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Near North, owner convicted

PHOTO: AP/WIDE WORLD

Near North National Group owner Michael Segal was convicted last week on fraud and racketeering charges.

Jury wants Michael Segal to forfeit $30 million, 60% stake in company

By SALLY ROBERTS

CHICAGO—A federal jury last week convicted Near North National Group Inc. owner Michael Segal on fraud and racketeering charges, capping a six-week trial that included allegations that he looted the brokerage's insurance premium trust account of $35 million for his own and his company's use.

Mr. Segal, 61, was incarcerated last Tuesday and could face more than 20 years in prison. The jury also recommended that he forfeit $30 million in illegal gains and 60% of his interest in the Chicago-based holding company, which includes Near North Insurance Brokerage Inc., formerly one of the nation's largest insurance brokers. The brokerage also was convicted on similar fraud charges.

No sentencing date has been set.

"We're very pleased with the verdict," said a spokesman for the U.S. Attorney for the Northern District of Illinois. "We think it sends an important message to those who are trusted with the fiduciary duty of holding other people's money that there are serious consequences to violating that trust and duty."

He noted that the U.S. Attorney's office be-

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Bill to extend TRIA backstop unveiled in House

By MARK A. HOFMANN

WASHINGTON—Risk managers and insurers hope Congress moves swiftly to pass legislation, introduced last week, that would extend the Terrorism Risk Insurance Act through the end of 2007.

TRIA, which created a federal backstop for private insurers' losses stemming from future catastrophic terrorist attacks, will expire on Dec. 31, 2005, unless Congress reauthorizes it. Insurers, risk managers and businesses have been urging Congress to move as quickly as possible to extend the act. To wait, they say, is to invite market disruptions.

Those urging TRIA's extension have found a sympathetic ear on Capitol Hill. Earlier this month, nearly 200 representatives signed a letter to Treasury Secretary John Snow, asking for administration support for extending the act. Last week, a group of Republican House members took the effort a step further, introducing legislation that would extend TRIA through the end of 2007.

In addition to extending the coverage backstop for two years, the Terrorism Insurance Backstop Extension Act—H.R. 4634—would require participating insurers to make terrorism coverage available for the life of

See TRIA/page 17

High court says ERISA pre-empts state cover suits

By JUDY GREENWALD

WASHINGTON—Employers and health care plans no longer face the threat of state malpractice lawsuits following last week's U.S. Supreme Court decision that held that participants cannot sue managed care companies in state court for coverage decisions.

If the court had upheld the right to sue in state courts, legal and benefits experts say, it would have led to higher health care costs.

However, as a result of the decision, there now is renewed interest in a federal patients' bill of rights that would make it easier for patients to sue for alleged wrongdoing by health plans.

In its unanimous June 21 decision in *Aetna Health Inc. et al. vs. Davila* and *CIGNA Healthcare of Texas Inc. vs. Calad et al.*, the Supreme Court affirmed that the Employee Retirement Income Security Act pre-empts state patient protection laws.

In the *Davila* case, Juan Davila alleged that his health maintenance organization had forced him to use Naprosyn, a lower-priced pain reliever than the Vioxx his physician had prescribed, which caused a severe reaction that nearly killed him and left him unable to take any sort of painkillers for his arthritis.

See ERISA/page 6

Late News

Judge sets claim deadline in Mission liquidation

A California judge has set Aug. 2 as the deadline for reinsurers and other general creditors to quantify thousands of contingent claims against the Mission Insurance Co. estate. Over the objections of two reinsurers, California Superior Court Judge J. Stephen Czuleger granted a motion by Mission's liquidator to set the cutoff date for all still-unquantified reinsurance and general creditor claims. While the court had earlier set a bar date for proofs of claim, those proofs were allowed to include contingent, unquantified claims for such future liabilities as incurred-but-not-reported losses. Mission was placed in conservation in 1985 and ordered liquidated by a California court in 1987.

Aspen to underwrite primary marine risks

Aspen Insurance U.K. Ltd. has recruited two marine underwriters and will begin writing primary marine business. John Henderson, formerly an underwriter at Marlborough Underwriting Agency Ltd.'s syndicate 1861, will join Aspen to underwrite marine liability business. Kevin Golson, also formerly of Marlborough, will underwrite marine hull business. Aspen, which mainly writes reinsurance business in London, is seeking to diversify into direct insurance lines, according to the company's chief executive, Chris O'Kane.

MS covered despite belated diagnosis

An employee cannot be denied long-term disability benefits on the basis of a pre-existing condition if her disease was neither diagnosed nor treated before the coverage period began, even if she did manifest symptoms earlier, says a federal appellate court. The decision by the 3rd U.S. Circuit Court of Appeals in Philadelphia in

See LATE NEWS/page 19

U.K. risk managers lobbying for exemption from licensing

AIRMIC warns that relief not likely before deadline

By SARAH VEYSEY and PETA MILLER

LONDON—While it remains unclear whether U.K. risk managers are subject to new regulations governing insurance intermediaries, the Assn. of Insurance & Risk Managers is advising its members to consider applying for a license as an intermediary rather than risk running afoul of the rules while the issue is debated.

London-based AIRMIC continues to lobby the U.K. Treasury and the Financial Services Authority for an explicit exemption for risk managers from the regulations, which implement the European Union's directive on the regulation of insurance intermediaries. But any such clarification is unlikely before a July 13 deadline to file applications for authorization under the regulations.

While some U.K. risk managers have concluded that they are not subject to the rules, many remain unsure and are seeking legal advice about how to proceed.

The E.U. Insurance Mediation Directive, which is intended to harmonize the regulation of insurance brokers and other intermediaries throughout the European Union, must be enacted by all member states by Jan. 14, 2005 (*BI,* May 10).

In the United Kingdom, the FSA, which regulates the insurance industry, has issued regulations to implement the E.U. directive. The FSA set a July 13 deadline for entities subject to the regulations to file applications for a license to operate under the directive.

While the regulations clearly apply to insurance brokers and other entities that receive remuneration for placing insurance contracts, some risk managers fear that they, too, could fall under the scope of the rules.

In particular, they worry that the act of placing insurance for corporate affiliates or subsidiaries could be viewed as an activity regulated by the directive.

AIRMIC has lobbied the FSA for an exemption from the directive, noting that other E.U. members, such as Belgium, have clarified that their regulations implementing the directive do not apply to risk managers.

Earlier this month, AIRMIC received a letter from the FSA on the matter, but its did not provide any further clarification, according to Stephen Browning, a partner at London-based law firm Barlow, Lyde & Gilbert, which is advising AIRMIC on the matter.

According to AIRMIC Executive Director David Gamble, the FSA's letter states that the regulator is "unable to properly conclude that group risk management companies

See RISK MANAGERS/page 16

Government accounting standard adopted

Public-entity employers required to report projected benefit costs

By GLORIA GONZALEZ

NORWALK, Conn.—New accounting rules call for public-sector employers to disclose the full projected cost of nonpension retiree benefits—such as retiree health care coverage—as well as the funding status of such programs.

The new rules, approved last week by the Governmental Accounting Standards Board, will require state and local governments to record the future costs of nonpension retiree benefits as an expense on their current financial statements, said Karl Johnson, project manager for GASB in Norwalk, Conn.

Private-sector employers already are required to account for such retiree benefit liabilities by the Financial Accounting Standards Board.

The GASB rules will apply to the estimated one-third of state and local governments that offer postemployment benefits other than pensions, Mr. Johnson said. The rules are technically voluntary, but observers say that public entities will have to comply with them if they want to be able to raise capital in the bond market.

The accounting change is designed to "provide a much more comprehensive view and assessment of the financial impact of offering these benefits," Mr. Johnson said.

Public entities with total annual revenues of $100 million or more must implement the rules in their first fiscal year after Dec. 15, 2006. Smaller entities will have additional time to make the change.

Event sponsors keeping eye on fireworks risks

By MEG SHREVE

As July Fourth approaches and a barrage of public firework displays light up the night sky, insurers and event sponsors are paying closer attention to the risks involved.

While state requirements for insuring public fireworks display permit holders vary, a 2003 fire at a Rhode Island nightclub that killed 100 people has brought more attention to pyrotechnic safety.

For example, according to information posted online by the American Pyrotechnics Assn., Texas' fire marshal requires proof of general liability coverage of at least $500,000, while Florida requires a $500 minimum, and Illinois regulations do not stipulate a minimum.

Along with a sponsor's general liability coverage, the pyrotechnic company must provide its own liability insurance.

Boynton Beach, Fla., for example, requires pyrotechnic companies to provide proof of insurance before staging shows, said Chuck Magazine, risk manager for the city. The contracts take into account the company's cost of insurance, he said.

This coverage, depending on the contract, can be far reaching. For example, if a Boynton Beach show is to take place over water, the operator's policy will name not only Boynton Beach but also the adjacent city, to ensure that all potential areas are covered.

The cost of insurance for these events is a reflection of the current state of the economy, said Eric Treend, associate senior vp of the pyrotechnics group at Britton-Gallagher & Associates Inc., an insurance brokerage firm

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Inside Business Insurance

Health care system heading toward shortage

Attendees of a recent Midwest Business Group on Health seminar heard of a brewing health care crisis: a physician shortage. Page 4

PRIMA highlights public risk strategies

Public entity risk managers gathered to compare notes at PRIMA's annual meeting. Page 4

Risk managers' fears may be unfounded

U.K. insurance buyers may be worrying needlessly about a new insurance regulation, Paul Winston writes. Page 4

Time of the essence on TRIA extension

Now is the right time to push for extending TRIA, one of this week's editorials says. Page 8

Privately sponsored rocket launch insured

Underwriters in the London market led the liability coverage that was arranged for the launch last week of the first privately financed space vehicle. Page 13

Online

- The **Datebook** area lists upcoming events as well as information on industry award competitions.
- Searchable **directory of consumer-driven health plan vendors** and all other listings of industry vendors found in *BI*'s Market Sourcebook.
- New **Opinion Poll** for readers: As health care costs continue to increase, how likely is your employer to offer a consumer-driven health plan?

Departments

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Bias suit against Wal-Mart gets class action status

By ROBERTO CENICEROS

SAN FRANCISCO—Last week's federal court ruling granting class-action status to a suit charging Wal-Mart Stores Inc. with gender discrimination could significantly increase the liability of companies facing bias suits, employment lawyers say.

If the decision stands, employers found guilty in discrimination cases could face huge punitive damages awards, they say. The decision by U.S. District Judge Martin J. Jenkins in San Francisco to certify the case as a class action ignores previous decisions on punitive damages and is only the first stage of what is likely to be a protracted case, the attorneys say.

Judge Jenkins' 84-page ruling states that plaintiffs suing Bentonville, Ark.-based Wal-Mart are entitled to injunctive relief and a jury award for punitive damages if they prove their allegations.

"That is what is getting general counsels', risk mangers' and business executives' attention," said Gerald L. Maatman Jr., an employment lawyer at Seyfarth Shaw in Chicago.

In the suit, which was filed in 2001, a group of current and former female employees of Wal-Mart charge that the retailer unfairly denied them promotions, compensation and job assignments because of their gender.

The suit states that while more

See CLASS ACTION/page 19

PHOTO: NEW YORK TIMES

Wal-Mart Stores faces a large class action suit charging that the company denied female employees promotions, compensation and job assignments because of their gender.

Marriage debate spurs rethink: Survey

Same-sex benefits mulled nationwide

One-third of U.S. employers surveyed are prepared to extend health benefits to the same-gender spouses of employees, according to a poll released last week by Aon Consulting, a unit of Chicago-based Aon Corp.

Although federal law and several states' laws uphold marriage as a union only between a man and a woman, the new legal ground laid by Massachusetts permitting same-gender marriages has employers around the country making complex benefit decisions, such as how to interpret the word "spouse."

PHOTO: NEW YORK TIMES

"This is an issue that affects employers nationwide, not just in Massachusetts," said Paul Sullivan, assistant vp of Aon's Research & Technical Services Group, based in Newburyport, Mass.

The U.S. Senate is expected to vote next month on a constitutional amendment that would define "marriage" strictly as a union between a man and a woman.

Aon spent two weeks conducting its poll this month and received anonymous responses from 216 employers that ranged in size from fewer than 500 employees to more than 10,000.

About 45% of the companies that responded said they have already reviewed their benefit plans to determine whether the word "spouse" can apply to same-gender spouses.

Thirty-three percent of the employers surveyed said they would grant an employee's request that the company's health benefits plan recognize a same-gender spouse.

Fewer organizations—15%—said they would be willing to offer retirement benefits to same-gender spouses.

In Massachusetts, the largest factor in the re-evaluation of benefits plans has been the Internal Revenue Code, said Mr. Sullivan, and it may prove the biggest dilemma for businesses across the United States.

"Tax policy, to some degree, drives benefit policy," he said.

Organizations with federally qualified retirement plans risk losing that tax-favored status if same-gender spouses are being recognized in violation of the 1996 federal Defense of Marriage Act, he said.

Nearly half of the companies surveyed have yet to consider whether they need to amend their policies to clarify whether spousal coverage will be provided to same-gender spouses.

The survey results are available at *www.aon.com/hrsurvey*.

—By Rupal Parekh

Errors & omissions

● A June 21 Late News item incorrectly stated that Price Forbes Ltd. is a unit of Alexander Forbes Ltd. Price Forbes is part of a global wholesale brokerage and underwriting management group comprising Price-Forbes' operations in the United Kingdom and Bermuda, ENCON Insurance Managers Inc. in Canada, and Crump Insurance Services Inc. and Victor O. Schinnerer & Co. Inc. in the United States.

Doctors wary of some efforts to improve quality of care

Forcing process changes can alienate docs, they say

By JOANNE WOJCIK

CHICAGO—Medical providers are becoming increasingly angry and feel insulted by many of the health care quality initiatives employers are promoting.

Many of the initiatives—such as computerized prescription order entry—are costly and time-consuming, forcing physicians to re-engineer their practices at a time when they are already strapped for cash due to declining reimbursements.

And the application of medical protocols doesn't always result in better outcomes, they point out, particularly when the patients don't comply with treatment guidelines.

Physicians warn that a disaster could be brewing if something isn't done to improve provider/payer relations: a doctor shortage. Half of today's practicing physicians are over the age of 65, and about one-third of them plan to retire in the next five years, a doctor said at a June 16 seminar of the Midwest Business Group on Health. At the same time, applications to medical schools have been declining for four years in a row, they point out.

Some of the employer quality initiatives are having a negative impact on providers, said Dr. Dennis Richling, president of the Chicago-based Midwest Business Group on Health.

"Sometimes, in my mind, (the initiatives) actually create conflicts and have unintended consequences and sometimes may not turn out with the results that we're looking for," he told a group of MBGH members attending a June 16 seminar in Chicago.

While many "employers are way

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PRIMA 25th annual conference

Public entities see benefits from pooling health care risks

By DAVE LENCKUS

FORT LAUDERDALE, Fla.—Forming a health care consortium can help public entities smooth out their budgets and better control their health care expenditures, but the purchasing coalitions are not for all employers and will not cut costs dramatically, a panel of experts said.

"There are circumstances where they work; there are circumstances where they don't work," said Richard G. Schell, area vp with Gallagher Benefit Services Inc. of Boca Raton, Fla.

"Beware of people telling you you'll save gobs of money," advised Glen R. Volk, area vp-actuarial services for GBS. "The medical trend is the medical trend," Mr. Volk told public entity risk managers at a session during the Public Risk Management Assn.'s 25th annual conference in Fort Lauderdale, Fla., held June 13-16.

Additional coverage on page 11

"Pooling smoothes things out" because pool members can create a premium structure that will allow them to avoid exorbitant increases after a bad year, Mr. Volk said. "So, it's worth doing, if it's done right. But it's not going to save you 15%. That's not realistic," he said.

A more realistic expectation would be 6%, said Bill Mason, risk manager for the city of Sunrise, Fla.

Ballooning medical care and prescription drug costs, provider consolidation and the prospect of an aging population should make pur-

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ERISA: State suit pre-empted

Continued from page 1

In *Calad*, Ruby R. Calad experienced postsurgery complications from a hysterectomy after a CIGNA discharge nurse determined she did not meet the plan's criteria for a continued hospital stay.

Writing for the court, Associate Justice Clarence Thomas wrote that any "state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." The decision overturned a 2002 decision by the 5th U.S. Circuit Court of Appeals.

The plaintiffs had argued that the HMOs' actions "violate legal duties that rise independently of ERISA" under the Texas Health Care Liability Act, but this is not the case, says the high court's opinion. The THCLA does impose a duty on managed care entities to exercise "ordinary care" when making health care treatment decisions and makes them liable for damages caused by their failure to do so, says the opinion.

"However, if a managed care entity correctly concluded that, under the terms of the relevant plan, a particular treatment was not covered, the managed care entity's denial of coverage would not be a proximate cause of any injuries arising from the denial," says the decision. Therefore, Associate Justice Thomas concluded, plaintiffs sued "only to rectify a wrongful denial of benefits promised under ERISA-regulated plans," which falls with ERISA's scope.

In a concurring opinion, which was joined by Associate Justice Stephen Breyer, Associate Justice Ruth Bader Ginsburg said the court's decision is consistent with governing case law. But she called for more action by Congress or the Supreme Court on the issue.

"A series of the court's decisions has yielded a host of situations in which persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief," Associate Justice Bader Ginsburg wrote.

In general, managed care companies prefer that disputes be heard in federal courts because state laws permit plaintiffs to seek noneconomic damages, including punitive damages, while ERISA bars such awards.

A ruling in the plaintiffs' favor would have led to more costly health care, legal and benefit experts say.

"The decision was a great one for employers as well as employees because state law-based claims for damages under these statutes only add to health care costs that ultimately get passed on to the consumers. So in the long run, I think, everyone wins," said Robin S. Conrad, senior vp at the National Chamber Litigation Center Inc., the legal arm of the U.S. Chamber of Commerce in Washington.

"The impact is felt by what won't happen," said James A. Klein, president of the American Benefits Council in Washington. "It just continues to give reassurance, not just to employers but to participants, that there is a logical, rational and uniform method by which claims disputes can and should be addressed, and doesn't inject further costly state tort litigation into the benefits process."

The decision "helps restore the erosion of ERISA the states have wrought to date," said Neil Trautwein, assistant vp for human resource policy at the Washington-based National Assn. of Manufacturers.

PHOTO: ZUMA PRESS

A state-law action that 'duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.'

Associate Justice Clarence Thomas
U.S. Supreme Court

"The most important thing, obviously, is it's a victory for common sense and rationality, which we know is not common in the world we deal in, and it also makes it clear…that we're talking about two different things in all these cases," said Helen Darling, president of the National Business Group on Health in Washington.

"One is about medical care, which is not the same thing as coverage," she said. The other is "an employer's ability to define and decide what they will pay for in terms of coverage," she said.

This is "completely different from medical treatment and the decision supports that idea. For instance, there's a lot of medical care that isn't covered," such as experimental new treatments, Ms. Darling said.

"It is very important for especially large employers, who are operating in virtually every state of the union, to have some confidence that they have the ability to determine what they are willing to pay for as part of a medical plan," said Ms. Darling.

Representatives of health plans also applaud the decision.

Alan Jay Lipsitz, executive director of the BlueCross & BlueShield Assn. in Washington, said, "as long as there was the specter of hope that lawsuits could be filed against HMOs just for not covering a procedure, when there are processes in place to in effect appeal those, the concern was, based on history, there would be a floodgate of lawsuits" and increased cost for health care plans, which would be passed along in the form of high premiums.

Karen Ignagni, president and CEO of Washington-based America's Health Insurance Plans, said, "I think the Supreme Court has sent a strong message" that states cannot create 50 different legal systems for employers.

Not everyone, though, is happy with the decision.

Susan Parkas Frederick, a senior committee director with the National Conference of State Legislatures in Washington, said the decision pre-empts state laws.

"We're obviously in support of the losing side on this," she said. "This case was an attempt to invalidate a Texas state law that was passed by the state legislature to protect its citizens. That impacts several other states with similar laws, as well."

Nine other states have patient protection laws comparable to the Texas law that was at issue before the Supreme Court: Arizona, California, Georgia, Maine, New Jersey, North Carolina, Oklahoma, Washington and West Virginia.

Ms. Frederick said she disagrees with the argument that there should not be numerous state laws on this issue. "That's why we have state government, because every state is different and each state chooses to deal with this issue in a way that's best for that state."

Also unhappy with the decision was Sarah Lock, a senior attorney with the Washington-based AARP. "It severely limits the kind of recovery that consumers can get under the federal law. It doesn't provide any disincentive for insurers to deny care," said Ms. Lock. "We think that the federal remedy isn't adequate to compensate victims who are denied medically necessary care."

Meanwhile, supporters of the decision say they are concerned that the ruling has sparked renewed interest in a federal patient bill of rights.

Rep. John D. Dingell, D-Mich., said last week that he would join with other Democrats to introduce legislation that would permit patients injured by health plans to seek redress under state laws that provide additional health care protections for patients than available under ERISA. An attempt to pass such a patient rights law in 2001 failed.

"Patients injured or killed as a result of their HMO's negligence need a clear road map for action and accountability and without legislation, crafty HMO attorneys will continue to tie up families in court for years to avoid accountability," Rep. Dingell said in a statement.

Aetna Health Inc. vs. Davila, U.S. Supreme Court, No. 02–1845; June 21, 2004.

Paul Winston

Seeing downside has its own risks

One downside to being a risk manager, I imagine, is a tendency to see hazards where others see none. Like a modern day Cassandra, cursed to see the downside, rather than accept situations at face value.

So, for example, where one person may focus on the petals or scent of a rose, a risk manager may focus on the risk of injury presented by sharp thorns.

It's an occupational hazard that must color their perceptions in everyday life. In their jobs, this attribute would serve them well, and ideally they are able to not let such risks overwhelm their perspective in a given situation or circumstance. In other words, be able to appreciate the rose, thorns and all.

Paul Winston

In the United Kingdom, there is a raging debate over whether new regulations designed to govern insurance brokers might also require risk managers to apply for licenses to operate. I can't help but wonder if this is a case where a natural tendency to identify and analyze risks has been taken too far.

As we report on page 3, the U.K. Financial Services Authority has issued regulations for implementing an E.U. directive on insurance intermediaries. The directive, which is being adopted by all E.U. member countries, has caused a stir among risk managers in only one country: the United Kingdom.

Part of the reason is the FSA used technical and legal language. It states that it will "regulate the activities of introducing, proposing or carrying out other work preparatory to the conclusion of contracts of insurance, or of concluding such contracts, or of assisting in the administration and performance of such contracts, in particular in the event of a claim."

The E.U. directive is little better, stating: "This Directive should apply to persons whose activity consists in providing insurance mediation services to third parties for remuneration." Elsewhere, it clearly refers to agents and brokers and states it would not apply "to persons with another professional activity, such as tax experts or accountants, who provide advice on insurance cover on an incidental basis in the course of that other professional activity."

Other countries that have adopted the E.U. directive decided that to apply it to insurance buyers would be contrary to common sense. In nearly all E.U. countries, application of the directive to risk managers is a nonissue.

U.K. risk managers, however, have pressed the FSA to specifically exclude risk managers. So far, the FSA has been unwilling, taking the view that entities should read the regulation and decide for themselves if it applies to them. It has emphasized, however, that the regulations state they should be applied to entities that conduct insurance "by way of business."

Rather than provide comfort to risk managers, though, this has caused many to agonize over whether the language has a trap that could snare them. They analyze the meaning of "by way of business" and "remuneration" and seek costly legal advice as to what they should do.

Perhaps this response is not surprising, given that multimillion-dollar coverage disputes can hinge on how a single word or term is interpreted. But I suspect this is a case where a common-sense reading of the regulation is required, rather than an overly cautious and intensively legal one.

As one U.K. risk manager wryly observed, when one takes FSA wording that should be as clear as water and invites lawyers to poke around, they are bound to stir up mud and cloud the issue.

As someone who is not a risk manager, trained to look for the downside in all things, it's easy for me to say the regulations probably don't apply to most U.K. risk managers. But there may be a few unique circumstances where they would, which may be why the FSA is unwilling to provide a blanket exemption.

The regulations could apply if risk management departments are set up as a freestanding business that charges for its placement services (hence "by way of business"), though this is probably extremely rare. Or if risk managers not only procure insurance for their own organizations and affiliated entities, but also for third parties, such as providing warranties or insurance policies to customers. Or perhaps in cases where a risk manager purchases all insurance directly from insurers without the services of an intermediary that is governed by the regulations.

In those limited circumstances, it probably makes sense to apply for a license. But in the majority of circumstances, it seems pretty safe to this layman to conclude, as those in other E.U. countries have done, that U.K. risk managers would not be subject to the regulations for intermediaries.

Sometimes a rose is just a rose.

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Editorial

Time to press for TRIA legislation

TIME IS CERTAINLY of the essence regarding reauthorization of the Terrorism Risk Insurance Act.

TRIA is set to expire on Dec. 31, 2005, if Congress doesn't extend it. That seems like a long way off, but it's not, particularly given the sometimes glacial pace of legislation. In fact, both insurers and risk managers have been urging Congress to reauthorize TRIA this year.

We agree. The sooner TRIA is extended, the better. Each day TRIA's fate goes unresolved is a day closer to possible market dislocations.

That's why we applaud a group of representatives who introduced a simple, clean TRIA extension bill last week. Although the measure would make some changes as to how of costs arising from any future catastrophic terrorist event would be borne by both individual insurers and the insurance industry as a whole, the centerpiece of the bill is to extend the program through the end of 2007.

That's a desirable goal, but we're fully aware that it won't be an easy one to achieve this year. For one thing, the current Congress really doesn't have much more time to deal with legislation. Between holidays, breaks for political conventions and the August recess, lawmakers will work for only about 30 more days before adjournment. Much of that time will be devoted to appropriations bills, leaving little opportunity to undertake such new business as a TRIA extension.

Fortunately, even though the bill was originally a Republican measure, it has picked up at least one Democratic co-sponsor and will, no doubt, pick up more as it progresses. That's as it should be, for the question of insuring terrorism requires a bipartisan answer, and bipartisan support is critical to achieving House approval.

Unfortunately, getting the extension through the House is likely to be the easy part. After all, the Senate took nearly a year to give TRIA the go-ahead the first time around. The lack of companion TRIA extension legislation in the Senate further confounds matters.

Complicated? Yes. Impossible? No. What's needed to get the extension enacted will be an all-out effort by both insurers and policyholders. In the end, the voices of the policyholders may prove to be the most persuasive.

Time is truly of the essence in reauthorizing TRIA, and there isn't much time left. Risk managers and others who support the extension need to make their opinion known to lawmakers now if they wish to make the most of what little time remains to guarantee a TRIA extension this year.

More than cost-shifting needed

AS EMPLOYERS STRIVE to control rising health care costs, the adoption of consumer-driven health plans is a step in the right direction but still poses challenges.

As we report in this issue's Benefits Management Take-Out Section, a growing number of employers are turning to consumer-driven plan design to help reduce health care costs. And recent government guidance is making the various savings accounts typically tied to consumer-driven health plans more attractive.

But while health reimbursement accounts, health savings accounts and flexible spending accounts offer options for funding health care purchases, cost shifting alone won't eliminate the problem of runaway expenses. Behavior must change, and not just at the consumer level.

To be sure, health plan participants must acknowledge and take responsibility for their lifestyle choices, which can lead to costly treatments.

But health care providers also need to be realistic about patients' ability to pay for services. Where lower-cost alternatives exist, it does little good for physicians, for example, to prescribe expensive medications that patients can't afford and, therefore, won't buy.

In addition, health care payers need to consider thoughtfully the impact of coverage denials that cut costs in the short term but increase expenses in the long term. For example, does denying a hospital stay for a woman in preterm labor make sense if her baby, born prematurely, has to spend weeks in a neonatal intensive care unit?

Employers that are succeeding in reducing costs through consumer-driven plans are facilitating healthier choices by their employees. As we've said before, employers shouldn't expect consumers to make good choices with insufficient information. Consumers need options, but they also must be educated to make informed decisions.

If consumers are to be expected to drive change in the health care system, they need more than a road map. They need to know the reasons for making the trip.

Schillerstrom

BI reporters' key beats

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

Agents/brokers: Sally Roberts.
Asian markets: Michael Bradford.
Aviation/space risks: Peta Miller.
Benefits–health care and ancillary benefits: Joanne Wojcik.
Benefits–retirement savings/pensions: Jerry Geisel.
Canada–risk management and benefits: Gloria Gonzalez.
Captives/alternative risk transfer: Michael Bradford.
Claims management: Meg Fletcher.
E.U. regulatory/legislative: Sarah Veysey.
Employment practices: Judy Greenwald.
Environmental risk management: Sally Roberts.
European benefits management: Sarah Veysey.
European industry operations: London bureau.
European public entity risks: Carolyn Aldred.
European reinsurance: Sarah Veysey.
European risk management: Peta Miller.
Federal regulation/legislation–benefits: Jerry Geisel.
Federal regulation/legislation–risk management: Mark A. Hofmann.
Health care industry operations: Gloria Gonzalez.
Inland marine/transportation: Michael Bradford.
Insurance coverage litigation: Douglas McLeod.
Insurance fraud: Douglas McLeod.
Latin American markets: Roberto Ceniceros.
Marine risks: Peta Miller.
Property/casualty industry operations: Judy Greenwald.
Professional liability: Dave Lenckus.
Property loss control/catastrophe risks: Mark A. Hofmann.
Regulation of insurance: Meg Fletcher.
Reinsurance: Judy Greenwald.
Risk management profession: Dave Lenckus.
Risk securitization/capital markets risk financing: Carolyn Aldred.
Runoffs/receiverships: Douglas McLeod.
Safety/ergonomics: Meg Fletcher.
Surplus lines/wholesalers: Roberto Ceniceros.
Tort reform: Mark A. Hofmann.
Work/life benefits and EAPs: Sally Roberts.
Workers compensation: Roberto Ceniceros.

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Pools: Consortium approach can bring benefits

Continued from page 4

chasing groups attractive to public entities, Messrs. Schell and Volk said.

Consortium members should realize several benefits in addition to smoothing out the budget process and curbing cost increases, according to the panel. Those include flexibility in plan design, improved cash flow, greater access to data and increased control of plan operations.

A disadvantage is that consortium members "are giving up some level of control" by agreeing to make collective decisions with their partners, Mr. Mason noted.

Among the first factors that a public entity's management must consider before joining or creating a consortium is the size of its own group. The panelists agreed that a group should be no larger than 1,000 lives. Larger groups can self-insure their health care risks, the experts said.

The suggested minimum group size ranged from 100 to 600 lives.

Labor union buy-in to plan design also is critical. Mr. Mason said that Sunrise's inability to secure support from its labor unions prevented the city from participating in a consortium.

'Beware of people telling you you'll save gobs of money. The medical trend is the medical trend.'

Glen R. Volk
Gallagher Benefit Services Inc.

When creating a consortium, public entities should "plan big but start small," Mr. Mason advised.

Mr. Schell agreed. He recommended that two or three groups initially form a consortium.

"If you have four, you might as well have 30," Mr. Mason said. "You're going to find there are too many philosophies when you start big."

Then, after rates have been determined based on the collective group's experience, some individual groups will see they face higher costs than before and will drop out. Afterward, the recalculated rates for the remaining groups will spike, and the effort "implodes," Mr. Mason said.

To increase the odds of creating an enduring and successful consortium, members should have similar philosophies, management style and benefit slates, Mr. Schell advised. Groups with dissimilar benefit slates also could form successful coalitions, but they would face higher administrative costs, Mr. Schell noted.

To ensure that the consortium runs smoothly over the long term, members should agree on several points and codify them in a set of bylaws, the panelists suggested.

Since consistency in membership is important to maintaining a smooth operation, members should be willing to make two- or three-year commitments.

Requiring such commitments might scare away some potential members, Mr. Mason noted. But consortium partners should be seeking others with the same "philosophy in managing this type of risk," Mr. Mason said.

But purchasing coalitions also have to address a situation that could drive away members: "Good groups get tired of carrying dogs," Mr. Schell noted.

To prevent discord stemming from disparate results, the bylaws should contain a provision under which members with results that deviate more than 10% from the group's average results pay additional premium. Those with the best experience should earn a premium credit, Mr. Schell said.

The bylaws also should specify how the organization's surplus eventually would be distributed and the length of notice that members must provide to pull out of the pool.

James Buschman, risk manager of the City of Hallandale Beach, Fla., moderated the session.

More than 1,400 attend PRIMA's annual conference

FORT LAUDERDALE, Fla.— The Public Risk Management Assn.'s 25th annual conference, held June 13-16 in Fort Lauderdale, Fla., drew an estimated 1,421 attendees.

For public entity risk managers who missed part or all of the conference, PRIMA is making available the audio and PowerPoint presentations from most of the 80 sessions at the conference.

The materials, packaged on CD-ROM, are available for $14 per session or $229 for all sessions. Orders can be placed online at PRIMA's Web site, *www.primacentral.org*.

PRIMA's 2005 annual conference is scheduled to be held June 6-8 at the Midwest Airlines Center in Milwaukee.

PRIMA 25th annual Conference

Strategic risk management plan needs customization

By DAVE LENCKUS

FORT LAUDERDALE, Fla.—Risk managers who adopt a strategic risk management approach must tailor their programs to meet their organizations' needs, but some measures would help all risk managers who head into this area, a panel of experts says.

"It's important to realize that what worked for us in the District of Columbia probably will need to be tweaked in your organization," noted James J. Jacobs, chief risk officer for the District of Columbia.

That is because "there's no one single premise" of strategic risk management, risk management consultant Lisa S. Kremer explained during a session at the Public Risk Management Assn.'s recent annual conference in Fort Lauderdale, Fla. "Each organization is going to have to adopt a process to its own entity," said Ms. Kremer, director of enterprise risk management with Aon Risk Services Inc. of Northern California in San Francisco.

'It's important to realize that what worked for us in the District of Columbia probably will need to be tweaked in your organization.'

James J. Jacobs
District of Columbia

Ms. Kremer defined strategic risk management as "a method of risk management that takes an enterprisewide approach to monitoring and managing risk in support of an organization's strategic goal."

A guidebook for risk managers who plan to adopt a strategic risk management approach is expected to be published this year by the Committee of Sponsoring Organizations. COSO, formed in 1985 to study fraudulent financial reports, is a voluntary private sector organization dedicated to improving the quality of financial reporting through, among other things, effective internal controls.

In the meantime, risk managers should take several factors into account as they begin to take a more strategic approach, the experts said.

When Mr. Jacobs became the district's first risk manager in 2000, he began building a strategic risk management system.

"The first thing I had to do was find who my supporters were," Mr. Jacobs said.

Ms. Kremer advised risk managers that natural partners within their organizations would include the heads of the legal, auditing and disaster recovery departments.

Those team members should begin evaluating all organizational risks, not just property/casualty risks, she said. First, the risk manager must ensure that the organization's risks have been identified. Then, the risk manager must determine whether the organization has an established risk tolerance for those risks and assess whether the risk currently is within organizational risk tolerance parameters.

In fashioning a plan for managing those risks, the risk manager should gather as much information about them from sources outside of, as well as within, the organization, Ms. Kremer said.

The risk manager also should evaluate whether information about an organization's risks is being reported and shared throughout the organization.

Mr. Jacobs assessed which risks he could impact through his influence rather than through direct control. That strategy, he said, avoided turf wars and let him direct how some risks would be handled without assuming direct responsibility for them.

Risk managers next should prepare a strategic risk assessment report. The report should identify the "risk owner" or the part of the organization bearing that risk; how one risk links with others; the probability of the risk occurring; how the organization currently is handling the exposure; and how severe it could be. The last assessment will help risk managers determine which risks to address first.

In reporting to top management, who often do not have time to study thick reports, risk managers should summarize their findings in a risk map, Ms. Kremer said.

A risk map, on which risk managers can plot the severity and frequency of organizational risks, will allow management to quickly identify and prioritize key risks.

Along with a risk map, risk managers should include a presentation that quantifies organizational risks and notes whether those values are acceptable.

From there, the risk strategy is developed. The risk could be financed, transferred or addressed through solutions such as improvements in loss control or safety.

Corey Gooch, director of insurance and risk management for Advocate Health Care of Oak Brook, Ill., also was on the panel. R. Scott Moss, risk manager of Vancouver, Wash., moderated the discussion.

Between the Lines

Compiled by Joanne Wojcik

Fraud expert catches on with NAIC

The National Assn. of Insurance Commissioners' official spokesman for its new national consumer-awareness campaign knows a thing or two about fraud.

Mr. Abagnale

Before he embarked on an honest career, con artist Frank Abagnale Jr. impersonated a doctor, a lawyer and an airplane pilot, passed more than $6 million in bad checks in 26 countries and became the youngest man to ever make the FBI's most wanted list for forgery.

After serving time in prison, Mr. Abagnale joined the Federal Bureau of Investigation as a white-collar crime consultant. He was portrayed by Leonardo DiCaprio in the 2002 movie "Catch Me If You Can."

Now, he's helping the NAIC spread its anti-fraud message: "Fight Fake Insurance: Stop. Call. Confirm." The public-service announcements featuring Mr. Abagnale will encourage consumers to call their state insurance department if they suspect illegal activity or have questions before purchasing an insurance policy.

"Frank Abagnale's well-known expertise in fighting fraud will shine a spotlight on these scams so we can protect consumers from further harm," said Montana State Auditor/Insurance and Securities Commissioner John Morrison, who also chairs the NAIC Consumer Protections Working Group.

Shopping for insurance stinks

People would rather give up their sense of smell than shop for auto insurance, according to a survey conducted by Progressive Corp.

The Mayfield Village, Ohio-based insurer's survey found that, for $500, 35% of respondents would switch political parties; 37% were willing to give up their sense of smell for six months; 62% said they would forgo going to the movies; and 21% said they'd stop watching television.

Only 20% said they'd shop around for auto insurance, which is a much easier way to put $500 in their pockets, points out Progressive Product Development Manager Tom Hollyer.

Chubb offers stalking protection

Stalking victims who are forced to move, change jobs or alter their appearance to elude unwelcome followers can collect on their homeowners insurance for such costs if they are Chubb Corp. policyholders.

The lifestyle protection coverage is available for no additional charge to high-net-worth individuals insured under Chubb's Masterpiece Family Protection program.

Stalking is more prevalent than many realize: One in eight adults is now the victim of "persistent or unwanted attention," according to a recent study by criminal psychologists in the United Kingdom commissioned by the Warren, N.J.-based insurer. Of those, one in six is likely to be a professional woman in her 40s working as a manager, doctor or lawyer.

The study found that 94% of victims must make some change to their life, such as altering their appearance or their routine, and 40% must make lifestyle changes, such as moving or changing jobs.

Canadian study slams for-profit hospitals

For-profit health care facilities "are the cigarettes of health policy. They result in a higher likelihood of you dying prematurely and you paying too much money for them," asserts a new Canadian study slamming investor-owned, for-profit hospitals.

A shift to a for-profit hospital system would increase the cost of Canada's government-run health care system by as much as $7.2 billion Canadian ($5.28 billion) a year, the researchers reported in the Canadian Medial Assn. Journal this month.

The study's conclusions were derived from research showing that services at for-profit hospitals in the United States were, on average, 19% more expensive that those provided at nonprofit facilities. A similar percentage increase in the Canadian system's costs would drive up the current $38.4 billion Canadian ($28.17 billion) a year spent on hospital care in that country to $45.6 billion Canadian ($33.45 billion), without the purchase of any additional services, the study found.

Tips and feedback from readers are welcomed. Please send information to jwojcik@businessinsurance.com.

Products & Services

Vista expands trucking program

SAN ANTONIO—Vista Insurance Partners, a wholesale insurance broker, has expanded its transportation division to Arkansas, Oklahoma and Mississippi.

The San Antonio-based Vista Insurance transportation division, which originally covered risks only in Texas, now covers regional "for hire" trucking exposures and provides auto liability, excess auto liability, auto physical damage and truck cargo coverage. The division also has special expertise in long-haul and intermediate-haul trucking.

For more information, visit the company's Web site, *www.vistaprograms.net*.

Prime introduces events coverages

CHICAGO—Prime Insurance Syndicate, an excess and surplus lines insurer, is offering coverage to promoters of recreational and competitive events and to owners of restaurants and bars.

The Chicago-based Prime Insurance Syndicate has launched two programs, special events liability and liquor liability.

The special events package covers property, general liability, premises liability and fire damage legal liability. The liquor liability package provides coverage of assault and battery. Coverages can be written on a monoline or package basis. Limits can range from $100,000 combined single limit to $500,000/$1,000,000 with per-person sublimits ranging from $25,000 to $100,000.

For more information regarding the special events liability package, contact Rick Lindsey, company president, at 800-257-5590, ext. 5510. To find out more about the liquor liability package, contact Emanuelle Mercado, marketing and underwriting manager, at 800-456-4576, ext. 7809.

Keller publishes workplace safety manual

NEENAH, Wis.—J.J. Keller & Associates Inc. is offering a new workplace safety manual intended to help safety managers maintain secure operations that comply with Occupational Safety and Health Administration regulations.

The guide, "Workplace Safety Pro: Your A to Z Guide to a Complete Safety Program," provides information to help safety managers create workplace safety programs, including in-depth data on how to be OSHA-compliant. The manual also discusses a variety of safety topics, including strategies for reducing accidents and developing emergency plans, as well as successful safety program case studies, best practices and agency contacts.

A copy of the Neenah, Wis.-based Keller's "Workplace Safety Pro: Your A to Z Guide to a Complete Safety Program" can be obtained by telephoning 800-327-6868. When ordering, reference action code 1978. More information can also be found by visiting the company's Web site at *www.jjkeller.com*.

Schinnerer expands tech E&O program

CHEVY CHASE, Md.—Victor O. Schinnerer & Co. Inc. has expanded coverage of its technology errors and omissions liability program.

The Chevy Chase, Md.-based Schinnerer & Co.'s TechVantage program offers coverage to technology firms and professionals within the industry—such as system designers, Web designers, data processors, custom programmers and Internet service providers. It has expanded coverage to include computer hardware design and manufacturing companies.

The program includes coverage under basic E&O and broad E&O forms. Both forms include coverage for all employees, unauthorized access and the introduction of viruses, joint ventures and newly acquired subsidiaries, as well as global coverage for wrongful acts committed if the claim is made within the United States. The broad form also features coverage for the infringement and violation of copyrights and trademarks, punitive damages and independent contractors.

TechVantage is written on a nonadmitted basis and is not available in Arkansas, North Dakota or New Hampshire. The maximum limit is $2 million. The minimum premium for the basic form is $1,500; the minimum premium for the broad form is $2,500.

For more information on the TechVantage program, call Mark Wolf, assistant vp, at 301-961-9867, or visit *www.planettechvantage.com*.

Express Scripts offers generic drug program

ST. LOUIS—Express Scripts Inc. has introduced a program to help prescription benefit plan sponsors lower costs by promoting the use of generics and low-cost brand-name medications.

The St. Louis-based Express Scripts' program, GenericsWork, is designed to help employers reduce their annual drug cost trends by increasing their generic-dispensing rate. The program also helps plan members lower out-of-pocket costs by encouraging them to ask their physicians for lower-cost generic and brand-name medications.

For more information about this program, visit its Web site at *www.genericswork.com*.

London coverage helps launch spacecraft

LONDON—Liability coverage for SpaceShipOne, which last week became the first privately funded manned craft to reach space, was underwritten in London.

The project's $100 million third-party liability coverage was led by Global Aerospace Underwriting Managers Ltd., sources said.

Amlin P.L.C. said that it led the portion of the project's coverage written at Lloyd's of London.

SpaceShipOne, which made its historic flight on June 21, was developed by Scaled Composites of Mojave, Calif., with funding from Seattle-based Vulcan Inc.

The vehicle was carried to an altitude of around 50,000 feet by another aircraft. SpaceShipOne's rocket engines then briefly took the craft beyond the Earth's atmosphere to a sub-orbital altitude of more than 62 miles before it re-entered the atmosphere and glided to a landing at Mojave Airport.

Robert Lilley, general aviation underwriter at Amlin, declined to discuss rates for such projects.

"We are being shown different projects all the time," he said. "While this is of interest, as underwriters there is not a large exposure because it is happening in the desert," he added.

—By Peta Miller

PHOTO COURTESY OF SCALED COMPOSITES L.L.C.

SpaceShipOne is lifted over California's Mojave Desert by a launch aircraft in advance of its historic flight on June 21.

U.S. mulls new tax on some foreign insurers

By DOUGLAS McLEOD

WASHINGTON—The U.S. Treasury Department is proposing regulations that would tax investment gains on stock held by foreign insurance companies doing business through branch offices in the United States.

Since 1996, the Internal Revenue Service has followed a general rule that foreign corporations' stock investments should not be treated as assets used in the conduct of a U.S. trade or business and that investment gains are therefore not "effectively connected income" for U.S. tax purposes.

The 1996 regulations, though, left open the question of whether the "asset use" test applies to foreign insurers.

In a notice of proposed new rules, the Treasury Department last week noted that insurers hold stock to fund claim obligations and to meet capital and surplus requirements, and that stock investments thus may be considered assets held for use in a foreign insurer's U.S. business.

Under the proposed rule, the IRS would bar foreign insurers from excluding stock gains under the asset-use test unless they control 10% or more of a company's stock. The 10% threshold is meant to distinguish a foreign insurer's investment holdings from its ownership interest in subsidiaries, the Treasury Department said.

The Treasury Department has set a Sept. 23 deadline for comments on the proposed rule, including the appropriateness of the 10% threshold.

The rule would affect a relatively small number of foreign insurers or reinsurers that do business in the United States through branch offices, observers say. It would not affect insurance companies operating through U.S.-domiciled subsidiaries, which are already taxed as U.S. businesses.

"I'm not sure it's going to be all that big a deal" for most foreign insurers, said Roy Sedore, a partner with Baker & McKenzie in New York.

AIRMIC Annual Conference 2004

U.K. risk managers urged to work with E.U. peers

By SARAH VEYSEY

MANCHESTER, England—As the international exposures of companies increase, British risk managers should collaborate more with their counterparts in continental Europe to share information and expertise.

That was the message from risk managers leading a workshop titled "One Europe—Yes, That Includes You, Great Britain!" at the Assn. of Insurance & Risk Managers annual meeting in Manchester, June 14-17.

There are many issues and developments at the European Union level that affect the day-to-day jobs of risk managers in the United Kingdom, said Geoff Taylor, director of risk management for the Europe, Middle East and Africa area at Nike Europe in Hilversum, the Netherlands; and Hans Berkers, director of group risk management and insurance at Amsterdam-based postal and courier service TPG.

"There is a huge amount going on about the environment and health and safety, for example, in the European Union. So we can get involved in that," said Mr. Taylor.

He said that the Brussels-based Federation of European Risk Management Associations is ideally placed to lobby the European Union on behalf of risk managers and to be the "risk manager voice" within Europe.

Mr. Taylor urged British delegates at the AIRMIC meeting to become more closely involved

See SHARING/next page

AIRMIC Annual Conference 2004

Captives may set standards for fronting arrangements

By PETA MILLER

MANCHESTER, England—Risk managers who have become dissatisfied with the cost and quality of their captive fronting arrangements should make minimum standards part of their fronting contracts, an insurer executive says.

At a session of the recent Assn. of Insurance & Risk Managers' annual conference in Manchester, England, Roger Gillett, president of Hamilton, Bermuda-based ACE Risk Management International, gave risk managers an idea of what they should look for in fronting companies.

Mr. Gillett noted that there are around 5,000 captives domiciled worldwide—450 of which were incorporated last year—which makes fronting a big opportunity for insurers.

The supply of fronting insurers has dried up in recent years, however, as many insurance companies have retreated from a business that they may have viewed as a sideline or found to be unprofitable, he said.

"Supply is less—there are fewer companies looking (at fronting) or capable of providing this service," he said.

Contributing to that situation, Mr. Gillett said, is "lots of confusion about whether this is profitable business or not."

However, "companies that (provide fronting services) successfully in the future will identify this as a true business in its own right and should make a profit,"

See FRONTING/page 15

Continued coverage on next page

World Updates

Willis acquiring Irish brokerage

Willis Group Holdings Ltd. will acquire Dublin, Ireland-based broker Coyle Hamilton. In a statement, Willis said it initially will acquire a majority shareholding and buy the remaining interest over several years. Coyle Hamilton had revenues of about 50 million euros ($60.7 million) in 2003, a Willis spokesman said, and it has about 500 employees in offices in Dublin, Limerick, Cork, Belfast and London. The Irish brokerage provides insurance and reinsurance brokering, risk management and employee benefit services.

European insurers' premium volume dips

European insurers' gross premiums fell 0.9% to 855.47 billion euros ($1.078 trillion) in 2003, according to the Comité Européen des Assurances. Life insurance accounted for 59.3% of the 2003 gross premiums, while 30.9% was nonlife insurance, and 9.8% was accident and health insurance, the Brussels, Belgium-based association said. The value of investments held by insurers in the 31 CEA member countries in 2003 rose 6.9% to 5.296 trillion euros ($6.671 trillion).

Bahrain proposes rules for intermediaries

The Bahrain Monetary Agency has outlined rules and guidance it proposes to apply to insurance intermediaries and managers. The consultation paper sets out licensing criteria, capital requirements, professional indemnity insurance requirements and recordkeeping rules for brokers, consultants, their representatives and others, the BMA said in a statement. The BMA's insurance rulebook has been under development since 2003, the Manama, Bahrain-based regulator said.

Briefly noted

Bermuda-based **AXIS Capital Holdings Ltd.** has begun offering limits of up to £15 million ($27.45 million) on a primary or excess basis for directors and officers, fiduciary and employment practices liability and professional indemnity coverage in Europe. AXIS offers similar coverages through U.S. and Bermuda units.... **Royal & SunAlliance Insurance Group P.L.C.** has sold Danish life and pensions unit Codan Liv & Pension to Stockholm, Sweden-based SEB Trygg Liv for around £173 million ($318.3 million) to focus on property/casualty business. London-based RSA had held a 71.7% stake in Copenhagen, Denmark-based Codan.

Sharing: AIRMIC urges cooperation

Continued from previous page
with FERMA to get their and other European risk managers' views across.

"AIRMIC members should see FERMA as their own association, as well," he said.

With many more multinational companies today, risk managers increasingly are dealing with international exposures, according to Mr. Berkers.

For example, he noted, many companies around Europe are putting a great deal of effort into being compliant with corporate governance standards in the countries in which they operate.

One way to more effectively deal with such cross-border risk management issues is to adopt an enterprise risk management model, Mr. Berkers suggested.

Risk managers can use such a model to be seen as a resource within their companies rather than be seen as an internal adversary, he said.

Risk managers need to show their bosses how a risk manager can help save money rather than cost money, and using an enterprise-wide model to assess the total cost of risk—not just the insurance cost—across an organization can be one way of doing this, he said.

'We, as risk managers, are used to dealing with lots of different things. For example, property and casualty (risks) require completely different risk assessments...so we are very used to assessing and managing different things.'

Geoff Taylor
Nike Europe

Mr. Berkers said he supported the notion of a chief risk officer in multinational companies to help manage risks across Europe. He noted that risk managers in the United Kingdom could benefit from looking at risk management models being used in other European companies.

Chief risk officers within European companies frequently report to the supervisory board—which is above the management board—of their companies, giving them an important voice, he noted.

But chief risk officers need help from other departments within a company to be able to properly assess and manage risk, Mr. Berkers said. "If you think about it, the CRO is like a sheep with five legs. So you need a council approach" to go in the desired direction, he said.

Such an approach involves bringing different departments, including legal, health and safety and audit, among others, into a risk council.

"If we don't step up to the plate," and become the "apostles" for applying risk management within companies, "we are just going to become insurance buyers again," Mr. Berkers warned.

As companies become more international in scope, they also need to be transparent to shareholders in the various countries in which they operate, noted Mr. Taylor.

This, he said, is one of the reasons that the European Union has mandated the adoption of International Accounting Standards by all publicly quoted companies in the European Union (*BI*, April 5).

And as companies discover new exposures in new territories as they expand, risk managers are well equipped to help their organizations deal with this, Mr. Taylor said.

"We, as risk managers, are used to dealing with lots of different things," he said. "For example, property and casualty (risks) require completely different risk assessments…so we are very used to assessing and managing different things," he said.

Risk managers are therefore better equipped than some other company departments—such as, for example, the treasury department—to deal with "more esoteric, emerging risks," Mr. Taylor said.

But he acknowledged that some risk managers don't yet have the credibility within their organizations to be able to take on such a role.

AIRMIC pays tribute to former exec

MANCHESTER, England—During the annual conference of the Assn. of Insurance & Risk Managers, AIRMIC paid tribute to Roger Miller, a former executive director of the association who died recently after battling leukemia.

Mr. Miller was executive director of AIRMIC from 1983 until 1993. A former employee of Commercial Union P.L.C. in London, he was the founding chairman of the London-based Institute of Risk Management. Until shortly before his death, Mr. Miller was the editor of AIRMIC's newsletter, AIRMIC Express.

AIRMIC attracts over 650

MANCHESTER, England—The Assn. of Insurance & Risk Managers' annual conference attracted 670 attendees to the Manchester International Convention Centre in Manchester, England, June 14-16.

Attendees had dozens of educational lectures and workshops to choose from.

Also at the meeting, Andrew Cornish, head of insurable risk for Centrica P.L.C., became chairman of AIRMIC, succeeding Nick Chown, director of risk management for the Metropolitan Police Service.

Next year's conference will be held June 13-15 in Brighton, England. For more information, call 44-207-480-7610, send e-mail to *enquiries@airmic.co.uk* or visit *www.airmic.com*.

Fronting: Captives may set standards

Continued from page 13

he said.

In the meantime, risk managers have been left in a difficult position, Mr. Gillett said. Fronting service is seen as poor and costly, with various surveys showing that risk managers are unhappy with such arrangements and are concerned about a lack of price transparency, he said.

'We have lots of work to do to bring levels of service up to where anyone would say it is good. On a general basis, the industry is only providing a satisfactory service.'

Roger Gillett
ACE Risk Management International

He noted that risk managers also are concerned about premium flow.

Whereas banks take 24 hours to move money, companies acting as fronts can sometimes take months, he noted.

"We have lots of work to do to bring levels of service up to where anyone would say it is good. On a general basis, the industry is only providing a satisfactory service," he said.

To address some of these problems, the parents of captive insurers should insist upon minimum levels of service from their fronting companies—and back up those requirements with penalties, Mr. Gillett advised.

"You need to be asking for service level agreements; you need to get the company committed to minimum levels of service," including those for response times, he said.

In addition, Mr. Gillett said risk managers should use only fronting companies that carry at least an A rating.

He also suggested that buyers seek long-term commitment from the insurer providing fronting services.

"These programs take a lot of effort. You need to get commitment from the most senior people you can find. And check the track record of the fronting company," he said.

2% gain in premiums worldwide: Report

By SARAH VEYSEY

The total global premium volume of direct insurers increased 2% in 2003 to $2.941 trillion, according to research by Swiss Reinsurance Co.

Nonlife insurance premiums grew by 6% to $1.268 trillion, while life insurance premiums fell by 0.8% to $1.673 trillion, the report notes. The increase in nonlife premiums was driven, in part, by continued hard market conditions, according to the report.

"The biggest (rate) increases were in third-party liability rates prompted by higher claims payments and the necessary strengthening of reserves relating in part to the soft-market phase at the end of the 1990s," Swiss Re states. Property rate hikes, however, "were lower than in the previous year, reaching a stable level over the course of the year," the report notes.

But despite the rate increases, "persistently low investment returns" will result in "average" profits for the industry overall in 2003, Swiss Re notes.

Copies of "World Insurance in 2003: Insurance Industry on the Road to Recovery" are available at *www.swissre.com*.

2003 PREMIUM VOLUME

Premium volume by region in millions of dollars

Total Business	Premium volume 2003	Premium volume 2002	% increase
Americas	$1,156,512	1,094,583	2.7%
Europe	1,022,158	846,697	1.1
Asia	685,753	628,918	2.6
Worldwide	2,940,670	2,632,473	2.0

Source: Swiss Re

Risk managers: Exemption from regulation is urged

Continued from page 3

are not carrying out regulated activities by way of business."

A spokesman for the London-based Financial Services Authority said that the FSA has made clear that, under the regulations, if a company carries out the purchase of insurance "by way of business," then it would be subject to the directive.

The FSA spokesman also noted that only the U.K. Treasury could establish an exemption from the E.U. directive.

"We are aware of AIRMIC's concerns and are currently considering the positions in our attempt to reach a solution acceptable to all concerned," said a spokesman for the Treasury.

The London-based Confederation of British Industry is lobbying the Treasury to hold another period of public comment on implementation of the directive. This would enable businesses to express their concerns about the effects of regulation on risk management, according to a CBI spokesman.

Many CBI members did not take part in the initial consultation process about the directive, the spokesman noted.

'I think one of the difficulties is that...the consultation stage has been undertaken with those who expected to be regulated and not with those who didn't.'

Christian Wells
Lovells

A spokesman for AIRMIC added that the association had not participated in initial consultation on the directive, because it had received no indication from the Treasury that risk managers might fall within the new rules' scope.

"I think one of the difficulties is that...the consultation stage has been undertaken with those who expected to be regulated and not with those who didn't," said Christian Wells, a partner at law firm Lovells in London.

At AIRMIC's annual conference earlier this month (see stories, page 13), a survey of risk managers revealed that 88% believed FSA regulation would affect their jobs negatively. And of the 106 risk managers questioned, 6% of respondents said there was a strong possibility that the change might cause the risk management function of their companies to be moved overseas, with 8% describing that as a small possibility.

There will likely be instances of "regulatory arbitrage," said Lovells' Mr. Wells. Some multinational companies will very likely move their risk management functions out of the United Kingdom, he noted, and others may change the way they perform corporate risk management activities.

Seeking authorization from the Financial Services Authority by the July 13 deadline 'might be a sensible precautionary interim measure.'

Christopher Sibley
Marsh Ltd.

"Some people may well simply stop performing these sorts of group risk management activities in-house and make their insurance brokers deal direct with every company in the group, which is going to be pretty expensive for the brokers and, therefore, ultimately for the customers," he said.

In the absence of any indication that U.K. risk managers may be exempted from the new rules, Mr. Gamble is advising risk managers that, unless they are sure that the directive will not apply to them, they should consider applying for FSA authorization by the July 13 deadline.

Some companies will likely apply for authorization and then use the six month "window" before the rules comes into force in January 2005, "either to decide to reorganize their business so as not to require authorization, or…modify the way they operate so as to minimize the impact of the regulations," noted Mr. Wells.

Christopher Sibley, compliance officer at Marsh Ltd. in London, told delegates at the AIRMIC conference that seeking authorization "might be a sensible precautionary interim measure."

But some risk managers have concluded that the FSA regulations would not apply to them.

Alan Burton, risk manager for British Telecommunications P.L.C., said at the AIRMIC meeting that his company is consulting with legal advisors and was likely to conclude that it would not be subject to the regulations.

He said that while BT's risk management department does carry out what the FSA might consider a regulated activity, and does receive remuneration for doing so, it does not do so "by way of business," which is one of the key criteria used to determine whether FSA rules apply.

Determining whether or not the directive applies to a risk manager is, in itself, a costly and time-consuming process, according to Christopher Holden, insurance risk manager at London's Tubelines, which maintains part of the London subway system.

Mr. Holden said that he is confident that his activities would not be subject to FSA regulation. But he noted that risk managers must be able to show that they are either FSA-authorized or are clearly exempt by the time the rules come into effect in January, or insurers and brokers will not, by law, be allowed to deal with them.

Mr. Holden said that he now plans to document for his brokers why he and his advisers do not believe he is subject to the FSA regulations.

Health: Doctor shortage seen

Continued from page 4

out ahead in understanding that the way to ultimately reduce cost in the long run is to make quality better," the concept of pay for performance is an insult to many physicians, asserted Dr. Gordon Schiff, director of clinical quality research in the department of medicine at John H. Stroger Jr. Hospital of Cook County in Chicago.

"Physicians really are trying hard to do a good job, and the idea of pay for performance really is not addressing the kind of obstacles people experience," he said.

"Nothing encourages physicians better than their own egos. They want to be better than their peers," said Dr. Mark Goodwin, medical director at the Edward Hospital Catheterization Lab and Cardiovascular Institute in Naperville, Ill., and executive vp of Midwest Heart Specialists, a 56-person cardiology practice.

But when his group improved the health status of a significant number of its patients, its income fell because it had fewer patients to treat.

"We get paid less—a lot less—because all those we helped don't come to us anymore," he said. "So there's a disincentive for doing quality care in medicine today."

"In health care, we just say 'fix this,'" he said. "We don't worry about unintended consequences," such as the reduced income to providers that make the investment of time and resources to make people well.

"We don't get paid a nickel more from Humana, Blue Cross, Blue Shield or anyone else based on our quality data," he said.

Instead of using pay-for-performance incentives, employers should support physicians who want to do their jobs better by providing things like computerized prescribing devices or helping them to create standards of care, Dr. Schiff suggested.

Switching from paper to computers will require many doctors to make a significant investment in staff as they re-engineer their practices, he said.

"Free is not cheap enough for some physicians," he said. "I would want support for trying to do these things better."

As for widespread application of medical protocols, "I think it's going to be hard to fine-tune a formula that will work," he said.

A cardiology practice in Naperville, Ill., lost income after the health of a significant number of its patients improved. 'We get paid less—a lot less—because all those we helped don't come to us anymore. So there's a disincentive for doing quality care in medicine today.'

Dr. Mark Goodwin
Midwest Heart Specialists

Dr. Schiff described as an example the results of a diabetes study involving 246 diabetic patients who were treated in a veterans hospital for 18 months.

Despite intensive nurse case management, many did not improve. In fact, the condition worsened in some patients, Dr. Schiff said.

To illustrate how difficult it is to force some patients to follow treatment protocols, Dr. Schiff told of one of his patients who had uncontrolled diabetes. She rarely took insulin because she didn't like the way it made her feel, he said. To encourage her to take insulin, he went as far as importing animal insulin from the United Kingdom, something she insisted on.

Her most recent blood glucose test, which should register below 7%, showed a deterioration from 11.4% in December 2003 to 12.5% in May 2004. "You could say I'm a bad doctor and I actually am poorly controlling her diabetes," he said. "But this is the real story in the real world with this disease."

Part of the reason for the poor results is the fact that disease management programs generally include patients who haven't been following their doctor's treatment recommendations in the first place, he said.

"We're beating up on doctors, but these are hard patients to control," he said.

All of the pressure that is being placed on physicians today, from rising medical malpractice liability insurance rates to lower reimbursements and the imposition of protocols, is making medicine a less attractive profession, which ultimately will result in a doctor shortage, predicts Dr. Goodwin.

Today, about half of the practicing physicians are over the age of 65, and about 30% of them are planning to retire in the next five years, he said. At the same time, applications to medical schools have declined for four years in a row, he added.

"Why is that? Well, I have four kids; they're 20, 18, 16, 14. They look at life a little bit differently. They're not interested in doing what I do, they think I'm nuts because of the hours I work. And certainly…you wouldn't pick medicine if you're looking for a little bit better hours," Dr. Goodwin said.

"Twenty years ago, a doctor would be thrilled to say their son or daughter was going to med school. Today, if a doctor says his son or daughter is going…most doctors would turn to him and say, 'What's the matter?' because we consider it a failure if your kids pick medical school now," he said.

MGA enters pact with Berkshire

SAN FRANCISCO—Managing general agent American All Risk Insurance Services Inc. has formed a partnership with Berkshire Hathaway Inc. unit National Liability & Fire Insurance Co. to write workers compensation business in California.

The program, which will begin in October, replaces an arrangement AARIS had with Everest National Insurance Co., according to a statement from AARIS' parent, Acacia Pacific Holdings. Everest Re Group Ltd. earlier announced the termination of that contract.

"We are very excited about our new affiliation with Berkshire Hathaway," said Steven Hartsook, marketing vp for San Francisco-based Acacia, in the AARIS statement. "They share our long-term view of the California workers compensation marketplace. This new partnership will enable us to maintain and increase our current premium volume, improve our services and maintain our strong focus on underwriting and claims."

Acacia could not be reached for comment on their projected premium volume under the transaction.

Last year, AARIS produced about 12% of Hamilton, Bermuda-based Everest Re's gross premiums in 2003, according to an Everest Re, which reported gross premiums written of $4.57 billion for the year.

Early last week, Everest Re said AARIS had sent notice of its contract termination following a statement by Everest Re that it was aware AARIS was considering representing another, unnamed insurer instead. Everest Re said it has "developed contingency plans for writing California workers comp business."

—By Roberto Ceniceros and Gavin Souter

TRIA: House bill for extension through 2007 unveiled

Continued from page 1

the backstop under coverage terms, such as limits, that are substantially the same as those used for other risks.

The measure would also increase the deductible that individual insurers participating in the program must pay in 2007 to 20% of their applicable direct earned premium, up from the 15% that would apply to 2005 and 2006.

The bill would also increase the size of the aggregate industry retention under the program to $17.5 billion in 2006 and $20 billion in 2007, up from the $15 billion currently set for 2005.

In addition, the bill would require the Treasury Department to make a final determination about whether group life insurance should be covered by TRIA. Treasury also would have to report on long-term solutions for expanding the availability and affordability of terrorism insurance in the absence of a federal backstop.

Rep. Pete Sessions, R-Texas, is the bill's chief sponsor, and Reps. Richard Baker, R-La., Eric Cantor, R-Va. and Sue Kelly, R-N.Y. signed on as original cosponsors. Rep. Baker is chairman of the House Financial Services Committee's Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises, and Rep. Kelly is chairman of the Financial Services Committee's Subcommittee on Oversight and Investigations. Both lawmakers played critical roles in moving TRIA forward in the House in 2001.

During the news conference at which the bill was unveiled, Rep. Baker said that there would probably be only one extension of the program. In addition, Rep. Cantor said that the bill's supporters hope to get the measure passed before the end of the year. No companion legislation, though, has been introduced in the Senate.

The Risk & Insurance Management Society Inc. welcomed the legislation, issuing a statement saying that the society "is extremely pleased to see that legislation has been introduced in the House of Representatives to extend TRIA for two years. RIMS urged Congress to pass TRIA for a longer period initially and strongly supports H.R. 4634 and urges it to be passed this year."

Insurer groups were similarly supportive.

"The Property Casualty Insurers Assn. of America commends the House for their strong leadership in support of extending the Terrorism Risk Insurance Act," said Carl Parks, senior vp-federal government relations in the PCI's Washington office. "This step opens the door to final action on a TRIA extension this year and raises awareness of the importance of TRIA to our economy. We look forward to working with Congress and the administration to work through the details of the proposal," Mr. Parks said.

'I certainly would not say this is on any kind of a glide path. There may be more reasons why we will be unsuccessful than why we will be successful.'

Joel Wood
Council of Insurance Agents & Brokers

"This shows that Congress is focused on this issue now and that there is a desire to extend TRIA," said Julie A. Rochman, senior vp at the American Insurance Assn. in Washington. "That is, I think, significant progress—to have taken the debate to this point so far in advance of the actual deadline and to have nearly 200 members of the House sending a letter to Secretary Snow calling for an extension. Obviously, the House has been a little bit ahead of the Senate. No doubt the Senate will get involved as well."

"It is the first legislative kickstart that we've had. There's been a lot of intrigue among members, a lot of concern about the potential implications of not acting this year. But heretofore, we did not have any major leaders agree to step up to the plate and make this a major priority," said Joel Wood, senior vp-government affairs for the Council of Insurance Agents & Brokers in Washington.

Mr. Wood cautioned, though, that the measure could face significant obstacles.

"I certainly would not say this is on any kind of glide path. There may be more reasons why we will be unsuccessful than why we will be successful," he said.

Obstacles include the fact that lawmakers must deal with appropriations bills and "the lack of discipline in the Senate—any single debate can go on endlessly," Mr. Wood said. In addition, there are fewer than 30 working legislative days left in the year.

"There is certainly a scenario for us getting to the finish line on this, but it will require an extraordinary amount of effort, not only on the insurance side but among policyholders," he said.

An opponent of TRIA's extension said that the House move was nothing more than "a game."

Bob Hunter, director of insurance for the Consumer Federation of America in Washington, noted that TRIA requires the Treasury Department to report to Congress on the status of the program at several different points over the next year or so. He said that the insurance industry had not objected to that provision when TRIA was approved.

"It's all bogus that they have to rush this thing ahead of the study. I think they're afraid of the study," he said. Mr. Hunter has long contended that the private market can deal with terrorism exposure except for in a handful of cities.

"I don't think this bill's going anywhere," he said.

Fireworks: Event sponsors keeping eye on risks

Continued from page 3

in Cleveland. Rates, he said, are high, but coverage is not as expensive or difficult to obtain as in the 1980s.

Mr. Treend also explained that the fire at the Station nightclub in West Warwick, R.I., in 2003 during a concert by the rock band Great White was a high-profile event that brought more attention to pyrotechnic insurance (*BI*, March 17, 2003). The higher rates for this coverage are making it harder for smaller operators to find affordable insurance, he said. Major public firework displays in large cities usually have coverage limits in the range of $1 million to $5 million.

Furthermore, LeConte Moore, head of the entertainment and media division at Marsh Inc. in New York, suggested that the Rhode Island fire changed the way organizers handle insurance, with a heightened awareness of indemnity agreements and exclusionary language in insurance policies. Mr. Moore said legal counsel has become more involved with these contractual issues and is paying more attention to the details.

Because of the nature of public displays, managing risk is a key issue in planning such events, observers note.

American Pyrotechnic Assn. Executive Director Julie Heckman cited the relationship among sponsors, pyrotechnic operators and public safety officials as an essential triad in ensuring public safety during firework displays. "These parties need to be actively involved in every step of the process," Ms. Heckman said. All three can work together to coordinate crowd control, monitor display areas and keep the public out of an area after a show.

Mr. Magazine, too, stressed the importance of working with pyrotechnic operators to ensure safety at public firework events. He gave an example of a show several years ago that he was forced to postpone when the crowd encroached on the display area. Public safety officials then had to move about 100 spectators back 10 to 15 yards.

Chris Rogers, director of risk control for Chicago-based Aon Corp.'s entertainment practices group, said that sponsors should look for operators with experience and a "good track record." He also recommended a "good documented predoor-opening risk survey" before events. Other precautions, such as informing the crowd of the location of exits and instructing them how to react in case of an emergency, are also important, along with making sure event staff have proper emergency training.

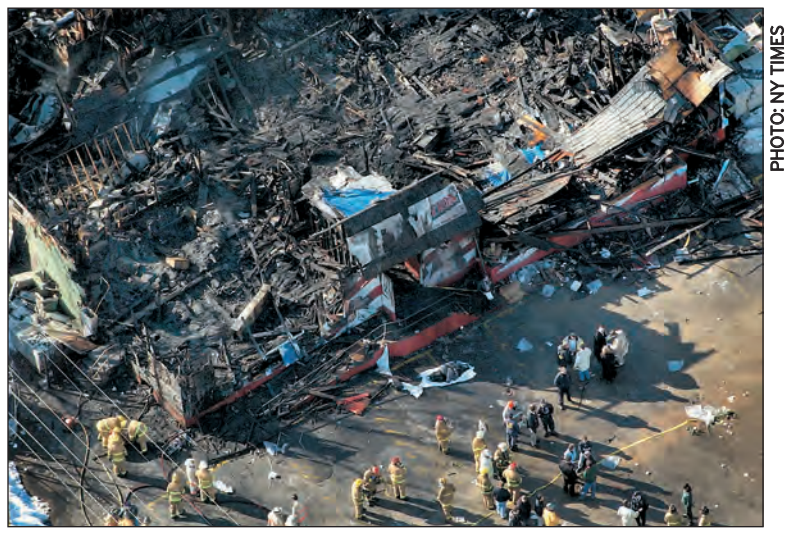


PHOTO: NY TIMES

An indoor pyrotechnics display during a concert by the rock group Great White led to a fire at the Station nightclub in West Warwick, R.I., on Feb. 20, 2003, that killed 100.

Currently, there is no national licensing program for pyrotechnicians. Requirements vary from state to state, but the industry generally follows the National Fire Protection Assn. Standard Code for Outdoor Fireworks Display 1123, which outlines procedures and safety requirements for the handling of fireworks for public displays.

Guy Colonna, NFPA assistant vp and staff liaison to the Committee on Pyrotechnics, said that public-display accidents and other incidents often stem from technicians who are not licensed or who did not follow Code 1123 requirements. As part of the code, there has to be a site plan mapping out where the fireworks will be delivered and kept, where the show will be staged, where fireworks will be loaded, the fallout zone, access routes and even where the spectators can park.

"There can be a disconnect between what constitutes a really pretty show" and the site the sponsor may have available, he said. It is up to the operator to determine what is suitable and safe.

Segal: Near North owner could face 20-year sentence

Continued from page 1
lieves Mr. Segal ultimately will be required to forfeit his entire 100% ownership of Near North National Group.

'Near North is addressing the circumstances on an ongoing basis. While we are shocked and disappointed by this week's events, this in no way changes our commitment to clients and carriers.'

Mark Veselack
Near North National Group

"Near North is addressing the circumstances on an ongoing basis," said Mark Veselack, president of Near North National Group, in a statement. "While we are shocked and disappointed by this week's events, this in no way changes our commitment to clients and carriers."

A spokeswoman for Mr. Segal had no comment on the conviction except to say that an appeal will be made. She also condemned Mr. Segal's quick incarceration.

"I don't know of any cases of white-collar issues like this where they hauled someone off to jail before the sentencing had ever been given," she said. "Martha Stewart is not in jail."

The judge said he considered Mr. Segal to be a flight risk.

On June 21, after about eight hours of deliberations, the federal jury convicted Mr. Segal on 13 counts of mail fraud, one count of wire fraud, seven counts of making false statements, three counts of embezzlement, one count of tax conspiracy and one count of racketeering.

Near North Insurance Brokerage, which was indicted and added as a defendant to Mr. Segal's case in June 2003, was convicted on 11 counts of mail fraud, three counts of embezzlement and seven counts of making false statements. The brokerage faces probation and fines of up to $10.5 million, according to the U.S. Attorney spokesman.

Mr. Segal's longtime bookkeeper, Daniel E. Watkins, who also was indicted and added as a defendant with Near North last year, pleaded guilty in March to embezzling up to $120,000 from the brokerage for his personal use. He faces up to 10 years in prison and fines of up to $250,000.

In his plea agreement, Mr. Watkins admitted to providing cash and to paying expenses for Mr. Segal and his family out of Near North's premium trust account, charging it to postage, maintenance and travel expense accounts, at Mr. Segal's direction.

The trial

During the six-week trial, the prosecution alleged that beginning as early as 1990, Mr. Segal took millions of dollars from the premium fund trust account to expand his business and to finance a lavish lifestyle, which included maids, chauffeurs, beauty treatments for his family and extravagant gifts.

The prosecution also alleged that Mr. Segal, a politically connected Chicago businessman, made political contributions and provided discounted and sometimes free insurance to several Chicago politicians and prominent business leaders, reimbursing the expenses with money from the trust account.

'I don't know of any cases of white-collar issues like this where they hauled someone off to jail before the sentencing had ever been given. Martha Stewart is not in jail.'

Spokeswoman for Michael Segal

Under Illinois law, licensed insurance agents must maintain trust accounts for all premiums collected from policyholders. The balance in the trust, if maintained properly, should equal the amount of premium and nonpremium funds deposited into the trust minus lawful withdrawals, like premium remittances and agent commissions. Under Illinois law, it is illegal to use the fund as a general operating account or claim payment account.

Near North's premium trust account was illegally in the hole by more than $20 million dollars at various times, the prosecution alleged.

Several witnesses testified during the trial that Mr. Segal was warned about the growing deficit in the trust account, but that those warnings largely went ignored.

In the summer of 2001, Near North notified the Illinois Department of Insurance about its deficit problems and worked with the department to resolve the issue, according to the brokerage.

In late 2001, Near North obtained $10 million in loans from New York-based American International Group Inc. and Novato, Calif.-based Fireman's Fund Insurance Co. to replenish the fund, according to the original criminal complaint.

The defense contended that Mr. Segal was a victim of bad accounting at the brokerage and that no insurer or customer was ever harmed.

It also maintained that Mr. Segal was a victim of a scheme by former Near North executives who tried to wrest control of the company from Mr. Segal and then went to the FBI about the premium fund deficit in retaliation.

In a separate lawsuit, Mr. Segal is suing the former employees—Tim Gallagher, Matthew Walsh and Dana Berry—who now work for Chicago-based Aon Corp.

The aftermath

The verdict closes a two-and-a-half-year saga, which began in January 2002, with Mr. Segal's arrest by FBI agents at a hotel near his company's Chicago offices.

Within days, he resigned as chairman and chief executive of Near North, which he helped build into the 18th-largest broker of U.S. business in *Business Insurance's* 2003 rankings, based on the company's U.S. brokerage revenues of $119.9 million in 2002.

Over the next two years, Mr. Segal twice tried to sell the brokerage—first to Chicago-based private equity investment firm Frontenac Co. L.L.C. and then to Chicago-based broker Hub International Ltd.

Neither company gave specific reasons for the collapse of their deal, but it is possible that the departure of a number of Near North producers and clients following Near North's indictment was to blame.

Last August, Near North stuck a deal with Chicago-based Mesirow Insurance Services Inc. to transfer its Chicago office accounts and about 100 employees to Mesirow.

Several other Near North operations—including its Los Angeles-based film and entertainment brokerage office; its Las Vegas-based gaming brokerage office; THB Intermediaries Inc., its reinsurance brokerage unit; and DMI Brokerage L.L.C., its wholesale brokerage unit—bought out their ownership from Mr. Segal.

Other executives and producers left Near North to join competitors. William C. Bartholomay, Near North's former president, last year joined Willis Group Holdings Ltd. as its group vice chairman.

Near North National Group now comprises the remnants of Near North Insurance Brokerage in Chicago; International Film Guarantors Inc., a Los Angeles-based motion picture completion bond unit; Near North National Title Corp., its Chicago-based title insurance and escrow services unit; Chicago-based Exchange Services Group, a provider of section 1031 tax-deferred exchanges; and Midvale, Utah-based Envision Technology Solutions L.L.C., its risk management information systems unit, according to the company's Web site.

Seeking the young and the extraordinary

BI soliciting nominations for 40 under 40 roundup

CHICAGO—*Business Insurance* is seeking nominations for its "40 Under 40: People to Watch" feature, a roundup of men and women who are doing extraordinary work in the commercial insurance industry before celebrating a 40th birthday.

Anyone working in the commercial insurance industry serving the buyers of risk and benefit management services, and whose birth date falls after Oct. 4, 1964, is eligible for consideration. Candidates may nominate themselves or may be nominated by someone else.

There is no formal nomination form. Simply send a 250- to 300-word statement detailing the nominee's qualifications to: 40 under 40, *Business Insurance*, 360 N. Michigan Ave., Chicago, Ill. 60601-3806.

Please include a resume, if possible, and be sure to state the candidate's date of birth.

Names also can be e-mailed to *40under40@businessinsurance.com*, as long as "40 under 40" is in the subject line.

The deadline for nominations is Aug. 2. Winners will be featured in the Oct. 4 issue of *Business Insurance* and on *www.businessinsurance.com*.

ADVERTISER INDEX

Issue of June 28

Late News

Continued from page 1

Shirley McLeod vs. Hartford Life & Accident Co. revolved around a belated diagnosis of multiple sclerosis. Ms. McLeod, a former employee of now-bankrupt Valley Media Inc., had been treated for numbness in her left arm. She was not diagnosed with MS, though, until four months after her effective date of coverage in August 1999. The court ruled Hartford should not have denied her LTD benefits.

Best foresees dip ahead in P/C results

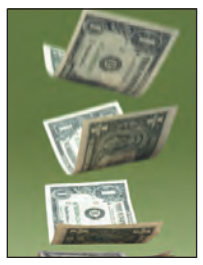
The U.S. property/casualty insurance industry posted strong results for this year's first quarter but is unlikely to sustain them throughout the year, according to A.M. Best Co. The industry posted a 93.3% combined ratio in the first quarter, compared with 99.7% for the same period a year ago, said Best. The biggest challenge facing insurers "will be to maintain market discipline in light of flattening premium rates and increased surplus levels," a Best report said. The report said history indicates that first-quarter results are unlikely to be sustained through the year.

High U.S. drug costs may invite price controls

If the pharmaceutical industry does not address the high cost of prescription drugs in the United States, political pressure for lower prices could lead to government price controls or increased drug reimportation, according to an Ernst & Young report. In 2000, brand-name retail drug prices in the United States were 60% higher on average than the prices in Canada, Germany, France, Italy, Sweden, Switzerland and the United Kingdom, according to a study by Boston University's School of Public Health. Two years later, U.S. prices were 77% higher than the seven-nation average, the study found.

Guidance offers leeway to high-deductible plans

Federal officials are providing transition relief for high-deductible health insurance plans that fail to meet the federal requirements for health savings accounts because of state mandates related to nonpreventive coverage. The Internal Revenue Service and the U.S. Treasury Department released guidance that provides transition relief for health plans in states that mandate certain coverages without regard to deductibles or require low deductibles for nonpreventive care. Without the relief, such plans would not qualify as high-deductible plans for purposes of establishing HSAs.



R.I. comp insurer planning expansion

Rhode Island's workers compensation insurer of last resort, Beacon Mutual Insurance Co., has created a unit to offer workers comp coverage to Rhode Island-domiciled employers with operations outside of the state. Beacon previously provided coverage for policyholder's out-of-state business through a fronting arrangement with Fairfield Insurance Co., a unit of General Re Corp. But that option is no longer available. As a result, Beacon is investing $20 million to create a privately held stock subsidiary, Castle Hill, and it will seek licenses in several other states.

HealthExtras acquires Florida PBM

Prescription benefit manager HealthExtras Inc. has acquired Managed Healthcare Systems Inc., an Oakland Park, Fla.-based PBM, in a cash-and-stock deal valued at up to $44 million. The combined entity will serve more than 2.2 million members and 920 clients, which include managed care plans, self-funded employer groups, local and state government agencies as well as workers compensation and hospice clients.

P&I club taps members for supplementary premium

The American Club has announced it will levy extra premium from members to pay for occupational disease-related claims deterioration and other adverse factors in the 2000, 2001 and 2002 policy years. The protection and indemnity club, which provides third-party liability insurance to members from the shipping industry, said in a statement that it will levy a "supplementary call" on members for three policy years. The calls will be 40% of the advance call for 2000, 35% of the advance call for 2001 and 30% of the advance call for 2002.

Briefly noted

IBM Corp. has settled personal injury suits and workers compensation claims of about 50 former employees who charged that working with toxic chemicals at an IBM disk drive plant in San Jose, Calif., caused them to develop cancer. The settlements—terms of which were not disclosed—came after a California state court jury found in IBM's favor in two similar cases in February. Armonk, N.Y.-based IBM continues to face cancer and birth defect lawsuits by about 110 former workers in New York....**USA Risk Group (West) Inc.** has acquired the assets and ongoing business of Captive Insurance Solutions L.L.C., including its CaptiveGuru Web site. Both companies are based in Scottsdale, Ariz....Mark Ricciardelli has been appointed group president and chief executive officer of Bermuda-based **Alea Group Holdings**. Mr. Ricciardelli was formerly group president and chief operating officer. He replaces Dennis Purkiss, who will remain at the company until the end of the year and then become a consultant to the group on a 12-month contract....The House of Representatives has approved legislation that would extend the **National Flood Insurance Program** through Sept. 30, 2008. President Bush is expected to sign the bill, which was previously approved by the Senate....The New York State Insurance Department has scheduled two public hearings to consider a request by the New York Compensation Insurance Rating Board to **raise workers compensation rates** by 29.3%. The first hearing is scheduled for 11 a.m., June 28, at 25 Beaver St. in New York City; the second is scheduled for 11 a.m., June 30, at 1 Commerce Plaza in Albany.

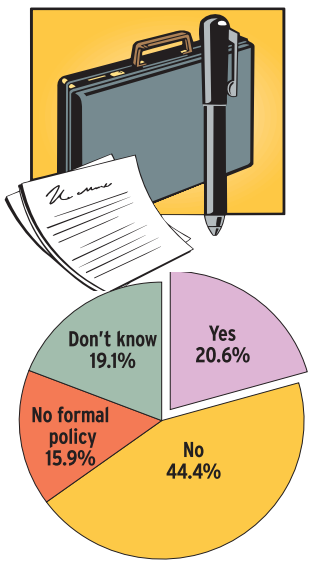
Check out BusinessInsurance.com

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.

Online Poll

[6/21-6/25]

Has your company revised its policy regarding sexual harassment during the past year?



BI Stock Index

[6/21 - 6/25]

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**	
2261.60	-0.40
Dow Jones	
10371.80	-0.43
S&P 500	
1134.32	-0.06

Largest gains

PMA Capital Corp.	15.09%
Clark Inc.	10.91%
Penn-American Group Inc.	9.26%
Argonaut Group	5.52%
Fairfax Financial Holdings	4.85%

Largest losses

Trenwick Group Ltd.	-36.36%
ESG Re Ltd.	-14.81%
Sierra Health Services	-5.30%
Gainsco Inc.	-5.06%
ACE Ltd.	-3.97%

Weekly change by market segment

Brokers	2.66%
Insurers/Reinsurers	0.38%
Managed Care Organizations	-1.37%

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

Class action: Judge certifies Wal-Mart suit

Continued from page 4

than 72% of the hourly sales employees at Wal-Mart are women, female employees hold only one-third of management positions in the company. In addition, only 10% of Wal-Mart's store managers and about 4% of its district managers are women, the suit notes. Among the company's 20 top competitors, women hold more than 56% of management positions, even though the percentage of female hourly workers at these companies is comparable to that at Wal-Mart, the suit states.

According to court papers, the class includes 1.5 million women employed over the past five years at 3,400 stores, "thus dwarfing other employment discrimination cases that have come before."

A spokeswoman for Wal-Mart said in a statement that last week's class certification by Judge Jenkins has "absolutely nothing to do with the merits of the case" and that the company plans to appeal the decision.

The decision ignores other court rulings on punitive damages in employment practices cases, said Mr. Maatman.

'A case as famous—or as closely watched—as Wal-Mart has raised the stakes' for other pending employment-related class action suits seeking punitive damages.

Gerald L. Maatman Jr.
Seyfarth Shaw

Past federal appeals court decisions have severely restricted the ability of plaintiffs in class action suits to collect punitive damages in such cases, he said. One appeals court ruled that to collect punitive damages, each individual plaintiff in a class must prove he or she suffered injury and is entitled to compensatory damages.

In addition, another appeals court ruled that plaintiffs cannot win compensatory and punitive damages if they are seeking injunctive relief, Mr. Maatman said.

And other class action suits seeking punitive damages are pending in various courts, he said.

"This issue is being fought out in various courtrooms throughout the United States," he said. "So, obviously, a case as famous—or as closely watched—as Wal-Mart has raised the stakes."

The claim for punitive damages should disqualify the case to be certified as a class action, said D. Gregory Valenza, an employment defense expert at Jackson Lewis L.L.P. in San Francisco.

"If it were me, I would be looking to fight punitive damages," Mr. Valenza added. "If the class is going to stay certified, I would want punitive damages to be out of the class."

He also noted that the ruling is a preliminary decision and case facts still must be presented for the plaintiffs to eventually win punitive damages.

"It's a very early decision in a big, winding case," Mr. Valenza said.

While defense attorneys contend that Wal-Mart has legal precedent on its side, at least one federal appeals court has ruled that plaintiffs can win punitive damages in an employment-related class action, said Richard T. Seymour, a plaintiffs attorney at Lieff Cabraser Heimann & Bernstein L.L.P. in Washington.

"Businesses are fighting that, and businesses are losing," Mr. Seymour said.

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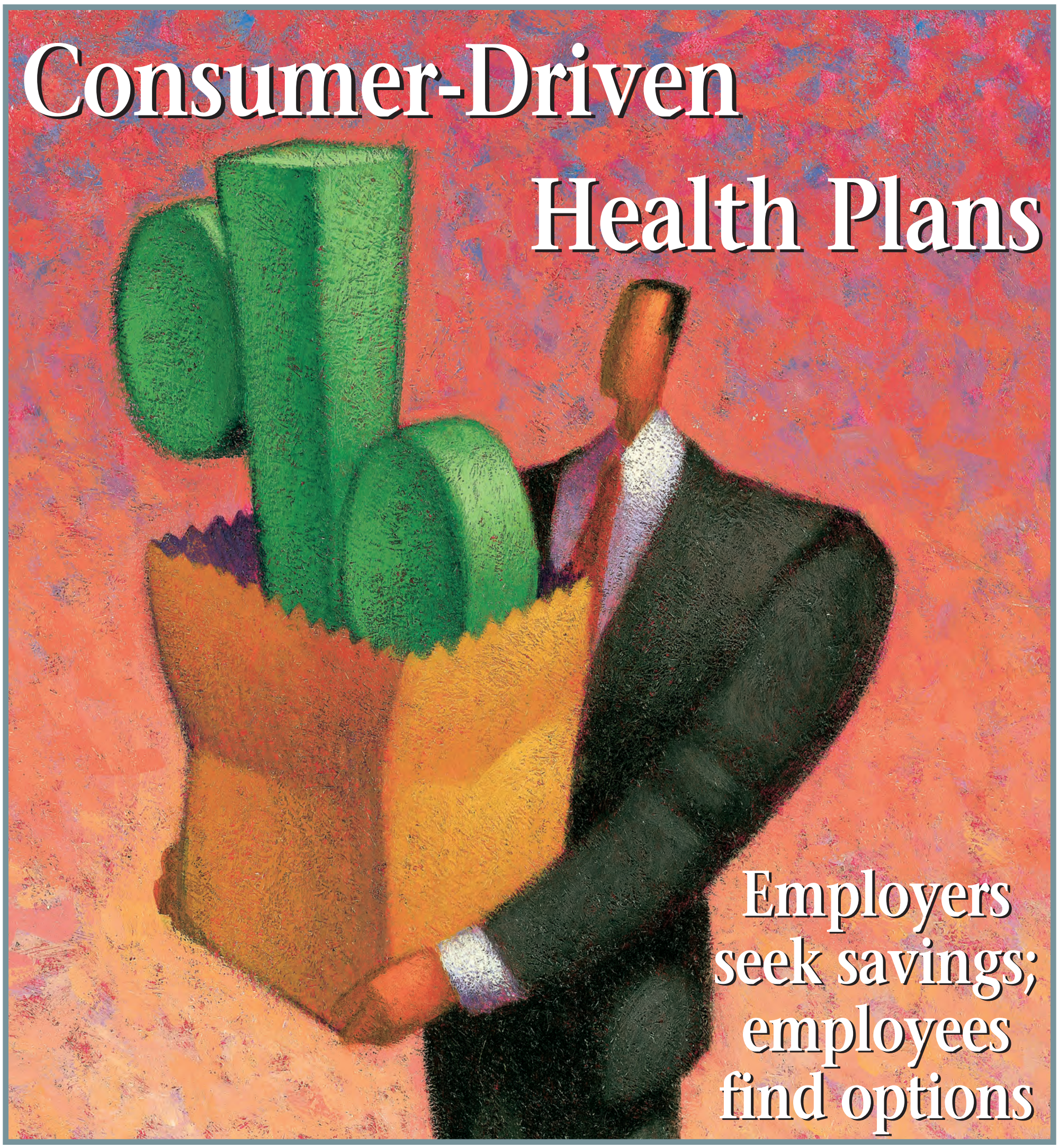
Benefits Management

June 28, 2004

Consumer-Driven Health Plans



Employers seek savings; employees find options

Business Insurance

Special Take-Out Section

Benefits Management

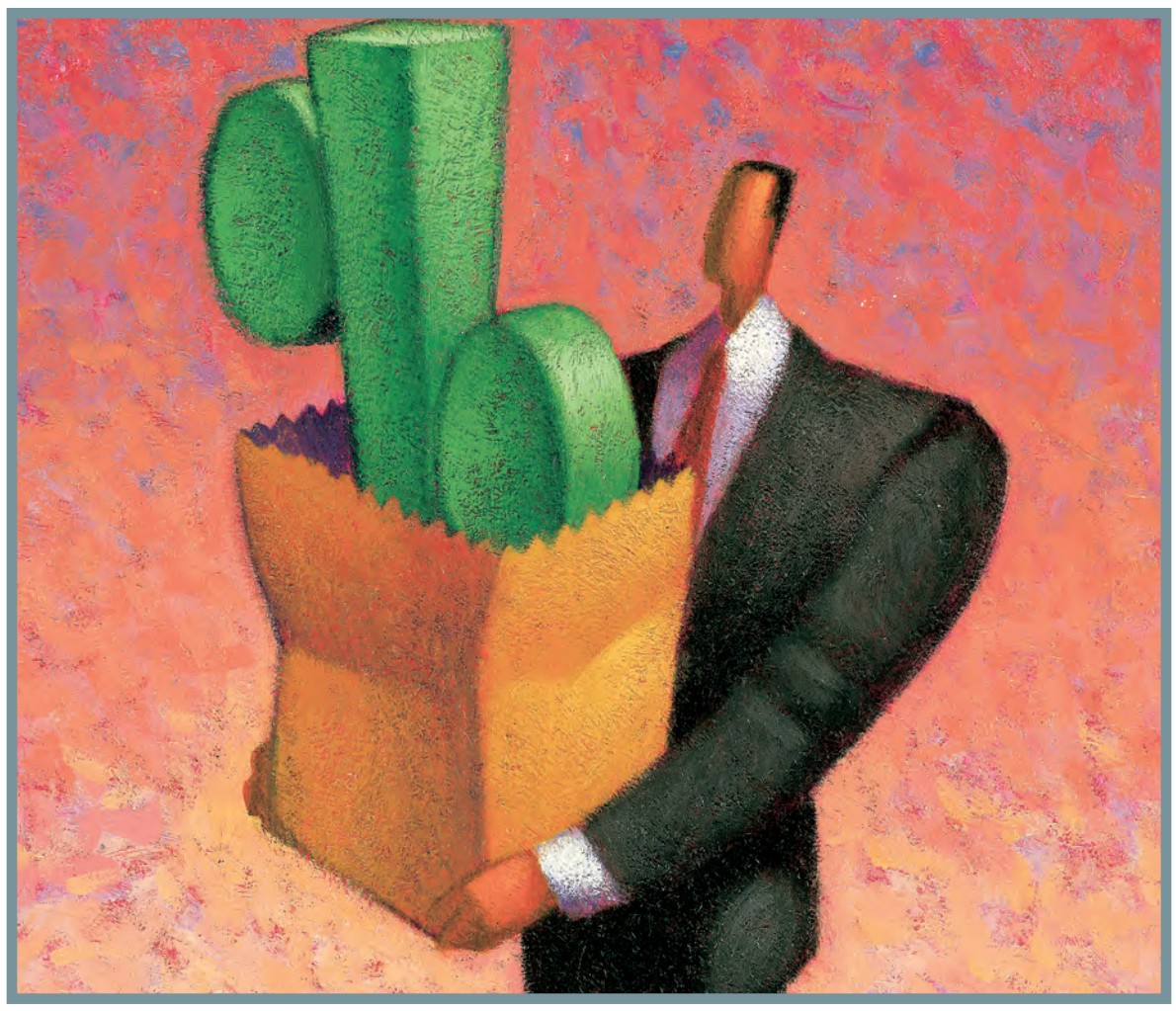
June 28, 2004

Inside

***BI*'s Directory of Consumer-Driven Health Plans is available in the directories area of the *BI* Web site, *www.businessinsurance.com*.**

The searchable directory allow registered subscribers to find information by using various search criteria, including company name and revenue, among other data.

PDF copies of this and other *Business Insurance* online directories can be purchased by e-mailing the Crain Information Center at *biorders@crain.com*.



Many approaches, one goal: Turning users into consumers

By JOANNE WOJCIK

The consumer-driven health care market is already evolving as each vendor joining the fray tries to differentiate itself rather than simply offering "Me too!" products.

At one end of the spectrum are the simple high-deductible plans coupled with a health care spending account, which at the beginning were synonymous with consumer-driven health plans.

At the other end are complex, build-it-yourself programs in which employees select from a variety of plan options—such as copayments, deductibles or provider networks—to tailor coverage to meet their specific health care needs and budgets.

The consumer-driven environment is taking shape in the way Regina Herzlinger, the Harvard Business School professor who literally wrote the book on consumer-driven health care, had envisioned.

"The new consumer-driven health insurance system will enable consumers to choose from a large array of differentiated health insurance options with the support of employers or other groups who will help to provide the pretax money to buy them," she wrote in the introduction to her newly published book, "Consumer-Driven Health Care: Implications for Providers, Payers and Policymakers."

And the "new intermediaries" she discusses, who would "supply enrollees with the information and assistance so they can select intelligently among those options," are also emerging. Financial services firms are joining with health plan vendors to serve as trustees managing the funds employees will invest in their health savings accounts, and technology companies are developing Web-based systems designed to help employees shop for their health care services, much as they do today for other consumer goods and services.

When the consumer-driven health care concept was introduced in 2000, there were only a few players in the market.

Minneapolis-based Definity Health, originally founded as HealtheCare in 1998, is considered the pioneer of consumer-driven health plans. The company in January 2000 began selling a high-deductible preferred provider organization product that included a "personal care account" members could tap to pay out-of-pocket expenses within the deductible. It also provided an allowance for preventive care services. The basic idea behind the plan was to reduce employers' costs by changing plan participants' buying behavior.

Definity was soon joined by Alexandria, Va.-based Lumenos and Oak Brook, Ill.-based Destiny Health, both of which launched similar products in the summer of 2000.

Today, stimulated in large part by federal government moves that have facilitated the use of health care expense accounts, 42% of health insurers either offer a consumer-driven product or have one in development, according to a recent poll by Avon, Conn.-based Eastbridge Consulting Group Inc. Contributing to the growth were a June 2002 Internal Revenue Service ruling permitting employees to roll over health reimbursement account funds and last year's passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which created health savings accounts.

See PLANS/next page

Government HSA guidance expected to answer key questions, boost use

By JERRY GEISEL

New federal guidance, expected within days, could resolve many of the questions that have been building about health savings accounts and spur adoption of HSAs.

Regulators, moving at what many say has been unprecedented speed, already have addressed key issues that have been raised about the new accounts, which are funded by tax-deductible contributions by employers and employees and are used to pay for uncovered health care expenses.

'The IRS and Treasury have moved at lightning speed. It is absolutely unprecedented.'
Bonnie Whyte Employers Council on Flexible Compensation

The first set of guidance, issued in late March, dealt with preventive services. While the law creating HSAs said preventive services could be covered on a first-dollar or low-deductible basis by the otherwise high-deductible health insurance plans that must be linked to HSAs, exactly what would be considered a preventive service was not clear.

In Notice 2004-23, the IRS and Treasury helped clarify the issue by providing a safe harbor for benefits that it considers to be preventive and, therefore, not subject to the cost-sharing requirements of the high-deductible plan linked to the HSA. Under law, the health insurance plan must have a deductible of at least $1,000 for single coverage and $2,000 for family coverage.

Services in that preventive safe harbor include periodic health evaluations, such as annual physicals; child and adult immunizations; and smoking-cessation and weight-loss programs.

See LAWS/page T10

Plans: Many novel approaches

Continued from previous page

But not all products billed as "consumer-driven" involve high-deductible insurance coverage combined with either an employer-funded HRA or an HSA, which can be funded by employers, employees or both (see story, page T3). In fact, many are just as Ms. Herzlinger described: an assorted menu of different health insurance options on which employees can feast.

Range of options

"What is consumer-driven health care? If I look at the range of things that we're playing with right now with our clients, they all involve the consumer more financially in purchasing health care," observed Scott Keyes, a senior consultant at Watson Wyatt Worldwide in Minneapolis. "But there is also a choice component."

"Some might decide that a high-deductible plan is the right way to go. But if I don't want to do that, that's being a consumer, too. Some people are willing to buy their way out of being a consumer," he said. "There isn't going to be a one-size-fits-all" solution, he said.

"There is no question that consumer-driven health care is a movement, not a plan design" said Desmond Hussey, vp-product development at Trumbull, Conn.-based Oxford Health Plans Inc., which in January began marketing MyPlan, a consumer-driven health plan that combines a high-deductible preferred provider organization plan with an employer-funded HRA.

"Definity and Lumenos, they were sort of the creators of this one plan design," he acknowledged. "Oxford sees it as part of a choice. We believe that MyPlan will work for some people but not for others. We'll sell an Oxford MyPlan alongside other Oxford products to the same employer. We have a commitment to providing choice to employers, as long as it meets their primary objective right now, which is cost control," he said.

Similarly, Louisville, Ky.-based Humana Inc. last year began offering SmartSuite, a package of between four and six plan designs that employers can offer. Among the choices are two health maintenance organizations, four PPOs and four high-deductible options called Coverage First, which may or may not also include an HRA.

To help employees decide among the options, Humana has developed an online financial modeling tool that projects probable out-of-pocket costs based on the prior year's claims experience and any changes in health status, such as a planned pregnancy, explained Beth Bierbower, vp for product innovation.

UnitedHealth Group Inc. also offers two consumer-driven products: the high-deductible iPlan, and Overture, which is based on a tiered benefit strategy in which the employer provides a "defined" financial contribution, and employees can either accept the basic plan or make additional contributions to purchase higher benefit levels, according to Meredith Baratz, vp-marketing and product design for UnitedHealth Group in New York.

In addition, with last year's purchase of Golden Rule Insurance Co., which had been marketing medical savings accounts to the individual and small-group market, UnitedHealth Group plans to begin offering an HSA product in 2005, Ms. Baratz said.

Wausau Benefits Inc.'s consumer-driven plan, which was launched in 2002, also lets employees choose from several provider networks, which range in cost. The company began offering an HRA product in 2003 and will introduce an HSA later this year, according to Jay Caldwell, product director of emerging markets for the Wausau, Wis.-based insurer.

Beginning next year, CIGNA Corp.'s consumer-driven plan, which debuted in January 2003, will allow employers to set up separate funds for medical, pharmacy or preventive care services, said Jake Biscoglio, assistant vp-product development in Bloomfield, Conn. It will also include an incentive program to encourage behavioral changes, such as providing increased HRA contributions if an employee completes a health risk assessment, complies with a disease management program or uses online decision-support tools.

Destiny Health's Vitality Program, included in the consumer-driven health plan the company began offering in August 2000, rewards plan members for healthy lifestyle choices not only with additional HRA dollars but also with special health club rates, vacation discounts and even airline miles.

Destiny Health also gives plan members the option of purchasing—or using Vitality points to purchase—benefit riders for hospital indemnity and disease-specific coverage, to protect them from having to dip into their HRAs to pay for catastrophic illnesses, such as a heart attack or cancer.

"Before the term 'consumer-driven' was coined, we thought of ourselves as a health insurer that focuses on creating the right incentives in all of the areas of health care," said Ryan Levin, vp-product development and risk management at Destiny Health, whose South African parent company, Discovery Holdings, started offering consumer-driven health plans in that country in 1993.

"We have this philosophy that a consumer-driven plan should be structured in such a way to change behavior in areas where (consumers) have discretion," he explained.

Because there is a difference between, for example, heart bypass surgery and one-time prescription drug orders, "our product tries to separate health care costs into two buckets," he said. "The fund focuses on the discretionary expenses," while the riders provide first-dollar coverage for events that members cannot control.

Impressed by both the Vitality reward program and the catastrophic safety net, Tufts Health Plan began marketing Destiny's consumer-driven health plan under its Liberty brand in September 2003, said Mark Gauyna, vp-consumer-driven health sales at Tufts in Waltham, Mass.

"We've taken their product and put it on our paper, using our network and medical management," Mr. Gauyna said.

Great-West Healthcare Consumer Advantage, which was introduced in January, also carves out scheduled and routine services, such as physical therapy or knee surgery—"things where you can actually engage the consumer because they have time. These aren't emergency situations," said Cindy Donohoe, vp of marketing and product development at the Denver-based health insurer.

"Some services that they use are going to be covered at a lower rate than other services, so if they have cancer, they have heart disease, they're in the hospital, that would be covered at a high rate.

"But if it's a more scheduled service—where they can impact the cost—then that will be covered at a lower rate," she explained.

Vivius Inc.'s consumer-driven health plan allows employees to establish varying copayments, deductibles and provider networks for each covered family member.

"Our plans are custom-tailored to the individual," explained Dr. Lee Newcomer, chief medical officer and executive vp of the Minneapolis-based company.

An employee can either build his or her own provider networks or ask his or her primary care physician to help design one using the specialists to whom the employee would be referred when under that physician's care, he said. Premiums vary based on the fees those providers charge, he added.

For example, premiums for plans created by members in Arizona can vary by as much as 45% depending on the hospital selected, according to Dr. Newcomer.

The situation is similar in Denver, he said. "If you walk across the street from St. Joe's to St. Luke's, you can save about $80 a month," Mr. Newcomer said.

Norwalk, Conn.-based HealthMarket provides provider cost information on its Web site so plan members can make more price-conscious purchasing decisions when they need care, said Glen Moller, vp and chief marketing officer.

"For example, if you go on the Web site and do a doctor search, you would see a number of different doctors come up with a color-coded chart that shows what their costs are," he said. "Green means 'lower than average,' red means 'higher than average.' The objective is to get people to look up their doctor's cost in advance."

HealthMarket will pay 100% of a maximum allowable charge, or MAC, rate, which is accepted by approximately 70% of the providers in the Private Healthcare Systems Inc. network with which it contracts. But members are free to choose providers both in and out of the network; they just have to pay any amount that exceeds the MAC, Mr. Moller said.

Standing out in the crowd

In an effort to stay one step ahead of the emerging competition, the vanguard of the fledgling consumer-driven health care market is hard at work dreaming up new product innovations.

Definity last year teamed up with Medco Health Solutions Inc. and Evolution Benefits, a vendor of debit-type cards that allow employees to tap their accounts at the point of service, to offer the first pharmacy-only consumer-driven health plan.

Meanwhile, Lumenos recently partnered with Mellon Financial Corp. to provide trustee services on a new HSA that it is selling for the 2005 plan year.

And Aetna HealthFund, launched in September 2001, is working on combining a high-deductible plan with an HMO, according to Robin Downey, head of product development in Middletown, Conn.

"The HMO product would have to meet the large-deductible definition," Ms. Downey explained. But it still would require plan members to select a primary care physician and obtain referrals from that PCP for specialist care, she added.

And, like many other consumer-driven health plan vendors, Aetna is developing a product that would permit employer-funded HRAs to be used in combination with employee-funded flexible spending accounts.

Aon Corp., one of the first employers in the nation to offer Definity's plan in 2001, recently added a second Definity plan with an even higher deductible and a smaller HRA.

The Gold plan has a $1,000 HRA and a $2,000 annual deductible, while the Silver plan has a $500 HRA with a $2,500 deductible, according to John Reschke, vp-employee benefits in Aon's Chicago headquarters.

But these plans are just two of numerous options available to Aon employees, he said.

"We still have a national PPO and HMOs in major locations. So, in an area like Chicago, the Definity plan could be the fourth option. In other areas, it may be the PPO and Definity," Mr. Reschke said. "Each person has the flexibility to choose the plan that's right for them."

Plan flexibility is in the cards

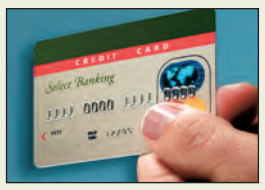
Three companies that began issuing debit-style cards for use with flexible spending accounts are gearing up to compete for consumer-driven health plan business.

Waltham, Mass.-based Med-i-Bank Inc., or mbi, is considered the dominant player in the market, with nearly 1 million cards issued. However, less than 10% of the cards are being used in conjunction with health spending accounts or health reimbursement accounts linked to high-deductible health plans.

Approximately one-third of the 600,000 group health plan members using Avon, Conn.-based Evolution Benefits Inc.'s "Benny Card" are enrolled in high-deductible health plans and are using the card to access HRAs; the first HSA plans go on line July 1.

And New York-based Motivano Inc.'s SmartFlex card is used by more than 150,000 FSA users and about 20,000 employees with HRAs. The first HSA cards are being issued this month.

In addition, consumer-driven health plan vendors can use virtually any bank that operates on either the Visa or MasterCard network to issue debit cards that plan members can use to access funds in their FSAs, HSAs and HRAs.



"Debit cards make spending accounts more palatable to the end user," explained Victoria Nipple, executive vp at mbi, which introduced its first FSA card in 1998.

"In consumer-directed health care, you're trying to get employees to act like consumers," and using a debit card to complete a health care transaction makes employees feel that they—and not a third party—are purchasing those services directly, observed Chris Byrd, executive vp of Evolution Benefits.

To capture more consumer-driven health plan business, card vendors such as Motivano are developing the capability to deduct funds from more than one type of account, such as both an HRA and an FSA.

"Say a company decides to offer an HRA for pharmacy; we can set up a separate bucket of employer funds and pull transactions for that," said Mark Keck, executive vp of Motivano.

Motivano also can deduct payments for permitted transactions done over the Internet, but it will ask for another form of payment if a card is being used for something that's not on the list of approved purchases, according to Mr. Keck.

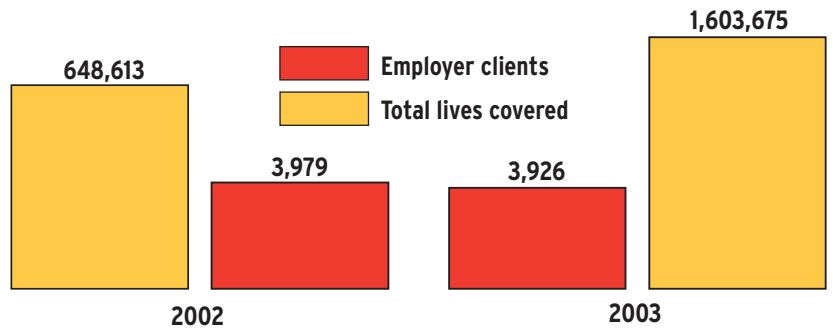
Similarly, Evolution's electronic substantiation methodologies ensure that only eligible expenses are applied to the accounts accessed with the card, which can accommodate numerous accounts, the company said.

And mbi can issue a single card that members can use to access not only FSAs, HRAs and HSAs but also transit and dependent care accounts.

—By Joanne Wojcik

USAGE OF CONSUMER-DRIVEN HEALTH CARE PLANS

Number of covered lives and employer clients of the 10 largest providers*



* Based on providers in each year's ranking
Source: *BI* survey

NUMBER OF EMPLOYER CLIENTS

Largest plan providers by number of employer clients as of Dec. 31, 2003

Company	Employer clients
HealthMarket Inc.	2,500
Destiny Health	890
Blue Cross & Blue Shield of Minnesota	425
HealthAllies Inc.	355
The Choice Care Card	310

Source: *BI* survey

Largest consumer-driven health care plan providers

Ranked by number of total covered lives with employer clients in 2003

Rank	Company/Address	Phone/Fax/Web site	Health plan name(s) *	Total covered lives	Employer clients	Plan options	Principal officer
1	HealthAllies Inc. 400 N. Brand Blvd., Suite 950, Glendale, Calif. 91203	818-546-4662 Fax: 818-502-1138 *www.healthallies.com*	AIG Health Companion, HealthAllies, UnitedHealth Allies, UnitedHealth Basics	335,136	355	Dental, FSA, HMO, HRA, HSA, indemnity, PPO, prescription drugs, vision	Andrew Slavitt, CEO
2	Definity Health 1600 Utica Ave. S., Suite 900, St. Louis Park, Minn. 55416	952-277-5500 Fax: 952-277-5501 *www.definityhealth.com*	–	320,000	90	HRA, HSA, PPO, prescription drugs	Tony Miller, CEO
3	Humana Inc. 500 W. Main St., Louisville, Ky. 40202	502-580-1000 Fax: 502-580-3127 *www.humana.com*	CoverageFirst, SmartSelect, SmartSuite	205,500	117	HMO, HRA, PPO, prescription drugs	Michael B. McCallister, president/CEO
4	UnitedHealth Group 450 Columbus Blvd., Hartford, Conn. 06103	646-728-6411 *www.unitedhealthgroup.com*	iPlan, Overture	180,000	300	Dental, FSA, HRA, HSA, indemnity, PPO, prescription drugs, vision	Dr. William McGuire, chairman/CEO
5	Aetna Inc. 151 Farmington Ave., Hartford, Conn. 06156	860-273-0123 *www.aetna.com*	Aetna HealthFund	174,082	161	Dental, FSA, HMO, HRA, HSA, PPO, prescription drugs, vision	Dr. John W. Rowe, chairman/CEO
6	Lumenos 1725 Duke St., Suite 400, Alexandria, Va. 22314	703-236-6300 Fax: 703-236-6510 *www.lumenos.com*	–	140,000	56	HRA, HSA, PPO, prescription drugs	Chip Tooke, CEO
7	First Health 3200 Highland Ave., Downers Grove, Ill. 60515	630-737-7900 Fax: 630-737-7856 *www.firsthealth.com*	–	96,000	5	Dental, FSA, HRA, HSA, indemnity, PPO, prescription drugs, vision	Edward L. Wristen, president/CEO
8	Wausau Benefits 115 W. Wausau Ave., P.O. Box 8046, Wausau, Wis. 54402-8046	715-841-2000 Fax: 715-841-7569 *www.wausaubenefits.com*	Wausau Benefits Consumer-Driven Health Care	80,957	32	FSA, HRA, HSA, indemnity, PPO, prescription drugs, vision	Fred Moore, president/CEO
9	HealthMarket Inc. 20 Glover Ave., Norwalk, Conn. 06850	800-248-7390 Fax: 203-229-1200 *www.healthmarket.com*	HealthMarket's Consumer Driven Health Plans	40,000	2,500	HRA, indemnity, prescription drugs	Steve Wiggins, CEO
10	The Choice Care Card 45 State St., Montpelier, Vt. 05602	888-278-2555 Fax: 802-223-7887 *www.choicecarecard.com*	–	32,000	310	Dental, FSA, HMO, HRA, HSA, indemnity, PPO, prescription drugs, vision	James A. Hunter, president

* If different from company name
Source: *BI* survey

Visit *www.businessinsurance.com* for more information and to access the full searchable Directory of Consumer-Driven Health Plans.

Checklist helps employers evaluate CDHP elements

By JOANNE WOJCIK

Employers shouldn't just dabble in consumer-driven health care if they really want to make it work, a health care actuary warns.

"The key thing that I try to tell individuals is they really shouldn't consider (consumer-driven health care) as an experiment or just another option," said Brent Greenwood, a principal in Atlanta for Reden & Anders Ltd., an actuarial consulting firm. Reden & Anders is a subsidiary of Ingenix, a Salt Lake City-based health care technology company that itself is owned by UnitedHealth Group, a major provider of consumer-driven health plans. Reden & Anders recently developed a checklist to educate employers about consumer-driven health plans and health reimbursement accounts and health savings accounts.

"Something like this will become a long-term fixture if they introduce it," he said.

Employers may benefit from providing to their entire employee population the health care purchasing information given to those enrolled in their consumer-driven health plan, Mr. Greenwood said.

'The key thing that I try to tell individuals is they really shouldn't consider (consumer-driven health care) as an experiment or just another option.'

Brent Greenwood
Reden & Anders Ltd.

"If you're going toward this consumer-centric philosophy, it's going to extend to other products. It's just as good offering quality and cost information to those plan members," he said.

Mr. Greenwood also advises employers to closely examine employee demographics, income levels and past health care utilization patterns before offering a consumer-driven plan involving a high deductible, because such plans may chiefly attract people with higher incomes and those who already are infrequent users of health care services.

Indeed, one challenge that employers face in implementing a consumer-driven health plan is "dealing with the potential adverse selection," in which those who use health care services the most remain in more expensive traditional plans, he warned.

One way to prevent this is to ensure that the contribution levels don't tip the scale one way or the other, he suggested.

"Contribution rates are more likely to attract employees than the benefit design," Mr. Greenwood said. "It's still too new of a product for them to differentiate it in any other way."

In addition to the above points, Reden & Anders' checklist advises employers to ask themselves other questions, including:

- How will a consumer-driven health plan fit into the organization's current health care strategy? Is the intention to reduce cost, to provide more employee choice, to increase employee awareness of value and cost, or to improve employee satisfaction with the benefit plan?

"A smaller employer's strategy is usually just to reduce cost," Mr. Greenwood said, whereas "the decision process becomes a little more complex if you're a larger employer, and also if there are multiple states."

- How savvy are the employees, not only about their own health and the health care system, but also about using information technology?
- Can employees be influenced to join a consumer-driven health plan? How willing are they to manage their own health care?
- Should the plan be introduced on a pilot basis, as an option, or as a full replacement?
- Should the plan have a health reimbursement account, which is funded with employer-only contributions, or a health savings account that can be funded by employers, employees or both?

"A lot of employers don't understand the difference between the two," he said. "There's a lot of nuances that they have to consider when trying to make their choice."

For example, employers may want to continue offering a prescription drug program on a carve-out basis, which is not allowed in plans combined with HSAs, he explained.

"There's also the forfeiture or portability issue," Mr. Greenwood added.

While employees essentially own HSAs, which must be managed by financial trustees, employers can choose whether to make HRAs the property of employees, so they can take them when they leave employment.

"This is more or less an employee retention strategy: If you do not have portability with an HRA, they may want to stay," he said.

Laws: HSA guidance expected to increase use

Continued from page T3

Additionally, a wide array of screening services, such as those used to detect cancer, heart and vascular diseases also would be considered preventive.

That preventive care guidance was eagerly sought by employers, who say it is cost-effective to have few or no cost-sharing requirements for preventive services to encourage employees to use them. That can result in early detection of conditions that could be much more expensive to treat later on. Subjecting preventive services to the high health insurance plan deductible that would apply to other services, experts have said, would discourage the use of those services.

Last week, the IRS and Treasury released guidance, Notice 2004-43, that provides transition relief for health plans in states that bar or require low deductibles for preventive care. Without this relief, such plans would not qualify as high-deductible plans.

Just one month after the first set of guidance on preventive services, federal regulators released a second set, largely dealing with the interplay of HSAs and flexible spending accounts and an HSA cousin, health reimbursement arrangements.

For example, under the guidance, an FSA or HRA can be used to provide reimbursement for a very limited range of benefit expenses, including vision and dental care, not covered by the HSA.

Also, an FSA or HRA can be used to reimburse employees for health care expenses after the deductible in the high-deductible plan had been met. Regulators also said an HRA can be offered alongside an HSA, if the HRA can be tapped only for reimbursement of health care expenses after an employee retires.

Given that it typically takes regulators years to start providing answers on benefit legislation, benefit executives were surprised at the speed at which the IRS and Treasury have moved to resolve HSA issues.

"The IRS and Treasury have moved at lightning speed. It is absolutely unprecedented," said Bonnie Whyte, executive director of the Employers Council on Flexible Compensation in Washington.

While employers may not have liked all the answers regulators provided, "the guidance has helped the market move," Ms. Whyte said.

But employers considering HSAs have been eager for more guidance, and they may soon get it. Treasury Department officials have sent out word that the guidance likely will be released by either the end of June or first week of July.

"The next round should soon be here," Ms. Whyte said.

One vital issue not addressed in the first rounds of guidance but which should be in the next set, observers say, is whether certain prescription drugs used to prevent medical conditions from getting worse could be considered preventive and thus eligible for first-dollar or low-deductible coverage.

Examples of such drugs could be cholesterol-lowering medications, which have been linked to a reduced risk of heart disease.

"Employers are looking for more flexibility in this area," said Dave Repko, health and group welfare leader in the Cleveland office of Towers Perrin, noting the use of such drugs can be cost-effective.

Similarly, the next round of guidance is expected to resolve whether wellness, disease management and employee assistance programs can be considered preventive and thus entitled to more generous coverage than other medical conditions.

Many other questions also could be addressed. For example, employers have been seeking guidance on whether employees can change the amount they agreed to contribute to the HSA after a plan year has begun. Changes in contributions decided earlier are allowed for FSAs in situations where an employee's status, such as the birth of a child, changes during a plan.

Additional questions before regulators involve whether employers can tie their contributions to an HSA to an employee's contribution, much like employers with 401(k) plans have the freedom to match employees' salary deferrals, based on plan design. "It is a key question employers would like to get resolved," Mr. Repko said.

Similarly, employers would like to know if their contributions to HSAs can be conditioned on employees taking actions to detect potential problems, such as having their blood pressure checked.

"The issue is, can an employer condition its contributions upon employee behavior?" said Jay Savan, a Towers Perrin health and group welfare leader in St. Louis.

As more guidance is produced, employers considering a plan design overhaul will be in a better position to decide whether to link a high-deductible plan with an HSA or an HRA. One big difference between the two is that employers do not have to advance fund the HRA, while retaining complete control of the high-deductible plan's design.

Some say that HRAs are a better choice, from an employer perspective, because of that design flexibility.

"I think HSAs would be great, if you didn't have all those (design) rules," said Barry Barnett, a principal with the HR unit of PricewaterhouseCoopers L.L.P. in New York.

Others say the immediate vesting requirements of employer contributions to HSAs and employees' freedom to withdraw funds for any purpose, though still subject to taxes and penalties, could blunt the appeal of HSAs.

"Employers are very concerned about funds they contribute for medical care being used for nonmedical purposes," said Andy Anderson, a consultant with Hewitt Associates Inc. in Lincolnshire, Ill.

"Employers want employees to be good consumers, but they also want to protect them from making choices," said Kathy Klug, a director with Mellon's Human Resources & Investor Solutions in Minneapolis.

By contrast, in an HRA, an employer must limit its use to reimbursement of health care expenses.

On the other hand, because employees will contribute to an HSA but are not allowed to contribute to an HRA, they may be more careful consumers of health care services if they know it is their money that is at stake, said Joe Martingale, national strategy health care leader with Watson Wyatt Worldwide in New York.

Unquestionably, the rules governing HSAs are much more complex than those involving HRAs. Still because employees are investing their own money, they will have a vested interest in learning the rules, said Steve Putterman, senior health group consultant with Mercer Human Resource Consulting in New York.

HOW HRAs, HSAs COMPARE

Health reimbursement arrangements and health savings accounts differ in several ways

ISSUE	HRA	HSA
Funding	Employer; Notational accounts	Employer and/or employee; cash contributions
Contribution limits	Decided by employer	$1,000 to $2,600 for individual coverage; $2,000 to $5,150 for family coverage
Vesting	Decided by employer	Immediate
Account balance rollover	Typically offered	Required
Design	Employer controlled	Set by law
Distributions	Only for health expenses	No restrictions, but taxable if not used for health expenses

Treatment quality data vital to informed choices

By JUDY GREENWALD

Giving employees the ability to knowledgeably select physicians and hospitals based on cost and quality is a critical component of consumer-driven health care.

Yet, while significant data is available on hospitals, information on physicians is lagging seriously, and it may be some time before it is adequately developed, observers say.

But efforts are under way to rectify the situation, and, in the meantime, health care plans are developing alternative approaches to ensure informed, quality care, including educating employees about established treatment procedures for their particular conditions and encouraging them to seek second opinions.

Employers agree that employee education is an important issue.

"It's absolutely critical," said Janice Pushaw, director of global benefits strategy for Benton Harbor, Mich.-based Whirlpool Corp., which offers consumer-driven plan options to its employees. "I honestly believe that consumerism and educating our employees is absolutely the right way to go," she said.

"You can't manage what you can't measure," said Casey Tincler, controller for Norwood, Mass.-based Gibson Engineering Co. Inc.

"I think we're in the early stages of the development and distribution of that data, both on the point of availability as well as consumer friendliness," said Tom Billet, Stamford, Conn.-based senior consultant with Watson Wyatt Worldwide.

Physician data lacking

There is a growing body of data available on hospitals. Vendors that operate in this area analyze Medicare data as well as information from 18 states that release patient discharge data. Information is available on the frequency of procedures, complication rates, postoperative infection rates and mortality rates, among other data.

In addition, the Washington-based Leapfrog Group, a consortium of major employers, publishes data on hospital quality and safety through information voluntarily provided by the hospitals.

"Our members have access to very deep, robust data around hospital quality for most key procedures that are hospital-based," said Chris Delaney, vp of marketing for Minneapolis-based Definity Health, a consumer-driven health care plan provider.

Hospital data is "becoming more sophisticated, and it's becoming easier to use, both as consumers and as employers who may be deciding on a network," said Ronald Bachman, a principal with PricewaterhouseCoopers L.L.P. in Atlanta. "Certainly, the insurance carriers themselves are using that kind of database" to restructure networks and develop centers of excellence, he said.

But significantly less information is available on physicians, and it is sorely missed, observers say.

Employees "are hungry for quality information on physicians," said Pamela Norley, a Marlboro, Mass.-based senior vp of Fidelity Investments who is responsible for health and welfare strategy and products. "Otherwise, it's just word of mouth or referrals from your neighbors and friends. Any information that we can get into the hands of participants…will be well received."

Peter Fatianow, senior vp of corporate services for Lakewood, Colo.-based Health Grades Inc., a health care services rating company, said his firm offers information on physician credentials, whether doctors are board certified and whether they have had any state medical board sanctions levied against them. But "everybody looks for who does the best work. That data is just not available in the marketplace," Mr. Fatianow said.

"I think things are more advanced on the hospital side than on the physician side," Mr. Billet said. While hospital data is out there, the data available on physicians can best be described as "embryonic," he said. "There are small pockets of data available primarily about physician qualifications and credentials" but "very little of what I'll call 'true quality data' and probably little or no outcomes data."

"The only outcomes data I can even really think of on the physician level that's in the public domain is in a few states where there are outcomes around cardiac surgery—for example, in New York, New Jersey and Pennsylvania," Mr. Billet said. In addition, "there have been some efforts made around satisfaction surveys of physicians, but that's about it," he said.

"There's no reporting requirements like (Medicare) that would give us a database," PwC's Mr. Bachman said. It is going to be up to the health insurers "to be forced by their own consumer base to provide that information," and this may become a focus of competition among them, he said.

Observers say that one of the key challenges to compiling this information is developing an adequate sample size.

Kevin Haugh, vp of product management for White Plains, N.Y.-based ProAct Technologies Corp., which manages human resource and benefit management functions for employers, said: "If you don't have enough observations, you

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Consumerism brings savings, member satisfaction

By GLORIA GONZALEZ

When National Leisure Group faced a rate increase of about 35% for its preferred provider organization plan in 2003, the company decided to try something new.

In an effort to rein in its rising health care coverage costs, the Boston-based travel agency decided to switch to a consumer-driven health plan offered by Minneapolis-based Definity Health, according to Kathleen Federico, senior vp of human resources for NLG.

The consumer-driven plan is the only health plan that NLG offers, and about 80% of the company's 1,250 employees participate, Ms. Federico said. For single coverage, NLG contributes $1,000 to the employee's personal care account, and the individual has a $500 deductible once the account is exhausted. For family coverage, the company contributes $2,000 to the PCA with a $1,000 deductible.

Under its consumer-driven plan, the rate of increase in plan costs was only 8% this year, with part of that increase stemming from the extra costs of providing medical coverage for new employees joining the company after an acquisition, Ms. Federico said. "We're very pleased with the results that we're seeing."

NLG is one of many companies that have turned to consumer-driven plans in the last couple of years in the hope of cutting their health care coverage costs.

Achieving cost savings "is certainly a driving force" behind the consumer-driven movement, acknowledged Scott Keyes, a senior consultant for Watson Wyatt Worldwide in Minneapolis. "Many employers have been satisfied that they can save 5% to 10%" by implementing a consumer-driven strategy.

A survey by Watson Wyatt and the Washington-based National Business Group on Health found that optimism about consumer-driven plans' ability to reduce costs was the most common reason employers opted to introduce such plans. Twenty-four percent of respondents cited the potential for savings as their primary reason for offering consumer-driven plans, while 22% said they implemented such plans to increase employee sensitivity to the cost of health care.

Consumer-driven plan vendors say that optimism about the savings potential is well founded.

For 2004, costs for about 50 large Definity clients that were also clients in 2003 are expected to increase by just 3.6%, on average, based on utilization experience, said Chris Delaney, vp-marketing for Definity. This rate, when compared to an average industry trend near 14%, translates into more than $18 million in total savings for 2004, he said. A similar analysis of actual health care costs for 2003 showed Definity clients saved a total of nearly $16 million last year when compared to the industry trend.

In addition, a survey of members of Aetna HealthFund—a division of

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Education: More treatment quality data needed

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can't draw any good, objective conclusions. It's hard to get that data on the individual physician in a statistically reliable way."

Furthermore, there can be a legitimate statistical analysis if a surgeon performs a particular procedure frequently enough, "but what about procedures that are less commonly performed?" Mr. Fatianow asked.

In addition, the physician of record may not be the doctor who performed a particular procedure, "so there's a lot of little nuances in the data. It sounds easy, but it's not," he said.

Then there is the issue of physicians who are not surgeons, such as family practice or internal medicine specialists. "What measures can you use to rate those types of physicians?" Mr. Fatianow asked.

"It's difficult, because there's no surgery, there's no outcome. They're seeing patients, and it's a little bit more subjective, and the data just isn't there in terms of patient satisfaction or anything else," he said.

Helen Darling, president of the Washington-based National Business Group on Health said, "It's also much costlier to get physician data (than hospital data) because you've got so many more of them, and physicians are much less likely to be automated, to have the electronic capability" than are hospitals.

"Unless it's legislated that the data is going to be collected—and it's going to be available for analysis—it's only going to be spotty here and there," Mr. Fatianow said. "You're not going to have a national data set to analyze, which is what we have for Medicare."

Initiatives under way

This information may eventually be developed, though.

Such data will ultimately be available, "but I think it'll be a long time coming," said Mr. Billet.

"We're still years away" from being able to compare two physicians based on cost and quality, agreed Mr. Delaney. However, he said, "you will see a lot happening in the next two years just given the momentum…and the widespread desire to get to that degree of data."

But efforts in this area are already under way. For example, the Care Focused Purchasing initiative, an employer and industry coalition spearheaded by New York-based Mercer Human Resource Consulting, is developing measurements to evaluate the cost and quality of provider as well as hospital care. Using data provided by health plans, the "first generation" of data, which will measure efficiency and quality, is expected to be available by the middle of next year, said Ray Herschman, a Chicago-based principal with Mercer.

In addition, Bridges to Excellence—a consortium of health plans, employers and others that promotes quality care—will recognize physicians who meet its standards by highlighting them in physician directories and within participating companies. The coalition's goal is to help patients identify doctors who are best able to treat their particular conditions. Bridges to Excellence's data will also be incorporated into The Care Focused Purchasing initiative database.

Meanwhile, some health plans are taking other approaches to help employees become better health care consumers. This includes raising plan participants' awareness of evidence-based medicine, the protocols that have been established for treating certain conditions based upon clinical practice.

Paul Weaver, CEO of the provider and consumer information solutions products line at Salt Lake City-based Ingenix Inc., a health care data and research company owned by UnitedHealth Group Inc., said Ingenix "has well-established expertise in standards of evidence-based medicine."

Ingenix is "able to help people assess the degree to which doctors follow" treatment protocols by making patients aware, for instance, that their doctors should prescribe aspirin if the patients have suffered heart attacks.

Mr. Weaver noted the Washington-based National Committee for Quality Assurance has a program that recognizes and rewards doctors who follow approved clinical protocols for patients with heart conditions or stroke and diabetes. Ingenix has an agreement that allows it to identify in its directories the doctors who meet its standards.

Passing on information on evidence-based medicine to employees is "the direction that many organizations are headed in," said Ann Mond Johnson, president of Chicago-based Subimo, which provides health care research tools. "Good organizations are already communicating that information to their physicians, and so it's not a surprise" that providing it to employees is the next step, she said.

Definity makes data from the Dartmouth Atlas available to its members, said Mr. Delaney. The Dartmouth Atlas' data helps make employees aware of how supply drives demand in health care, which leads to certain procedures such as back surgery, gall bladder surgery and hysterectomies being performed much more frequently in certain geographic areas, he said. The atlas is a project of the Dartmouth Medical School faculty in Hanover, N.H.

David Cowles, executive vp of Medford, Mass.-based Benemax Health Plans, offers plan participants a second-opinion service in conjunction with the Boston-based Partners HealthCare system. Patient information is sent for analysis to Harvard Medical School faculty specialists, who respond within five days with a report that averages 15 pages in length. The specialists recommend a change in treatment 85% of the time, said Mr. Cowles.

Mr. Cowles said employees are very happy with the program. "It really sends a message that their employer is not just providing a benefit because he has to but because he really cares."

Net tool keeps health in mind

By MEG SHREVE

Some employers are using an online health-risk assessment tool to drive consumers to lead healthier lives.

Pohlman Inc., an auto-parts manufacturer in Chesterfield, Mo., in March 2003 became the first company to implement the Internet-based tool. The program, MyChoice, was developed by Mercy Health Plans, a subsidiary of the St. Louis-based Sisters of Mercy Health System, in conjunction with Health Trio, a health care technology company in Nashville, Tenn.

Five other companies have since joined Pohlman in using the MyChoice program, which is available to both self-insured and fully insured companies.

The concept behind MyChoice "is derived from the consumer taking personal responsibility for health," said Bill Bennett, senior vp of Mercy Health.

The program asks users to complete a health risk questionnaire and then helps them identify behavioral changes that could improve their health, such as quitting smoking, losing weight or undergoing preventive health screenings. Those who agree to make the changes may qualify for reductions in the health care premiums they pay.

Another feature of the program allows users to log in periodically to track their progress in meeting their health care goals. In addition, MyChoice provides general information on health and wellness, as well as discussions of specific medical conditions.

According to Jim Sullivan, executive vp of Pohlman, the program boosted employees' awareness not only of health issues but also of health care cost trends and how improving their own health could help reduce these costs. MyChoice acts a "constant positive motivator," he said.

Pohlman, which is self-insured, used an "education media blitz" to "keep the idea of wellness and fitness in front of people," Mr. Sullivan said. The company held monthly meetings, mailed newsletters, sponsored benefit fairs, conducted weight-loss contests and provided smoking-cessation and nutrition classes to increase awareness of wellness issues.

"Everyone wants to be healthier, but very few do anything about it," Mr. Sullivan said. "This program keeps it on their minds."

In the year before it implemented MyChoice, Pohlman saw a 28% rise in its health care costs. With 80% enrollment among its 225 employees, Pohlman has seen a 5% reduction in those costs this year. Initially, the company spent the year prior to the introduction of the program educating employees about what MyChoice would entail.

Pohlman's human resource manager, Rick Brown, said there was some concern among employees about how the program would work out. "The unknown is much scarier than the known," he said. But, overall, most employees were "pleasantly surprised," he said.

In order to encourage employees without Internet access to use the program, Pohlman set up 10 computer stations and provided assistance to help employees with the enrollment process. After that, employees could schedule computer help sessions through human resources.

Overall, he said that employees found the program helpful.

He noted that one employee who had been experiencing headaches found out after going to a sponsored benefits fair that he had dangerously high blood pressure. Another participant, having obtained diabetes information through MyChoice, went from needing insulin to controlling his diabetes through his diet.

"I think the majority of employees find it beneficial," Mr. Brown said. "They have an interest in being able to have some active participation in their own health care."

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Hartford, Conn.-based Aetna Inc. that offers consumer-driven options—showed that employers offering consumer-driven plans experienced health care cost increases of 3.7%, on average. The company analyzed claims and utilization data for 13,500 HealthFund members.

Aetna estimates that first-year savings for HealthFund members can be as high as 8%, a spokeswoman said.

Communication critical

For these plans to be successful—particularly in terms of enrollment—employers must carefully communicate the changes to employees, consultants say.

"What's the key to a successful consumer-driven health plan? Communication, communication, communication," said Daniel Plante, senior manager at Pricewaterhouse-Coopers L.L.P. in Chicago. "That will make or break the success of these plans."

Communication is crucial to promoting enrollment; if employees don't understand a new plan, they won't enroll in it, Mr. Plante said.

Watson Wyatt's study found that first-year enrollment in consumer-driven health plans has ranged from 1% of employees to 33%, with an average of between 10% and 15%.

If an employer were to simply offer a consumer-driven plan without developing a good plan design and a proper communication strategy, its enrollment rate would be only 4% to 5% of the employee population, estimated Doug Kronenberg, chief strategy officer for Lumenos. With a good plan design and effective communication, though, that rate can be as high as 75%, he said.

"What's key to (boosting enrollment) is providing employees with the opportunity to understand how this thing works," he said.

"Under a CDHP offering, employers will have better (communication and health information) tools, but not enough will fully utilize these tools without more prompting," said Richard Ostuw, a principal with Towers Perrin in Stamford, Conn. "Employers have been pretty passive in recent years about communicating with employees."

And it is important to begin the communication process well before the enrollment period, consultants say, noting that employers often don't give their employees enough time to consider the differences among the health plans.

Before Benton Harbor, Mich.-based Whirlpool Corp. introduced consumer-driven options in January, it held mandatory discussions about the change with employees and local health care providers starting six months prior to enrollment, said Janice Pushaw, director of global benefits strategy for Whirlpool. And the effort paid off, with 40% of eligible employees enrolling in the plan, which is offered by Definity.

Although it is still too early to make precise projections, Ms. Pushaw said she expects Whirlpool to see a 7% reduction in its health care costs due to the consumer-driven offerings. The projection reflects employees' increased awareness of health care costs, she said. "It's no longer isolating people from what the true cost of their visit is," she said.

The company based its consumer-driven offerings on the coverage provided under its PPO and traditional indemnity plans.

For single coverage, Whirlpool contributes $750 to the employee's personal care account; it contributes $1,125 for two people and $1,500 for family coverage. Preventive care is provided at no cost to employees, Ms. Pushaw said.

Rating satisfaction

Employees who do enroll in consumer-driven health plans tend to be satisfied with these plans, according to vendor-conducted studies.

Nine out of 10 members of Aetna HealthFund said that their plan met their expectations and that they were likely to renew. And more than 95% of Definity members have re-enrolled in each of the past four years, ahead of industry norms in the mid- to high-80% range.

"The retention has been pretty high, and more people have joined them, which suggests positive word of mouth," said Helen Darling, president of the National Business Group on Health, which represents more than 200 employers.

Observers attribute employees' satisfaction levels to the greater control they have under the plans. "People really like the control, and they like the opportunity to save money," said Grace-Marie Turner, president of the Galen Institute Inc., a nonprofit research organization that studies health policy.

Another attraction, observers say, is that some employees can save money under consumer-driven plans, if they use them properly.

For example, 60% of NLG employees had no out-of-pocket expenses because they stayed within the parameters of their personal spending accounts, Ms. Federico said.

Getting their employees more involved in health care decisions was a key factor in NLG's decision to convert to a consumer-driven plan, Ms. Federico said. "They do have to be more aware and more involved than they were in the past. Once people get used to it, they find it very positive," she said.

Although such behavioral changes take time, studies indicate that participation in consumer-driven health plans does encourage better consumerism. More than half of the employees surveyed by Lumenos said they are more knowledgeable about their own health, and nearly one-fourth said they are more active in areas such as exercise, diet and regular checkups since enrolling in the program.

The earliest signs of behavioral changes have been in the areas of prescription drugs and physician office visits, vendors say. For example, Aetna HealthFund's study showed a 5.5% decrease in pharmacy costs, which was driven by a 13% decline in overall prescriptions and a 7% increase in overall generic utilization.

Companies that offer consumer-driven health plans are seeing their prescription drug costs drop by 10% to 20%, on average, said Mr. Plante of PwC. "As individuals look at the full cost of drugs…people are much more engaged in wanting to make a change," he said.

There is, however, some employee dissatisfaction with consumer-driven health plans. In particular, some employees with long-term conditions such as diabetes and asthma are concerned about consumer-driven health plans because they feel that their employers are trying to shift more costs onto them, Mr. Plante said.

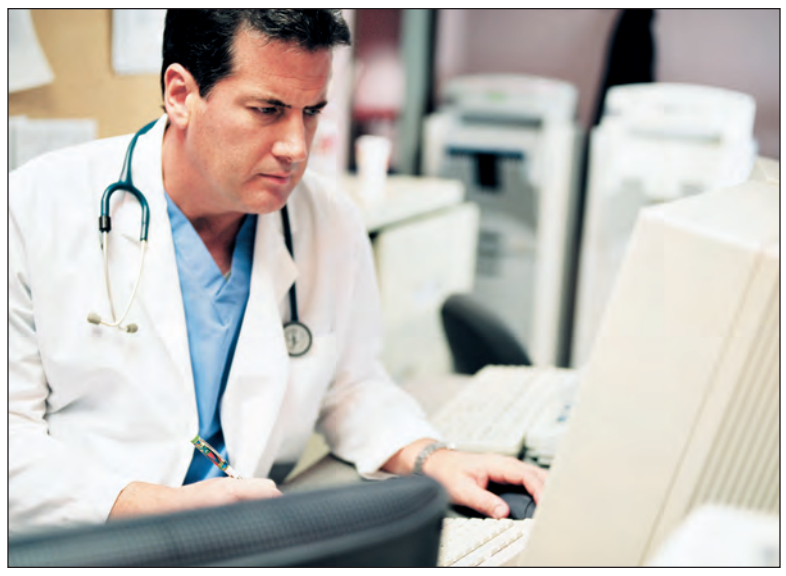
In addition, because consumer-driven plans require employees to become actively involved in health care decisions, employees can easily become dissatisfied with the plans if they fail to take steps to obtain that information, he said.

As a result, employers need to make sure employees understand that being educated health care consumers will help them make better health care decisions—and save money, Mr. Ostuw said.

America's Health Insurance Plans' 2004 Institute

Patients eager for 'Web visits'

By JOANNE WOJCIK



Most patients want to communicate with their doctors via the Internet—with nearly one-third saying they'd even switch providers if they could e-mail them—but few doctors are conducting so-called "Web visits," research shows.

Doctors are more likely to interact with patients online, however, when offered payment for those Web visits, according to Eric Zimmerman, senior vp of marketing at Emeryville, Calif.-based RelayHealth Corp., a clinical online communication service provider that gives providers and their patients an opportunity to communicate securely over the Internet.

Moreover, research suggests that the Internet ultimately could reduce the cost and enhance the quality of health care, Mr. Zimmerman said during a session at America's Health Insurance Plans' 2004 Institute, held June 16-18 in Chicago.

"There's a core group of consumers who are starting to view online (interaction) as a switching criterion," Mr. Zimmerman said. "Yet, fewer than one in five doctors have actually interacted online with patients."

When asked why they are not using the Internet to communicate with patients, providers cite a litany of reasons, including the need to see patients in person, the potential for being overwhelmed by a high volume of e-mails and liability fears, he said.

But, the reason most often cited by physicians for not conducting Web visits is that they are not reimbursed for them, Mr. Zimmerman said.

"If you flip the question on its head and say to physicians, 'What would encourage you to consider the online environment to actually provide service and care,'" he said, their No. 1 answer is "reimbursement."

Two years ago, when physicians were asked how much they would like to be reimbursed for online visits, the answer was about $57. But that sum dropped to an average of just $33 per five-minute online consultation when physicians were surveyed a year later, Mr. Zimmerman said.

Many patients say they are willing to pay for online consultations, but would pay only a nominal sum of between $5 and $7—the equivalent of the convenience fee most online consumers pay for services such as purchasing airline tickets, he said.

"This is a convenience fee. That's how they're thinking of this," he said.

To test the feasibility of Web visits, RelayHealth conducted a two-year pilot study in which patients made nominal copayments for online consultants and providers received reimbursements slightly less than that paid for in-person office visits.

The study, which began in 2001, involved San Francisco-based Blue Shield of California's preferred provider organization, 10 self-insured employers, 282 doctors and 3,688 patients and a comparable control group.

Communications were conducted via RelayHealth's secure Internet connections for appointments, medical refills, laboratory results and other routine communications as well as nonurgent medical consultations. Doctors could prescribe medications online, receive automatic eligibility checking, collect copayments and submit claims for Web visits conducted with participating health plan members.

Among the findings of RelayHealth's report:

- Doctors said they had more time to review patients' files and medical research before prescribing treatment and could attach resource materials for patients to fine-tune treatment, which was particularly helpful for patients with chronic conditions.
- Doctors saved time because of reduced interruptions and the ability to handle patient queries when it was most convenient for them.
- Web visits also saved time and were more convenient for patients. They didn't have to take time off from work to see their doctors, and they were able to send queries whenever they had the time or when they were suffering the symptoms for which they sought treatment.
- Patients reported feeling more comfortable communicating online, which made it possible for them to be more candid with their doctors.
- By having a printed reminder of their doctor's instructions, patients said they were better able to follow a prescribed treatment regime.
- Health care costs dropped by more than $1.50 per member per month net of reimbursement.

"We were very satisfied with the results, and we were somewhat surprised at the magnitude of the dollar savings," said Duncan Ross, program director in network management at Blue Shield of California in San Francisco.

"The primary focus really was on satisfaction. We were aiming for a pilot that was somewhat cost-neutral. We absolutely wanted to track costs. But the bigger question was, what kind of response would we get from the physician and member community?" he said.

As a result of the pilot, in 2003 Blue Shield expanded the use of Web visits to its health maintenance organization plan members and is incorporating it into its medical management programs, Mr. Ross said.

Hundreds attend AHIP conference

Hundreds of executives from all areas of the health insurance industry attended America's Health Insurance Plans' 2004 Institute, held June 16-18 in Chicago. This was the first meeting of the organization formed by the merger of the American Assn. of Health Plans and the Health Insurance Assn. of America.

The institute featured keynote speeches by former Senate Majority Leader George Mitchell, D-Maine, and syndicated columnist and co-host of CNN's "Crossfire" Robert Novak, as well as educational seminars addressing current issues in health care and an exhibit hall.

The 2005 institute will be held June 8-10 in Las Vegas.

For more information about AHIP, visit the organization's Web site, at *www.ahip.org*.

America's Health Insurance Plans' 2004 Institute

Voters quizzed on health issues

By JOANNE WOJCIK

While most Americans agree that the medical malpractice liability and health care systems need to be changed, they aren't exactly embracing all of the solutions that policymakers have proposed, a new survey shows.

For example, as employers increasingly turn to tax-free savings accounts to help people pay for their health care, many Americans are not very enthusiastic about the idea, according to a survey by America's Health Insurance Plans.

Of those surveyed, 63% said they would be more likely to vote for a candidate who would support legislation establishing tax-free savings accounts to help people to pay for their health care. And an even lower percentage—56%—said they would be more likely to vote for a candidate who supports using medical evidence to evaluate every new health care law to assess how much cost and benefit it would add to the system, something that many employer groups also have supported.

However, 77% would be more likely to vote for a candidate who supports legislation to reduce medical mistakes by allowing doctors, nurses and hospitals to report incidents without fear of being sued. Meanwhile, 72% would be more likely to vote for a candidate who supports reforming the medical malpractice liability system by reducing the amount of money that trial lawyers make from punitive damages.

The AHIP Battleground Survey was conducted in April 2004 to gauge how big of a role health care issues will play in voters' decision-making this November. Survey participants were given a list of proposed health care reforms and asked to rate whether they would be more or less likely to vote for a candidate who supports a particular proposal.

The poll included 800 registered voters in 17 states who were surveyed between March 31 and April 5. The surveyed states, viewed as swing states for the presidential election, were: Arkansas, Arizona, Florida, Iowa, Maine, Michigan, Minnesota, Missouri, New Hampshire, New Mexico, Nevada, Ohio, Oregon, Pennsylvania, Washington, Wisconsin and West Virginia.

Among other findings:

- 74% would be more likely to vote for a candidate who supports full disclosure of medical quality and safety information so that people can compare and choose the best doctors and hospitals.
- 75% would be more likely to vote for a candidate who supports using competition among different private-sector health plans to give seniors the best benefits at the most affordable cost.
- 70% would be more likely to vote for a candidate who supports legislation encouraging doctors and hospitals to base treatment on the best and most recent available evidence from scientific research methods.
- 70% said they would be more likely to vote for a candidate who supports encouraging doctors and hospitals to incorporate uniform standards of medical evidence in their treatment decisions.

The AHIP Battleground Survey is available at www.ahip.org.