

**COURT STOPS N.Y. COMP BOARD FROM IMPOSING BAILOUT LEVY ON SOLVENT TRUSTS / PAGE 3**

**CATASTROPHE LOSSES HIT \$13B IN FIRST HALF OF 2008 / PAGE 3**

**SAFETY CONCERNS DON'T BAR CLAIM ALLEGING HIRING BIAS, COURT RULES / PAGE 3**

## In Brief

**ACE shareholders OK redomestication bid**

Shareholders of ACE Ltd. have voted in favor of initial steps to redomesticate the company to Switzerland. If approved, the move will transfer the insurer's place of incorporation from the Cayman Islands—where ACE was established in 1985—to Zurich, Switzerland. The company says its Bermuda operations will be unaffected, and ACE executive offices will remain in Bermuda principally, according to a company spokesperson. ACE Group Holdings' executive offices are expected to remain in New York.

**House OKs bill to help monitor building codes**

The House of Representatives has approved legislation that would create a national program to encourage local governments

See **IN BRIEF** page 21

# N.Y. mulls fate of contingents

*Officials to consider lifting partial ban*

By **SALLY ROBERTS**

**NEW YORK**—The fate of contingent commissions, including whether the world's largest brokers should again be allowed to collect the incentive payments, could be determined by public hearings set to begin today in New York.

New York Insurance Superintendent Eric Dinallo and New York Attorney General Andrew Cuomo are holding the hearings prior to issuing regulations on broker and agent compensation and how that is disclosed. The largest insurance brokers have criticized the current system that resulted in 2005 and 2006 from settlements with New York officials, saying it puts them at a competitive disadvantage.

While those settlements involving certain brokers and insurers prohibited paying and receiving contingent commissions and called for

significant disclosure requirements, the agreements don't include all producers and insurers doing business in New York, the New York Insurance Department said in a statement.

"Those who sell insurance deserve to be fairly compensated and those who buy insurance deserve to be fairly treated," Mr. Dinallo said in a statement. "These hearings will help us understand how best to ensure the marketplace is competitive, transparent and fair to all."

Today's hearing is in Buffalo, N.Y. Additional hearings will be held July 23 in Albany, N.Y., and July 25 in Manhattan.

While stressing that the impetus behind the earlier agreements was the concern that insurance buyers were not being treated fairly and that the law was not being followed, a source close to the matter



NYTIMES

**New York Attorney General Andrew Cuomo, left, and Insurance Superintendent Eric Dinallo are holding hearings on broker compensation.**

said that a "rollback" of the settlements' prohibitions on contingents is possible.

However, the New York-based Risk & Insurance Management Society Inc. plans to reiterate its opposition to contingent commissions.

"There is an inherent conflict of interest in a transaction where a broker accepts payment from an insurance buyer and carrier," Terry Fleming, RMS director of external

See **COMMISSIONS** page 20

## BENEFITS MANAGEMENT

**CONSUMER-DRIVEN HEALTH PLANS**

Consumerism movement boosts retail medical clinics; HSA adoption grows but future remains unclear;

employers need to work on communication when switching to CDHPs;

employers offer advice on how to make the change to high-deductible plans; plus *B/I's* exclusive ranking of CDHP providers. **Page 9**

# RRGs hail bill to study regulators' authority

*Measure also would allow property coverage*

By **MARK A. HOFMANN**

**WASHINGTON**—Risk retention group advocates say they hope that a measure directing the federal government to examine whether states are trying to unlawfully regulate RRGs becomes law.

The provision is contained in an amended version of the Increasing Insurance Coverage Options for Consumers Act of 2008, which last week won approval of the House

Financial Services Committee's Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises.

The measure also would allow RRGs to provide commercial property in addition to liability coverage to their members, an expansion of RRG offerings long sought by risk managers.

The measure, introduced by Reps.

See **RRG** page 19

# Mass. plans revisions to health reform rules

*Changes would let more plans pass muster*

By **JERRY GEISEL**

**BOSTON**—More employer plans will meet the requirements of Massachusetts' health care law if draft rules approved last week are put in place.

The Massachusetts Health Insurance Connector Authority, the state agency charged with implementing key elements of the 2006 law that has a central goal of moving Massachusetts closer to universal coverage, approved the revisions unanimously.

That goal is drawing nearer. About 350,000 previously uninsured individuals—out of an uninsured population estimated at 450,000 to 600,000 prior to the reform law—now have health insurance coverage. Many are in a program in which the state subsidizes enrollees' health insurance premiums.

Provisions of the landmark law

that are particularly important to employers and employees are those that require state residents to be enrolled—starting Jan. 1, 2009—in health care plans providing so-called minimum creditable coverage. Individuals, including employees, who are not enrolled in plans that meet minimum coverage standards can be hit with tax penalties of more than \$900. This year, those penalties apply only to those who are not enrolled in a health care plan.

The law, though, left it to Connector to lay out the benefit design requirements that health plans would have to meet to qualify as providing minimum creditable coverage.

Responding to comments and criticisms that its earlier rules were too rigid and not sufficiently detailed—increasing the chances

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## On the Web



### BI VIDEO

#### New series highlights specialty risks

*Business Insurance* begins its Specialty Risks video series with a look at Lloyd's of London as it celebrates its 320th anniversary. Lloyd's Chairman Lord Peter Levene and Julian James, executive chairman of Lockton International and former Lloyd's director of worldwide markets, discuss the market. Go to [www.BusinessInsurance.com/video](http://www.BusinessInsurance.com/video).

### WOMEN TO WATCH

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*Business Insurance* will publish its third annual "Women to Watch" report in the Dec. 1, 2008, issue and invites readers to nominate outstanding women working in insurance, risk management and employee benefits worldwide. Go to [www.BusinessInsurance.com](http://www.BusinessInsurance.com).

### BI DIRECTORIES

#### CDHP directory updated for 2008

*Business Insurance's* directory of consumer-driven health plan providers has been updated for 2008. You can buy and download the full content of this and other *BI* directories online at [www.BusinessInsurance.com/directories](http://www.BusinessInsurance.com/directories).

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# N.Y. comp board barred from collecting levy

Judge rules board has right to tap self-insureds, but only when trusts declared insolvent

By ROBERTO CENICEROS

**NEW YORK**—A New York judge, citing a technicality, has annulled millions of dollars levied on self-insured employers in the state to cover insolvent group self-insured trusts, but has yet to rule on the constitutionality of a state law that allows assessments.

Although the New York State Workers' Compensation Board has the authority to assess individual companies and group self-insurance trusts to cover workers comp liabilities from trusts that are insolvent, the board failed to prove that certain trusts were already insolvent, New York Supreme Court Justice Kimberly A. O'Connor ruled last week.

Insolvency cannot be prospective or speculative, Justice O'Connor ruled in invalidating emergency assessments.

The ruling stems from a lawsuit filed by 13 group self-insurance trusts managed by New York-based First Cardinal L.L.C., which sought to block the board's assessments.

Observers say the assessments on all self-insureds in New York have climbed from \$8 million three years ago to \$67 million this year.

The assessments followed defaults by several trusts, including

**\$67M**

ASSESSMENTS on New York employers with self-insurance programs for workers compensation risks so far in 2008.

some managed by Hamilton, Bermuda-based Compensation Risk Managers L.L.C. Under a June 2 agreement, the board will manage CRM claims and CRM is surrendering its third-party administrator license in the state.

New York's group self-insurance trusts are pools of privately managed companies generally considered too small to self-insure individually.

Trust defaults have brought into question whether employers that self-insure on their own and group trusts that have properly reserved for their losses should have to pay

for the liabilities of failed trusts.

Under New York law, financially sound self-insured employers are obligated to pay the workers comp liabilities of failed self-insured employers, said Steve Perroots, chair of the New York Self-Insurer's Assn. and a senior director for claims at Marriott International Inc. in Bethesda, Md. NYSIA represents large, individually self-insured employers.

Some group trusts disagree with that view.

First Cardinal has argued in two lawsuits, including the one that Justice O'Connor ruled on last week, that the SWCB has no authority to assess self-insureds.

See **TRUSTS** page 20

## Cat losses hit \$13B in first half

Increased weather losses reflect climate change: Report

By RICHARD MILLER

Some 400 natural catastrophes in the first half of 2008—one of the deadliest such periods in terms of its human toll—led to overall losses of roughly \$50 billion, with about \$13 billion of that total insured, according to research released last week.

As in previous years, the first half of the year was marked by a large number of weather-related catastrophes, which totaled about 300 in the first six months of 2008, according to the research. The data was presented by Munich Reinsurance Co. unit Munich Re America in conjunction with the Insurance Information Institute.

"To this extent, the year is following the long-term trend towards more weather catastrophes, which is influenced by climate change," Munich

Re Board Member Torsten Jeworrek said in a statement.

The largest number of events ever recorded in one year was 960 in 2007. Last year, natural catastrophes led to overall losses of \$82 billion, for which the insurance industry paid about \$30 billion, Munich Re said.

This year will likely go down as one of the deadliest due to natural events, Munich Re said.

The earthquake in the Chinese province of Sichuan, the cyclone in Myanmar, and other natural catastrophes between January and June have killed more than 150,000 people.

The death toll is higher in the first six months of 2008 than in the full years since 2004—the year of the tsunami in South Asia, Munich Re noted.

The full presentation can be viewed [www.munichreamerica.com](http://www.munichreamerica.com).

### U.S. INSURED CATASTROPHES

As of June 30. Losses in millions of U.S. dollars.

	Fatalities	Estimated overall losses	Estimated insured losses
Severe thunderstorms	118	\$9,250	\$8,140*
Flood	24	Up to \$10,000	Up to \$10,000
Winter storm	12	\$1,000	\$745*
Wildfires	0	\$50	\$30

\*Property Claim Services (PCS)  
Source: Munich Re Group

PHOTO: NOAA

## Safety concern doesn't bar claim for hiring bias

Interviewer's query on medical needs triggered lawsuit

By JUDY GREENWALD

**CINCINNATI**—A supervisor interviewing a job applicant may have violated a federal disability law when he ended the interview after asking the applicant about his prescription drugs, according to a federal appeals court ruling.

An observer says the ruling should prompt employers to better train their employees who conduct interviews with job applicants.

In its July 1 decision in *John Doe vs. The Salvation Army*, the 6th U.S. Circuit Court of Appeals in Cincinnati said the Salvation Army may have violated the Rehabilitation Act of 1973 when the interview question was asked and subsequently failed to hire the applicant.

The Rehabilitation Act is compa-

table to the Americans with Disabilities Act and applies to entities that receive federal funds, including the Salvation Army.

According to the decision, the pseudonymous Mr. Doe suffers from paranoid schizophrenia and was hospitalized or lived in group homes because of his condition from 1995 through 2005.

In 2005, while still under medical supervision, he began working with the Columbus, Ohio-based Center for Vocational Alternatives. In May that year, a COVA job developer contacted Charles Snider, the supervisor at the Salvation Army's Adult Rehabilitation Center warehouse, and arranged for Mr. Doe to be interviewed for a truck driver job.

When Mr. Doe told Mr. Snider he could not work on Fridays because he had to see his doctor and pick up his medicine, the supervisor asked him what type of medication he took. Mr. Doe told him he took psychotropic medication.

"According to (Mr.) Doe, at that

READ the full court ruling at *Business Insurance's* Knowledge Center [www.BusinessInsurance.com](http://www.BusinessInsurance.com)

**SLEEP RULING:** Appeals court rules former hostage's sleeping problems can be considered a disability. PAGE 6.

point, Snider 'stopped the interview and said that his insurance would not cover me,'" according to the opinion. The supervisor said he ended the interview by indicating he wanted to first check whether the center's insurance policy would cover a driver using psychotropic drugs. But he never did so, and subsequently hired nine other drivers, the opinion stated.

Mr. Doe filed suit, charging violation of the Rehabilitation Act. A district court granted the Salvation Army's motion for summary judgment, holding that Mr. Doe failed

to establish the elements for a prima facie disability discrimination case.

"We think there is a genuine issue of material fact as to whether the Salvation Army discriminated against Doe solely because of his record of a disability," said a three-judge panel of the appeals court in overturning the lower court dismissal of the case and ordering further proceedings.

The opinion said the Salvation Army argued—and the district court agreed—that Mr. Doe was rejected for safety concerns, not for reasons based solely on his disability.

"However, it was immediately after Doe revealed his specific medications that Snider abruptly ended the interview," the opinion said. "An employer may not base a hiring decision on a perceived notion that the applicant's disability renders him incapable to perform the job," the decision said.

See **BIAS** page 6

# Investment, catastrophe losses hit Cincinnati Financial

After rating downgrade, insurer seeks to diversify stock portfolio as financial companies get hammered amid credit crisis

BY JUDY GREENWALD

**CINCINNATI**—Cincinnati Financial Corp. is struggling to deal with a declining investment portfolio while simultaneously contending with the impact of catastrophes and the softening market.

While the insurer has been downgraded by one rating agency, observers say it remains well-capitalized, with a respected management.

For 2007, Cincinnati Financial reported \$4.26 billion in revenues and \$855 million in net income, and posted \$2.41 billion in commercial lines net written premiums.

The insurer, which focuses on small-commercial business, works with a network of independent agents.

For this year's first quarter, however, the insurer reported a \$42 million loss, which reflects \$232 million in investment losses, compared with a \$62 million profit for the first quarter last year.

Cincinnati's largest common stock holding—accounting for about 25% of its equity portfolio at the end of the first quarter—is Cincinnati-based Fifth Third Bancorp, whose stock closed at \$11.84 on July 10, down from a 52-week high of \$41.17.

Observers say the insurer has historically done well with an investment strategy that has focused on

financial stocks, but is now being affected by overall economic and financial market trends.

"We are in the process of developing a more refined investment policy," which will lead to a more diversified portfolio, said Kenneth W. Stecher, Cincinnati Financial's president and chief executive officer.

Furthermore, the insurer—which posted \$43 million in catastrophe losses for this first quarter vs. \$3 million for the same period a year ago—said last month that it has preliminarily estimated \$115 million in second-quarter cat losses

compared with \$11 million in catastrophe losses it posted for the second quarter of 2007. The insurer plans to release its second-quarter 2008 results Aug. 6.

Mr. Stecher, who was formerly chief financial officer, assumed his new position earlier this month from John J. Schiff Jr., who retains his chairman post.

The management changes were "long planned and well in the normal course of business," said John L. Ward, CEO of Cincinnati-based Cincinnatus Partners L.L.C.

Despite its strong balance sheet, Standard & Poor's Corp. has lowered Cincinnati Financial's operating companies' financial strength ratings to A+ from AA-. However, the insurer's fundamentals are "still very strong," said Polina Chernyak,

an S&P analyst in New York. "Given time and proper strategic management, the company might emerge from this weaker position, and they still have enough financial flexibility at the parent company to raise the capital if needed."

Among other rating agency actions:

- Oldwick, N.J.-based A.M. Best Co. Inc. placed the insurer's A++ financial strength ratings under review with negative implications.

- New York-based Moody's Investors Service placed Cincinnati Financial units' Aa3 financial strength rating under review for possible downgrade.

- New York-based Fitch Ratings put the insurer's property/casualty units' AA rating on a negative rating watch.

\$232M

INVESTMENT LOSSES reported by commercial insurer Cincinnati Financial in the first quarter of 2008.

## Cash balance pensions not age-biased: Court

2nd Circuit rules for Equitable, Verizon

By JERRY GEISEL

**NEW YORK**—Joining three other federal appellate courts, the 2nd U.S. Circuit Court of Appeals ruled last week that cash balance pension plans do not violate federal age discrimination law.

In a unanimous decision, the New York-based appeals court affirmed two separate lower court rulings finding that cash balance plans sponsored by Verizon Communications Inc. and Equitable Life Assurance Society—now known as AXA Equitable Life Insurance Co.—do not discriminate against older workers.

Closely following other appeals court rulings on the issue, the 2nd Circuit said while the benefits provided to younger employees are worth more than the same benefits provided to older employees—in terms of a retirement age annuity that could be purchased—that difference is the result of time and compound interest and does not constitute age discrimination under federal law.

The 2nd Circuit is the fourth appeals court to rule that cash balance plans are not age discriminatory. In an August 2006 landmark ruling, the 7th U.S. Circuit Court of Appeals overturned a 2003 decision by a federal judge in Southern Illinois that IBM Corp.'s cash balance plan discriminated against IBM's older workers.

Last year, two courts—the 3rd U.S. Circuit Court of Appeals in a case involving Pittsburgh-based PNC Financial Services Inc. and the 6th U.S. Circuit Court of Appeals in a case involving World Color Press

Inc.—also rejected age discrimination charges.

All the courts have rejected the argument made in numerous suits that the plans are age discriminatory because the same earned benefit will produce a smaller retirement-age annuity for older employees than younger employees.

The appeals courts' rulings, coupled with a 2006 federal law that protects new cash balance plans from age discrimination suits "should be the death knell of cash balance plan litigation," said Nancy Ross, a partner with McDermott, Will & Emery L.L.P., in Chicago. Ms. Ross represents AXA Equitable.

The decisions "will quash participants' desires to challenge these plans. We haven't seen new litigation in this area for some time," Ms. Ross said.

Still, there is at least one more appeals court to be heard from on the issue. The 9th U.S. Circuit Court of Appeals soon is expected to rule on a lower court ruling dismissing age discrimination charges against Southern California Gas Co., a subsidiary of San Diego-based Sempra Energy.

About 1,200 to 1,500 employers now sponsor cash balance plans, so named because benefits are expressed as a cash lump sum. Employers rapidly added the plans in the late 1980s and throughout the 1990s, until the plans were enveloped by legal controversy.

More recently, some cash balance plan sponsors, including IBM and Verizon, have frozen their plans as part of a shift away from defined benefit plans in favor of enhanced 401(k) plans.

4

APPEALS COURTS that have ruled cash balance plans don't discriminate.

## Some terror cover hard to find: GAO

Large urban buildings require complex programs to cover risks

By MARK A. HOFMANN

**WASHINGTON**—Certain commercial property policyholders continue to face problems finding terrorism coverage at prices or limits they consider reasonable, according to the Government Accountability Office.

In a report sent Friday to the chairmen and ranking members of the Senate Banking, Housing and Urban Affairs and the House Financial Services committees, the GAO said that "commercial property terrorism insurance coverage appears to be available nationwide at rates policyholders view as reasonable." But some policyholders, particularly those that "own large, high-value properties in areas where many large buildings are clustered, particularly in urban areas viewed as at high risk of attack," are experiencing "challenges," the GAO said. The GAO said high-risk areas include "Manhattan and to a lesser extent certain areas of other major cities



Some policyholders in Manhattan and other urban centers have a tough time finding reasonably priced terrorism coverage, according to a report.

such as Chicago and San Francisco."

The GAO said that those policyholders have responded in several ways, including buying coverage "from a large number of insurers in complex insurance programs,

adding to what can be a time-consuming and onerous process."

Others are buying standalone coverage or self-insuring, the report said.

"Policyholders said that, through such approaches, they have generally been able to meet their current requirements for terrorism insurance coverage," according to the GAO.

The report said that policyholders, insurers and analysts alike attributed their ability to find coverage to both the federal government's terrorism insurance backstop and the soft property market.

The GAO prepared its report by gathering and analyzing data on insurance and reinsurance industry capacity, terrorism insurance take-up rates and terrorism insurance pricing. It also interviewed more than 100 industry participants ranging from policyholders to regulators in various parts of the country.

The GAO plans to issue a more detailed report later this year.

## BI to profile top women in industry

Nominations requested for third annual focus on outstanding leaders

*Business Insurance* invites readers to nominate outstanding women working in insurance, risk management and employee benefits worldwide for its third annual Women to Watch report, which will be published in the Dec. 1 issue of the magazine.

While the insurance industry historically has been led by men, more and more women are taking leadership roles at their organizations.

To explore this trend, *Business Insurance* continues to examine how professional opportunities for

WOMEN TO WATCH

women are evolving.

As part of the report, *BI* will profile women executives who are doing outstanding work in insurance, reinsurance, risk management, employee benefits and related fields, such as law and consulting.

*Business Insurance* editors will review nominees and select individ-

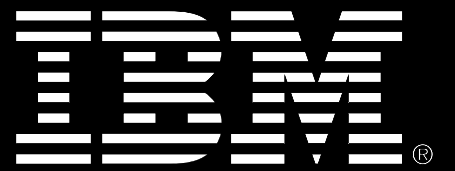
uals as Women to Watch.

Among criteria for inclusion are: recent professional achievements, influence on the marketplace and contributions to the advancement of women in business.

The list is open to women leaders worldwide.

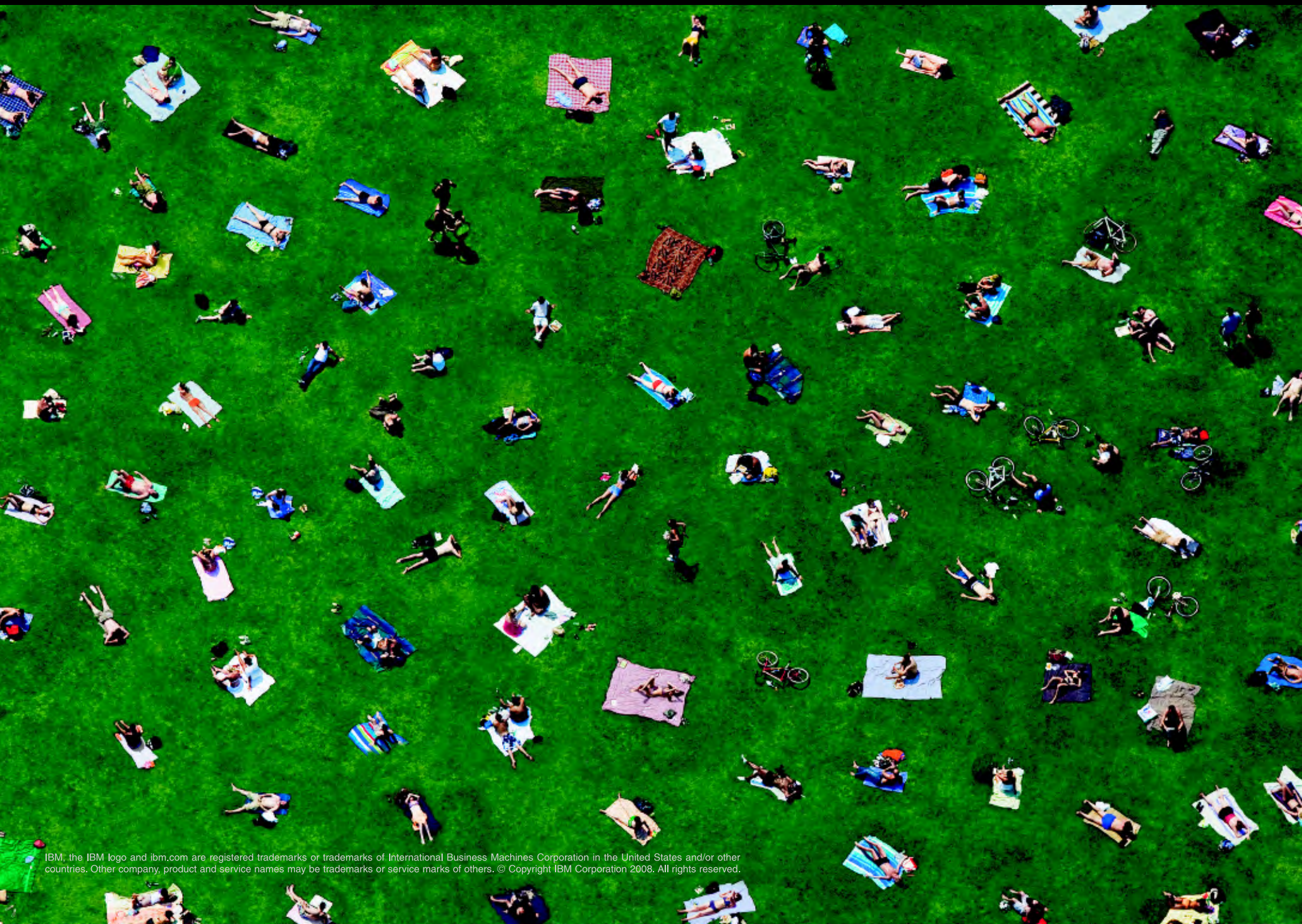
Download the 2008 Women to Watch nomination form at [www.businessinsurance.com/women-to-watch](http://www.businessinsurance.com/women-to-watch).

The deadline for submitting nominations for this special feature is Monday, Aug. 11.



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# Court: Insomnia can be a disability

Effect on a person's daily activities not needed to qualify, judge rules

By JUDY GREENWALD

**WASHINGTON**—Sleeping is a major life activity and sleeplessness can be a disability under federal law, a federal appeals court ruled in an employment discrimination case involving a student at the FBI Academy who was not permitted to graduate.

The decision by the U.S. Court of Appeals for the District of Columbia in *Martin Desmond vs. Michael B. Mukasey* involved a man whose sleeplessness began after he was held hostage during a 1997 armed robbery. Mr. Desmond testified he was counseled that was a sign of post-traumatic stress disorder.

In 2000, he attended the FBI Academy's new agent training unit in Quantico, Va. Mr. Desmond contended his disclosure that he suffered from PTSD set off a series of events that led to his dismissal from the academy.

The FBI said he was dismissed because he lacked the cooperativeness and emotional maturity required by its training standards.

Mr. Desmond subsequently sued, charging disability discrimination under the Rehabilitation Act, which is the equivalent of the Americans with Disabilities Act for federal agencies. Both prohibit discrimination against those with a disability, which is defined as an impairment that substantially limits a major life activity.

Sleep can be considered a major life activity, the appeals court said.

"Without expressing our own views on the issue, we believe that Desmond's evidence suffices to allow a jury to conclude that receiving two to four hours of sleep per night for five months constitutes a significant restriction on the ability to sleep as compared with both his own ordinary experience and with the average experience of the general public,

and hence a substantial limitation under the Rehabilitation Act," said the unanimous opinion by a three-judge panel, which overturned a lower court decision and remanded the case for further action.

Mr. Desmond's attorney, Lisa J. Banks of Katz, Marshall & Banks L.L.P. in Washington, said the decision is particularly significant because it says sleeplessness can be considered a disability even if it does not affect day-to-day activities. "It need not affect anything other than your ability to sleep," she said.

A spokesman for the U.S. Attorney General said the office was still reviewing the decision.

*Martin Desmond vs. Michael B. Mukasey, U.S. Attorney General, U.S. Department of Justice, and Federal Bureau of Investigation, U.S. Court of Appeals for the District of Columbia Circuit, No. 07-5139, July 1, 2008.*

## Bias: Questions to skip during interview

CONTINUED FROM PAGE 3

Reacting to the ruling, Jonathan T. Hyman, an employer attorney with Kohrman Jackson & Krantz P.L.L. in Cleveland, said, "Questions such as, 'What kind of medication are you taking?' just shouldn't be asked in a job interview."

The decision says "it's incumbent upon employers to make sure that

anybody who is interviewing prospective employers for jobs has the right kind of training on the types of things they can and can't ask at job interviews," Mr. Hyman said.

A question that may seem "innocent enough" when asked during an interview can "really be spun to look much worse than it may have been intended" when repeated in a deposition or in front of a jury, Mr.

Hyman said.

Mr. Doe's attorney, Jane P. Perry, of Columbus, Ohio-based Ohio Legal Rights Service, said the court was "exactly right" in its ruling.

The Salvation Army's attorney could not be reached.

*John Doe vs. The Salvation Army in the United States; the Salvation Army Eastern Territory, 6th U.S. Court of Appeals, No. 07-3822, July 1, 2008.*

## Commentary

# Iraq events reawaken experience in Vietnam



**DAVE LENCKUS**

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Risk managers increasingly are paying attention to how our nation's soldiers should be welcomed back to the workplace from their tours in Iraq and Afghanistan.

Americans are showing they can disagree vehemently about war and politics but still reach across that emotionally charged divide to work together to help veterans reacclimate to civilian life. It's a critical effort, since 37,000 vets have been injured in Iraq and Afghanistan, and more than one-third of all vets face mental health challenges. Moreover, 154,000 vets from current and past conflicts are homeless, according to government statistics.

But vets haven't always had widespread public support, as many Vietnam vets can attest.

Linda, a small woman with a sky-high dream, wants to support today's young vets and help right some past wrongs through an ambitious effort to raise \$1 million for veterans of both Iraq/Afghanistan and Vietnam conflicts.

It's her way of extending a personal thank you.

At birth, Linda was named Oanh, which means "white bird" in Vietnamese. In 1970 at the age of 10, she and two brothers were brought to this country by her mother and stepfather, an American GI who eventually adopted all three children. The couple later split up, but Linda still calls him Dad. You can tell he still loves hearing that from her.

For about five years before she came to this country, Linda lived with her grandmother, a dotting, serene and wise woman, in a pastoral village northeast of what then was called Saigon in South Vietnam.

Eventually, the war came to the village. Oanh began hearing horror stories of how the Viet Cong, the South Vietnamese who fought for North Vietnam, viciously dealt with informants. She had to take shelter in a dugout under her cot as bullets ripped through her bedroom when the VC attacked the South Vietnamese military post across the dirt road from her home.

Other times, though, she felt safer—such as when the Americans came to the village to perform medical checkups on the children, and especially when American combat troops paraded down the road in front of her home on their way beyond the rice paddies to search for the VC.

Early images from the Iraq war began jarring loose those memories for Linda, as did conversations she had around the same time with Vietnam vets she met through friends and work. It

moved her to pick up a personal journal she had begun writing years earlier but had laid down.

This time, she wrote until she had no more to write. She wrote about her lovely grandmother. She wrote about how life for her in the village swung from playing pick up sticks to investigating dead bodies. She wrote about her painful separation from her mother.

When she finished her catharsis, she had a book.

**One woman's dream is to support today's young vets and help right past wrongs.**

The book, "Beyond the Rice Paddies," now belongs to veterans. Linda has self-published it and is donating half of her royalties to various veteran organizations for Iraq/Afghanistan and Vietnam vets.

Linda also plans to use part of the royalties to fund a school project in her former village, Hiep Hoa, which is outside of Bien Hoa. Many graying vets are involved in similar projects in Vietnam.

The remaining royalties would cover Linda's printing costs.

A reviewer for [www.bloggernews.net](http://www.bloggernews.net) "really enjoyed" the book. Historian and author Marc Leepson wrote a favorable review of it in the July/August issue of *The VVA Veteran*, the Vietnam Veterans of America's magazine.

The book is available for \$11.95 on [www.amazon.com](http://www.amazon.com).

Now, some disclosures. I edited the book, but for no remuneration. Also, Linda is my better half—much better.

That's Linda's story.

We'd also like to hear yours. If you are a vet, whether you're 25 or 65, and think that sharing your experiences in returning to civilian life would help other vets or employers, please write.



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# Business Insurance OPINIONS

## Comp reforms should consider self-insureds

EFFORTS TO RESTRUCTURE the system that backstops New York's workers compensation system should take due consideration of the role of self-insured employers in the state.

As has been made clear by recent disputes about who should have to pay to bail out defaulting self-insured group trusts, the system must be revamped. While the primary concern of lawmakers should be to ensure that injured workers are looked after, they also should be concerned that the system funding the backstop is fair. Currently, that is not the case.

In particular, recent levies imposed on all self-insureds in the state to support the liabilities of several financially troubled self-insured group trusts failed to take account of the different self-insurance structures that are in place.

Large self-insureds rightly argue that they are different from the trusts. The trusts, they say, are similar to mutual insurance companies, run by private managers who calculate required reserves for the group and even pay dividends when there are surpluses. Large self-insureds stand alone and are required to post security, such as letters of credit or surety bonds, to backstop their own liabilities.

As a result, many of them say they should be treated as separate entities in the case of defaults. We agree and urge New York lawmakers to bear those differences in mind as they consider reforms.

One possibility is to create separate security funds for the different types of companies. The funds could then adopt a risk- and credit-based system for assessing how much each entity should have to pay into a backstop. That would be a more logical approach. While it might be a basic principle of insurance that the losses of the few are more easily borne by the many, individual premiums should reflect the individual risks.

*Lawmakers should be concerned that the system funding the backstop is fair. Currently, that is not the case.*

## Federal backing needed to better RRG regulation

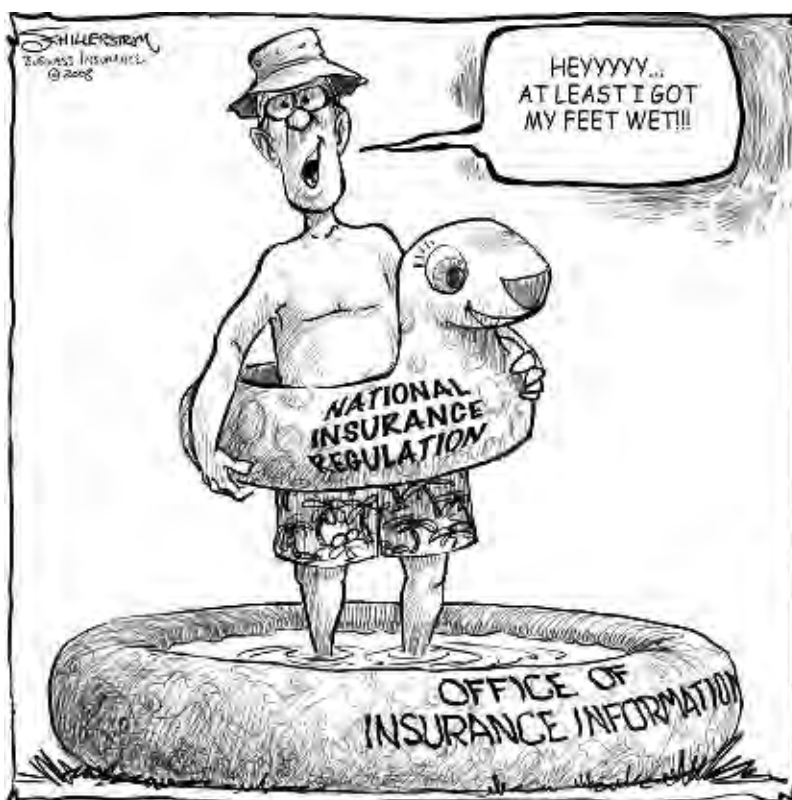
CONGRESS MADE ITSELF quite clear when it passed the Liability Risk Retention Act more than two decades ago that nondomiciliary states should keep their regulatory hands off of risk retention groups.

Unfortunately, not all states have honored Congress' intent, and some have attempted to regulate RRGs domiciled in other states through burdensome registration requirements or tried to forbid RRGs from writing certain coverages for policyholders within their borders.

That's why we think Congress would be wise to move favorably and swiftly on the Increasing Insurance Coverage Options for Consumers Act of 2008.

As we report on Page 1, the act would not only allow RRGs to write commercial property coverage for their members, it also would direct the U.S. comptroller general to conduct a study examining whether states are trying to unlawfully regulate RRGs chartered in other states through either direct or indirect methods. In addition, the bill also calls for the comptroller general to study what sorts of legal fees RRGs must pay to defend themselves against illegal regulatory actions and report back to the congressional committees with recommendations.

We believe action to curb the regulatory power grab by some states is long overdue. While the comptroller general can do nothing directly to remedy the situation of nondomiciliary states flouting the law, Congress can and should. If some states choose to ignore federal law when it comes to RRGs, Congress needs to set them straight.



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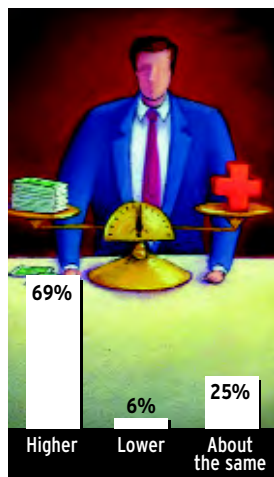
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Based on claims experience to date, are your company's health care costs this year running higher or lower than projections?



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## Risk managers must prepare for new tort risks

Risk managers must be ready for the next wave of complex environmental and toxic tort risks, write Peter Gillon and Reed Rubinstein, who are shareholders at Greenberg Traurig L.L.P. in Washington. With emerging issues such as climate change, nanotechnology and biotechnology, risk managers need to recognize and respond effectively to minimize these potential exposures and losses as the industry cannot afford to repeat mistakes of the past. There is no reason for risk managers to be caught flat-footed, they say.

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## CONSUMER-DRIVEN HEALTH PLANS

**HSA ADOPTION GROWING, BUT ACCOUNTS' FUTURE IS UNCERTAIN / Page 13**

**COMMUNICATION EFFECTIVENESS SETS TONE IN SWITCHING TO CDHPs / Page 14**

**HIGH-DEDUCTIBLE PLANS: EMPLOYERS' TIPS ON MAKING THE SWITCH EASIER / Pages 14-16**

# BENEFITS MANAGEMENT



## EXPLAINING Consumerism

# Retail clinics rise with high-deductible health plans

*Cost and convenience aside, one employer finds the quality of certain in-store care at least equal to traditional providers*

By **JOANNE WOJCIK**

Much of the growth in the retail medical clinic industry has been attributable largely to insurers adding them as in-network providers in traditional health plans, but the consumerism movement is expected to further boost this fledgling market.

When retail clinics appeared on the health care scene in the early part of this decade, they seemed like they could be a natural complement to consumer-driven health plans that also were emerging at the time. In fact, retail clinic growth has pretty much coincided with that of CDHPs.

Even though retail clinic providers saw consumer-driven plans as a potential growth catalyst, disappointing initial enrollment in CDHPs forced retail clinics to consider alternatives, said Tom Charland, chief executive officer of Merchant Medicine L.L.C., an online consulting and research company that focuses on retail medicine.

"We had not yet actually figured out how to get the attention of employers and, at the time, it was cash-only" to visit a retail clinic, recalled Mr. Charland, who is also a former executive of Minneapolis-based MinuteClinic Inc., the largest and one of the first providers of retail clinics.

"So we went through a whole process of working with employers and insurance companies. This was back when insurance companies were first hearing about getting medical care in a retail store," Mr. Charland said. "The medical directors at these insurance companies were looking at us sideways and were not real excited about the idea."

### 'Some proving to do'

"Health plans and employers initially wanted to understand whether retail clinics were actually going to reduce costs or whether they were an additive service on top of other things people were doing,"

said Steve Raetzman, senior health care consultant at Watson Wyatt Worldwide in Arlington, Va. "So the industry had some proving to do."

But once the CDHP market started to ignite, so did the retail clinic industry. Today, there are nearly 1,000 retail clinics operating in the United States compared with about 100 in 2006. MinuteClinic is the largest, with 511 clinics in 24 states (see box, page 12).

"Once we saw it start to take off, it was an accidental synergy that was remarkable," Mr. Charland said. "So that's why we had a number of employers start to get very interested in it."

Towson, Md.-based Black & Decker Corp. was among the first employers to contract directly with MinuteClinic in 2005 so its employees could access the clinics in nearby Target stores as an in-network provider, said Ray Brusca, vp of benefits at the manufacturer (see story, page 12).

At the time, Black & Decker's health plan administrator, Bloomfield, Conn.-based CIGNA HealthCare, did not recognize the clinics as an in-network option, he said.

"CIGNA was opposed initially to the use of clinics," Mr. Brusca said. "Its medical director was convinced

See **CLINICS** page 12

**LARGEST BY NUMBER OF CLIENTS**

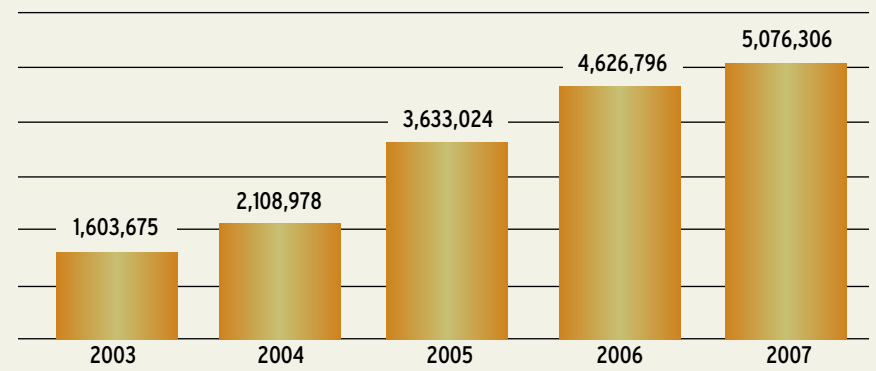
Plan providers by number of employer clients as of 12/31/07

Company	Employers
UnitedHealth Group Inc.	22,500
Aetna Inc.	7,444
Flexible Benefit Service Corp.	4,876
Harvard Pilgrim Health Care	2,600
Health Net of California	2,500

Source: BI survey

**CONSUMER-DRIVEN HEALTH PLAN UTILIZATION**

Total number of covered lives among the top 10 largest providers in each year's ranking



Source: BI survey

# Largest consumer-driven health care plan providers

Ranked by number of total covered lives at employer clients in 2007

Rank	Company/Address	Phone/Web site	Health plan name(s)*	Total covered lives	Employer clients	Plan options	Principal officer
<b>1</b>	UnitedHealth Group Inc. 9900 Bren Road E., Minnetonka, Minn. 55343	866-799-1331 <a href="http://www.unitedhealthgroup.com">www.unitedhealthgroup.com</a>	Definity	2,316,000	22,500	Dental, FSA, HRA, HSA, PPO, prescription drugs, vision	Gregg Kimball, vp-product distribution, UnitedHealthcare
<b>2</b>	Aetna Inc. 151 Farmington Ave., Hartford, Conn. 06156	860-273-0123 <a href="http://www.aetna.com">www.aetna.com</a>	Aetna HealthFund HRA, Aetna HealthFund HSA	927,000	7,444	Dental, FSA, HMO, HRA, HSA, indemnity, PPO, prescription drugs, vision	Ronald A. Williams, chairman/CEO
<b>3</b>	CIGNA HealthCare 900 Cottage Grove Road, Bloomfield, Conn. 06152	860-226-6000 <a href="http://www.cigna.com">www.cigna.com</a>	CIGNA Choice Fund	580,000	360	Dental, FSA, HRA, HSA, indemnity, PPO, prescription drugs, vision	Tom Richards, senior vp-product
<b>4</b>	Humana Inc. 500 W. Main St., Louisville, Ky. 40202	502-580-1000 <a href="http://www.humana.com">www.humana.com</a>	CoverageFirst, High- deductible health plan, PCA, SmartSuite, SmartExpress	564,700	N/A	Dental, FSA, HMO, HRA, HSA, indemnity, PPO, prescription drugs, vision	Michael B. McCallister, president/CEO
<b>5</b>	UMR <sup>1</sup> P.O. Box 8077, Wausau, Wis. 54402-8077	866-881-0800 <a href="http://www.umar.com">www.umar.com</a>	-	266,352	300	FSA, HRA, HSA, indemnity, PPO, prescription drugs, vision	Jay Anliker, president
<b>6</b>	Meritain Health 300 Corporate Parkway, Amherst, N.Y. 14226	800-828-6922 <a href="http://www.meritain.com">www.meritain.com</a>	-	123,000	76	Dental, FSA, HRA, HSA, indemnity, PPO, prescription drugs, vision	Elliot Cooperstone, CEO
<b>7</b>	Medica 401 Carlson Parkway, Minnetonka, Minn. 55305	952-992-2900 <a href="http://www.medica.com">www.medica.com</a>	Medica Direct	122,034	1,955	Dental, FSA, HMO, HRA, HSA, indemnity, PPO, prescription drugs, vision	David Tilford, president/CEO
<b>8</b>	Flexible Benefit Service Corp. 10275 W. Higgins Road, Suite 500, Rosemont, Ill. 60018	847-699-6900 <a href="http://www.flexiblebenefit.com">www.flexiblebenefit.com</a>	Flex125, FlexHRA, FlexHSA	90,720	4,876	FSA, HRA, HSA	John DiVito, president
<b>9</b>	Harvard Pilgrim Health Care 93 Worcester St., Wellesley, Mass. 02481	888-888-4742 <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a>	Best Buy HSA/PPO, Best Buy HMO/PPO	60,000	2,600	FSA, HMO, HRA, HSA, PPO	Charles D. Baker, president/CEO
<b>10</b>	Health Net of California 21281 Burbank Blvd., Woodland Hills, Calif. 91367	818 676-6775 <a href="http://www.healthnet.com">www.healthnet.com</a>	Optimizer HMO, E-Z Access HSA	26,500	2,500	Dental, HMO, HRA, HSA, indemnity, PPO, prescription drugs, vision	Gina Stassi, commercial officer

\*If different from company name. 1 Formerly Fiserv Health Plan Administration. N/A=Not Available.

Source: BI survey  
Researched by Kevin Edison and Karen Tucker

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200815

# Clinics: Retail health care growing

CONTINUED FROM PAGE 9

that all the visits would have follow-ups with primary care physicians," thereby increasing, rather than reducing, the use of medical services.

Fortunately, Black & Decker's experience proved otherwise, and CIGNA as well as most major insurers now include most retail clinics in their provider networks.

Being from MinuteClinic's home state, Blue Cross & Blue Shield of Minnesota was among the first health insurers to embrace the retail clinic concept, said Louise Clyde, director of allied network management at the Egan, Minn.-based Blues affiliate.

## Birthplace of the retail clinic

"Minnesota is the birthplace of the retail clinic," Ms. Clyde said. "Retail clinics bring care to the member rather than the member looking for care."

In tracking utilization by member type, BCBS of Minnesota is finding that retail clinic users are younger than the general population, are sig-

nificantly less ill than those visiting other medical providers and are twice as likely to be enrolled in a CDHP than any other plan type, Ms. Clyde said.

She also said BCBS of Minnesota's experience has found that the care delivered by retail clinics can be equal to or better than traditional medical providers.

For example, applying both the National Committee for Quality Assurance and Minnesota's own Institute for Clinical Systems Improvement guidelines, BCBS found that retail clinics performed better than urgent care and doctors' offices in treating patients for two specific conditions, Ms. Clyde said.

While both urgent care centers and doctors' offices provided appropriate care for respiratory infections 84% of the time, retail clinics did so 93% of the time, she said.

In addition, urgent care centers and doctors' offices provided appropriate care for sore throats 81% of the time compared with 97% for retail clinics.

Although quality may eventually

be a selling point for retail clinics, most health industry experts are finding that cost and convenience are primary reasons why individuals use the clinics, which is why experts say enrollment growth in CDHPs likely will spur additional growth of retail clinics.

"There are 11 million people in consumer-driven plans now. It could be a contributing factor to the growth of the retail clinic market," said Amrita John, a Bloomfield, Conn.-based director in the product area at CIGNA. Moreover, hospital systems and physician groups are jumping into the market, causing further expansion, she added.

"There's enough membership in those plans now to suggest that the people who use them are becoming more aware of their alternatives and purchasing behaviors as it relates to the utilization of care," said Chip Phillips, president of MinuteClinic. "And, as people become more aware...they begin to ask more questions with respect to price and service. As we assume more financial responsibility for the cost of our care, we start to pay more

## LEADING RETAIL CLINIC OPERATORS

Operator	Total clinics	States	Retail partners
MinuteClinic	511	24	CVS, Quality Food Centers, Cub Foods
TakeCare	181	13	Walgreens
Little Clinic	60	6	Kroger, Publix, Fry's Food
RediClinic	35	5	Wal-Mart, H-E-B Grocery
Target Clinic	24	2	Target

Source: Merchant Medicine L.L.C.

attention to where and how we're spending those dollars."

"Retail clinics can become a big part of the health care delivery system," particularly since they are proving to be "no worse and maybe

even better than traditional care," said Abir Sen, co-founder and chief strategy officer of RedBrick Health, a Minneapolis-based CDHP communications and education company.

## Black & Decker sees retail clinic as a good tool

Retail clinics are a win-win for employers and employees, according to a three-year study of one employer's utilization.

The analysis of preferred provider organization claims data from January 2005 through November 2007 was extracted from Towson, Md.-based Black & Decker Corp.'s data warehouse, which is administered by Mercer HealthOnline, a product that is offered by Mercer L.L.C.

"Regardless of the number of visits, for each visit that someone goes to a convenient care retail clinic vs. a physician's office, it is approximately 40% less expensive for the plan than if they went to a doctor's office," said Raymond Brusca, Black & Decker's vp of benefits.

The savings are also net of the additional financial incentive provided to plan members by Black & Decker, which is \$10 off their usual \$25 copayment for a primary care office visit, he said.

In its first year, the study also looked at whether employees followed up their visit to a MinuteClinic with trips to their primary care doctors for the same conditions. Other retail clinics were studied in subsequent years. The research found that primary care visits occurred usually when follow-up care was required.

What Black & Decker and its consultant were unable to measure, however, was the reduction in time away from the job for employees who used the clinics during the workday and how many emergency room visits were avoided.

Because the Mercer study was conducted prior to Black & Decker's introduction of a high-deductible consumer-driven health plan this year, the company and its consultant now are tracking retail

clinic usage by CDHP members to see if it's any greater than employees enrolled in PPO plans.

"Our initial analysis shows it's going like gangbusters," Mr. Brusca said.

Although there is no reduced copayment for CDHP members, Black & Decker encourages them to use retail clinics by reminding them of the lower cost compared with hospital emergency rooms, doctors' offices and urgent care centers.

"The way that we've pitched this is, it still makes sense because, whether you're paying out of pocket or you're going to use your HSA dollars, why would you want to spend \$75 for an office visit when they can spend \$49 at a MinuteClinic," Mr. Brusca said.

"It's no different than deciding to use a generic drug, over-the-counter allergy treatment or a prescription," Mr. Brusca said. "So they still save."

Black & Decker plans to use the retail clinics during its fall open enrollment to boost CDHP enrollment for 2009. Currently, only 4%, or 300 employees, are enrolled in the company's high-deductible HSA-linked plan.

Black & Decker employs approximately 7,500 workers in 49 states.

"We will use the retail clinics as one example, along with buying generics and over-the-counter drugs, as a way employees can find the most cost-effective solution for their medical needs," Mr. Brusca said. "So we really view the retail clinics as good for everybody." Regardless of whether retail clinics involve a traditional plan or a consumer-directed plan, "we're incenting you to go there," he said.

—By Joanne Wojcik

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# HSAs' reign among consumer-driven plans may come to an end

*Plans could be limited in the future, despite current support*

By **JERRY GEISEL**

Washington's five-year honeymoon with health savings accounts may be coming to an end, though no one envisions a divorce.

The honeymoon began after Congress—at the urging of the Bush administration—authorized HSAs as part of broader Medicare prescription drug legislation it passed in late 2003.

That law showered HSAs with tax breaks. Enrollees in high-deductible health insurance plans to which HSAs must be linked can make tax-deductible or pretax contributions to HSAs, while funds can be withdrawn tax-free from the accounts to pay for uncovered health care expenses.

In late 2006, lawmakers approved and the president signed a bill that allows employees to make bigger HSA contributions and clarified an interaction problem between HSAs and so-called grace periods for flexible spending accounts. This made it easier for employers to move from first-generation consumer-driven health plans linked to health reimbursement arrangements to plans linked to HSAs.

All that activity helped accelerate HSA adoption, said Gregg Larson, national HSA product leader with Affiliated Computer Services Inc. in Minneapolis.

As of Jan. 1, 6.1 million people were enrolled in high-deductible health insurance plans linked to HSAs, a number that nearly doubled in just two years, according to a survey by America's Health Insurance Plans, a Washington-based industry trade group.

Now, however, there are signs that the honeymoon may be coming to an end among lawmakers and, depending on the outcome of the November presidential election, the White House.

One sign came in April when the House of Representatives passed legislation to require banks and other

financial institutions that administer HSAs to substantiate that account distributions are for health care-related expenses, such as prescription drug copayments.

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

To handle that, many banks would have to acquire new administrative systems and those costs would be passed onto account holders. Those added costs and com-

plexity might result in some banks withdrawing from what already is a low-profit business, experts have said.

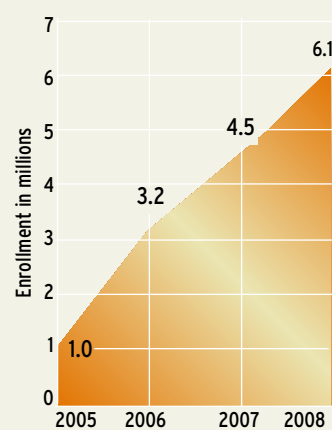
At the same time the substantiation legislation was being considered, several legislators blasted HSAs.

Rep. Pete Stark, D-Calif., who chairs the House Ways and Means Health subcommittee, said HSAs over the long term would lead to higher health care costs because enrollees may delay getting needed care, resulting in more expensive

See **HSAs** next page

## ON THE RISE

How enrollment in high-deductible health insurance plans linked to HSAs has grown.



Source: America's Health Insurance Plans

Eager to jump-start HSAs, the Bush administration pushed regulators to develop guidance quickly.

"This was an important priority for the administration," recalled Bill Sweetnam, then-benefits tax counsel for the Treasury Department and now a partner with Groom Law Group in Washington.

The first batch of Internal Revenue Service guidance came a little more than three months after HSAs became available, which was lightning speed compared with other employee benefit issues. The guidance laid out which health care services are preventive and thus, under the law authorizing HSAs, fully covered by linked health insurance plans.

The guidance kept coming at a rapid clip, with the most recent batch issued last month. The latest direction, among other things, describes services that onsite corporate medical clinics can offer at little or no cost without employees losing their eligibility to participate in an HSA.

Since passage of the authorization legislation, regulators have had company in giving HSAs special treatment. Three years after first blessing HSAs, Congress further sweetened the arrangements.



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# Switch toward high-deductible plans not easy for employers

*Proper plan design and communication essential to secure employee enrollment*

By **LOUISE ESOLA**

For scores of companies that have faced double-digit annual increases in health care costs, making the move to high-deductible health plans has become the ticket to limiting increases by forcing employees to better manage their care and costs.

The switch, however, is never easy, according to experts and companies that have made the change, including Louisville, Ky.-based Humana Inc.; Smithfield, R.I.-based Sperian Protection USA Inc.; and Atlanta-based BlueLinx Co. (See related stories.)

"The reality is that for the last 20 years, employees and their families have been insulated from the actual costs of health care," said Randall Abbott, a Wellesley Hills, Mass.-based senior consultant with Watson Wyatt Worldwide. "This is changing the mindset of those who've been accustomed to not

sharing the costs of care. For many, this is a role they don't want to assume."

## *A tough sell*

Consumer-driven health plans can be a tough sell to employees, some of whom are accustomed to using their health insurance coverage cards at every doctor visit and never seeing a bill thereafter, Mr. Abbott said.

"Employees tend to be skeptical of anything new," said Bill Sharon, senior vp for Aon Consulting in Tampa, Fla.

While employees may have been accustomed to \$10 or \$15 copayments and the ability to pay modest contributions for expensive emergency room visits and brand-name prescription drugs, those days are over for a host of companies.

For instance, with high-deductible health insurance plans, the coverage doesn't kick in until the employee first meets that

deductible, which pushes workers to act as more savvy consumers when it comes to shopping around for cheaper services and seeking generic drugs.

These plans often come with health savings accounts. HSAs allow employees whose deductibles this year are at least \$1,100 for individual coverage and \$2,200 for family coverage to contribute pretax dollars into an account to pay medical expenses.

Also, health reimbursement arrangements linked to high-deductible health plans allow employers to fund the accounts that help employees pay for uncovered health care expenses.

Employers are providing cash incentives, usually put in HRAs, for

employees that participate in health risk assessments and wellness programs, such as smoking cessation and weight-loss initiatives, steps that experts say can reduce health costs for both employers and employees.

## *Controversial approach*

The move to consumer-driven health plans, though, has its share of controversy.

Opponents of the movement argue that cash-strapped employees will forgo necessary health tests and doctor visits to avoid high bills and that adoption of consumer-driven health plans is another way for companies to shift more costs to employees.

A major issue in implementing

high-deductible plans, Mr. Abbott said, is when employers underestimate employees' concerns or fail to communicate effectively.

"A lot of employers feel that they can announce (the switch to consumer-driven plans) and leave it there for employees at open enrollment," Mr. Abbott said.

Aon's Mr. Sharon said employers also can get into trouble if they "oversell" a CDHP by making it sound better than it is.

"There are good stories and bad stories out there about how to present these plans," Mr. Sharon said. "When the plan is designed correctly and the communication is done effectively, companies can see 40% to 50% enrollment" in high-deductible health plans.

## HSAs: Future of plans may depend on next president

CONTINUED FROM PREVIOUS PAGE

treatment later on.

Another panel member, Rep. Xavier Becerra, D-Calif., labeled HSAs as tax shelters for the wealthy.

Indeed, Bush administration officials warned of a presidential veto if the substantiation legislation, which the Senate has yet to consider, received final congressional approval.

But whoever becomes the next president might not take the same line.

Sen. Barack Obama, D-Ill., the presumptive Democratic presidential candidate, is at best lukewarm about HSAs. Responding earlier this year to questions posed by the American Academy of Family Physicians, Sen. Obama described HSAs as a helpful way of saving taxpayers money "in the current health care environment. But the current health care environment is unsustainable and health saving accounts don't do enough."

By contrast, Sen. John McCain, R-Ariz., the presumptive Republican presidential candidate, has been more supportive. While offering no specifics, he said, if elected, he would work to encourage and expand HSAs. The accounts "take an important step in the direction of putting families in charge of what they pay," Sen. McCain said on his Web site.

The contrasting views means the future of HSAs could depend on the outcome of the November presidential election, said Grace-Marie Turner, president of the Galen Institute, an Alexandria, Va.-based health policy organization.

Others say that regardless of the election results, HSAs are here to stay simply because millions of

people already have coverage through them.

"There are too many to wipe them out. It would be very difficult to reverse course at this point," said Ted Nussbaum, a principal with Watson Wyatt Worldwide in Stamford, Conn.

Other Washington observers agree, but say if Sen. Obama is elected and the Democrats continue to control Congress, there could be a drive to limit HSA availability.

"I don't think HSAs will be taken away, but I also don't expect them to be improved. Depending on the political climate, there could be an effort to pare back the tax breaks for those above certain income levels," said Frank McArdle, a consultant in the Washington office of Hewitt Associates Inc.

There are numerous precedents in the benefits realm of linking tax breaks to income. For example, tax credits for dependent care expenses and adoption expenses are linked to income. In addition, employees covered by corporate pension and savings plans can make full tax-deductible contributions to individual retirement accounts only if their incomes are below certain levels.

Still, Mr. McArdle noted, attempts to link HSA eligibility to income would be strongly resisted by congressional Republicans.

Sen. McCain would be likely to offer proposals to further sweeten HSAs, but if Democrats continue to control both congressional branches, such proposals would have little chance of passage, observers say.

Indeed, proposals the Bush administration has made during the past two years to boost maximum contributions that can be made to HSAs have received scant attention from lawmakers.

## Manufacturer's move to high-deductible plans requires continual employee education

By **LOUISE ESOLA**

As a company that manufactures protective equipment for workers, Smithfield, R.I.-based Sperian Protection USA Inc. saw candid information as the way to help its employees withstand the sting of high-deductible health insurance plans.

"We made a conscious decision that we wouldn't dance around the issue and that we would take it head-on," said Mike Vittoria, vp for human resources, who helped Sperian Protection introduce consumer-driven health plans to its 1,500 employees in 2004. "We realized that they weren't convenient plans and we were upfront. Employees will respect that, we thought."

At the time, like many companies, Sperian Protection was facing double-digit health insurance premium increases. As a result, it turned to consumer-driven health plans to help manage those costs. For the company, the new plans weren't introduced to shift costs to employees—it still pays a hefty portion of the health bill—but to urge workers to take responsibility for their own health and to see the dollar signs for themselves, Mr. Vittoria said.

"They started to become aware that health care wasn't free," Mr. Vittoria said. "We saw value in getting our employees involved in the cost of health care."

Sperian Protection began its trek into consumer-driven health four years ago by linking health reimbursement arrangements to preferred provider organizations, which came with a \$3,000 deductible for single coverage and the company's help in covering the deductible

for certain services.

A complicated balancing act, by maintaining a high deductible for employees, the company was able to negotiate unspecified lower premiums from an insurer and give employees the opportunity to take charge of their HRAs.

By studying its workforce over the years, Sperian Protection saw that 80% of employees had less than \$1,000 in claims per year.

The effort has saved and continues to save money for the protective equipment maker, Mr. Vittoria said.

It has, however, required extensive communication.

"This requires a lot of re-educating the workforce," Mr. Vittoria said. "Employees (in 2004) didn't like it. We had one employee (at an information meeting) say 'I should go to the doctor and just give them my card and never see a bill.' Employees want their health care to be convenient."

"We're probably the most complicated plan out there," Mr. Vittoria said, calling the plan an "HRA carved out of a PPO."

Currently, the offerings include a menu of plans with both HRAs and health savings accounts, which allow employees to save for future health costs.

Among current coverage offerings is a "layered" plan



PHOTO COURTESY OF SPERIAN

**Sperian Protection USA Inc., a safety equipment manufacturer, turned to consumer-driven health plans as a way to decrease health care costs.**

deductible in which the employee pays the first \$2,250 for single coverage and the company pays all costs between \$2,250 and \$10,000. After \$10,000, insurance picks up the costs.

It isn't easy to grasp and requires Sperian Protection to hold monthly meetings for employees, Mr. Vittoria said.

"We don't do the once-a-year open enrollment meeting," he said, adding that most employees are satisfied with the CDHP. "We are constantly educating the workforce."

A major key in keeping costs low is Sperian Protection's focus on health and wellness for its workforce. To be eligible for one of the health plans, the company requires all of its employees to participate in a health risk assessment aimed at identifying illnesses and risks before an expensive trip to the emergency room, Mr. Vittoria said.

# Humana to employees: Do the math to see the value of CDHP

*Insurer turns to regular meetings, feedback sessions and 'health mentors' to answer questions and boost enrollment*

By LOUISE ESOLA

Even a company that sells health insurance had a tough time moving its employees from traditional offerings to complicated consumer-driven health plans.

The human resources experts at Humana Inc. say times were tough in 2000 when the Louisville, Ky.-based insurer overhauled its plan designs. True to form, employees were confused and, at times, angry when they saw the change would force them to pay more attention to the cost of care, said Debbie Triplett, human resources director of associate benefits programs and policy.

who do the math will choose a consumer-driven health plan easily."

In 2001, 18% signed up for the second year of Humana's high-deductible plan, Ms. Triplett said. That figure grew gradually until this year, when the consumer-driven health coverage became employees' only option.

Currently, Humana, which self-insures health coverage, offers its 26,000 employees nationwide one plan with varying deductibles that range from \$1,200 to \$6,000 per year. The higher the deductible, the

lower the payroll deduction, she said. Plans are linked to HSAs, she said.

All plans come with incentives, such as wellness programs, to help employees cover their deductible, she said. Employees who stay healthy often see the plans as a way to save more in their health savings accounts.

"We believe in consumerism and

**26,000**

**HUMANA** employees currently are offered a high-deductible health plan with deductibles that range from \$1,200 to \$6,000 per year.

getting our associates to think about health care the same way they think about buying a TV," Mr. Cockerell said, adding that employees will pay attention to the cost of care the same way they would in buying anything else.

Changing thinking, however, hasn't been easy, Ms. Triplett said. To help employees better understand the

program, Humana has regular meetings and has enlisted selected employees to act as "health mentors," go-to people from whom puzzled employees can get answers.

Humana also has used meetings and feedback sessions to enhance its program as well as offer the same plans to its clients.

Part of the program is the Web site [www.familyhealthbudget.com](http://www.familyhealthbudget.com), which provides anyone, both Humana employees and the public, access to calculators to help determine health care costs.



COURTESY OF HUMANA INC.

**Louisville, Ky.-based Humana Inc. wants employees to think about health care the way they would buy a TV—considering the cost.**

"We have so many people (in our workforce) who do not touch health care as part of their jobs," said Ms. Triplett, who's based in Louisville. "We couldn't assume all the company's employees would know everything" about consumer-driven health plans.

A leader in the movement, Humana began offering high-deductible health plans, which came with lower payroll deductions and hundreds of dollars in wellness incentives, as an option for employees to help the company fight double-digit cost increases.

"We saw health care robbing the company budget for other programs, so we took action," Ms. Triplett said.

A "not so surprising" 6% of employees signed up that first year for the high-deductible plan, which had a lower premium than other plans, she said.

Employees at the time were unfamiliar with CDHPs, she said.

### Early adopters

Ms. Triplett and Tray Cockerell, Humana's human resources business leader, took a closer look at the figures and saw it was mainly accountants and actuaries who were the first to make the switch.

"They are the ones that took the information and did the math," said Mr. Cockerell, also based in Louisville. "They ran the numbers and saw that if they were healthy, they could benefit. We want all our associates to do the math. Those



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# Materials distributor builds employee support for HDHP

*BlueLinx's 'bumpy' first year with its high-deductible health plan proved 'a learning experience'*

By **LOUISE ESOLA**

Prior to introducing consumer-driven health plans at BlueLinx Co., few of the 3,600 workers at the construction materials distribution company knew the cost of going to the emergency room vs. visiting the doctor's office.

Dean Adelman, the Atlanta-based company's chief administrative officer, helped introduce a high-deductible health insurance plan in 2007 that was much different from the long-familiar health maintenance organization plans.

"(Reception) was difficult and the first year was bumpy," Mr. Adelman said. "HMOs are pretty much free (to employees), so it was a shock. For over 30 years we trained people to pay \$10 to go see a doctor, and

now we're asking them to look at the cost. It's been a learning experience."

**'Our biggest success so far has been getting people to move from brand-name drugs to generic, because they now see the cost.'**

Dean Adelman, BlueLinx Co.

The company began offering high-deductible plans to handle skyrocketing health premiums by getting employees involved in health costs and control, he said.

"Our biggest success so far has been getting people to move from brand-name drugs to generic, because they now see the cost," Mr. Adelman said.

This year's coverage comes with deductibles that range from \$1,500 to \$4,500, with the company offsetting half the deductible by depositing that amount in an employee's health savings account. Employees add to their HSAs with pretax income.

Once the deductible is met, employees must pay 20% of all services.

A highlight of the plan is that most preventative services, such as annual physicals, are covered 100%. BlueLinx also offers incentives, such as \$100 for taking part in a company-sponsored health risk assess-

ment, he said. The idea is to help employees catch any medical conditions early to avoid expensive

## WHAT THE PLAN OFFERS

BlueLinx Co.'s initial shift to a consumer-driven approach with an HSA was tough. In addition to HMO and PPO options, its HDHP this year offers **deductibles ranging from \$1,500 to \$4,500 and 20% coinsurance** above the deductible. BlueLinx also covers most **preventive services at 100%** and offers **\$100 incentives** to employees who complete health risk assessments.

treatment later, Mr. Adelman said.

BlueLinx still offers traditional plans, such as HMOs and PPOs, but they have heftier payroll deductions

and don't feature incentives.

While the first year was tricky because most employees did not understand the high-deductible plan, Mr. Adelman said this year has been easier. Last year, more than half the employees who enrolled in the HDHP linked to an HSA did not spend all the money in their health savings account, money they can save and apply to future medical expenses.

Currently, about half the company's employees are enrolled in the consumer-driven plan, and Mr. Adelman expects that to increase. "Anyone who signed up for the (consumer-driven health) plan in 2007 stayed with it," he said.

"It's been a learning experience and we are seeing a lot of success stories. People are losing weight and getting off their Lipitor (cholesterol-reducing prescription medication)," Mr. Adelman said. Wellness initiatives have allowed employees to save on health costs, thus save their own money, he said. "In the long term, people see the savings."

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# International NEWS

## Mandate disclosure of broker pay: AIRMIC

*Buyers are not satisfied with level of disclosure*

By SARAH VEYSEY

**LONDON**—The U.K. risk managers' association has clarified its stance on the transparency of broker remuneration and called on the regulator to require such disclosure to be automatic.

Until recently, the Assn. of Insurance & Risk Managers had shied away from an outright call for regulatory action to make disclosure of brokers' pay automatic, preferring a market-led solution.

In its final submission to a Financial Services Authority investigation into broker remuneration, AIRMIC said that many buyers are not getting the information they require under the current voluntary system.

AIRMIC called for the regulator to make disclosure full and automatic. It suggested the best way to proceed should be for a market-led solution to the issues raised in the FSA discussion paper on broker remuneration, "Transparency, disclosure and conflicts of interest in the commercial insurance market," in March.

The British Insurance Brokers' Assn., in its formal response to the FSA, however, said it believed the current system was sufficient and that there was no evidence that commercial insurance buyers wanted a change.

BIBA said, however, that it would support an industry-led drive, rather than a regulatory order, towards greater transparency.

Under current FSA rules, commercial insurance buyers have the right to request—and be told—information about payments received on their business.

The FSA, which has regulated insurance brokers since 2005, has investigated the transparency of broker pay and said it wants to move forward with a solution to improve transparency by the end of this year.

In March, the FSA set out potential ways in which transparency could be improved: more rigorous enforcement of current rules; an enhanced regime for voluntary disclosure, or mandatory disclosure; and invited comment, which ended in June.

"We have been waiting and watching to see how the voluntary regime works, but it seems to us that many commercial buyers are still not getting the necessary information," said Kip Berkeley-Herring,

chairman of AIRMIC's insurance steering group.

AIRMIC said that while a large majority of its members received satisfactory disclosure from brokers, and some 67% received automatic disclosure of broker pay, many buyers were not receiving the level of disclosure that they wanted.

In its FSA response, AIRMIC said that it believed there should be "full and automatic disclosure of total broker remuneration," and that remuneration information should be calculated to a standard formula to enable easy comparison between brokers.

AIRMIC also said it was "vital that an insurance intermediary clearly defines their status as agent of the insurer where this is the case."

AIRMIC said that it believed the best way to proceed is to develop a market-led solution similar to the contract certainty work in 2005 and 2006, where the FSA set targets to improve the production of policy documentation.

In its response, BIBA reiterated its view that no regulatory intervention was needed to make broker disclosure mandatory. "We believe that the current combination of high-level principles, plus a rule requiring disclosure on request is sufficient," said Eric Galbraith, chief executive of BIBA, in a statement.

"There is no evidence that the current regime affords commercial customers inadequate protection or that these commercial customers want change," he added.

Steve White, head of compliance at BIBA, said the group favors—and is working on—a market accord for greater transparency.

"A solution that provides for greater transparency for the commercial customer in respect of the intermediary's status, the services provided and how those services are paid for, while disclosing the details of the remuneration upon the request of the commercial customer is one which has widespread support," he said.

"We are still to finalize the details (of the market accord) but are pleased with the support we are receiving," he said.

At AIRMIC's annual conference in Edinburgh, Scotland, last month, an FSA representative said it would state its preferred option in the last quarter of this year and move ahead swiftly with any regulatory response.

**67%**  
OF AIRMIC members received automatic disclosure of broker pay

## Insurers face antitrust scrutiny

*Italy's larger policyholders concerned about lack of competition*

By MICHAEL BRADFORD

**ROME**—Italy's antitrust authority is looking further into whether links among the country's rival insurers and banks are impeding competition in a marketplace that large policyholders confirm is short on choice of insurers interested in their accounts.

A spokeswoman for the Autorità Garante della Concorrenza e del Mercato, Italy's Rome-based antitrust agency, confirmed that the authority has decided to continue its probe into the corporate governance of banks and insurers that begun a year ago.

She referred to a recent speech by the authority's chairman, Antonio Catricalà, in which he expressed concerns about widespread links among financial services companies, such as competitors with common board members and large shareholdings in each other's operations.

Mr. Catricalà said in his speech that one unidentified company has 13 board members who also sit on the boards of competitors and another has 10 members who hold seats with competitors.

While the chairman did not identify companies under investigation, there is widespread market speculation that Assicurazioni Generali S.p.A. is among the companies that remain under investigation. A spokeswoman for the antitrust authority would neither confirm nor deny that Trieste, Italy-based Generali was being investigated. Generali said it had no comment to make on any investigation.

The competition authority hopes to complete its investigation by the end of the year, its spokeswoman said. If anticompetitive links are discovered, the authority will advise Parliament that the conditions exist and it will then be up to lawmakers whether legislation should be passed that would disallow such relation-



Antonio Catricalà, chairman of Italy's antitrust agency, is concerned about anticompetitive links among banks and insurers.

ships among competing insurers and banks, she said.

Buyers and other sources, meanwhile, say the antitrust investigation is not expected to have a big impact on the Italian market, which already is marked by a dearth of competition.

"In theory, there is a lot of concern about this," said Benito Pagnanelli, president of Pagnanelli Risk Solutions Ltd. in Milan, referring to the issue of potential anticompetitive links among insurers. But, he added, the investigation is likely to produce little in the way of meaningful changes.

Mr. Pagnanelli and other Italian market experts gathered at a roundtable discussion hosted earlier this month by *Business Insurance Europe*, *Business Insurance's* sister publication, in Milan to talk about major issues in their marketplace. Lack of insurer choice was among their concerns.

"From the standpoint of big insurance buyers, there is not enough competition," said Paolo Rubini, who is director of risk man-

agement at Telecom Italia in Milan and vice chairman of the Associazione Nazionale dei Risk Manager e Responsabili Assicurazioni Aziendali, Italy's risk management association.

"I agree with (Mr. Rubini) that there is not enough competition, especially from Italian companies," said Roberto Bosco, corporate risk manager at Mediaset Group Rti. S.p.A. in Milan and chairman of ANRA.

That lack of competition is a problem peculiar to large risk management accounts, however, and does not extend to smaller buyers, the roundtable participants noted.

"When you talk about big risks and sophisticated products, I agree with you that there are very, very few carriers in the market that can meet your needs," said Marco Maraccani, general manager for Italy at AIG Europe in Milan, a unit of New York-based American International Group Inc. That's not so with smaller risks, he said.

A fragmented market of insurers chasing small accounts provides a more robust marketplace for those policyholders, said Mr. Maraccani.

"The statement that there is not sufficient competition, I would say, reflects just areas of risk where you need the support of the international market. But for smaller risks, from the rates I see, there is too much competition," said Mr. Pagnanelli.

"In that respect, the situation in Italy is not different than in any other country," said Maurizio Castelli, sales director for continental Europe and Asia at XL Insurance, a unit of Hamilton, Bermuda-based XL Capital Ltd.

"There is an issue with carriers that are able to provide sophisticated service, global networks and that kind of service. The number is very limited. And that is not different in Italy from any other place."

## High Court rules in favor of Lloyd's

*Investors argued they were misled in reinsurance-to-close deals*

By SARAH VEYSEY

**LONDON**—The High Court in London has ruled that Lloyd's of London did not conceal information about the exact nature of reinsurance-to-close deals underwritten in the early 1990s from a group of individual investors.

Among other allegations, the investors, or names, who underwrote with unlimited liability at Lloyd's, claimed that a brochure provided to them when they began underwriting, and subsequently was amended annually, indicated that reinsurance to close meant that the contracts with policyholders were novated, or ended their liabilities at the end of each underwriting year.

The names argued that they believed they could resign from Lloyd's and their estates could be



Lloyd's has won a round in a lengthy court battle with investors over reinsurance-to-close deals.

distributed without residual exposure.

Lloyd's, however, contended that the documents circulated to the names did not say that reinsurance

to close would mean that policies were novated.

Justice David Steel ruled that Lloyd's did not deliberately conceal from the names the nature of reinsurance to close and ordered that the names pay monies they owed to Lloyd's, as well as legal costs.

"This judgment is a victory for Lloyd's. It will help us close a chapter in our history and we hope it is the end of a decade of failed litigation brought by the names," Sean McGovern, Lloyd's general counsel, said in a statement.

"We are now seeking orders against the claimants preventing them from bringing similarly vexatious claims against Lloyd's," Mr. McGovern added.

Michael Freeman, an attorney representing the four dozen individual investors, reportedly said he would appeal the ruling.

## Market Moves



### Partnership offers special investigation program

**RALEIGH, N.C.**—MJM Inc. said it has partnered with Matrix Absence Management Inc. to provide anti-fraud programs and services to Matrix's clients.

Raleigh, N.C.-based MJM—a provider of investigative products and services to insurers, self-insured corporations and third-party administrators—and Matrix Absence Management—a San Jose, Calif.-based firm that provides customized management of disability, workers compensation and family leave programs—formed the Matrix Absence Management SIU Program. The program provides investigation and surveillance, integrated Internet-based technologies, and enhanced antifraud programs and measurement tools.

The relationship designates MJM as the managing partner for all investigative assignments conducted by Matrix Absence Management throughout the country.

The program also has implemented Matrix SIU CaseTrak, which allows claims professionals to view streaming investigative video, detailed reports, still photographs and more from their desktops.

### Ironshore forms excess casualty unit

**NEW YORK**—Bermuda-based Ironshore Inc. has established an excess casualty unit called IronSelect.

The unit will write excess umbrella casualty coverage for midsize commercial risks, such as manufacturers, retail and wholesale operations, and contractors. IronSelect is based in IronShore's New York office.

Bob Piller has been named president of IronSelect. He reports to Greg Flood, chief executive officer of Ironshore Holdings Inc., and is responsible for building and expanding the IronSelect platform and product suite.

Previously, Mr. Piller served as senior vp at Schaumburg, Ill.-based Zurich North America, where he was responsible for underwriting excess casualty business in six territories—Boston, Chicago, Dallas, Los Angeles, San Francisco and Nashville, Tenn.

### Law firm forms insurance fraud department

**IRVINE, Calif.**—Palumbo Bergstrom L.L.P. has launched a special investigation and insurance fraud department within its insurance defense practice in Irvine, Calif.

The department will focus on representing insurers investigating and handling suspect insurance claims. It will work closely with the special investigation units for the firm's insurer clients, as well as law enforcement.

David Wasson, a partner, will head the new practice.

### Consulting firm opens Montreal office

**MONTREAL**—Sibson Consulting has opened an office in Montreal, the New York-based company said.

Sibson is the human resource consulting division of New York-based Segal Co., an independent benefits, compensation and human resources firm.

The office is at 1250 Rene Levesque Blvd. West, Suite 2200, Montreal, Quebec H3B 4W8, Canada. The phone number is 514-989-3735 and the fax is 514-934-4640.

Genevieve Lussier, a consultant, will lead the office, which will be known as Conseillers Sibson.

### Max Specialty expands reach in surplus lines

**RICHMOND, Va.**—Max Specialty Insurance Co. said it now is an eligible surplus lines insurer in 47 states, after recently adding California to its list.

Max Specialty is a Richmond, Va.-based insurer, licensed as an admitted insurer in Delaware. It is a subsidiary of Max Capital Group Ltd. Max Specialty offers property, ocean and inland marine, casualty, excess liability and umbrella insurance products.

### OneBeacon buys entertainment brokerage

**LOS ANGELES**—OneBeacon Insurance Group Ltd. said it has agreed to acquire Los Angeles-based Entertainment Brokers International Insurance Services, which specializes in the entertainment, sports and leisure industries.

Entertainment Brokers provides commercial insurance products, including professional liability coverage, from its locations in Los Angeles and New York. It also provides excess workers compensation coverage as a wholesaler from its Westlake Village, Calif., office.

Canton, Mass.-based OneBeacon offer's a range of specialty and segmented commercial and personal insurance products sold primarily through independent agents.

The acquisition is expected to close in the third quarter.

### TO SUBMIT ITEMS

*BI's Market Moves* column reports on activities by insurance industry companies and related entities. Personnel changes appear in *Comings & Goings*, while new product offerings appear in *Products & Services*. Please send *Market Moves* news to: Kristin Gunderson Hunt, *Business Insurance*, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; [khunt@businessinsurance.com](mailto:khunt@businessinsurance.com). P&S items should be sent to Colleen McCarthy at [cmccarthy@businessinsurance.com](mailto:cmccarthy@businessinsurance.com) and C&G items should be mailed to Allison Martinat at the above address or e-mailed to [amartinat@businessinsurance.com](mailto:amartinat@businessinsurance.com).

# Emerging Risk STRATEGIES

## So who really needs ERM?

*Prioritized, focused plans are essential to successfully mitigate risks*

By John J. Hampton

At April's RIMS 2008 conference in San Diego, a considerable buzz existed around the topic of enterprise risk management. At the same time, the question persisted, "Who needs it?"

My answer is, at least four people within an organization: the chief executive officer, the chief financial officer, the internal auditor and the risk manager.

If ERM means listing the 2,000 to 3,000 or so risks that face an organization, no one really needs it. An undisciplined approach to identifying risk and integrating risk mitigation into a single program will bog down after much expenditure of time and money. On the other hand, a disciplined ERM structure is just what is needed by the CEO, CFO, auditor and risk manager, among others.

The disciplined structure has four components:

- Hierarchy of categories: Risks are organized in clusters with five to nine subrisks from the C-suite on down.

- Risk owners: Each category or subcategory is assigned to a risk owner.

- Alignment with business model: The categories match operating units, staff functions and key initiatives.

- Visual risk clusters: Risk relationships are presented visually using technology to explain mitigation efforts.

To illustrate, let us use a lightly disguised and somewhat simplified public utility. Central Power & Light is a regional power producer with three main subsidiaries: Central Fossil, which operates natural gas, coal and oil-fired electric generating units; Central Nuclear, which operates two nuclear generating stations; and Central Energy Trading, which buys and sells electric and gas commodities, trades in environmental credits, and is responsible for all planning and risks involved with long-term generation.



John J. Hampton is the KPMG Professor of Business and Dean of the School of Professional and Continuing Studies and Graduate Business Programs at St. Peter's College in New Jersey. He specializes in business ethics, legal liability and enterprise risk management. He is a former executive director of RIMS. To read Mr. Hampton's columns and interviews, visit [www.BusinessInsurance.com/ERM](http://www.BusinessInsurance.com/ERM).

- Energy trading: First-level risk owner.

- Business disruption: Changes in conditions that affect long-term capabilities to generate electricity.

- Environment disruption: State or federal regulations that limit the use of coal or oil in peak generating periods.

- Federal agencies: Conflicting federal agency environmental regulations or interpretations of existing regulations.

- EPA: Relations with the Environmental Protection Agency.

- Water, air and ground pollution: EPA regulations for cooling, water usage; discharge into the air, wetlands and porous surfaces; and related exposures.

The four individuals have different interests in the risk if the EPA were to deny permission to build the critically needed nuclear power facility:

The CEO and CFO seek transparency and accountability. The Sarbanes-Oxley Act requires the CEO and CFO of public companies to verify internal controls and reliability of financial statements. Rating agencies require risk programs to achieve favorable ratings on debt issues. The internal auditor is responsible for monitoring compliance with company policies and directives. The risk manager needs to present the wetlands exposure to insurers and others as part of risk management and the purchase of liability coverage.

All four individuals can go into the ERM structure and work down to ground pollution as shown in Figure 2.

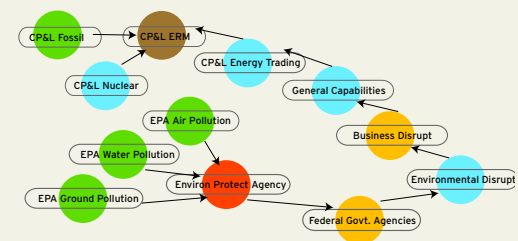


Figure 2. Risks from the top to EPA

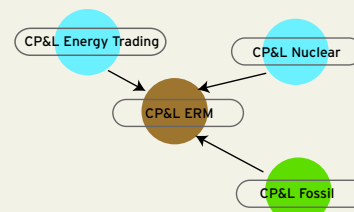
The questions common to all parties are: What is being done to mitigate risk? What are the plans, the activities and the timetable?

Mitigation activities can be stored in the ERM knowledge warehouse and accessed directly. Over time, a complete history of risk activities and mitigation will be created, stored in one place and be accessible to authorized users. The user can open and read the documents.

The original question was who needs ERM. The answer is that an ERM program with hierarchical risks and risk owners, visual risk clusters and a high-tech platform can serve the needs of many users. The logic is inescapable. Companies need enterprise risk management. It just has to be done right.

Figure 1 shows the top-level risks in its ERM program using (with permission) the Riskconnect Visual Risk Cluster Tool.

Figure 1. CP&L ERM program.



The company wants to develop a new nuclear power plant that has possible wetlands impact. The project is critical to the future of the company. The risk was assigned to the energy trading company. Although a critical risk, it is far down the hierarchical ERM structure:

# RRGs: Regulation by states examined

CONTINUED FROM PAGE 1

Dennis Moore, D-Kan., and Deborah Pryce, R-Ohio, would be the first expansion of the Liability Risk Retention Act since 1986, when federal lawmakers amended the original 1981 law that gave RRGs their special status (*BI*, April 21).

The measure also contains provisions relating to the corporate governance of RRGs. It was one of three insurance-related measures the subcommittee approved last week (see related story).

RRG advocates have long argued that some states attempted to over-

certain coverages. For example, a federal judge earlier this year ruled that the California Insurance Department could not enforce an order banning a Montana-domiciled RRG from writing medical stop-loss coverage for California policyholders (*BI*, March 17).

The new bill, which would change the LRRRA's name to the Risk Retention Act, instructs the U.S. comptroller general to conduct a study to determine if states have attempted to unlawfully regulate the operation of an RRG that is not chartered in that state through a unilateral cease and desist order or

other means. In addition, the bill also directs the comptroller general to determine costs to RRGs associated with such state actions, RRGs' ability to pay fees associated with challenging nondomiciliary state actions and possible legislative solutions. The bill calls on the comptroller general to report to relevant congressional committees within a year of its enactment.

RRG proponents welcomed the bill.

For example, the Risk & Insurance Management Society Inc. "is in favor of the study

since some nondomiciliary states have exceeded their authority, in our opinion," said Terry Fleming, RIMS director-external affairs and director of the division of risk management for Montgomery County in Rockville, Md.

"I think that's very good idea," said Robert Myers, general counsel of the National Risk Retention Assn. and managing partner in the Washington office of Manning, Morris & Martin L.L.P.

He noted that a 2005 Government Accountability Office report about RRGs failed to look into the

practices of states, adding "basically only told one side of the story."

"Periodically, some states take more liberties with their construction of the law than others," said Mr. Myers. "It does need some attention because some states are abusing their authority."

"Some states take more liberties in their interpretation of the law and realize that they can get more information or concessions than they're entitled to under the federal law because it is so expensive in terms of time, effort and money to fight them," Mr. Myers said.

"As a captive manager, if you're dealing with a \$200 (registration) fee, you're not going to spend upwards of the six figures in legal fees. You tend to bite your lip and pay it," said Jon Harkavy, vp and general counsel for captive manager Risk Services L.L.C. in Washington.

"In most of these cases, it's just not cost effective for an RRG to challenge these things—it's so terribly expensive," said Mr. Harkavy. "Basically the state regulators have chosen to ignore it."

"RRGs need some sort of cost-effective way of resolving difficulties with the states," said Mr. Harkavy. "Quite frankly in many ways, the pre-emptions afforded by the Risk Retention Act—on the registration issue particularly—have become a federal right without a real remedy."

For its part, the Kansas City, Mo.-based National Assn. of Insurance Commissioners said it had taken "no formal position" on the bill.

The Indianapolis-based National Assn. of Mutual Insurance Cos. opposes expansion of RRG powers.

"The expansion of the RRGs into broader commercial insurance, including liabilities owed to individual consumers, is problematic and we do not believe such an expansion should be approved at this time," said Jimi Grandi, vp-government and political affairs in NAMIC's Washington office in a statement issued after last week's vote.

The outlook for the bill in this Congress remains murky. Although the House could vote on the measure soon, the Senate has not considered the issue.

## Federal insurance office may assist OFC effort

By MARK A. HOFMANN

**WASHINGTON**—Proponents of an optional federal charter for insurers and producers may have received a boost for their cause courtesy of a House panel.

That's because the House Financial Services Committee's Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises last week approved the Insurance Information Act of 2008.

The measure would create an

isolation, said the proposed new office would lay a "solid foundation for the OFC."

The Risk & Insurance Management Society Inc. also welcomed the move.

"RIMS is in support of the OII, in hopes of there will be an OFC at a later time," said Terry Fleming, RIMS director-external affairs. Mr. Fleming also is director-division of risk management for Montgomery County in Rockville, Md.

The National Assn. of Insurance Commissioners weighed in against any effort to turn the Office of Insurance Information into an avenue to an OFC.

"Some members of Congress and industry lobbyists have made claims that this bill is the first step to an

'optional federal charter' for insurance," NAIC President and Kansas Insurance Commissioner Sandy Praeger said in a statement. "The NAIC unequivocally opposes any attempts to use this bill as a vehicle for such a misguided policy."

The panel also approved the National Assn. of Registered Agents and Brokers Reform Act of 2008, which would amend the Gramm-Leach-Bliley Act to reestablish the National Assn. of Registered Agents and Brokers as a nonprofit corporation whose purpose is to provide a mechanism through which licensing and other insurance producer qualification requirements and conditions can be adopted and applied on a multistate basis.

**RIMS 'is in favor of the study since some nondomiciliary states have exceeded their authority, in our opinion.'**

Terry Fleming, Risk & Insurance Management Society Inc.



RIMS

**'Periodically, some states take more liberties with their construction of the law than others.'**

Robert Myers, Manning, Morris & Martin L.L.P.



rule federal law that clearly says only the RRG's domiciliary state has the right to regulate an RRG through a variety of methods.

That is the cornerstone of the Liability Risk Retention Act, which allows RRGs that have met the licensing requirements of one state to provide coverage to policyholders in any state with minimal interference from nonchartering state regulators.

Nevertheless, states have subjected RRGs domiciled in other states to onerous registration requirements and tried to bar RRGs from writing



AP PHOTOS

**'The NAIC unequivocally opposes any attempts to use this bill as a vehicle for such a misguided policy.'**

Sandy Praeger, NAIC

Office of Insurance Information in the Treasury Department. The new office would collect and analyze insurance data and information and issue reports on insurance issues.

The body also would establish federal policy on international insurance issues and determine whether individual state policies are consistent with policies agreed upon by the federal government and other governments or foreign regulators.

The Secretary of the Treasury would have limited powers to recommend pre-emption of state policies that are not consistent with federal policy and international agreements.

During consideration of the bill, Rep. Melissa Bean, D-Ill., who has cosponsored OFC leg-

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## State liquidation bureau makes improvements

*Auditors analyzed New York bureau's procedures in several areas, many deficiencies corrected*

By DOUGLAS McLEOD

**NEW YORK**—An audit of the New York Liquidation Bureau's internal controls found that dozens of past shortcomings in its procedures for managing insolvent insurers' estates have been corrected or are in the process of being fixed.

The audit, by Edison, N.J.-based accounting firm Amper, Politziner & Mattia, is the first phase of a larger review of the bureau's operations that will include audits of the bureau's finances and those of dozens of insurer estates, several of them decades old.

Long a target of complaints about

poor management, lack of transparency and the slow pace of its work, the Liquidation Bureau has undertaken a reform push under Special Deputy Superintendent Mark G. Peters, who took over in April 2007.

Amper Politziner examined the bureau's procedures in several areas, from claims adjudication and reinsurance collections to information technology. The firm focused on the bureau's management of 26 of its more than 60 insurer estates, including such large 1980s-era insolvencies as Union Indemnity Insurance Co. and Ideal Mutual Insurance Co.

Auditors found 84 deficiencies in its financial reporting procedures, 39 of which have already been corrected and the remainder of which are in the process of being fixed, according to the report.

One high-priority problem, for example, was that the bureau's general ledger balances—calculated using a computer system put in place in 1994—did not reconcile with claims balances of individual estates, especially those that predated 1994, the audit found. A reconciliation of those balances will be completed for the bureau's audited 2006 financial report, which is expected to be

released shortly, according to the bureau.

Auditors also found that too many people have access to digital records of the bureau and its estates, and that the bureau has relied too heavily on an outside consultant for reinsurance billing and other functions without proper oversight. The bureau is tightening access to its records and is moving previously outsourced functions in-house, the report says.

Along with the upcoming release of its audited 2006 financials, the Liquidation Bureau says it will complete audited 2007 financials by the end of this year.

# Commissions: New York hearings explore contingents

CONTINUED FROM PAGE 1

affairs, said in an e-mail.

RIMS President Janice Ochenkowski will testify at the July 25 hearing.

A complete list of those scheduled to testify at the hearings was unavailable last week. While representatives from New York-based Marsh & McLennan Cos. Inc., Chicago-based Aon Corp. and London-based Willis Group Holdings Ltd. are expected to testify, insurers contacted last week by *Business Insurance* that reached settlements concerning the commissions said they were not planning to, were still considering it or did not know if they would participate in the hearings.

"Before we...take any action, we want to have a robust dialogue with the public and have as much information at our disposal as possible," said Robert Easton, New York deputy superintendent of insurance and general counsel. "We're approaching these issues with fresh eyes."

A spokesman for Mr. Cuomo's office said only: "We look forward to productive and informative hearings."

## THE ISSUES

New York Insurance Superintendent Eric Dinallo and New York Attorney General Andrew Cuomo are seeking oral and written testimony addressing the following insurance-related issues:

- Is disclosure of compensation necessary?
- Should disclosure requirements apply to all agents and brokers?
- Should disclosure be required when the amount of producer compensation cannot be ascertained at the outset of the customer/producer relationship?
- Are there certain categories of transactions that should be exempt from some or all disclosure requirements?
- Should certain types of compensation be permissible?
- Should steering associated with contingent commissions be considered an unfair act or practice within the meaning of New York's insurance law?

In 2005, the world's three largest brokers entered into agreements with then-New York Attorney General Eliot Spitzer and then-New York Insurance Superintendent Howard Mills to settle charges that they steered buyers to insurers that paid the highest contingent commissions.

As part of those settlements, Marsh, Aon and Willis collectively paid more than \$1 billion in client restitution and agreed to stop collecting millions of dollars a year in contingent commissions.

Other brokers, including Itasca, Ill.-based Arthur J. Gallagher & Co. and Glen Allen, Va.-based Hilb, Rogal & Hobbs Co., reached similar settlements that curbed their ability to collect contingents with other state attorneys general, who took Mr. Spitzer's lead and initiated their own investigations.

Since 2006, however, Marsh, Aon and Willis have persuaded New York authorities to amend their agreements to allow them to accept profit-based commissions from insurers on business in which the brokers act as a managing general agent; certain fees from insurers for brokerage transactions; and, most recently, contingent commissions for up to three years after acquiring a business.

It's unclear, however, whether these amendments signal willingness on the part of Messrs. Dinallo and Cuomo to further erode the ban on Marsh, Aon and Willis from accepting contingents.

While observers say that, at the time, it was presumed by all parties involved in the New York settlement agreements that regulatory action banning contingents and requiring full disclosure industry-wide would follow, it never happened.

Instead, a two-tiered market has developed where most brokerages continue to accept contingents and do not fully disclose their compensation to buyers.

And that is unfair, according to Marsh, Aon and Willis.

"The issue is less about contingent commissions and more about the unlevel playing field," said Dan Glaser, chairman and chief executive officer of Marsh Inc. "The existing framework is unfair since a small number of brokers are prohib-



AON

**'As we have said for some time, we believe strongly that our clients, our colleagues and our industry are best served when brokers disclose what we do and how we get paid.'**

Steven McGill, Aon Risk Services

**'The existing framework is unfair since a small number of brokers are prohibited from earning contingent income while the vast majority of our competitors continue to receive such income.'**

Dan Glaser, Marsh Inc.



MARSH



CIAB

**'We do think a national (disclosure) scheme makes sense and maybe New York will set the standard' since the NAIC model has gone nowhere.**

Ken A. Crerar, Council of Insurance Agents &amp; Brokers

ited from earning contingent income while the vast majority of our competitors continue to receive such income without any disclosure obligation."

"I'd love to see an environment in which full disclosure is a regulatory requirement for all brokers," said Mr. Glaser. "My fundamental belief is that all competitors should compete under a single set of rules."

"As we have said for some time, we believe strongly that our clients, our colleagues and our industry are best served when brokers disclose what we do and how we get paid," said Steve McGill, chairman and CEO of Aon Risk Services in Chicago.

A spokesman for Willis confirmed that Don Bailey, CEO of Willis North America Inc., will testify at today's hearing in Buffalo, but declined to divulge the content of his statement "out of respect for the process."

Willis Chairman and CEO Joe

Plumeri, however, has been outspoken about his belief that contingent commissions create a conflict of interest with clients and should be eliminated in the brokerage market.

The brokerage last month agreed to buy rival HRH, which still collects contingents. When the deal was announced, Mr. Plumeri reiterated his opposition to contingents, but also said that—absent an agreement with states allowing collection of contingents for three years after an acquisition—the HRH deal would not have happened. He said it showed the compensation disparity among brokers and agents.

Meyer Shields, an insurance brokerage analyst with Stifel, Nicolaus & Co. Inc. in Baltimore, said it's unlikely that the New York hearings will result in an industrywide ban on contingents.

"Clearly, any efforts to completely stamp out contingents have failed and I think it will continue to

fail because it's a legal process," he said "It's difficult to see how you could say a fully disclosed revenue stream that is present in just about every other industry's distribution is somehow disallowed in insurance if it's disclosed adequately."

With that said, Mr. Shields said, rather than lifting the contingent ban on Marsh, Aon and Willis, full disclosure is a more likely regulatory outcome.

"If there's greater transparency, then there's not really an economic disadvantage to them," he said in noting the ability of competing brokers and agents to charge lower fees and commissions while not disclosing contingent commissions they are receiving on the back end from insurers.

The courts have determined clearly that contingents are a legitimate form of compensation, said Ken A. Crerar, president of the Council of Insurance Agents & Brokers in Washington, referring to the a New York appeals court ruling that contingent commission agreements are not illegal (*BI*, June 23).

"Our belief continues to be that disclosure is the most important component," Mr. Crerar said.

"We do think a national (disclosure) scheme makes sense and maybe New York will set the standard" since the NAIC model has gone nowhere, he said, referring to the National Assn. of Insurance Commissioners' model producer compensation language, which was drafted shortly after the compensation scandal erupted in 2004 but not widely adopted.

CIAB Chairman George Steadman III, chairman, of Rutherford Cos., planned to testify on behalf of the association.

# Trusts: N.Y. comp board barred from collecting levy

CONTINUED FROM PAGE 3

Both sides said they found Justice O'Connor's findings to be favorable.

The board is pleased because the court found the board has the legal right to pay the claims of injured workers by assessing self-insured employers, Zach Weiss, the board's chair, said in a statement.

Richard E. Honen, a partner at Phillips Lytle L.L.P. in Albany, N.Y., who represents First Cardinal, said he, too, is pleased because the decision means litigation is proceeding as he planned.

The lawsuit Justice O'Connor

ruled on was aimed at quickly vacating the board's current assessments based on the agency's improper practices, Mr. Honen said.

Justice O'Connor still must rule on a companion lawsuit, which seeks a declaratory judgment that the state law under which the board is pursuing assessments is unconstitutional.

The board has moved to dismiss that lawsuit as duplicative and is awaiting the judge's decision, a spokesman said.

Meanwhile, stopgap legislation that Gov. David A. Paterson signed into law recently allows the board



NY TIMES

**New York Gov. David A. Paterson recently signed legislation that temporarily eases the state's workers comp board assessments.**

to borrow more than \$52 million from the state's Uninsured Employers Fund to offset this year's assessments, but does not address future assessments (*BI*, June 30).

Additionally, the law created a task force to find a permanent fix to the financing issues.

Large, independent self-insured employers hope to establish two guaranty funds, which would divorce them from liability for claims that are filed by injured employees against the defunct group trusts. One guaranty fund would backstop large self-insured employers and the other would back group trusts.

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# News In Brief

CONTINUED FROM PAGE 1

to administer and enforce building codes. The House passed the Community Building Code Administration Grant Act last week. The bill, which was introduced by Rep. Dennis Moore, D-Kan., would require the federal government to award matching grants to local governments for, among other things, staff development and capital expenditures dedicated to administering building codes. Companion legislation has been introduced in the Senate.

## Pa. holds hearings on insurer merger

The Pennsylvania Insurance Department held hearings last week on the proposed merger of Pennsylvania's two largest health insurers, Philadelphia-based

Independence Blue Cross and Pittsburgh-based Highmark Inc. The focus of the hearings, which continue this week, is whether the deal would make the state's insurance market less competitive.

## Swiss Re says Lippe to become COO

Swiss Reinsurance Co. has named Stefan Lippe as deputy chief executive officer and said he will become chief operating officer of the company on Sept. 1. Mr. Lippe, currently head of reinsurance products at Swiss Re, will succeed COO Andreas Beerli, who will retire in 2009. The reinsurer also named Brian Gray, currently head of property and specialty underwriting, as chief underwriting officer.

## House panel approves student health cover bill

Legislation approved by a House panel last week would allow seriously ill college students to continue coverage under their parents' health insurance plans even if they can't maintain status as full-time students. The measure, cleared by the House Energy and Commerce Committee's

Health subcommittee on a voice vote, would allow college students to retain coverage for up to 12 months after they take a leave of absence.

## Fitch negative on managed care

Fitch Ratings changed its outlook on the U.S. health insurance and managed care sector to negative from stable, citing concerns about earnings, debt, competition and companies' difficulties in projecting cost trends, among other factors. The outlook means Chicago-based Fitch expects the industry to see more downgrades than upgrades in the next 12 to 18 months.

## N.J. ups age cover cap for adult dependents

Legislation signed into law by New Jersey Gov. Jon Corzine allows employees' children to retain coverage through a parent's group health insurance plan until age 31. That provision, included in a broader health reform measure, amends a 2006 law that had allowed older dependent children to continue coverage through a parent's group plan until age 30.

## Noted

**PartnerRe Ltd.** has received approval for its Partner Reinsurance Europe Ltd. subsidiary to operate as an admitted reinsurer in Brazil....**Pennsylvania's** Senate has confirmed Joel Ario as the **state's insurance commissioner**. Mr. Ario has served as the state's interim commissioner since being nominated by Gov. Ed Rendell more than a year ago....**Property/casualty insurance premium rates** dropped 11% on average in June compared with those of a year earlier, according to MarketScout. But the Dallas-based electronic insurance exchange also reported that the 11% drop, when compared with the 14% decline registered between June 2006 and June 2007, represented the largest year-on-year moderation of rate declines in the past three years....**American International Group Inc.'s** Chinese operation has received permission to open a branch office in Beijing. Shanghai-based AIG General Insurance Co. China Ltd. said it received approval from the China Insurance Regulatory Commission to establish an office in Beijing as part of plans to expand its geographic footprint in China.

# Massachusetts: Health care reform law may be revised

CONTINUED FROM PAGE 1

that mainstream employer plans would not pass the minimum creditable coverage threshold and employees would be slapped with hefty penalties—the Connector is proposing revisions to the rules with the possibility of more changes after comments are received and the review process completed.

make it easier for certain consumer-driven health care plans—high-deductible health insurance plans linked to health reimbursement arrangements—to qualify as offering minimum creditable coverage.

Additionally, the proposals would ease requirements on the minimum number of preventive care visits that health plans must offer and more carefully define which noncore services are eligible for more limited coverage.

On the other hand, the board proposed ending special treatment that current rules give to high-deductible health insurance plans linked to health savings accounts. Under those rules, HSA-linked plans automatically are considered as offering minimum creditable coverage.

Under the proposal, that free pass would end after Dec. 31, 2009, with HSA-linked plans having to meet the same minimum coverage standards as other plans. Other board-proposed changes would allow coverage to be combined—in this case through the HSA and the linked high-deductible health insurance plans—increasing the likelihood that the arrangements would be considered minimum creditable coverage.

However, other existing rules concerning what constitutes minimum coverage remain in place. Those requirements:

### WHAT IS CREDITABLE COVERAGE?

To avoid being hit with financial penalties, Massachusetts residents, unless they receive a special waiver, will have to be enrolled in health plans that meet these standards:

- Annual deductibles for in-network covered services no higher than \$2,000 for single coverage and \$4,000 for family coverage.
- Out-of-pocket limit, including deductibles, for in-network services no higher than \$5,000 for individual coverage and \$10,000 for family coverage.
- If carved out from a health care plan, annual deductibles for prescription drug coverage no higher than \$250 for individual coverage and \$500 for family coverage.
- If plan deductibles and out-of-pocket limits exceed permitted maximums, coverage from HRAs or HSAs can be combined with linked high deductible health insurance plans to satisfy creditable coverage requirements.

"This is still a work in progress," said Connector Authority Executive Director Jon Kingsdale.

The proposed rules, which aren't expected to be finalized until October, would, among other things,

for family coverage;

- And cap the annual out-of-pocket limit, including deductibles, for in-network services at \$5,000 for individual coverage and \$10,000 for family coverage.

Benefit experts welcome the proposed changes, which they say will significantly increase the chances of employer plans meeting the minimum coverage requirements and spare those employers—to prevent employees from being hit with new taxes—from having to revamp their plans.

"The board has been open to issues raised by employers and the consulting community. The proposed changes and clarifications are reasonable and pragmatic," said Randy Abbott, a senior consultant in the Wellesley Hills, Mass., office of Watson Wyatt Worldwide.

"I do not have a single client who will not pass these rules," Mr. Abbott added.

"In all, these are very welcome changes," said J.D. Piro, an attorney with Hewitt Associates Inc. in Norwalk, Conn.

The most significant change involves HRA-linked high-deductible health insurance plans. Those plans, in many cases, would not meet the creditable coverage standard of maximum deductibles of \$2,000 for individual coverage and \$4,000 for family coverage.

Under the proposed rules, though, any employer contributions to an HRA would be recognized as an offset to the deductible, increasing the chances that the plan



**Jon Kingsdale is executive director of the Massachusetts Health Insurance Connector Authority, which is charged with implementing key parts of the state's health care reform law.**

would satisfy the coverage requirements. This same combination of coverage also would apply to HSA-linked plans starting in 2010.

Another change included in the board-approved draft plan would ease a requirement that health plans that impose a deductible provide three annual preventive visits for those with single coverage and six annual visits for those with family coverage before a deductible is charged. Instead, the proposed rules would allow plans to meet the requirement by providing a schedule of preventive visits that meets nationally recognized standards.

Still, even with the proposed changes, some employer plans, such as those with out-of-pocket limits that still would be too high, will not meet the creditable coverage standards, noted Rich Stover, a principal with Buck Consultants L.L.C. in Secaucus, N.J.

"The out-of-pocket limit is going to trip up some companies," Mr. Stover said.

In such cases, employers have two basic options: boosting benefits or leaving their plans as is, resulting in employees being taxed.

The approaches, said Andy Anderson, of counsel with Morgan, Lewis & Bockius L.L.P. in Chicago, will result in either more work and cost for employers or an employee relations issue if an employer makes no changes and employees are penalized.

As a result, legal challenges to the Massachusetts law could be brought alleging that the law relates to employee benefits plans and, thus, is pre-empted by the federal Employee Retirement Income Security Act, Mr. Anderson said.

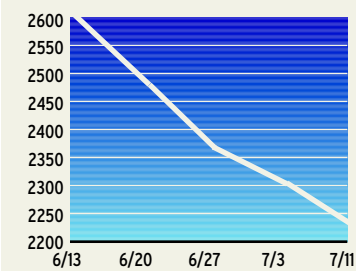
Mr. Kingsdale, though, said the law was designed carefully to avoid an ERISA pre-emption challenge, noting that the law imposes no design requirements on employers.

## Stock Index

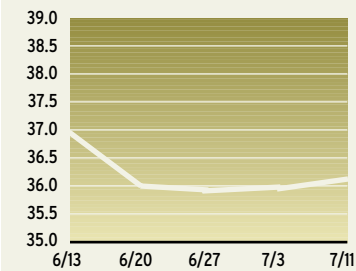
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Up-to-the-minute data for all 82 companies that comprise the BI Stock Index can be found at [www.IndustryFocus.com](http://www.IndustryFocus.com).

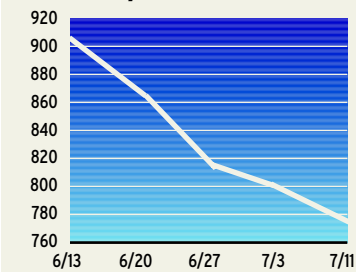
### BI STOCK INDEX



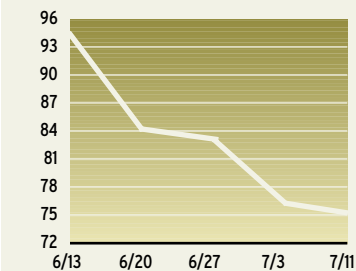
### BI BROKERS INDEX



### BI INSURER/REINSURERS INDEX



### BI MANAGED CARE ORGANIZATIONS INDEX



Percentage change of BI Stock Index vs. key indicators

Index	Value	Change
BI STOCK INDEX	2245.18	-3.41%
DOW JONES	11100.54	-1.67%
S&P 500	1239.49	-1.67%

### LARGEST GAINS

Ambac Financial Group	28.57%
Meadowbrook Ins.	7.79%
MMC	7.27%
SCOR S.A.	6.59%
Fairfax Financial	4.60%

### LARGEST LOSSES

XL Capital Ltd.	-18.22%
EMC Insurance Group	-17.20%
Old Republic Intl.	-12.23%
AIG	-12.04%
Hartford Financial	-10.80%

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



## Justice blind, but one judge shows he has ear for rhyme

A few well-chosen words can have far more effect than an avalanche of verbiage.

Judge Ronald B. Leighton of the U.S. District Court for the Western District of Washington in Tacoma, demonstrated that recently when confronted with a 465-page fraud complaint against GMAC Mortgage L.L.C. and other defendants.

According to Judge Leighton's order, defense attorneys asserted that the complaint was "repetitious and needlessly long" and requested that the attorney for the plaintiffs, led by Presidio Group L.L.C., remove unnecessary material and resubmit it.

Judge Leighton was happy to oblige.

Citing Shakespeare's observation that "brevity is the soul of wit," the judge added that "brevity is also the soul of a pleading."

He said that the plaintiffs attorney, Dean Browning Webb, failed to "balance the tension" between competing federal rules of civil procedure. Rule 8(a) requires a "short and plain statement" of complaint, while rule 9(b) requires the party to state his or her claim "with particularity." For example, wrote Judge Leighton, the plaintiff's "allegations continue for 87 pages—including a 37-page pit stop to quote e-mails."

Judge Leighton ended with a stylistic flourish of his own:

*"Plaintiff has a great deal to say,  
But it seems he skipped Rule 8(a),  
His complaint is too long,  
Which renders it wrong,  
Please rewrite and refile today."*

Poetic justice, anyone?

# Business Insurance END PAGE

Contributing: Roberto Cenicerros,  
Judy Greenwald, Mark A. Hofmann

## At least our virtual selves will eat right, get exercise

Playing interactive video games usually isn't the first—or second or maybe even 30th—activity that comes to mind when considering how to promote a healthy lifestyle.

But CIGNA HealthCare is taking just that approach by establishing a virtual health care community within the Second Life online universe.

CIGNA's community, located on a Second Life island, will feature seminars, interactive displays, educational games and health consultations to help people learn how to live better.

The "virtual community enables us to reach an entirely new group of people that might not respond to health education messages delivered through more traditional channels," Keith Dixon, president of Bloomfield, Conn.-based CIGNA's health care solutions, said in a statement announcing the virtual community.

The Second Life island currently is undergoing testing.

If the strategy works out as planned, it may underscore the positive effect a virtual experience can have on real-life situations.



## IT workers know all your secrets

Your e-mail at work may not be as confidential as you think.

One-third of participants in a recent survey of 300 senior information technology professionals admitted they had used administrative passwords to access confidential or sensitive information to which they otherwise would not be privy, such as salary details and employees' personal e-mails.

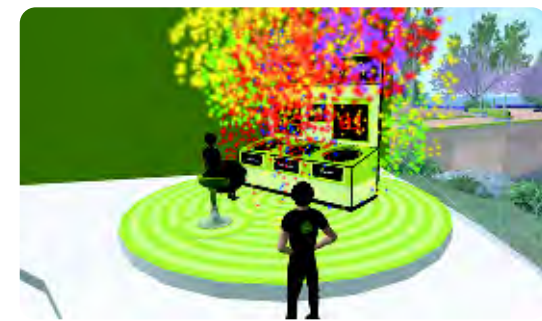
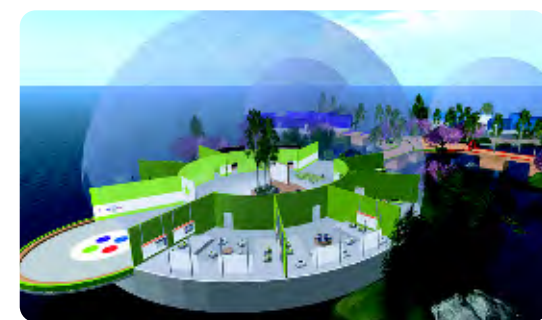
The survey was conducted by Newton, Mass.-based Cyber-Ark Software Ltd., a software security firm.

"It's easy—all you need is access to the right passwords or privileged accounts and

you're privy to everything that's going on within your company," Mark Fullbrook, Cyber-Ark's U.K. director in London, said in a statement.

Among other survey findings, 30% of privileged passwords get changed every quarter and 9% never get changed, which provides indefinite access even to those who have left the organization, according to Cyber-Ark.

"Companies need to wake up to the fact" that—absent tightened, layered e-mail security that includes limiting password access—"snooping, sabotage and hacking will continue," Mr. Fullbrook said.



COURTESY OF CIGNA VIELIFE/METHOD

Screen shots of CIGNA's Second Life island, which is in a testing phase.

## Doc's itchy palm leads to bogus surgeries

A California doctor convicted of health care fraud for performing needless "sweaty-palm" surgeries and bilking insurers of more than \$9 million has been sentenced to 10 years in prison.

Between 2002 and 2004, William W. Hampton performed more than 400 unnecessary thoracic sympathectomy operations, commonly called sweaty-palm surgery, said the U.S. Attorney's office in Los Angeles in a statement.

So-called "marketers" working for Los Angeles-area surgery centers where Dr. Hampton performed the operations recruited people with private health insurance to undergo surgery, prosecutors said.

Each patient received \$1,200 or reduced-price plastic surgery for receiving a sweaty-palm operation, which is typically performed to eliminate excessive perspiration, prosecutors said. Such surgery requires deflating the patient's lungs and cutting or cauterizing a nerve near the spinal column.

Patients received one preoperative consultation while being

wheeled into an operating room and zero follow-up care, prosecutors added.

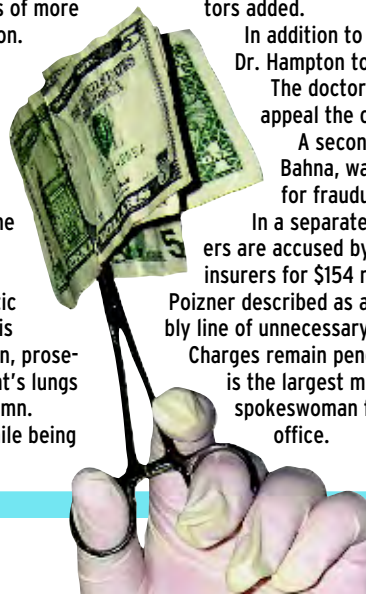
In addition to 10 years in prison, a federal judge ordered Dr. Hampton to pay more than \$2.4 million in restitution.

The doctor's lawyer, however, reportedly said he will appeal the conviction.

A second doctor involved in the scheme, Mamdouh S. Bahna, was sentenced last year to 58 months in prison for fraudulently billing insurers.

In a separate prosecution, Dr. Hampton and a dozen others are accused by Orange County, Calif., of fraudulently billing insurers for \$154 million in what Insurance Commissioner Steve Poizner described as a "medical fraud factory operating an assembly line of unnecessary surgeries."

Charges remain pending against Dr. Hampton in that case, which is the largest medical fraud prosecution in the nation, said a spokeswoman for the Orange County District Attorney's office.





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