list due to its fitness and wellness programs, according to Hewitt.

Many employers have offered these programs out of genuine concern for their employees who are having difficulty balancing work/life issues, Mr. Werker said. "Most employers are doing this altruistically at this point," he said. "If there is a payback in terms of reducing absences, that's a plus."

Having EAP and wellness programs is also seen as a good recruiting tool, and an employer risks being seen as being uncompetitive or failing to show good leadership if it does not implement such programs, Ivanhoe Cambridge's Mr. Smith said. "It's common for leading employers to have it," he said.

Not for everyone

Not all Canadian employers, though, are in a rush to implement these types of programs. The Morneau Sobeco study showed that 31% of Canadian employers neither have wellness programs in place nor have plans to implement them.

One reason Canadian employers hesitate to implement wellness programs is that they do not sustain the same responsibility for health care costs as do their counterparts in the United States, Ms. Jaworski said.

For example, wellness programs that feature smoking cessation programs are popular in the United States because they focus on decreasing smoking-related health care costs for employers, but Canada's single-payer health care system places the responsibility for the bulk of these costs on the government. Canadian employers "don't need to face the full burden of health care costs as they do in the U.S.," she said.

Another key reason is that smaller companies simply do not have the time or the resources to devote to these types of programs, Mr. Werker said. The Morneau Sobeco study showed that only 36% of small employers—defined as those with fewer than 200 employees—had wellness programs.

Other employers are simply not willing to pay the costs of these types of programs, particularly because it can be hard to measure the return on investment, Mr. Werker said. "The benefits haven't been well documented, well researched or well publicized," he said.

Providers of EAP and wellness programs say companies can achieve a return on investment of 3-to-1 or 4-to-1. Husky's overall wellness, fitness and child care programs costs about $3 million a year but saves the company about $6 million a year, Mr. Doull said. The company's absenteeism rates are about one-half of the manufacturing industry's average, and its prescription drug costs are about one-third the industry average, he said. "We've calculated a fairly significant return on the investment," Mr. Doull said.

Ivanhoe Cambridge measures success based on the feedback it receives from employees rather than on its return on investment, Mr. Smith said. Employees "see it as a very positive thing, even if they don't use it," he said. "There's a comfort level knowing that it's there."

A recent survey by FGIworld found that 53% of the employees who access the company's work/life and wellness programs said their productivity had increased, while 57% said they felt healthier.

In addition, the EAP has enabled Ivanhoe Cambridge to help its employees who are facing life-threatening situations, Mr. Smith said. There have been several instances in which managers have called the EAP counselors out of concern that certain employees might be suicidal and asked for advice on how to help them. "We've actually intervened in some pretty serious situations," he said.

Based on all the anecdotal evidence of the help provided to employees, the company considers its EAP to be a success, Mr. Smith said. "We think it's money well spent," he said.

Companies enlighten workers to corporate fashion

By RUPAL PAREKH

With more and more employees leaving suits on their hangers to don jeans for work, some employers are wondering whether "casual Fridays" have gone too far.

Frustrated by workers' inappropriate office attire, some companies are shelling out thousands of dollars to bring wardrobe consultants into the workplace to enlighten employees about the dos and don'ts of corporate fashion.

Employers are even teaming up with retailers to offer corporate clothing discounts and spending allowances to help motivate employees to put the "business" back in "business casual."

The business casual trend originated about 10 years ago in Silicon Valley, Calif., during the dot-com boom and gradually spread to other industries around the country, observers say.

While the relaxing of workplace dress codes makes employees happy, it can be a double-edged sword for companies, according to Jill Bremer, a professional image coach and the owner of Oak Park, Ill.-based Bremer Communications.

Once companies break loose of the confines of the traditional suit, Ms. Bremer said, an increased number of clothing options creates more room to make mistakes. "Business casual is especially hazardous for women," she noted.

"People show up looking too sloppy, or too provocative, especially in the summer time," Mary Lou Andre, president of Organization by Design, a Needham, Mass.-based wardrobe management and fashion-consulting firm, observed.

"The pendulum is definitely swinging back to a more-conservative style of dress in the workplace," Ms. Andre noted.

Indeed, there are some indications that employers are cutting back on casual dress codes. According to the Alexandria, Va.-based Society for Human Resource Management's 2004 Benefits Survey—an annual study compiling data about company-sponsored benefits—57% of employers that responded sanctioned at least one casual dress day per week in 2004, down slightly from 60% of employers allowing that option in 2001. While causal dress was acceptable any day of the week among 51% of companies responding to the survey in 2001, slightly fewer—48%—permitted it in 2004.

One way organizations are trying to prompt employees to improve their on-the-job look is by hosting wardrobe seminars, in which consultants give guidelines for business casual dressing, offer tips on selecting office-appropriate clothing and underscore the impact appearance can have on business.

"It really helps for them to hear it from somebody from the outside, who can be objective and be the messenger," said Ms. Bremer, who has several regular corporate clients who invite her to conduct presentations for employees once or twice a year.

On average, such seminars run between one and three hours, consultants say, with costs ranging anywhere between $1,000 and $4,000. Corporate business has grown exponentially over the past few years, they say, with typical clients being banks, real estate companies, pharmaceutical companies and law firms, among others.

Many of the criticisms about inappropriate workwear are echoed among bosses. With female employees, they complain, the problems include revealing clothing, a lack of hosiery and open-toed shoes; with male employees, the problems include wrinkled and overly laid-back clothing.

Moreover, employers are concerned that employees who are lazy about their appearance may approach their work in a similar manner, the consultants say.

"The way that employees act and the way they dress are connected," said Anthea Tolomei, a San Francisco-based clothing consultant who for 14 years provided her services to a variety of companies nationwide, including Pfizer Inc. and Deloitte & Touche L.L.P, both based in New York.

"Some employees are not as guilty as they appear to be," Ms. Tolomei pointed out. "It's just that they're not given any direction."

In some cases, employees' dress becomes a problem because employers have not been thorough in outlining workplace dress policies or because rules in the employee handbook have not been enforced. At times, Ms. Tolomei said, she has even witnessed managers dressing inappropriately, which, in turn, gives their employees the green light to dress similarly.

But a major reason why employers often let dress codes slide, according to Ms. Tolomei, is "sensitivity to discrimination." Especially in the current legal environment, "people are afraid to scrutinize or give too much criticism," she said.

Among companies that are revising workplace dress standards, some are cushioning the crackdown with financial incentives.

Over two years ago, Retail Brand Alliance, Inc., the Enfield, Conn.-based parent company of Brooks Brothers, Causal Corner and Petite Sophisticate, and other stores developed a suite of services especially for the corporate community—allowing firms to offer employees voluntary "soft benefits," according to Michael Moseman, director of corporate incentive services.

RBA, as part of its services, offers a corporate discount program. Under the program, companies can enroll free of charge to offer workers a 15% discount on in-store purchases of regularly priced merchandise across all RBA brands.

"As companies look for more and more creative ways to compensate their employees, these types of discounts come into play," Mr. Moseman said.

Using an online enrollment system, employees register for a personalized, corporate membership card that is valid for 24 months and can be renewed upon expiration.

Currently, more than 1,000 companies participate in the corporate discount, with about 155,000 employees enrolled. "We average about a 22% to a 26% participation rate" among companies that join, said Mr. Moseman, who noted that "reactivation rates have been very strong."

Companies that are either corporate discount members or are in the process of joining the program also have available to them the option of free seminars, hosted by an RBA representative, on workplace dress for employees. Smaller companies may hold the seminars in one of the representative's stores while larger organizations can arrange for the seminars to be held in their own places of business.

"There's an entire generation that grew up in what was a progressively more casual atmosphere and then entered the workforce in the period of time where business casual was really taking over," said Mr. Moseman. Employers are "very aware of the fact that if they're expecting employees to upgrade their wardrobe," they need to provide something "to soften the blow a little bit," he added.

New Brunswick, N.J.-based Rutgers University offers discounts to Brooks Brothers stores. North Carolina beginning in July 2004 started offering all state employees discounts to RBA retailers, as well as to Hampstead, Md.-based Jos. A Bank Clothiers, another retailer that offers employers a corporate discount program.

Durham, N.C.-based Duke University also participates in such discount programs. "We do have discounts that we offer to all of our 30,000 employees" for clothing and shoes, said a spokeswoman for the university, which began providing such perks about seven years ago. Duke currently offers discounts to Jos. A. Bank, Brooks Brothers and Polo Ralph Lauren factory stores, among others.

In addition to conducting seminars, Ms. Andre works with employers who are willing to foot the bill for workwear for certain employees.

"Some companies establish clothing allowances, and we actually encourage them to do that because then employers can control the results better." Spending allowances usually range from $500 to $5,000 for a "one-shot deal," Ms. Andre explained.

Individual RBA stores such as Casual Corner have been approached by companies seeking to subsidize wardrobes, Mr. Moseman said. "In a tough economy, companies are looking for all sorts of concepts and services that make them more attractive," he said.

Keeping up appearances

Workplace attire can be a complex and sensitive topic to address with employees. Experts make the following recommendations for employers:


PHOTO: KRT

- **More is better.** In developing workplace dress codes, companies should be very detailed about what is and isn't acceptable attire, specifying appropriate skirt lengths, types of shoes, collars vs. no collars, etc.
- **Give employees the chance to improve their dress.** Highlight key parts of the dress code policy and hand it out as a reminder.
- **When talking to a specific employee about their inappropriate clothing, steer clear of personal opinions.** Be sure to cite business reasons why their on-the-job attire does not adhere to the dress code. During these discussions, always ask a third party to be present in the room.
- **The mere establishment of policies is not effective alone.** To maintain a culture of dressing professionally, post reminders in break rooms, send e-mails and hold regular informational sessions.

Thompson: Medical community needs to embrace technology, preventative care

Continued from page 4

fruit," is for employers to be more aggressive in promoting health care prevention.

If the nation's health care system is to be successfully transformed, "We have to become healthier," said Mr. Thompson, now a partner with the law firm Akin, Gump, Strauss, Hauer & Feld L.L.P. in Washington.

Employers, the former HHS secretary said, should make it more difficult for employees to smoke at or near workplace facilities. "Make it (smoking) inconvenient," he said, noting that nearly one-tenth of what the nation spends on health care services is related to tobacco use.

Also in the area of prevention, medical schools need to overhaul their curriculum. "Our health care system waits until you get sick, then we spend thousands. Medical schools devote nothing" to educating future physicians on prevention, which is where huge sums could be saved, he said.

On the technology front, the medical profession is light years behind other industries, Mr. Thompson said, a tardiness that can have fatal consequences, such as when a nurse administers the wrong medication because she didn't correctly read a prescription due to the sloppy handwriting of a physician.

Mr. Thompson contrasted the health care system's technologically backward ways with other industries. While in Russia, for example,

> "Our health care system waits until you get sick, then we spend thousands."
>
> **Tommy Thompson**
> **Akin, Gump, Strauss, Hauer & Feld L.L.P.**

Mr. Thompson was able to withdraw funds from a savings account he maintains at a financial institution in a small Wisconsin town.

"You can go around the world and get cash from an ATM," he said, but if you have a stroke while on a trip, it can take days to get the records, complicating treatment. The remedy, he said, is for Congress to set a deadline for the health care industry—perhaps 24 months—to adopt electronic medical records.

Mr. Thompson said federal legislators need to take action on another front: pass legislation to provide funding for pools, organized by the states and administered by insurers, to cover the uninsured. The huge number of the uninsured—currently about 45 million people—is a drag on the economy and a cost that employers with health care plans subsidize when providers cost-shift uncompensated care to patients in insured plans, he said.

Mr. Thompson also urged the medical community to do a better job of lobbying for reform of malpractice laws to limit damages for pain and suffering.

Doctors have to do more than "one-day" parades before legislators, he said. Instead, physicians need to emulate plaintiffs' attorneys, who do the "heavy lifting" and make their presence felt and their views known every day in the nation's state capitals and in Congress, he said.

Medicare drug law could impact entire health system

Injection of 'capitalism' needed, ex-official says

By JERRY GEISEL

WHITE SULPHUR SPRINGS, W.Va.— The 2003 federal law that will add a prescription drug benefit to the Medicare program next year has the potential to be a catalyst for far-reaching and beneficial changes to the nation's health care delivery and financing system, a former Bush administration official predicts.

While public attention has focused on the prescription drug benefit that resulted from the Medicare Modernization Act, the law's impact may extend far beyond the drug benefit, said Tom Scully.

Speaking earlier this month at the Council of Insurance Agents & Brokers' annual Employee Benefits Leadership Forum, Mr. Scully, the former administrator of the U.S. Centers for Medicare & Medicaid Services, said the 2003 law could help to break the iron grip Medicare now has on the entire health care system.

The 2003 law gives health insurers rich federal payment rates to provide coverage to beneficiaries who opt out of the traditional, fee-for-service Medicare program in favor of plans—most likely preferred provider organizations—offered by the insurers.

That could erode the power of Medicare, which Mr. Scully described as a "single-payer, price-fixed behavioral nightmare."

With Medicare now controlling so much of the health care market—hospitals often derive 50% of their revenues from the federal program—private health insurers have little leverage in negotiating rates and other terms with providers, said Mr. Scully, now a senior counsel with the law firm of Alston & Bird L.L.P. in Washington.

"How much leverage can (insurers) have to drive the behavior of hospitals if Medicare is so big?" Mr. Scully asked.

But if, eventually, 40% to 50% of the 41 million Medicare beneficiaries receive coverage from private insurers, the leverage of private insurers will increase and that of Medicare will decline.

And that, Mr. Scully said, will be a good thing for the entire health care system. The combination of low and fixed Medicare payment rates and the lack of utilization review have led providers to order services for patients that may not always be necessary.

"In Medicare, there is no oversight. No one does UR. It is a nutty system," he said.

But as private insurers get into the Medicare market, the current lack of oversight may end, Mr. Scully said. Rather than just pay bills, insurers will become more aggressive than Medicare has been in challenging provider behavior such as ordering medical services and tests that may not necessary.

When insurers start questioning, for example, the necessity of MRIs, "things will start to change," Mr. Scully said, citing what he says is the positive influence of capitalism in the health care system and the erosion of what he likened to old "Soviet-East German" style of price fixing.

And, the former CMS regulator said private insurers now are rushing to get into the Medicare market, responding to what Mr. Scully described as the "oversized" premium rates the 2003 law set.

"The money is there," he said.

Ultimately, as insurers penetrate the Medicare market, significantly increasing their negotiating heft with providers, there will be a "sea change" affecting the entire health care market, he said.

But to inject more competition and improve quality in the health care market, additional action is necessary, Mr. Scully said.

Today, consumers lack sufficient information to judge how quality varies among providers. And that, Mr. Scully said, is a "big deal." "You can't drive quality without consumer information."

Legislators will fight to try to ensure better access to quality information, but that drive will face opposition from hospitals that oppose the distribution of such information, he said.

CIAB forum brings benefits experts together

WHITE SULPHUR SPRINGS, W.Va.—Now in its fourth year, the Council of Insurance Agents & Brokers' annual Employee Benefits Leadership Forum attracted more than 350 insurers, benefit brokers and other insurance professionals to the Greenbrier resort in White Sulphur Springs, W.Va.

The key purpose of the meeting is to provide an opportunity for benefit producers and insurers to forge relationships, much as the CIAB's annual fall meeting—also held at the Greenbrier—has been for the property/casualty industry.

The benefits meeting is one that will "continue to grow and expand," said CIAB Chairman J. Hyatt Brown, who also is chairman and chief executive officer of Brown & Brown Inc. in Daytona Beach, Fla.

In addition to networking opportunities, the meetings also have featured well-known politicians. This year's keynote addresses were delivered by former Secretary of the Department of Health & Human Services Tommy Thompson and former administrator of the Centers for Medicare & Medicaid Services Tom Scully.

Next year's meeting will be held May 31 through June 3 at the Greenbrier. For more information, contact the CIAB at 202-783-4400

—By Jerry Geisel

PRODUCTS & SERVICES

UnitedHealth offers early retiree option

MINNEAPOLIS—UnitedHealth Group is offering a new health plan option for large employers' early retirees.

The Pre-Funded Retirement Plan from Uniprise, a division of UnitedHealth Group, which administers the program, is designed to offer early retirees affordable access to medical coverage and reduce employers' overall health care costs. The plan design is customizable, and employers can use a variety of account options, including a health reimbursement arrangement, cafeteria plan or credit system. By using the HRA or a similar account, any remaining funds in the pre-65 account can be applied toward post-65 coverage. At retirement, employees have access to medical coverage without medical review and can use the account funds to pay for the medical plan's ongoing cost.

Contact Christopher Bowler, product manager, at *christopher_a_bowler@uhc.com*.

Chubb offers products for nonprofits

WARREN, N.J.—Chubb Corp. has introduced a portfolio package of coverages for nonprofit organizations.

The ForeFront Portfolio consists of five insurance coverages, including directors and officers and entity liability, crime, kidnap and ransom and extortion, employment practices liability and fiduciary liability. The program allows the customer to purchase only the protection needed. Those purchasing the EPL coverage section have access to Warren, N.J.-based Chubb's employment practices liability loss prevention program, which provides customers with the chance to receive premium reimbursement for approved loss prevention expenses.

The maximum capacity is $25 million per coverage section. Crime, kidnap and ransom and extortion are nonaggregated coverages. D&O, entity liability, EPL and fiduciary liability each have their own individual aggregate limits per policy year. Optionally, D&O and EPL coverage sections can be made subject to a combined aggregate limit per policy year. Fiduciary liability is subject to its own separate aggregate.

More information on the portfolio can be obtained by visiting *www.chubb.com/businesses/csi/chubb3738.html*.

SOA issues study of insurance M&As

SCHAUMBURG, Ill.—The Society of Actuaries has published a book that takes an in-depth look at the mergers and acquisitions process within the insurance industry.

The guide, "Insurance Industry Mergers & Acquisitions," includes information on M&A financing, tax and accounting issues and post-acquisition integration. It also features information on M&A transactions consisting of commentary and case studies compiled by executives and outside advisors involved in the M&A process.

More information on the book can be found by visiting the Schaumburg, Ill.-based SOA's Web site, at *www.soa.org*. To order a copy, visit *http://books.soa.org*.

Ascentis enhances HR product line

BELLEVUE, Wash.—Ascentis Corp., a Bellevue, Wash.-based provider of human resources management systems, has added two products to its HROffice line of software.

The company's HROffice HRMS software automates HR and benefit processes for small to midsize organizations. The newest editions to this product line are the HROffice Ethics Trainer and the HROffice Compliance Advisor.

The HROffice Ethics Trainer is a program designed to help companies meet various statutory and regulatory requirements, such as, the Sarbanes-Oxley Act and stock exchange requirements. Employees take the training online and receive a certificate upon completion. Employers have the ability to download a variety of reports and to see who has completed training.

Bellevue, Wash.-based Ascentis' second product, HROffice Compliance Advisor, helps companies manage HR requirements and automate corporate compliance procedures.

The online compliance program leads the user through more than 100 HR topics to determine a company's areas of risk. The user is then provided with a prioritized list that details what to do and also includes recommendations highlighting the specific HR needs, such as proper communications, documentation and reporting related to compliance.

The company can be contacted at 800-229-2713 or through its Web site at *www.ascentis.com*.

We'd like to report on new risk management and employee benefit products and services offered by your company. Send information about your new offerings to: Carrie A. Peinado, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; telephone: 312-649-5313; fax: 312-649-7801; e-mail: cpeinado@businessinsurance.com.

COMMENTARY

Senior Editor David Lenckus

Stop med mal lawsuits without tort reform

Not much would be worse than needing brain surgery—unless, of course, it's your doctor messing up the procedure by operating on the wrong side of your head.

In recently filed medical malpractice litigation, that is exactly what two patients claim happened to them in procedures performed by different surgeons at separate hospitals in the Chicago area.

As scary as those incidents are—for hospital risk managers as well as the public—there is a more alarming story out there.

According to a Chicago area physician who has been studying medical errors and has developed a system to reduce them, there appears to be a problem in a relatively large number of hospital emergency rooms that creates a health risk for patients and a medical malpractice risk for hospitals and doctors.

It is a problem that even the finest of staffs may not be able to trump, says the physician, Dr. Dan Sullivan, president and chief executive officer of The Sullivan Group of Oakbrook Terrace, Ill.

Data collected by Dr. Sullivan in 2003 and 2004 on 90,000 high-risk emergency room patients at 300 hospitals nationwide—about 7.5% of all U.S. hospitals—shows that 9,700 patients had severely abnormal vital signs. Among that group, 1,600 were discharged without their vitals being reassessed.

That means some ER patients are being discharged even when their blood pressure, respiratory rate or body temperature, for example, is abnormally high.

How can something like that happen?

Dr. Sullivan says there are several reasons, but the most common is that not all pieces of a patient's chart are kept together. So, an ER doctor sometimes makes discharge decisions without having a patient's full medical chart—including vital signs—at hand.

Another unsettling statistic is that among 25,000 patients who complained about chest pain, only 20% were questioned about all of the risk factors that could lead to a diagnosis of thoracic aorta dissection. With TAD, the blood flow seeps in between the three layers of the aorta lining and causes chest pain. Left untreated, TAD is deadly.

A doctor would not look for TAD risk factors among the low percentage of patients with obvious causes for their chest pain, such as patients with shingles or those who suffered trauma to their chests, Dr. Sullivan said. But physicians would investigate TAD risk factors in about 90% of patients who complain of chest pain, he estimated.

Why wouldn't a doctor question a patient about risk factors that could indicate such a dangerous health condition? The doctor actually might question the patient but forget to ask about one or more of the many factors, Dr. Sullivan said.

That is what happened a few years ago when a pregnant woman visited a Chicago-area hospital ER and then her primary physician after she experienced chest pain. Neither the ER doctor nor the primary care physician remembered that pregnancy is a TAD risk factor, Dr. Sullivan said. Shortly after seeking medical care, the woman's aorta ruptured, killing her and her fetus.

Dr. Sullivan's program combines elements designed to minimize ER diagnostic and treatment errors.

The first piece is a Web-based educational tool on the best course of treatment for high-risk patients, such as those who complain about chest and abdominal pain.

The second piece is a medical records tool that includes either an electronic or paper checklist of health risk factors that physicians should be researching for their high-risk patients. The tool also prompts physicians to ensure that patients' vital signs are normal before releasing them.

The third piece is a physician performance evaluation tool that would be used during the peer review process.

The cost of the program is about one-third of the price hospitals pay for a medical dictation tool.

Risk Manager of the Year James D. Hinton, vp-risk and insurance at Nashville, Tenn.-based HCA Inc., cut the hospital chain's ER claim count 38% from 2002 through 2004 after starting the program.

Hospital risk managers should not make the dangerous bet that their facilities do not have the kind of problems that Dr. Sullivan's research has uncovered. Whether risk managers turn to Dr. Sullivan's product, look for help elsewhere or develop their own tools, the data suggests that they need to do something to ensure that their ER departments are not a hotbed of med mal claims.

Those efforts should be more proactive than funding lectures for physicians or waiting for med mal liability reform.

Tips and feedback from readers are welcome. Please send information to dlenckus@businessinsurance.com.

RIMS: Time running out to renew TRIA

Continued from page 6

bill has, as leaders in both houses await a Treasury Department study of the TRIA marketplace, a study that must be issued by June 30.

But "Why the delay?" Rep. Kanjorski queried. "The delay is there because of someone named DeLay," he said.

Rep. Kanjorski noted that the House Financial Services Committee gave its unanimous approval last fall to a bill that would have extended TRIA for two years. But the measure never made it to the House floor because House Majority Leader Tom DeLay, R-Texas, opposed it. Instead, he said he could accept only a six-month extension, which extension backers rejected.

That's because a six-month extension would be like having no extension at all, said Rep. Kanjorski. It would have been meaningless in terms of the construction sector, which requires years to work on projects.

In addition to criticizing Rep. DeLay, Rep. Kanjorski took aim at the White House. "Leadership in the administration is just totally absent" on TRIA extension, he charged.

Backers of extending TRIA need to focus on Republicans, because they control the congressional agenda, he said. "It's absolutely essential that government exercise a role in something like this, where there is a vacuum," he said.

"I think noise is important," said Rep. Kanjorski, adding that he does not believe that his office has received more than five telephone calls regarding TRIA over the past three years. "We're not going to get it by public demand; we're going to get it by forceful advocacy," he said.

Rep Kanjorski also reiterated several times his belief that tort reform provisions should not be tacked onto extension legislation. Using a TRIA extension bill as a vehicle for tort reform would cost the measure Democratic support, he said. Instead, if tort reform is to be addressed, it should be addressed directly, he said. Even then, civil justice reform should be approached carefully, he said.

"Don't be too damn fast to move everything to the federal system," he said, adding that the federal courts are already jammed and could grind to a halt if asked to handle more of the tort cases currently being tried in state courts.

European Commission to probe insurance sector

Possible bid-rigging, other anti-competitive practices to be investigated in E.U. states

By BARBARA COCKBURN

BRUSSELS, Belgium—The European Commission in the coming months will be examining Europe's commercial insurance market to determine whether there has been any anti-competitive behavior.

The so-called "sector inquiry" of the commercial insurance market, including reinsurance and insurance brokerages, was initiated because of concerns that in some areas "competition may not be functioning as well as it could," the commission said in a statement.

The commission began similar sectorwide inquiries in the banking and utilities industries last week. The examination follows other probes into insurance-sector competition in recent years (see box).

The commission's insurance inquiry is at a preliminary stage. Bernhard Friess, head of the financial services division within the directorate general of the European Commission in Brussels, Belgium, said the commission would welcome suggestions from industry participants on what issues it should examine.

In its published decision, the commission wrote, "There are indications that in certain areas of insurance to business, insurers' associations and committees jointly set standard policy conditions, offering only limited possibilities for the demand side to negotiate terms of coverage or otherwise restricting competition."

"Distortive forms of cooperation may also take place within the framework of insurers' associations and in the context of co-insurance arrangements between insurers. Similarly, certain arrangements for distribution of insurance products and services to business may give rise to competition concerns," the commission wrote.

Mr. Friess noted that while it is appropriate for insurance companies to work together to pool large risks and to share information to standardize policies and contract clauses, "it's potentially dangerous from an antitrust point of view, because it can lead to collusion and price fixing."

Drawing a parallel to investigations in the United States, Mr. Friess said that the investigations by New York Attorney General Eliot Spitzer "can partly come into play here, because there are allegations that some brokers have been rigging bids or receiving money from insurers for some of the business brought to them."

The inquiry, which will cover all 25 E.U. member states, will be done in phases, and more information will be available later this year, the commission said.

Lesley Ainsworth, a partner in the E.U. competition practice at the London law firm of Lovells, said: "The E.C. is in the early stages of the investigations, but one outcome could be investigations…into individual companies. And another possibility is that the commission will make recommendations to the regulatory framework."

Ms. Ainsworth noted that there have only been a "few sectoral investigations in the past, mainly in the (telecommunications) sector, for example into mobile phone

See PROBE / next page

All eyes on insurance

Recent insurance-related probes in Europe have led to settlements and/or changes in practices.

- Germany's competition regulator in March fined 10 insurers a total of 130 million euros ($171.7 million) for engaging in anti-competitive practices with regard to commercial business.
- Also in March, the European Commission and London aviation market underwriters reached an agreement on changes designed to boost transparency and competition. The E.C. began its investigation after the Sept. 11, 2001, terrorist attacks led many aviation insurers to withdraw from the market or revise coverage terms.

Loss of reputation tops list of worries for companies

Companies in the United Kingdom view a loss of reputation as the greatest risk they face, according to a survey by London-based Aon Ltd.

Business interruption ranked second in Aon's survey of the 1,000 largest U.K. companies. The 2005 survey, released last week, is the ninth biennial risk management and risk financing survey that Aon has conducted.

Other top risks identified by U.K. companies in 2005 were, in order: failure to change, product liability/tampering and the impact of regulation or legislation.

By comparison, in the 2003 survey, business interruption and failure to change tied as respondents No. 1 risk, followed by employee accidents, employee recruitment and retention and, in fifth place, loss of reputation.

Aon also asked U.K. companies about risks for which purchasing adequate insurance was a concern. In 2005, the coverage areas cited most were business interruption, product liability/tampering, physical damage, directors and officers liability and general liability.

In the 2003 survey, Aon found that business interruption coverage was the leading area of concern, but D&O liability coverage didn't make the top five.

The percentage of companies in 2005 with risk management/insurance departments rose sharply, to 84%, from 54% in the previous survey. The risk management/insurance function reported to the corporate finance or treasury department at 52% of the companies surveyed this year, while 23% reported to a company secretary or legal department, and 8% reported to the chief executive.

Looking at risk audits, Aon found that 50% of the surveyed companies have conducted audits this year on health and safety or work-related absence, physical damage, major disasters or incidents, environmental pollution or corporate responsibility.

Of the companies surveyed, 82 risk managers, insurance managers, finance directors and company secretaries responded. Fifty-seven percent of the responding companies reported annual sales of more than £1 billion, 31% had sales between £250 million and £1 billion ($453.2 million and $1.81 billion), and 13% had sales of less than £250 million.

Aon's "2005 Biennial Risk Management & Risk Financing Survey" is available at *www.aon.co.uk*.

—By Regis Coccia

What has U.K. managers losing sleep in 2005?

Among the top risks cited by companies in the United Kingdom:

- The loss of reputation
- Failure to change
- Product liability/tampering
- The impact of regulation or legislation

U.K. court clarifies public liability question in asbestos lawsuit

By CAROLYN ALDRED

MANCHESTER, England—A U.K. judge has rejected an insurer's attempt to challenge the way asbestos injury liability typically is allocated to public liability insurers.

In his ruling, issued earlier this month, Judge Michael Kershaw of the Manchester High Court ruled that a public liability insurer providing coverage at the time an individual's asbestos-related mesothelioma developed—rather than the insurer on the risk when the asbestos fiber was inhaled—must compensate the victim.

The ruling is in line with the current market practice for public liability policies but contrary to that for employers liability claims, where liability usually is assigned to the insurer whose policy was in force when the fibers are inhaled, according to Victor Rae-Reeves, a partner with the London-based law firm of Clyde & Co.

The Manchester court case marks the first time this issue has been tested in court in the United Kingdom, and many insurers were watching the case closely, said Mr. Rae-Reeves. Had the judge found that the earlier insurer should provide compensation, some insurers would have been forced to reopen their books and increase reserves for old years, he said.

The case stemmed from the 1991 death of a mesothelioma victim who had been exposed to asbestos fibers due to the negligence of the Bolton Metropolitan Borough Council, where he worked on sites as a contractor in the early 1960s, according to court papers.

After it received a claim from the victim's family, Bolton sought coverage from Municipal Mutual Insurance Ltd., which insured the municipality from 1979 to 1991, the period during which the individual's mesothelioma tumor developed. MMI—by then in runoff—denied coverage, arguing that the liability for the injury arose out of circumstances which occurred before its policy period—namely, the inhalation of the asbestos fibers.

Bolton then sought coverage from Commercial Union Assurance Co. Ltd., which provided its public liability coverage during the period when the mesothelioma victim worked in the municipality. Commercial Union also denied coverage, relying on standard market practice for resolving such claims.

Judge Kershaw ruled that under the terms of the public liability policies, the injury or illness had to occur during the policy period and that in the ordinary use of language, "bodily injury or illness" did not include the inhalation of fibers that were potentially—but

See ASBESTOS / page 35

Updates

Cooperation urged for buyers, industry

Brokers and insurers need more cooperation and communication from risk managers if the industry is to improve its service standards and meet a U.K. mandate to provide contract certainty, an insurance industry panel said. The panel discussion took place at the Assn. of Insurance & Risk Managers Conference 2005 in Brighton, England, last week. The panel of major brokers and insurers discussed the U.K. Financial Services Authority's requirement that insurers provide contract certainty from policy inception beginning Jan. 1, 2007.

Corvus opts not to bid on RSA

U.K. investment group Corvus Capital Inc. has said it is no longer considering a bid for London-based insurer Royal & SunAlliance Insurance Group P.L.C. Earlier last week, Corvus had said it was considering a number of potential acquisition targets, of which RSA was one. But in a statement last Friday, Corvus said it "remains mindful of the complexities inherent in a company operating within the insurance sector such as RSA and, with this in mind, would only have intended to proceed with an offer for RSA with the cooperation of its existing management." A spokesman for RSA said the company had nothing to add to a statement made earlier in the week in which it said it had received no approach from Corvus and was not in talks with anyone about a possible takeover.

Marsh restructures CMS operations

The U.K. arm of Marsh Inc. is restructuring its Client and Market Services practice. The unit, which handles the London market servicing operations and some retail servicing operations for Marsh in the United Kingdom, has operations in London; Norwich, England; and Pune, India. Management responsibilities in the unit have been reorganized along function lines and managers of specific functions will be responsible for areas such as documentation, broker support and claims.

Dequae takes over as FERMA president

Marie-Gemma Dequae has been named president of the Brussels, Belgium-based Federation of European Risk Management Assns. Ms. Dequae will begin her two-year term at FERMA's conference in Lisbon, Portugal, in October. Ms. Dequae, who is president of the Belgian risk management association BELRIM, is corporate risk manager for Kortrijk, Belgium-based metal transformation and material and coatings company N.V. Bekaert S.A.

Probe: Insurance industry practices scrutinized by European Commission

Continued from page 33

roaming charges. In that case, the sectoral investigation led to on-site investigations on a number of mobile phone network operators."

One risk manager, who asked not to be identified, said that with the increased focus on transparency in the insurance industry, the commission's investigation was a positive step. He said that while he was not aware of any anti-competitive behavior by insurers, risk managers should be entitled to have their risks placed without restriction and according to the risk itself and not other factors.

Insurance industry bodies pledged to cooperate with the commission.

A spokeswoman at the Comité Européen des Assurances said, "We will cooperate as far as we can, but we are not alarmed and we will follow this closely."

A spokesman for London's International Underwriting Assn. said, "Because the investigation is sector-wide, it will generally be looking at how the industry works, and we are happy to provide the E.C. with all the information it needs to understand the industry. "

An Assn. of British Insurers' spokeswoman said, "The retail insurance market is extremely competitive, and we would be happy to cooperate with the E.C. fully when they are ready to begin investigating."

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LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

IN RE PETITION OF BOARD OF DIRECTORS OF **CAVELL INSURANCE COMPANY LIMITED**, DEBTOR IN A FOREIGN PROCEEDING
CASE NO. 04-B-17990 (SMB)

NOTICE IS HEREBY GIVEN THAT ON JUNE 7, 2005, THE BANKRUPTCY COURT ENTERED AN ORDER (THE "ORDER") PURSUANT TO 11 U.S.C. § 304. THE ORDER SHALL REMAIN IN EFFECT PENDING A HEARING TO CONSIDER WHETHER THE BANKRUPTCY COURT WILL (I) ISSUE A PERMANENT INJUNCTION ORDER, PURSUANT TO SECTION 304 OF THE BANKRUPTCY CODE, PROVIDING FOR, AMONG OTHER THINGS, RECOGNITION OF THE SCHEME OF ARRANGEMENT, SUBSTANTIALLY IN THE FORM SET FORTH IN THE AMENDED EXHIBIT "A" FILED WITH THE BANKRUPTCY COURT ON JANUARY 12, 2005, AS AMENDED, IN THE UNITED STATES AND/OR (II) CONTINUATION OF THE ORDER, WHICH HEARING IS SCHEDULED TO BE HELD BEFORE THE HONORABLE STUART M. BERNSTEIN, CHIEF UNITED STATES BANKRUPTCY JUDGE, UNITED STATES BANKRUPTCY COURT, ONE BOWLING GREEN, NEW YORK, NEW YORK ON SEPTEMBER 8, 2005 AT 10:00 A.M.

CHADBOURNE & PARKE LLP
ATTORNEYS FOR THE PETITIONER
30 ROCKEFELLER PLAZA
NEW YORK, NEW YORK 10112
(212) 408-5100
ATTN: HOWARD SEIFE, ESQ.
FRANCISCO VAZQUEZ, ESQ.

LEGAL NOTICE

IN THE HIGH COURT OF JUSTICE
CHANCERY DIVISION
COMPANIES COURT
No 7601 of 2004
IN THE MATTER OF

UNIONE ITALIANA (UK) REINSURANCE COMPANY LIMITED

AND IN THE MATTER OF
THE COMPANIES ACT 1985

NOTICE IS HEREBY GIVEN that, by an Order dated 7 March 2005 the High Court of Justice of England and Wales sanctioned a scheme of arrangement under section 425 of the Companies Act 1985 **(the "Scheme")** between Unione Italiana (UK) Reinsurance Company Limited **(the "Company")** and its Scheme Creditors (as defined in the Scheme).

The Scheme became effective on 9 June 2005. Accordingly the Final Claims Submission Date by which Claims (as defined in the Scheme) must be submitted to the Company is 12 noon (London time) on 7 October 2005.

Scheme Creditors should note that Claims not submitted on a duly completed Claim Form (as defined in the Scheme) received by the Company by the Final Claims Submission Date will be deemed to have been satisfied in full and the Scheme Creditor concerned will not be entitled to payment in respect of them.

Blank Claim Forms will be sent by post to all Scheme Creditors of whom the Company is aware and for whom it has contact details. Claim Forms, as well as a copy of the text of the Scheme and of the Explanatory Statement required to be provided to creditors pursuant to section 426 of the Companies Act 1985, may also be obtained by writing to James Kay at Cavell Management Services Limited, PO Box 62, Rose Lane Business Centre, Rose Lane, Norwich NR1 1JY, Facsimile: +44 (0)1603 599441 Email: Unione.Scheme@cavell.co.uk. They may also be downloaded and printed from the website www.cavell.biz/schemes.

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Ref: JQS/GEQ/0402300

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LEGAL NOTICE

To all Creditors and Parties in Interest

Re: Cynthia J. Todorovich

PLEASE TAKE NOTICE that on May 21, 2005 Cynthia J. Todorovich filed a Voluntary Petition for Relief under Chapter 7 of Title 11 of the United States Code in the United States Bankruptcy Court for the Eastern District of Missouri, bearing case number 05-47032-172. Any persons having claims against Cynthia J. Todorovich or any questions regarding the case are directed to review the court file or to contact counsel for Ms. Todorovich:

Norman W. Pressman, Esq.
Robert A. Breidenbach, Esq.
GOLDSTEIN & PRESSMAN, P.C.
121 Hunter Ave., Ste. 101
St. Louis, MO 63124
(314) 727-1717
nwp@goldsteinpressman.com
rab@goldsteinpressman.com

LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT - SOUTHERN DISTRICT OF NEW YORK

In re Petition of Board of Directors of **UNIONE ITALIANA (UK) REINSURANCE COMPANY LIMITED,** Debtor in a Foreign Proceeding. — In a Proceeding Under Section 304 of the Bankruptcy Code — Case No. 04-B-17989 (SMB)

NOTICE IS HEREBY GIVEN THAT, in connection with the petition filed on December 20, 2004, pursuant to section 304 of the Bankruptcy Code (the "Petition"), by the Board of Directors (the "Petitioner") of UNIONE ITALIANA (UK) REINSURANCE COMPANY LIMITED (the "Company"), the United States Bankruptcy Court for the Southern District of New York (the "Bankruptcy Court") has entered a permanent injunction order dated June 8, 2005 (the "Order"), among other things:

1. Providing that the Scheme of Arrangement (as defined in the Order) shall be given full force and effect in the United States, and shall be binding on and enforceable against all Scheme Creditors (as defined in the Order) in the United States;

2. Permanently enjoining all Scheme Creditors from taking any action in contravention of, or inconsistent with, the Scheme of Arrangement;

3. Permanently enjoining all Scheme Creditors from: (a) commencing or continuing any action or legal proceeding in connection with any Claim (as defined in the Order) (including, without limitation, arbitration or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever), including by way of counterclaim, against the Company, or any property in the United States that is involved in the foreign proceeding, or any proceeds thereof, and seeking discovery of any nature against the Company; (b) enforcing any judicial, quasi-judicial, administrative or regulatory judgment, assessment or order, or arbitration award obtained in connection with any Claim, and commencing or continuing any act or action or legal proceeding in connection with any Claim (including, without limitation, arbitration, or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) or any counterclaim to create, perfect or enforce any lien, attachment, garnishment, setoff or other claim arising out of a Claim against the Company or any of its property in the United States, or any proceeds thereof, including, without limitation, rights under reinsurance or retrocession contracts; (d) invoking, enforcing or relying on the benefits of any statute, rule or requirement of federal, state, or local law or regulation requiring the Company to establish or post security in the form of a bond, letter of credit or otherwise as a condition of prosecuting or defending any proceedings (including, without limitation, arbitration, mediation or any judicial, quasi-judicial, administrative or regulatory action, proceedings or process whatsoever) and such statute, rule or requirement will be rendered null and void for proceedings; (e) drawing down any letter of credit established by, on behalf or at the request of, the Company, in excess of amounts expressly authorized by the terms of the contract or other agreement pursuant to which such letter of credit has been established; and (f) withdrawing from, setting off against, or otherwise applying property that is the subject of any trust or escrow agreement or similar arrangement in which the Company has an interest in excess of amounts expressly authorized by the terms of the contract and any related trust or other agreement pursuant to which such letter of credit, trust, escrow, or similar arrangement has been established; provided, however, no drawing against any letter of credit shall be made in connection with any commutation unless the amount has been agreed in writing with the Petitioner or permitted by further Order of the Court;

4. Requiring that all persons and entities in possession, custody or control of the Company's property in the United States or the proceeds thereof, shall turn over and account for such property or its proceeds to the Petitioner unless such a person or entity has a bona fide defense to this obligation to turn over;

5. Requiring that all Scheme Creditors that are beneficiaries of letters of credit established by, on behalf or at the request of the Company or parties to any trust, escrow or similar arrangement in which the Company has an interest, to: (a) provide notice to the Petitioner's United States counsel of any drawdown on any letter of credit established by, on behalf or at the request of, the Company, or any withdrawal from, setoff against, or other application of property that is the subject of any trust or escrow agreement or similar arrangement in which the Company has an interest, together with information sufficient to permit the Petitioner to assess the propriety of such drawdown, withdrawal, setoff or other application, including, without limitation, the date and amount of such drawdown, withdrawal, setoff or other application and a copy of any contract, related trust or other agreement pursuant to which any such drawdown, withdrawal, setoff, or other application was made, and provide such notice and other information contemporaneously therewith; and, (b) turn over and account to the Petitioner for all funds resulting from such drawdown, withdrawal, setoff, or other application in excess of amounts expressly authorized by the terms of the contract, any related trust or other agreement pursuant to which such letter of credit, trust, escrow or similar arrangement has been established unless such Scheme Creditor has a bona fide defense to this obligation to turn over;

6. Requiring that every Scheme Creditor that has a claim of any nature or source arising out of a Claim and that is a party to any action or other legal proceeding (including, without limitation, arbitration or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) in which the Company is or was named as a party, or as a result of which a liability of the Company may be established, is required to place the Petitioner's United States counsel (Chadbourne & Parke LLP, 30 Rockefeller Plaza, New York, NY 10112, Attn: Francisco Vazquez, Esq.) on the master service list of any such action or other legal proceeding, and to take such other steps as may be necessary to ensure that such counsel receives: (a) copies of any and all documents served by the parties to such action or other legal proceeding or issued by the court, arbitrator, administrator, regulator or similar official having jurisdiction over such action or legal proceeding; and, (b) any and all correspondence, or other documents circulated to parties named in the master service list.

Copies of the Order, the Scheme of Arrangement and the Petition are available upon written request to the undersigned counsel:

CHADBOURNE & PARKE LLP • Attorneys for the Petitioner • 30 Rockefeller Plaza • New York, New York 10112 • (212) 408-5100 • Attn: Howard Seife, Esq., Francisco Vazquez, Esq.

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LEGAL NOTICE

Asbestos: U.K. court clarifies public liability in asbestos case

Continued from page 33

not necessarily—harmful, court papers say.

Because the actual injury—the development of the mesothelioma tumor—occurred during the MMI policy period, it was liable to pay compensation, the judge said.

"The reason for this rather surprising situation of the later policy trigger is down to the wording of (public liability) policies. They usually refer to something along the lines of 'personal injury and disease occurring during the period of indemnity,'" said Mr. Rae-Reeves, who represented Commercial Union in the case while working as a partner with London-based firm Halliwells.

The case was being watched closely by the industry and "could have been really disastrous for some insurers if it had gone the other way," said Simon Chandler, a Bristol-based senior lawyer with the London law firm of CMS Cameron McKenna. "The outcome was widely expected and provides a degree of certainty in an area of English law which until now has been lacking."

Graham Rhodes, corporate risk officer for Bolton Council in Bolton, England, said he is pleased with the ruling but understands that MMI plans to appeal.

Trevor Groocock, finance director of London-based MMI Ltd., declined to comment on whether the company would appeal.

Bolton Metropolitan Borough Council vs. Municipal Mutual Insurance Ltd. and Commercial Union Assurance Co. Ltd.; MA 390033.

EPLI: Better documentation key to avoiding employment claims

Continued from page 4

lished policy to support any actions they take against drug- or alcohol-impaired employees, Mr. Molenaar said.

Written job descriptions also are crucial, according to Mr. Molenaar.

"What are you going to do if you don't have a written policy if they lie to you?" he asked, referring to applicants' statements about their ability to perform the necessary functions of a job.

Mr. Molenaar encouraged the attendees to document the essential functions of every job so that a judge in an employment practices lawsuit does not devise "a hair-brained assessment" of a job's primary functions.

"I don't believe people care as much about the right to go to court. They want to go somewhere to complain."

Dennis Molenaar
St. Paul Travelers Cos. Inc.

But employers should be careful how they determine what are the essential functions of a job. For example, for police work, tying the essential functions to performance on a physical agility test could be problematic, because police officers often cannot pass those tests three to five years after being hired, Mr. Molenaar noted. "You can't fire everybody" who cannot perform those agility tests, he said.

He recommended, though, that municipalities require police officers to pass agility tests before they can be promoted or transferred.

Once on the job, employees who believe they have been harassed should be able to consult a personnel manual before filing a grievance, Mr. Molenaar said.

The manual should cover various forms of harassment, he advised.

In particular, to help avoid sexual harassment claims, organizations should follow the guidelines that the U.S. Supreme Court outlined for public entities in a 1998 ruling. The high court found that a public entity would not be liable in a sexual harassment case if the entity had a written policy prohibiting such activity, had guidelines on how employees could report harassment, had identified a central person to whom employees could report problems, had investigated the claim adequately and had taken appropriate disciplinary action.

Employers should not underestimate the value a grievance policy will have in minimizing employment practices litigation, Mr. Molenaar said. "I don't believe people care as much about the right to go to court. They want to go somewhere to complain. If you don't give them that right, they'll go above you, and you're involved in a lawsuit."

Mr. Molenaar described job evaluations as "the most frustrating thing about employment law," because they are often poorly documented.

Evaluations should be performed annually, he said. Even if a check mark system is used, narratives should be included if the employee receives less than the highest marks, he said. Otherwise, "you'll never remember" the problem with the employee's performance years later during an employment practices lawsuit, he said.

Those records should be kept at least as long as the employee is on staff, and preferably longer, Mr. Molenaar advised.

Finite disclosure rules move ahead

NAIC subgroups approve tougher reporting requirements

BOSTON—State insurance regulators who are concerned about the misuse of finite reinsurance transactions are working to ensure that annual statement reporting guidelines for property/casualty insurers that are under development will go into effect for this calendar year.

During the National Assn. of Insurance Commissioners' summer meeting last week in Boston, two subgroups approved enhanced disclosure rules for insurers that use finite reinsurance. Specifically, the Blanks Task Force, which is responsible for overseeing the content of the annual statement form, adopted the recommendations of the Property and Casualty Reinsurance Study Group to toughen requirements.

The latest proposed rules would require an insurer to report any finite reinsurance agreement that would alter the company's policyholders' surplus by more than 3% or represent more than 3% of ceded premium or losses. The draft proposal also includes reporting requirements regarding contract terms and management's intent in entering into the contract.

Regulators also approved a standard form, to be signed by an insurer's chief financial and executive officers, attesting that risk transfer has occurred in the transaction and that there are no side agreements that would modify the contract's terms.

Comments on the proposal are due by July 1. The Blanks Task Force is expected to vote before July 15 to adopt a final measure that would apply to insurers' 2005 financial statements.

—By Meg Fletcher

Risk managers must embrace ERM

By DAVE LENCKUS

MILWAUKEE—Public entities can benefit just as much as private industry can from enterprise risk management, according to one self-proclaimed convert.

And risk managers ought to embrace enterprise risk management immediately or risk losing control over it to internal auditors, said Ruth A. Unks, risk manager for Maricopa Community Colleges in Tempe, Ariz., and a former president of the Public Risk Management Assn.

Ms. Unks acknowledges that she once resisted the concept, which is also known as holistic, integrated and enterprisewide risk management.

Now, though, "I'm an enthusiast, and I'm the cheerleader for it" in the MCC organization, Ms. Unks told a group of public entity risk managers during a session at PRIMA's annual conference, held in Milwaukee earlier this month.

A poll of the 20 session attendees showed that three-quarters had some interest in the concept but either were not ready to begin implementing it or were still skeptical about its potential benefits. The remaining five had begun implementing a program.

A successful enterprise risk management program helps an organization accomplish several goals, Ms. Unks said.

Among other things, it considers risk in the formation of organizational strategy—recognizing the interrelationships and interdependencies of risk. In doing so, it improves the organization's ability to seize opportunities it may not otherwise have. And it applies risk management at every level and unit of an organization.

Ms. Unks cautioned that, regardless of risk managers' skepticism of or preparedness to adopt the concept, they likely would see their organizations adopt enterprise risk management soon.

While Ms. Unks was initially skeptical about the concept, "pesky little" internal auditors at MCC were not. They were pushing the organization to adopt it, and she did not want someone outside of the risk management department heading that program, she said.

That scenario is going to be common at public entities, Ms. Unks predicted. While upper-level executives such as chief executive officers and chief financial officers often introduce and drive the concept throughout their organizations, internal auditors are the driving force in many organizations, and they can "leave traditional risk managers in the dust," she said.

That's because auditors are being urged by their professional organizations to promote enterprise risk management as a means of complying with the Sarbanes-Oxley financial and accounting disclosure act, Ms. Unks noted. She acknowledged that public entities do not have to comply with Sarbanes-Oxley but advised that they should.

Ms. Unks noted that, at a recent meeting of auditors she attended, about 500 indicated they were encouraging their organizations to develop enterprise risk management programs.

That is a lot of auditors "getting involved in risk management," Ms. Unks said.

"Internal auditors are learning about this stuff at their conference. They come back all drummed up for this, and, unless you partner up with them, you will be left behind," Ms. Unks warned session attendees.

"Don't let internal auditors lead the way on it," she urged them.

With enterprise risk management, "you have a seat at the table" with upper management during strategic planning to help guide them on not only "downside"—or insurable—risks but also on "upside" risks, which present opportunities to the organization as well, Ms. Unks said.

She said that entities can use enterprise risk management as a tool to manage a variety of risks:

- Financial risks. "As a result, we need to become a little more savvy on financial issues," Ms. Unks said.
- Expense control.
- Capital asset management, or keeping property well maintained.
- Disaster or crisis contingency planning.

But even with internal auditors and risk managers pushing the enterprise risk management concept, there are some common organizational barriers to it, Ms. Unks said. "Ours was not a walk in the park."

Among the most common barriers are:

- An organizational culture that resists change.
- Unclear benefits. "Unless senior management really sees the benefits of this, it will be an uphill struggle for you," Ms. Unks warned.
- No cookbook recipe. "It's really what fits best for your organization," she said.

No matter how a program is designed, though, the risk manager cannot expect to run it unilaterally, Ms. Unks cautioned.

"This is not just the risk manager leading the charge; this is a coordinated approach across the entity," she said. "Everyone in your organization should be dealing with risk, not just the risk manager."

2,000 attend PRIMA

The Public Risk Management Assn.'s annual conference, held in Milwaukee June 5-8, attracted approximately 2,000 attendees. The program included dozens of educational sessions including sessions on topics such as enterprise risk management, employment practices liability, terrorism risks, law enforcement risk and school violence.

The 2006 conference is scheduled for June 11-14 in Las Vegas at the Paris Las Vegas Hotel.

Additional information about PRIMA is available at the organization's Web site, *www.primacentral.org*, or by calling PRIMA at 703-528-7701.

CalPERS: Provider quality measures praised as health care cost increases shrink

Continued from page 1

many projections for expected HMO increases for California purchasers and come when health care spending increases are slowing nationwide.

Yet CalPERS' strategy for attacking costs—which included dropping 23 hospitals it deemed too expensive from its San Francisco-based Blue Shield of California HMO network beginning in 2005—drew praise last week for furthering a growing tactic of restricting medical networks based on cost considerations and not just on quality standards, as has been more common.

"Anything that sends the message to providers that if you want to stay viable in the employer sector…then you've got to be both highly efficient and high quality or you are not going to be viable," said Helen Darling, president of the Washington-based National Business Group on Health, "that is a message we want to send."

While CalPERS is to be commended for standing up to provider-generated costs, it lags private employers' efforts to hold health care consumers accountable for their health purchase decisions, Ms. Darling said.

Controlling provider charges and influencing consumer behavior are both necessary to control overall costs, she said.

CalPERS' announcement in 2004 that it was removing high-cost hospitals from its HMO plans strained provider relations and as well as relations with public employees and their unions who had to either forgo care at certain facilities or pay more to move into CalPERS' PPO plans.

But it also encouraged other employers to ask their health plans for options that would remove certain providers from networks based on cost and quality measures, Watson Wyatt's Ms. Bergthold said. "When they narrowed their network, that gave impetus and courage to smaller purchasers to ask for the same thing," she said.

> Providers are being sent the message that "you've got to be both highly efficient and high quality or you are not going to be viable."
>
> **Helen Darling**
> **National Business Group on Health**

There is now a "small ripple" of employers participating in emerging health plan arrangements that differentiate providers, excluding some based on price as well as quality, Ms. Bergthold added.

But Kirby Bosley, who heads Mercer Human Resource Consulting's health care practice in Los Angeles, said there is a "tremendous amount of activity" among her Southern California clients looking to differentiate doctors and hospitals based on cost efficiencies.

The activity is occurring across all plan types, including HMOs, PPOs and high-deductible arrangements, Ms. Bosley said. The movement—including CalPERS' exclusion of high-cost hospitals—is exciting because it tackles a root cause of cost increases, she said.

"So, rather than changing plan design or shifting costs, this says we are going to tackle the costs," Ms. Bosley explained.

Insurers are responding by providing a variety of new plans that screen physicians based on their clinical effectiveness and on how well they manage treatment resources. Hartford, Conn.-based Aetna Inc., for example, last year introduced its Aexcel Network of doctors in 12 specialty categories.

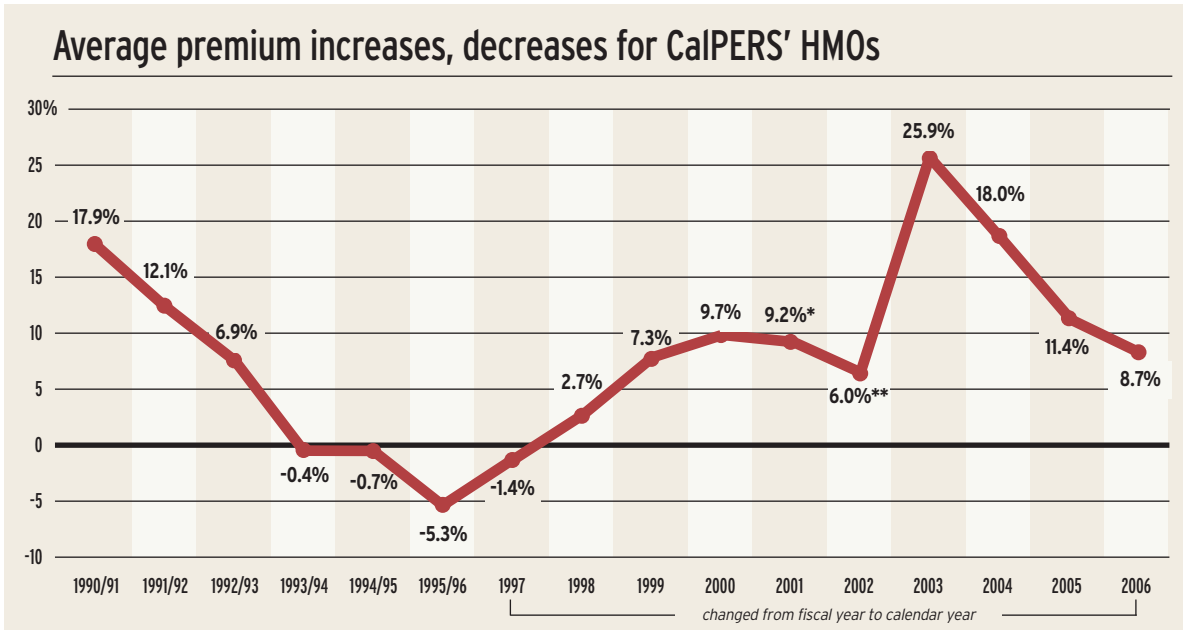
Self-funded employers can purchase the "high-performance" network as an overlay to a traditional network, said Don Storey, a physician and a senior medical director for Aexcel in Seattle. Depending on the plan design they chose, employers can limit their in-network benefits to only those specialists who participate in Aexcel.

Last year, 60,000 members in three cities were enrolled in Aexcel. There are now 300,000 members enrolled in nine cities, Dr. Storey noted.

For CalPERS, paring down its hospital network saved $31 million this year and a projected $45 million in 2006, its spokesman said. "Regional pricing" also saved $40 million in 2005 and impacted the 2006 rates, he added.

Regional pricing refers to CalPERS' reduction of premiums, beginning in 2005, for Southern California members below the premiums charged for Northern California members. That helped CalPERS retain Southern California public employers who might have sought plans that gave them better pricing because of their geographical location.

Retaining those employers, in turn, gave CalPERS greater negotiating leverage, the spokesman explained.



* The 2001 average increase includes an extra surcharge added to Kaiser's 2001 premium to repay that HMO retroactively for certain costs incurred by Kaiser in 1999 and 2000. The 2001 average without the Kaiser surcharge would be 8.6%.
** Increased copays reduced actual rate to 6.0%. Rate would have been 13.2% without copay changes.
Source: CalPERS

S&P: Future of brokerages

Continued from page 3

told the attendees. "I think every broker is negotiating higher commissions, and disclosing that to their clients," he said.

As a result of the probes into industry practices, there is a "minor trend" of larger customers splitting business between different brokers in an effort to diversify portfolios, Mr. Ryan said in the interview. As part of this movement, customers may place a small piece of their business, or a single line of coverage through a third, and sometimes a fourth broker, he said.

Business models for global brokers historically have focused on maximizing revenue, making small and midsize clients attractive because of attached contingent commissions. But in the absence of contingent commissions, global brokers will benefit from measuring profitability on a case-by-case basis, and generally targeting the largest clients, Mr. Ader said.

In the current environment, Mr. Ryan predicted that entering the market would be tougher for brokers in the large account market than those going after middle market and smaller market accounts.

One option that would be unfavorable for brokerages is a fee-based structure instead of commissions, both Messrs. Ryan and Eslick said, because that would dampen competition. Instead, they said, brokers simply should provide clients with clarity about transactions.

With risk management becoming ever-more complex and dynamic, Mr. Ryan said, brokers must assume "the role of the advocate" for their clients.

Standard & Poor's conference draws 650 attendees

Standard & Poor's Corp.'s industry conference "Insurance 2005: Under the Microscope," held June 12-14 in New York, drew a crowd of nearly 650 professionals, including insurance executives from both life and property/casualty segments, as well as regulators, analysts and bankers.

The annual conference, now in its 21st year, saw about a 25% jump in participation over last year's conference, Kathleen A. Corbett, S&P's president, noted in her opening remarks. This year also marked the first time the event was "sold out," she said, reaching full capacity.

More than 40 speakers and 20 S&P analysts participated in the event, which featured panel discussion topics ranging from terrorism risks to finite reinsurance and catastrophe management.

Next year's conference is again slated to be held in New York, but the exact dates and location have not yet been determined. For more information, visit *www.events.standardandpoors.com*.

—By Rupal Parekh

Health care: Court rejects private coverage ban

Continued from page 4

when asked to cover these services, Mr. Durant said.

Another obstacle is that Canadian employers are already dealing with escalating health care costs. In Canada, where most prescription drug costs are not picked up by the government, double-digit increases in drug costs account for about 65% of health care benefit expenses.

"Financially, I believe employers are tapped out," said David Haber, president of Vancouver, British Columbia-based Health Benefits Consulting Inc.

Canadian employers already carry the burden for a significant share of health care costs, observers note. Employers in Ontario and Quebec pay payroll taxes that fund their health insurance system, while many employers in Alberta and British Columbia pay monthly premiums for health care services on behalf of their employees.

Canadian employers are unlikely to pay for private health care services "unless they are going to get a break on the payroll taxes they're paying," Mr. Jackson said.

The development of a private health care system, though, could be beneficial to employers even if they do not receive a tax break if it allows employees to get access to care faster and return to work more quickly, consultants say.

Another key issue for employers is the development of insurance products that they could purchase to cover such services. Insurers are waiting for provincial legislatures to come up with plans to address the ruling before they make costly expenditures on developing such products, said a spokeswoman for the Toronto-based Canadian Life & Health Insurance Assn. Inc. "We simply do not know at this point," she said.

How the government responds to the Supreme Court decision is a key issue that adds to the uncertainty for employers, consultants say. Provincial officials will try to circumvent the ruling without creating a two-tiered medical system by decreasing the waiting times for public health care services, consultants say. "In that case, the private system doesn't evolve," said Tim Clarke, senior benefits consultant for Hewitt Associates based in Toronto.

Part of the solution may be for the provinces to delist certain services, removing them from the roster of government-covered services, as Ontario did last year for chiropractic services and routine optometry exams except for seniors and residents under 20 years old (*BI*, July 12, 2004).

Last year, more than 90% of Ontario employers indicated that they would not pay for these delisted services, which will be the likely reaction of employers if additional services are delisted in response to the Supreme Court ruling. "I think what employers reaction will be is, 'Our health care costs are already high enough, and we're not going to cover these services,'" Mr. Clarke said.

For the most part, employers must wait to see what steps government officials take to deal with the ramifications of the Supreme Court decision. "A lot of this is something employers should be aware of and thinking of, but there's not much that's actionable yet," Mr. Clarke said.

True-ups: Provision brought in 'back-end' commissions on fee-based placements

Continued from page 1

his fraud and antitrust complaint against the broker.

A spokesman for Mr. Spitzer's office also declined to comment.

Mr. Spitzer's lawsuit, filed last October, charged Marsh with rigging bids in favor of incumbent insurers and steering clients to those insurers paying it the highest contingent commissions.

Marsh e-mails cited in the complaint described an internal rating system by which Marsh officials identified insurers offering the most-lucrative PSA terms, and which Marsh then used to channel business in ways most profitable to itself.

"I will give you clear direction on who (we) are steering business to and who we are steering business from," a Marsh managing director said in explaining the rating system to colleagues in a 2002 e-mail attached to the complaint.

Mr. Spitzer's lawsuit also attached a copy of a 2003 PSA between Marsh and a unit of American International Group Inc. that granted Marsh additional commissions ranging from 1% to 3% on new business and for meeting volume targets on renewal business.

The AIG agreement attached to the complaint did not include a true-up provision, and Mr. Spitzer's complaint against Marsh does not specifically mention or describe true-up arrangements.

Marsh settled the Spitzer charges in January, agreeing to pay clients $850 million—slightly more than its 2003 PSA revenue of $845 million—from a fund to be established over four years. Marsh had already discontinued its contingent commission deals and later disbanded its Global Broking unit, which had centralized insurance placement duties in New York starting in the late 1990s.

The settlement covers U.S. policyholder clients that used brokerage unit Marsh Inc. to place coverage incepting from the beginning of 2001 through the end of 2004. Last month, Marsh mailed settlement offers to 135,000 clients. The offers, which require clients to agree not to sue Marsh over the alleged wrongdoing, list individual policies eligible for inclusion along with estimated contingent commissions attributable to each policy. Marsh is offering to pay clients about 52% of the contingent commissions it collected on those policies, a spokesman for the brokerage confirmed.

Explaining the formula that resulted in the offers, the Marsh spokesman noted that the offers "do not represent a return or refund of contingent commission; rather, they are offers of settlement intended to address on a no-fault basis the allegations raised in the New York attorney general's complaint."

Asked if the offers include amounts that Marsh collected under true-up provisions, the spokesman said only that "all contingent commissions and overrides recorded by Marsh for U.S. policyholder clients during the relevant period are included in the calculations." Marsh Global Broking started adding true-up provisions to a limited number of PSAs in the late 1990s, people familiar with the agreements say. The bulk of the true-up revenue related to excess casualty accounts, while a smaller amount came from directors and officers and professional liability business handled by Marsh's FINPRO division, these sources say.

Excess casualty became the focal point of true-up deals because it involved a relatively small number of large-volume clients and a handful of available insurers, one source said.

"It was a control issue," this person said.

Insurers that at various times had true-up provisions in their PSA agreements with Marsh included units of ACE Ltd., AIG, Chubb Corp. and Zurich Financial Services Group, sources familiar with the deals say.

Representatives of the four insurers declined to comment on the record.

Thanks to the true-up agreements, Marsh was able to collect tens of millions of dollars of "back-end" commissions on placements for clients that were paying Marsh in whole or in part with fees, a person knowledgeable about the practice says.

In quarterly statements to insurers, Marsh would report the premium volume on a book of business, including premiums from both fee-based and commission-based accounts, along with its average commission on the book, excluding fees, sources said. Insurers then would have to make up the difference between the average and the commission called for in the PSA.

The exclusion of fees had the effect of widening the spread between the average commission level and the PSA-mandated level.

If the average commission in a quarter turned out to be 8%, for example, and Marsh's production during the quarter entitled it to 12% or 15%, the insurer would pay the additional 4% or 7%, one person said.

If Marsh handled an individual client entirely on a fee basis and its PSA called for it to collect a 15% commission, the broker would effectively be receiving its fee from the client and an undisclosed 15% commission from the underwriter, the source said.

Marsh was "double-dipping on the same account," this person said

True-up revenues varied widely from quarter to quarter, along with PSA-prescribed commissions, but Marsh's revenue from the deals was huge, according to one source familiar with the practice.

As much as 30% to 40% of Marsh's excess casualty PSA revenue came from true-ups, this person said, amounting to tens of millions of dollars.

Marsh has long done more of its business on a fee basis than its major competitors and has cited various reasons for doing so. These include the need to reflect the costs of various services—such as claims handling—in its compensation, rather than just insurance transactional costs. Marsh officials have also noted in the past that commission revenue is vulnerable in soft markets to insurer rate cutting.

Particularly in excess casualty, though, Marsh Global Broking officials pushed local account representatives to do business on a fee basis to boost revenues under true-up agreements, one person familiar with the situation said.

The existence of the true-up provisions also allowed Marsh to cut its fees—and absorb such costs as Bermuda and London marketing expenses—because the costs were made up by insurers on the back end, sources say.

That competitive advantage brought in more business—boosting Marsh's volume-based contingent commissions—while the enormous revenues from true-up provisions reinforced Marsh's alleged efforts to steer business to favored insurers, one person familiar with Global Broking said.

By 2000, Marsh's own legal department had become uncomfortable with the true-up arrangements and pressed for them to be abandoned, one source said. It is unclear, however, whether the agreements were still in place at the time when Mr. Spitzer began his investigation of Marsh last year.

Marsh clients were kept in the dark about true-up provisions, as were most Marsh branch office executives, sources agree.

"It was quite secretive, how they went about collecting income on placements," one former Marsh official said. Marsh's attitude, this person said, was "the fewer people that know what's going on, the better."

HRH: Brokerage, insurer to pay $1.3 million to settle improper payment allegations

Continued from page 1

Court in Boston, Mr. Reilly also alleges that the HRH subsidiary—Boston-based O'Neill, Finnegan & Jordan—improperly steered the Massachusetts' group life contract in question to Unum by giving the insurer detailed information on another insurer's bid.

"This case highlights the inherent conflict of interest when a consultant or broker takes money from insurers for placing business with them and never reveals the financial incentives that they stand to gain," Mr. Reilly said in a statement.

"In this case, (Massachusetts) paid a fee for objective advice, and sought to protect itself by prohibiting these payments, yet these companies ignored the contract and placed their own interest before their obligations to the state," the attorney general said.

Neither company admitted any wrongdoing under the settlement agreement.

HRH was the world's eighth-largest broker in 2004, based on 2003 brokerage revenues of $555.7 million. At the time of the deal in question, OFJ was owned by Hobbs Group, which HRH acquired in 2002.

Secret payments alleged

OFJ was hired by the Commonwealth of Massachusetts' Group Insurance Commission in 2000 as a consultant to help select an insurer to provide basic life, accidental death and dismemberment and supplemental life insurance to state employees and retirees for a term of five years. GIC is one of New England's largest purchasers of group term life insurance, administering more than $3 billion in life insurance for Massachusetts employees and retirees.

To protect against conflicts of interest and to avoid paying unnecessary marketing costs, GIC's contract with OFJ prohibited the receipt of "direct or indirect" commissions from insurers. GIC paid OFJ a consulting fee of $59,885. GIC's contract with Unum, which called for annual premiums of more than $25 million, also banned the payment of "commissions or finder fees" to OFJ, court papers say.

Despite the contractual agreement, Unum and OFJ negotiated a "special producer agreement" whereby Unum agreed to pay OFJ additional compensation in return for placing insurance policies with Unum, the complaint states.

Pursuant to the SPA, Unum paid OFJ more than $450,000 in 2001 for "new business," all of which was attributable to OFJ's placement of GIC's policy, according to the complaint. Under the SPA, Unum expected to pay and OFJ expected to receive compensation up to $500,000 a year as a result of GIC's purchase of its Unum policy.

At the same time Unum and OFJ were negotiating the SPA, OFJ was providing information that assisted Unum in preparing its bid, its "best and final" offers and its presentations to GIC, including detailed pricing information on the principal competing bid, the suit states.

> "They betrayed our trust. ... I can never trust my consultants again in the same way, and I consider that extremely serious."
>
> **Dolores L. Mitchell**
> **Commonwealth of Massachusetts**
> **Group Insurance Commission**

In January 2003, GIC learned about the SPA and promptly demanded that Unum stop paying the brokerage on the GIC policy, the suit claims.

Unum and OFJ assured GIC that the payments would cease and that Unum would "recoup" its previous payments, according to the complaint. Mr. Reilly's suit charged, though, that the companies instead submitted misleading records and statements to GIC showing that the payments had been "recouped" when they had not.

"They betrayed our trust," said Dolores L. Mitchell, executive director of the GIC. "We have always depended on and trusted the word of our consultants. We have language in our contracts with consultants prohibiting them from taking commission money, because we want to be assured that they have no conflict of interest, and they violated that trust. I can never trust my consultants again in the same way that I did before, and I consider that extremely serious," Ms. Mitchell said.

"We were happy to cooperate and settle this matter with no admission of wrongdoing," a spokeswoman for HRH said noting that OFJ was part of Hobbs Group at the time of the alleged deception. "We look forward to continuing to do business with the commonwealth," she said.

"Although we have chosen to settle this matter, we dispute a number of the commonwealth's contentions, including the suggestion that the compensation paid to the broker led to higher costs for the Commonwealth of Massachusetts," Unum parent UnumProvident Corp. said in a statement.

"The compensation paid to the broker was not included in the price of the policy and, therefore, did not impact the commonwealth's costs. However, we have cooperated fully in settling this matter in an effort to put this fully behind us," the statement said.

ADVERTISER INDEX

Issue of June 20

ADVERTISER	PAGE #
Ace	7
Aetna Corporate	13, 15, 17
AIG	40
America's Health Insurance Plan	14
American Re-Insurance	10
Aon Corporation	2
ARAG Group	22
Assurex Global	12
Blue Cross Blue Shield of Minnesota	9R-A/D
Burnham System	32
Business Insurance	29
Carvill	39
ComPsych	19
Concern EAP	26
Dempsey, Myers & Co. LLP	6
EDS	27
Empire Blue Cross Blue Shield of NY	29R
Fidelity Investments	23
Flexible Benefit Service	9R-A/B
Integro	30
Liberty Mutual	5
MetLife	24/25
MHN, Inc.	16
Monitor Liability Managers	32
Standard Insurance	37
Swiss Life	31
United Healthcare	20/21

Pensions: Changes urged as vote nears

Continued from page 3

five years for employers with plans that are at least 80% funded and phased in over three years for employers with plans that are less than 80% funded.

Teresa Ghilarducci, an economics professor at the University of Notre Dame in Notre Dame, Ind., labeled the premium hike as "punitive" for those employers with well-funded plans. Those employers should not have to pay for an industry collapse, Ms. Ghilarducci said, alluding to legacy airlines and the huge losses the PBGC has incurred in taking over air carriers' pension plans.

Instead, she suggested a new revenue source to pay for benefits promised by those failed pension plans: a tax, of perhaps $1 or $2, imposed on each airline ticket. It is an arrangement, she said, that has a precedent, referring to a tax that coal mine operators pay on the coal they mine. The tax helps fund the health care benefits of retired workers whose companies have gone out of business.

Lynn Franzoi, senior vp-benefits for Fox Entertainment Group in Beverly Hills, Calif., urged the elimination of a proposed methodology—known as a yield curve—that employers would have to use to value plan liabilities.

Under that methodology, the interest rate—tied to corporate bonds of varying maturities—used to value liabilities would be based on the age of plan participants. Plan participants would be grouped into three broad age categories. The yields on bonds with the longest maturities would be used, for example, to value the liabilities of the youngest participants, and yields on bonds with the shortest maturities would be used to value the liabilities of older participants. Under current law, one interest rate—the yield on an index of long-term corporate bonds—is used to value liabilities.

> The new approach would be overly complex, making it costly and burdensome for employers, giving them another reason to scrap their defined benefit plans.
>
> **Lynn Franzoi**
> **Fox Entertainment Group**

Ms. Franzoi said the new approach would be overly complex, making it costly and burdensome for employers, giving them another reason to scrap their defined benefit plans. "We need to simplify things," she said, adding that she does not believe a yield curve would produce more certainty in valuing plan liabilities than the use of one uniform interest rate.

But Bart Pushaw, an actuary in the Dallas office of Milliman Inc., disagreed. Pension plans, he said, can have vastly different demographic profiles, ranging from plans predominately made up of younger employees decades away from retirement and collecting benefits, to mature plans with huge and immediate pension obligations.

The three witnesses, though, all agreed on the need for including in the legislation provisions to make it clear that cash balance and other hybrid plans are bona fide plans. Ms. Ghilarducci, for example, described the arrangements as the best hope for the continuation of defined benefit plans.

A separate bill introduced by Rep. Boehner would protect cash balance plans from age discrimination suits. Rep. Boehner said that proposal is a starting point for discussion and that he expects to incorporate a final proposal in the broader bill before the committee completes its action.

Other provisions in the legislation would require employers to amortize unfunded liabilities over seven years, bar employers with plans that are less than 80% funded from increasing benefits, eliminate the ability of employers with underfunded plans from claiming credit for prior contributions that exceeded minimum requirements and allowing employers to fund, on a tax-deductible basis, up to 150% of plan liabilities.

BI Stock Index [6/13 - 6-17]

Up-to-the-minute data for all 87 companies that comprise the *BI* Stock Index can be found at *www.businessinsurance.com*

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

***BI* Stock Index**	**2528.59**	**1.45**
Dow Jones	**10623.07**	**2.03**
S&P 500	**1216.96**	**1.57**

Largest gains

Vesta Insurance Co.	11.52%
Clark Inc.	9.77%
PMA Capital Corp.	9.13%
Zenith National Insurance	7.40%
Sierra Health Services	5.54%

Largest losses

Baldwin & Lyons Inc.	-4.87%
SCPIE Holdings Inc.	-2.53%
Marsh & McLennan Cos. Inc.	-2.41%
Aspen Insurance Holdings	-2.40%
Brown & Brown	-2.25%

Weekly change by market segment

Brokers	1.74%
Insurers/Reinsurers	1.69%
Managed Care Organizations	2.98%

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

Late News

Continued from page 1

woman who died in 2000 from injuries the plaintiffs claimed were caused by a Disneyland ride in Anaheim, Calif.

SEC subpoenas insurer on Gen Re finite deals

The U.S. Securities and Exchange Commission has subpoenaed Philadelphia Consolidated Holdings Corp., seeking information about its finite reinsurance contracts with General Reinsurance Corp. The SEC specifically requested documents from two units of the specialty insurer—Philadelphia Indemnity Insurance Co. and Philadelphia Insurance Co.—regarding finite risk transactions with Gen Re, the company said Thursday. Philadelphia Consolidated said it would cooperate with the request.

RRG formations, premiums grow

Risk retention groups generated nearly $2.2 billion in premiums last year, a 26.4% increase over the previous year, according to the Risk Retention Reporter's analysis of RRG's financial statements with state regulators. Premium volume climbed 37.4% in 2003 and 34.0% in 2002. At the end of last year, 186 RRGs were operating, up from 141 at the end of 2003. Eleven RRGs have been formed so far this year, compared with 25 formations during the first half of 2004, the Risk Retention Reporter found.

MassMutual probed after chief exec terminated

Massachusetts' attorney general and secretary of state said last week that they are looking at MassMutual Financial Group, following the company's recent termination of former chairman and chief executive Robert J. O'Connell. A spokesman for MassMutual declined to comment on the company's "interactions with regulators" but said the company is in the process of briefing regulators on matters surrounding Mr. O'Connell's termination. He also confirmed that it was "Mr. O'Connell's conduct" that spurred the board's decision to fire him. Mr. O'Connell denies any wrongdoing.

Integro expands executive team

Integro Ltd. said that John Chippindale, who most recently served as chief executive officer of global consumer and commercial business at Marsh, has joined the new brokerage as managing director and president of Integro Canada. Before his most recent position with Marsh, Mr. Chippindale was president and CEO of Marsh Canada. Integro, run by industry veteran Robert Clements and former Marsh Inc. executives Roger E. Egan and Peter F. Garvey, has recruited several other former Marsh senior employees since it formed in May.

Former governor to lead AIA

Former Montana Gov. Marc Racicot has been named president of the American Insurance Assn. Mr. Racicot, who was also chairman of the 2004 Bush-Cheney re-election campaign and previously chaired the Republican National Committee, most recently was a partner in the law firm of Bracewell & Giuliani L.L.P. He will succeed Robert E. Vagley as president of the AIA on Aug. 1. Mr. Vagley, who has served as AIA president since 1986, announced last year that he intended to step down.

Insurance execs say Spitzer probes help

The insurance industry will be better off because of increased disclosure brought about by New York Attorney General Eliot Spitzer's investigations, a group of insurance executives and analysts believes. A survey of around 100 executives and analysts at Standard & Poor's Corp.'s annual insurance conference in New York on Tuesday (see story, page 3) showed that three-quarters of the respondents believe the investigations will help the industry. "It is becoming apparent that the costs of fines and settlements will be manageable, so survey respondents are likely looking past the near-term impact toward the benefits of better disclosure by chastened insurance executives," Steven J. Dreyer, S&P managing director, said in a statement.

Former Marsh exec joins Wachovia

Brokerage Wachovia Insurance Services Inc. has named former Marsh Inc. executive William M. Choate as managing director. Mr. Choate, who most recently was managing director and head of global risk and insurance services at Marsh, will also serve as a senior vp for Charlotte, N.C.-based Wachovia Corp., the parent of Wachovia Insurance.

At *BusinessInsurance.com*

New **Online Poll**: In light of the recent insurance industry investigations, are you any less likely to use alternative risk transfer products than you were a year ago?

Items in the Late News column originally appeared in BI's Daily News feature on *www.businessinsurance.com.* Visit the BI Web site to sign up to receive BI's Daily News by e-mail.