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U.K. COMPANIES WATCHING FIRST CASE BROUGHT UNDER MANSLAUGHTER LAW / PAGE 3

COMPANIES FACE RED FLAGS IDENTITY THEFT RULE / PAGE 3



In Brief

Securities suit filings decrease in first half

Eighty-seven securities class actions were filed against U.S. companies in the first half of 2009, a 22.3% drop compared with 112 in each half of 2008. In addition, the second quarter saw the least amount of securities litigation since the first quarter of 2007, according to the Stanford Law School Securities Class Action Clearinghouse. Financial service firms continue to be the dominant focus of litigation, with 66.7% of the first-half 2009 lawsuits being filed against such firms, up from 50% in all of 2008, according to the report. Such lawsuits historically have occurred mostly against U.S.-based firms, but the amount of litigation against corporations based outside the United States has been increasing during the past decade and in recent years, the report found.

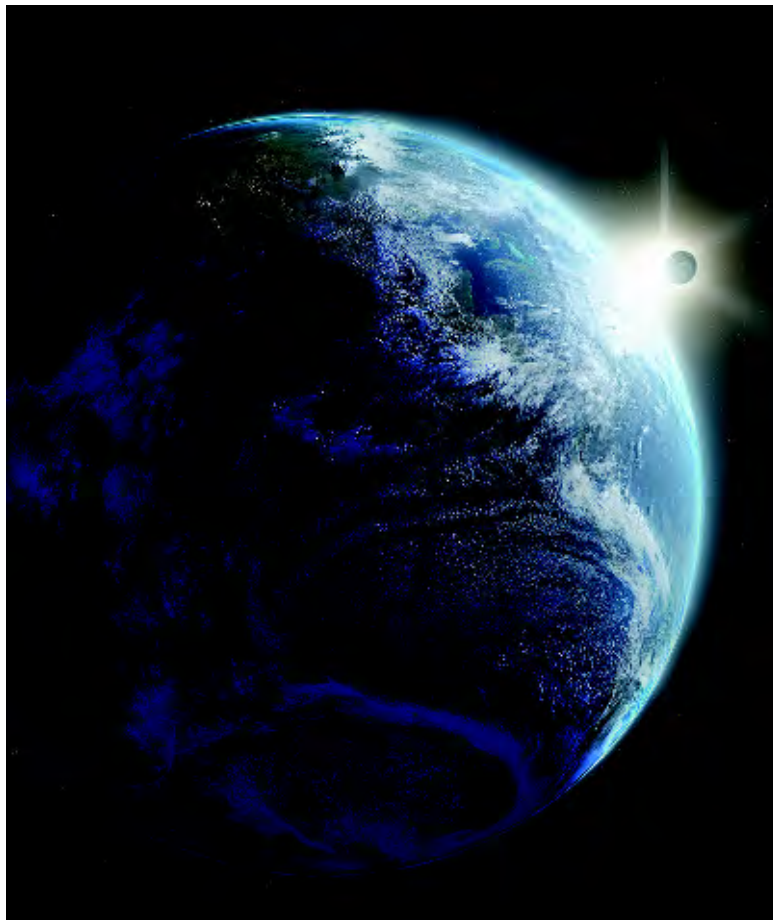
See **IN BRIEF** page 22

BENEFITS MANAGEMENT

CONSUMER-DRIVEN HEALTH PLANS

Find out why interest in medical tourism is on the rise, disease management programs are becoming more popular for consumer-driven health plan users, and how technology is improving the use and understanding of CDHPs. Also, we rank the largest CDHP providers.

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Insurance coverage on the final frontier

Space tourism a giant leap for insurers

By **ZACK PHILLIPS**

As last week's 40th anniversary of the moon landing focused attention on the future of manned space flight, observers said early providers of space tourism would face expensive pricing for property and liability cover and possibly scarce capacity.

The advent of private companies routinely taking paying passengers into orbit to visit space stations, or even to experience weightlessness on a suborbital flight, likely is at least several years from reality.

Vienna, Va.-based Space Adventures Ltd. has sent six passengers into space since 2001, reportedly for \$20 million or more per seat. Virgin Galactic, a division of Virgin Group Ltd., has sold 300 tickets for not-yet-scheduled suborbital flights, and a handful of other companies have planned suborbital flights.

See **SPACE** page 22

Health reform bills attract side issues

By **JERRY GEISEL**

WASHINGTON—Some may wonder why health care reform legislation contains a provision that would eliminate the ability of employees with flexible spending accounts, health reimbursement arrangements and health savings accounts to use them to pay for over-the-counter medications.

Benefit experts say there is no apparent policy reason beyond the need to raise revenue, but say the OTC provision illustrates how health reform measures moving through Congress have become magnets for proposals that have little, if any, connection to the core of the bills.

Attaching unrelated provisions to broader bills is a time-honored practice by federal legislators and their staffs who realize the chances of winning passage of bills can increase greatly if those proposals

See **REFORM** page 18

TACKED ON

Provisions not directly related to the core of the House and Senate health care reform bills—drastically reducing the number of uninsured—include:

- Barring flexible spending accounts, health reimbursement arrangements and health savings accounts from covering over-the-counter medications.
- Giving tax-favored treatment to employer-provided coverage to employees' same-sex or opposite-sex partners.
- Preventing employers with retiree health care plans from reducing benefits unless they also cut benefits provided to employees.
- Authorizing a study to examine the risk of self-funded plans not being able to pay claims.
- Remove roadblocks preventing states from establishing single-payer health care systems.

Regulatory plan includes federal insurance body

Administration's bill would give Treasury monitoring powers

By **MARK A. HOFMANN**

WASHINGTON—Supporters of a federal Office of National Insurance hope the Obama administration's call for such an entity within its broader financial services regulatory reform proposal will help them realize their goal.

The Obama administration proposed the new office as part of broad financial services regulatory reform legislation it unveiled last week. The draft fleshes out a proposal to create the office contained in the administration's June white paper on financial services regulatory reform and builds upon a measure introduced in May by Rep. Paul Kanjorski, D-Pa., that would create a



REUTERS

Treasury Secretary Timothy Geithner testifies on Capitol Hill in Washington last week.

similar Office of Insurance Information (*BI*, June 29).

The new office would have the power to "monitor all aspects of the

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Business Insurance®

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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FTC's Red Flags may color some surprised

Definition of 'creditor' expands impact of identity theft rule

By COLLEEN MCCARTHY

WASHINGTON—The Federal Trade Commission next week begins enforcing a data safeguard rule that requires businesses to develop identity theft prevention programs, but observers say many organizations remain unaware the rule applies to them.

Under the FTC's Red Flags Rule that goes into effect Aug. 1, financial institutions and creditors are required to implement a program that identifies and detects warning signs of identity theft. Organizations also must have measures to

safeguard data and respond to identity thefts.

"We are trying to get businesses to do their part," said Manas Mohapatra, an attorney with

Under the rule, companies are required to have written procedures that recognize red flags when someone may be using another person's information.

the FTC in Washington.

Some 9 million U.S. residents' identities are stolen each year, which the FTC said has been its No. 1 consumer complaint the past three years.

A number of initiatives and state laws already address data

and network security breaches, but the rule targets identity theft at "its point of origin" and "really picks up where data security leaves off," Mr. Mohapatra said. "We think this is a more comprehensive fraud detection program."

Under the rule, companies are required to have written procedures that recognize red flags when someone may be using another person's information. It will require employee training in identifying suspicious patterns or activities that point to fraud, Mr. Mohapatra said.

Organizations also must update their plan because the risks of identity theft and the methods of stealing personal information change rapidly, he said.

Since the rule was enacted in January 2008, the FTC said it has

extended its enforcement deadline twice to give more preparation time. To help build awareness, it has held outreach programs through a variety of trade associations, yet observers say many organizations remain unprepared.

Part of the confusion is due to the FTC's broad definition of "creditor," which includes just about any entity that defers payment for goods or services, observers say. The FTC says creditors can be finance companies, car dealers, health care firms, mortgage brokers, utility companies, telecommunications firms and non-profits involved in financial transactions.

Experts say the rule extends to retailers, universities, real estate brokers and service providers who may

See **RED FLAGS** page 18

Manslaughter charges filed against U.K. firm

Corporations face unlimited fines; execs, up to life in prison

By STUART COLLINS

BRISTOL, England—Insurers and lawyers are closely watching the United Kingdom's first prosecution of a company under a relatively new corporate manslaughter law.

The case, which returns to court next month, will test aspects of the new law. Because it involves a small firm, though, it may not shed much light on the law's implications for large companies, some observers say.

The Crown Prosecution Service has charged Cotswold Geotechnical Holdings Ltd. with corporate manslaughter in relation to the death of Alexander Wright in September 2008. Mr. Wright, who was employed by Gloucestershire, England-based Cotswold Geotechnical Holdings as a junior geologist, was taking soil samples inside a pit when the walls collapsed and crushed him. The pit had been excavated as part of a site survey.

The company was charged June 17 in Bristol Crown Court on with "gross breach of a duty of care" under the Corporate Manslaughter and Corporate Homicide Act 2007, as well as failing to discharge its duty of care to Mr. Wright under Section 33 of the Health and Safety at Work etc. Act 1974.

Peter Eaton, a director of the company, also was charged under common law with gross negligence, manslaughter and with an offense under the Health and Safety at Work etc. Act.

The defendants are scheduled to appear Aug. 19 at Bristol Crown Court for a plea and case management hearing. If they plead not guilty, as most experts believe likely, the case will go to a jury trial.

The company faces unlimited fines under the Corporate Manslaughter Act, while Mr. Eaton could face life in prison, a spokeswoman for the Health and Safety Executive said.

This is the first time a company has been prosecuted under the Corporate Manslaughter Act, which makes organizations liable for breaches of the general duty of care in incidents of death in the workplace or due to a company's operations. Prior to the Corporate Manslaughter Act, which went into effect on April 6, 2008, it was possible to prosecute a company for manslaughter under common English law, but convictions were rare and difficult to obtain.

Formerly, to bring a corporate killing case, prosecutors had to identify the "controlling" or "directing" mind at a company, and that individual would then face prosecution; in practice, this proved almost impossible and very few convictions were secured.

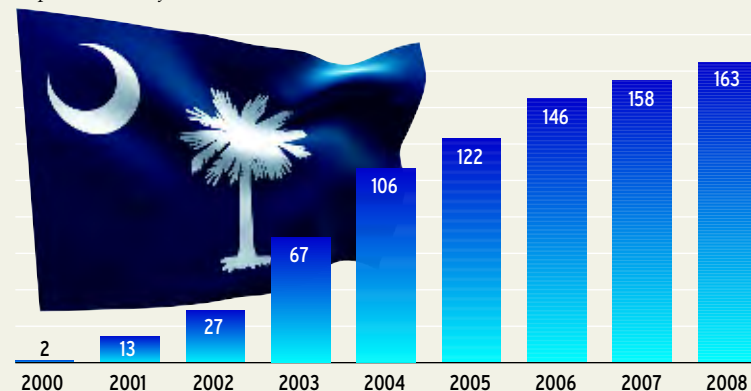
Prosecutors are looking into other incidents where they believe there is a realistic prospect of conviction for a charge of corporate manslaughter against a company, said a spokeswoman for the CPS.

Insurers, brokers and lawyers are watching the Cotswold case to see how the various provisions of the Corporate Manslaughter Act will be

See **MANSLAUGHTER** page 18

SOUTH CAROLINA'S CAPTIVE GROWTH

Captives licensed from 2000-2008



Source: BI surveys

South Carolina report finds captive concerns

By RODD ZOLKOS

South Carolina's top insurance regulator says the state's insurance department has addressed or is working to correct concerns about the state's captive insurance regulation raised in a report from South Carolina's Legislative Audit Council.

The recent audit found that "generally, the department's licensing and examinations of captives complies with state law and regulations." But it cited three issues with regard to captive insurance: The department didn't collect all required information from captive companies; the department lacked standard procedures for examining captives other than risk retention groups or special-purpose financial captives; and 43 of 53 scheduled captive examinations were not completed within the three-year period required by state law.

The audit came at the request of legislators, driven initially by concerns about rising workers compensation costs.

Since licensing its first two captives in 2000, South Carolina has experienced rapid growth as a cap-

tive domicile, with 163 active captives at the end of 2008, according to a *Business Insurance* survey.

Scott H. Richardson, director of the South Carolina Department of Insurance, said information that was missing from captive files has been added. In addition, he said the department is auditing all captive licensing files to ensure that required information is collected and filed properly.

Regarding the lack of standard practices, the director said the department previously used National Assn. of Insurance Commissioners procedures for reviewing pure captives but now has implemented its own practices.

As for the examinations not conducted within the required three-year period, Mr. Richardson said, "That was true," due to inadequate staff resources and making RRG examinations a priority over pure captive exams.

"We have a fair amount of RRGs, which is a pretty serious audit," Mr. Richardson said. "We didn't have the staff to do all the audits"

See **SOUTH CAROLINA** page 20

Ransom dispute may alter response to pirates' demands

Shipowner, cargo firm spar over sharing ransom in hijacking

By ZACK PHILLIPS

LONDON—A ransom payment dispute between a U.K. shipowner and a Chinese cargo shipper could significantly affect how insurers and others pay to release ships hijacked by pirates, legal experts and other observers say.

On April 6, Somali pirates hijacked the MV Malaspina Castle, which was on its way to China from a Russian port on the Black Sea. On May 9, the pirates released the ship for \$1.8 million in ransom.

Hangzhou Cogeneration Import

and Export Co. Ltd., a Chinese firm that shipped 30,000 tons of iron on the Malaspina, refused to contribute to the ransom. London-based shipowner Navalmar (U.K.) Ltd. took Hangzhou Cogeneration to arbitration, according to legal documents.

The arbitration is taking place in London, where the details and results of such cases are not released publicly. But Navalmar filed a related action in U.S. District Court for the Southern District of New York, which said the hijacking cost the firm \$3.6 million. In addition to the ransom, Navalmar paid \$512,000 to negotiate and deliver the ransom and \$75,000 to insure the ransom during delivery, according to the complaint, which also said the firm anticipates \$500,000 in claims from crew members.

The case is important because it could cast doubt on the largely informal process by which many shipowners, charterers, shippers and their insurers have been paying for ransom, observers say. A shipowner without separate kidnap and ransom insurance typically pays the ransom and then seeks reimbursement contributions from the various interests involved in the ship's voyage, under a concept known as "general average."

A general-average declaration means the ship had to incur an extraordinary expense to save it from peril, and the owner, cargo owner and other interests—and their insurers—should contribute

See **PIRACY** page 21



REUTERS

Above are members of the crew of the MV Malaspina Castle, which was hijacked by Somali pirates and released a month later when ransom was paid. The U.K. shipowner and Chinese shipper are at legal odds over the \$1.8 million.



AP PHOTO

A Harley-Davidson program that tests and matches injured or disabled workers with available jobs has put the brakes on workers comp and disability claims for the motorcycle manufacturer.

Harley-Davidson test quiets disability claims

By ROBERTO CENICEROS

PORTLAND, Ore.—Harley-Davidson Motor Co. relies on a functional assessment job-matching test to reduce workers compensation and disability claims among new hires.

The functional assessment system also has contributed to key improvements in the Milwaukee-based motorcycle manufacturer's return-to-work program for occupational and nonoccupational claims, Caroline O'Connell, Harley-Davidson's occupational health and safety lead, said during a panel discussion at the annual conference of the Disability Management Employer Coalition.

Harley-Davidson's system relies on several components, including post-offer employment testing, or POET, to evaluate the capabilities of prospective employees to make certain they are physically able to safely meet the demands of a job.

Hanover, Md.-based BTE Technologies Inc. provides the electronic functional assessment testing system and accompanying software.

BTE technicians also perform physical demand analyses, evaluating Harley-Davidson's work-sites. That helps assure BTE's electronic testing system objectively

See **HARLEY** page 20

BOEING: "Lean" process reduces workplace injuries, aircraft maker explains at DMEC's annual meeting. **PAGE 20**

UnitedHealth expands in Northeast

\$510M deal for Health Net operations suits both companies, analysts say

By JOANNE WOJCIK

WOODLAND HILLS, Calif.—UnitedHealth Group Inc.'s acquisition of Health Net Inc.'s operations in the Northeast may give it a stronger foothold in that market, but it is unlikely to stifle competition there, health insurance analysts say.

In a cash deal valued at approximately \$510 million, Minnetonka, Minn.-based UnitedHealth will acquire the New York, New Jersey and Connecticut operations of Woodland Hills, Calif.-based Health Net, as well as the exclusive rights to renew that business with Health Net's 578,000 covered lives in that area (see box). Expected 2009 revenues for these operations are approximately \$2.7 billion.

Health Net executives said the sale, which is subject to regulatory approval, is the end result of a strategic review the insurer began last November, looking at its North-

NEW CUSTOMERS

Under the deal, UnitedHealth gets renewal rights for Health Net's membership in Connecticut, New York and New Jersey, comprising:

437,000

commercial risk members

35,000

self-funded commercial members

55,000

Medicare Advantage members

51,000

Medicaid members

eastern and Arizona businesses.

"If Health Net were a force in the region, they probably would have held on to the business," said Neal

Freedman, an analyst at Standard & Poor's Corp. in New York. By freeing up the capital that was tied up in its Northeastern operations, Health Net will have the opportunity to grow in other markets, he said.

In addition to its operations in Arizona, which it has decided to retain, Health Net operates in California and Oregon.

Health Net's decision to leave the Northeast makes sense because "it's a very competitive market with a lot of regulation," said Stephen Zaharuk of Moody's Investors Service. "Without a lot of volume, they weren't able to negotiate good deals with hospitals and doctors."

By contrast, UnitedHealth has had a fairly strong presence in the region since acquiring Trumbull, Conn.-based Oxford Health Plans Inc. in 2004, Mr. Zaharuk said.

Sally Rosen, managing senior

See **UNITED** page 19

BI taking nominations for Women to Watch

Business Insurance is accepting nominations for the magazine's 2009 Women to Watch feature, with an extended deadline of Aug. 31.

The Women to Watch list is an annual feature spotlighting 25 women who are doing outstanding work in commercial insurance, reinsurance, risk management, employee benefits and related fields, such as law and consulting. Readers are encouraged to nominate candidates using the nomination form at www.BusinessInsurance.com.

A panel of senior editors of *Business Insurance* will select the honorees. Among the 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 worldwide. Prior honorees are not eligible.

Profiles of the women will appear in the Dec. 7 issue of *Business Insurance*, as well as at

BusinessInsurance.com.

A luncheon honoring the 2009 Women to Watch is planned for Dec. 8 in Chicago. For information, please contact Event Manager Becky Briggs at rbriggs@businessinsurance.com.

To download a nomination form, please visit www.BusinessInsurance.com or e-mail BI Editor Regis Coccia at rcoccia@businessinsurance.com.

Errors & Omissions

A story in the July 20 issue, "Employees' Social Networking Raises Employers' Liability Risk," misspelled the name of Rexford H. Stephens, a partner with Baker & Hostetler L.L.P. in Orlando, Fla.

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Questions Answers

Despite setting up operations in the midst of the worldwide financial crisis, Hamilton, Bermuda-based Torus Insurance Holdings Ltd. has found its timing wasn't all bad. The group is planning to expand. Clive Tobin, chief executive officer, recently spoke with *Business Insurance* Senior Editor Michael Bradford about Torus' arrival in the global marketplace.



Torus finds its launch in '08 was well-timed

Q: Why was Torus established as a Bermuda insurance entity?

We actually launched as a U.K. insurer with a particular focus on energy. We have a Bermuda holding company.

Our largest shareholder (Greenwich, Conn.-based First Reserve Corp., which provided \$720 million in equity funding) had done a lot of work studying the energy sector and found there was a considerable opportunity for energy insurers. Torus was started on the basis of long-term trends in energy—it was not the typical Bermuda company startup following a catastrophic event.

Q: How difficult was it for Torus to get established as the global financial crisis took hold?

The financial crisis created a serious impact on some of the largest insurers, and that presented a much bigger opportunity than we had expected.

We expanded to become a global insurer and reinsurer, which was different from our original plan to operate in Bermuda and London. Our goal is to operate in wholesale markets that are recognized for their regional expertise.

We are focusing on energy and high-quality local business in U.S. and Europe. Bermuda is a part of our operation, but our primary focus is to base our business onshore.

Q: Has Torus' first year of operation gone as you expected?

In our first year, we were surprised by the demand of opportunity. Our vision expanded dramatically and we were able to bring in a senior executive team.

The credit crisis drove the market to much greater syndication. Prior to the crisis, significant blocks of business were written with a few key partners. As those partners got into trouble, business began to be placed with a lot more people. As a result, Torus saw more opportunities.

Q: What did you find challenging about creating a startup insurer?

One of the critical things in the first year is whether you can attract a management team that will be able to build a viable and thriving company.

You only get one chance to get it right; you want to make sure that you get the company launched and it doesn't falter.

Q: There is debate that Bermuda is losing some of its prominence as a marketplace. What are the advantages of locating an insurance or reinsurance company there?

Bermuda is recognized for its underwriting expertise in a variety of markets.

As a result, there are certain blocks of business that target Bermuda, such as excess liability and catastrophe reinsurance. Bermuda is recognized as a leading cat reinsurance market.

There is a small, tightknit underwriting community in Bermuda and the exchange of ideas there allows for strong underwriting practices.

Q: Is the island's luster as an insurance marketplace dimming?

Bermuda has always been recognized as a laboratory for innovation and it will face some challenges to retain that prominence.

It has a well-deserved reputation for its expertise. Its reputation has been built on innovation and it needs to foster this. The old model of startup cat reinsurers is not one that is liked by investors.

We see Bermuda continuing to have catastrophe expertise, but it will have to write on behalf of third parties such as sidecars. While the current economic crisis has seen sidecars disappear, I have absolutely no doubt that that vehicle will return and grow.

I don't think investors want to see their capital subject to as much volatility as in the past.

They want to make sure that the expertise used to generate fee income is used on other people's capital.

Q: Is Torus planning to expand in its second year of operation?

Our U.S. network is Jersey City, Chicago and Houston. Later this year, we will be in Atlanta and Los Angeles or San Francisco.

We've got huge support. We have 70 people in London, 30 in the U.S. and 25 in Bermuda. We will have 60 in India by the end of the year providing technical support. We've got a lot of momentum.

Commentary

Risks need managing well beyond one's own

Among the many lessons driven home by the financial crisis and global economic downturn is that your risks don't end at your company's front door.

It's become pretty clear that risk management today means not only addressing the risks inherent in your own business, but the risks faced by your business partners as well. And it probably couldn't hurt to know something about what's going on with your business partners' business partners.

In a world with increasingly complex financial arrangements, greater reliance on outsourcing, exposure to counterparty credit risks, and production chains involving hosts of downstream and upstream partners, the implications for business sometimes seem a twist on the personal risk management message: When you enter into a business relationship, you better think about the risks associated with all the other companies with which your partner's done business.

Certainly a number of companies could relate as investment markets collapsed last year.

At last month's Bermuda Captive Conference, Shawn Murphy, president and chief investment officer at P.R.P. Performa Ltd., recalled that the Hamilton, Bermuda-based captive and reinsurance company fund manager's analysis led it to enter 2007 concerned about the collateralized debt obligation market. Based on that analysis, the fund manager made an effort to steer clear of those investment instruments.

"The problem that we saw is that we didn't get far enough away from it," said Mr. Murphy. In retrospect, he said, it's clear that the company needed not only to steer clear of CDOs in its own investments, but to get away from any entity that had anything to do with CDOs.

When the subprime mortgage market went south, many companies learned that not having subprime mortgage investments in their portfolios helped them only so far. Many companies' losses came from investing in companies that had their own substantial subprime mortgage investments.

Many have suggested that the financial crisis has spurred a broader acceptance of the need for enterprise risk management. I spoke not long ago with Raj Singh, chief risk officer of Swiss Reinsurance Co., and he noted that at companies like Swiss Re



**RODD
ZOLKOS**

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that have an ERM program in place, the financial crisis has served to stress and test those programs.

Meanwhile, he said, "It's forcing companies that were not into (ERM) into this direction."

Another implication of the financial crisis at Swiss Re, Mr. Singh said, was that it prompted the company to take some of what it had learned on the insurance side of the business and

When you enter into a business relationship, you better think about the risks associated with all the other companies with which your partner's done business.

apply it to the financial side. For example, applying the same kind of thinking that the company might engage in on its underwriting side concerning the possibility of extreme scenarios to its approach about possible financial events.

"You have to continually think the unthinkable," Mr. Singh said, adding that a company must continue to adjust and recalibrate its risk management approach to keep up with changing conditions in the face of a crisis.

For business, conditions have certainly changed in the past 18 months.

Going forward, it's clear that successful risk management will involve not just addressing the obvious risks, but finding ways to address those threats that have yet to show themselves, whether they're hidden in the future or in your partner's business practices.

Bill would have broadened coverage

By **JERRY GEISEL**

HARTFORD, Conn.—Connecticut legislators last week failed to override a gubernatorial veto of a bill that would have opened up the health insurance program covering state employees to Connecticut municipalities, nonprofit organizations and employers in the state with fewer than 50 employees.

But lawmakers overrode another veto of a measure to start to move the state close to universal health care coverage.

The theory behind the pooling bill was that cities, nonprofit groups and small employers would be part

of a much bigger purchasing entity by joining the state program and, as a result, pay lower rates compared with buying coverage on their own.

But in an earlier veto message, Connecticut Gov. M. Jodi Rell said the measure, while well-intentioned, would result in cost increases for the state and taxpayers because those most likely to join the program would be heavier than their average users of health care services.

In addition, the vetoed bill would have forced the state to stop buying coverage in the commercial market and switch to a self-insured plan, a move, Gov. Rell said, that also would increase costs for the state

due to contractual agreements now in place.

"The state currently has agreements for health care coverage in place through July 2011 which guarantee effective cost containment, including premium caps. Switching to a self-insured plan now would eliminate the premium caps and could result in an additional cost of at least \$69 million for health care...for 2010 alone," she said.

The other bill, which survived Gov. Rell's veto, calls for the establishment of a nine-member board to develop by Jan. 1, 2011, the outline of a universal health care system in the state.

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Business Insurance OPINIONS

More time is needed to review reform plans

WE WELCOME THE DECISION by Senate Majority Leader Harry Reid, D-Nev., to buck President Obama and delay Senate action on health care reform legislation until after lawmakers return to Capitol Hill in September.

President Obama had wanted Congress to pass reform bills before the August recess. But that arbitrary deadline, to put it bluntly, was dead wrong.

And President Obama ought to have known better, because bills of this size and importance deserve the utmost scrutiny. These bills have not gotten that so far from elected officials.

Consider this: The House Ways and Means Committee earlier this month passed a version of reform legislation after just one day of debate.

Can the chairman of that committee honestly say that was enough time for panel members and their staffs to understand and be aware of every provision tucked into that more than 1,000-page bill?

Of course it wasn't, nor was it enough time for the public to understand it. In the short time we've had to dig into the measure, we've discovered, as we report on page 1, several disturbing provisions, including one that could take away the ability of employers to design and offer health care plans that best meet their needs and those of their employees.

We don't know how much time Congress and the administration need to get it right on health care reform, but we know it is more than a couple of weeks.

President Obama and his health care reform allies in Congress would be wise now to stay away from artificial and unrealistic deadlines and take the time necessary to get it right.

Federal insurance office is a worthwhile idea

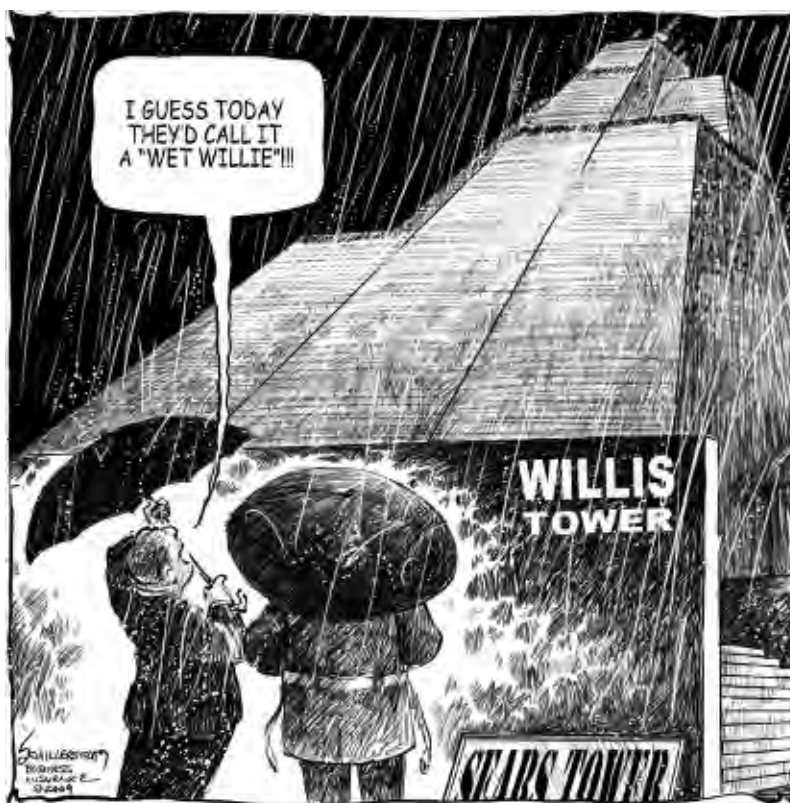
THE OBAMA ADMINISTRATION'S decision to include creation of an Office of National Insurance within Treasury as part of its larger financial services regulatory reform legislative package comes as a most welcome development in the regulatory debate.

As we report on page 1, the administration last week sent Congress draft legislation to establish the office. Although we would have preferred that the draft measure include provisions for an optional federal charter for insurers and producers, we like what we've seen. The office would give the insurance industry a federal advocate for the first time, guaranteeing the industry a place at the federal regulatory table that other financial institutions already enjoy.

It also would provide federal authorities with in-house expertise on insurance matters, and facilitate international cooperation on insurance issues. That's particularly critical as the insurance market continues to become ever more globalized. Foreign insurers and regulators have wondered who speaks for the United States in international matters when regulation is a matter handled by more than 50 jurisdictions. By representing the United States in the International Assn. of Insurance Supervisors, the office would provide that voice.

Financial services regulatory reform is inevitable in the wake of the economic turmoil of recent months. Insurance regulatory reform must be part of that, and the administration's advocacy of a new Office of National Insurance should help assure that it is.

In the short time we've had to dig into the measure, we've discovered several disturbing provisions.



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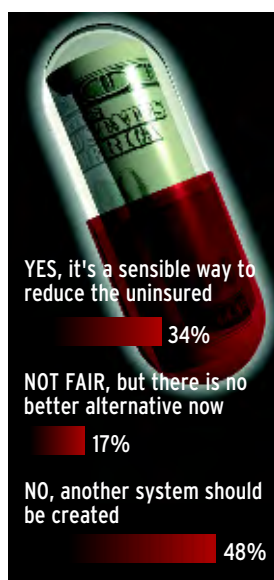
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How you can help, hurt your pandemic cover



Mr. Froderman



Mr. Merrill



Ms. Heald

Protecting a business from the unknown, such as a pandemic, can be a difficult task, say Troy Froderman, Anthony Merrill and Megan Heald of law firm Bryan Cave L.L.P in Phoenix. While pandemic insurance is available from a limited number of providers, there are a series of issues to either avoid or specifically include in more standard coverage to ensure that a business survives a pandemic, the authors say.

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CONSUMER-DRIVEN HEALTH PLANS

Largest consumer-driven health care plan providers ranked / [Page 10](#)

Medical tourism becoming a more attractive way to cut costs / [Page 12](#)

CDHP members more likely to use disease management programs / [Page 12](#)

Various forms of technology help users understand CDHPs / [Page 14](#)

BENEFITS MANAGEMENT

CDHP enrollment growing quickly

Employers, workers look to save money in sluggish economy

By **JOANNE WOJCIK**

Enrollment in consumer-driven health care plans linked to health savings accounts continues to gain ground as more employers offer the plans to reduce benefit costs and employees seek ways to save money in a down economy, experts say.

Enrollment in HSA-linked CDHPs, or health care plans with high deductibles, grew to 8 million lives at the beginning of this year, according to a May report from America's Health Insurance Plans. This compares with 6.1 million in 2008, 4.5 million in 2007 and 3.2 million in 2006.

Between January 2008 and January 2009, the fastest-growing market for such CDHPs was large groups, where penetration grew by approximately 35%, followed by small groups, which rose 34%, according to AHIP.

The Washington-based health insurance industry trade group does not track CDHPs linked to health reimbursement arrangements. HRA-linked plans would add to the 8 million lives covered by CDHPs.

Even in once hard-to-penetrate areas such as the U.S. Northeast, "almost every employer is offering a consumer-driven health plan as an option," said Laurel Pickering, executive director of the New York Business Group on Health, an employer health care coalition with 2,500 members.

Since Minnetonka, Minn.-based UnitedHealth Group Inc. in 2004 acquired pioneer CDHP vendor Definity Health Corp., it has become the market leader with nearly 3 million members, according to industry sources. WellPoint Inc. is No. 2, followed by Aetna Inc. and CIGNA Corp. (see chart, page 11).

Even though HSAs did not come into being until 2004 under the

Medicare Prescription Drug Improvement and Modernization Act of 2003, they are more prevalent than health reimbursement arrangements, the type of account the plans used when they were introduced earlier in the decade. According to a National Business Group on Health/Watson Wyatt Worldwide survey, 60% of CDHPs have HSAs, while 40% have HRAs.

"Four out of five employers are choosing HSAs over HRAs if they're introducing a plan today," said Alexander Domaszewicz, a principal and senior consultant with Mercer L.L.C. in Newport Beach, Calif. However, "Most large employers start with an HRA because they see it as the core offering, which they will build their health benefits around in the future."

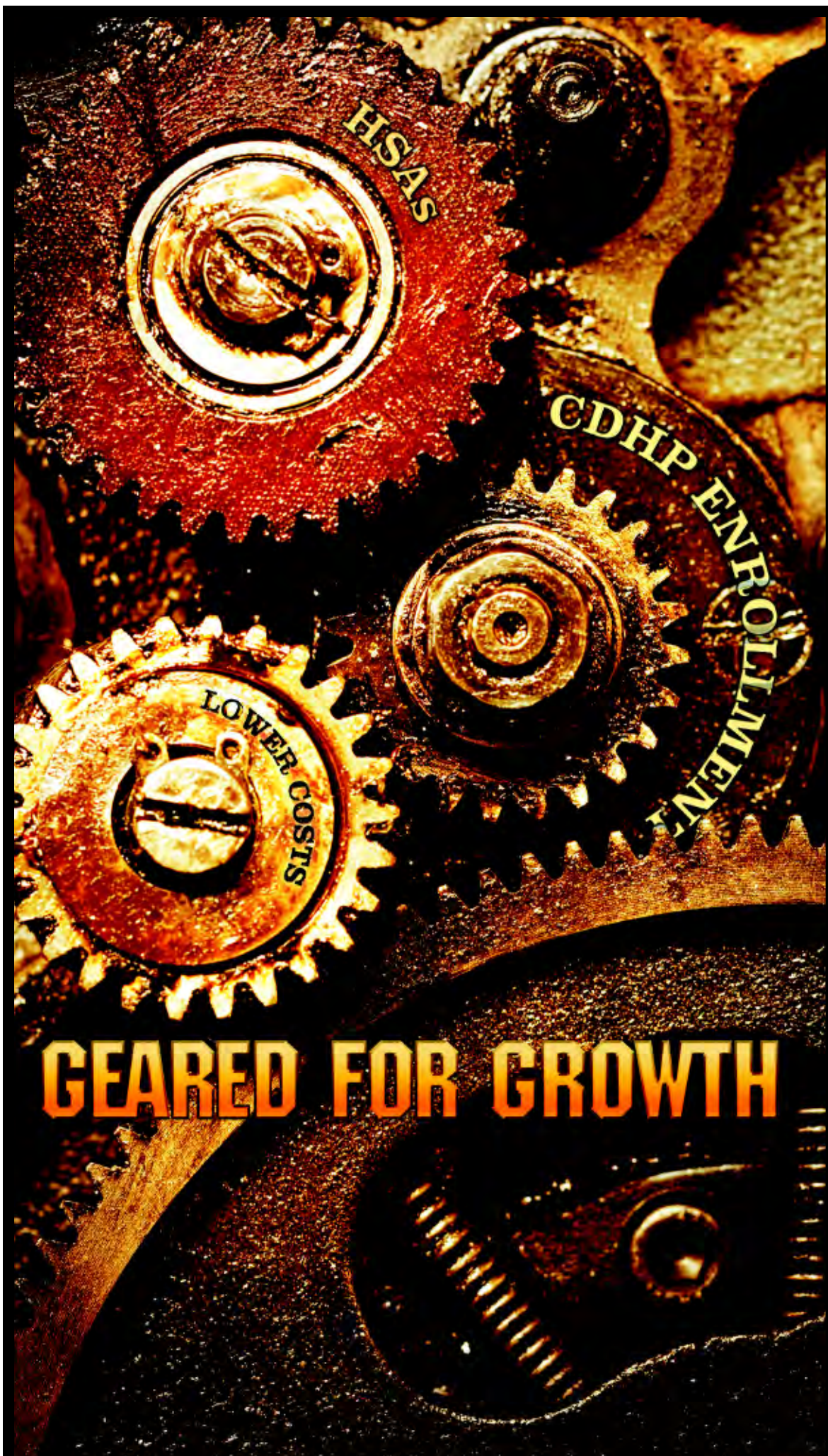
This is because HRAs permit more flexible arrangements, he said. For example, although prescription drug expenses are subject to the deductible in CDHPs with HSAs, employers can offer a separate drug plan if they have a CDHP with an HRA and avoid the deductible and copay, he explained.

Employers and employees can deposit funds into HSAs, while only employers can contribute to HRAs. Moreover, HSAs are owned by employees, so they can take them with if they leave their employer. By contrast, HRAs are the property of employers, which can choose whether to make them portable. Another significant difference between the two accounts is that money in HSAs cannot be tapped until it has been deposited; HRA funds are available at enrollment, just as with flexible spending accounts.

Benefit experts say the economic downturn has helped fuel the recent surge in employers offering CDHPs. Besides their premiums that are about 10% to 15% less than the typical preferred provider organization plan, CDHP annual claims

8 million

Lives enrolled in HSA-linked CDHPs at beginning of 2009, compared with 6.1 million in 2008.

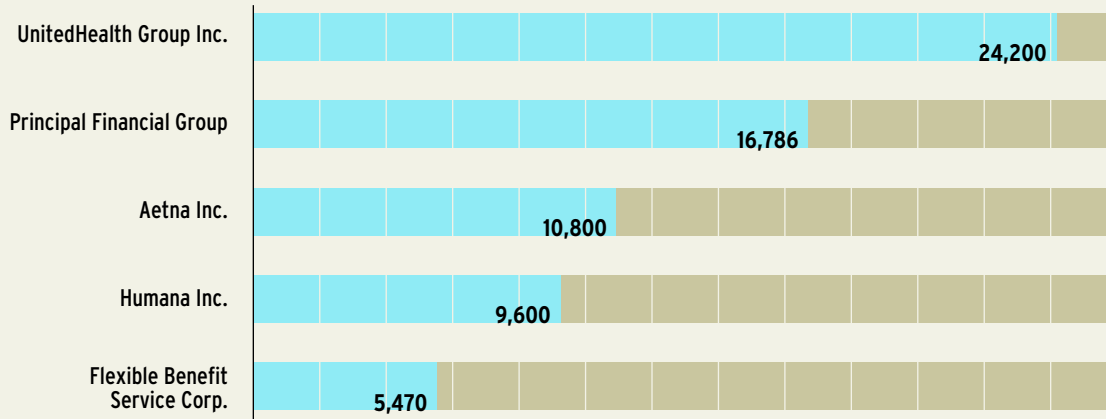


See **GROWTH** page 11

NEXT BENEFITS MANAGEMENT SECTION: Sept. 14 - Employee Wellness Benefits

LARGEST BY NUMBER OF CLIENTS

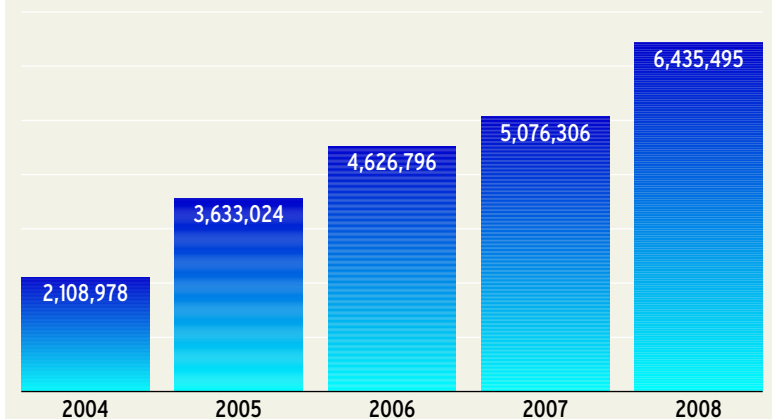
Plan providers by number of employer clients as of 12/31/2008



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 2008

Rank	Company/Address	Phone/Web site	Health plan name(s)*	Total covered lives	Employer clients	Plan options	Principal officer
1	UnitedHealth Group Inc. 900 Bren Road E., Minnetonka, Minn. 55343	866-799-1331 www.unitedhealthgroup.com	Definity	2,725,000	24,200	Dental, FSA, HRA, HSA, PPO, prescription drugs, vision	Gregg Kimball, vp-product distribution, UnitedHealthcare
2	Aetna Inc. 151 Farmington Ave., Hartford, Conn. 06156	860-273-0123 www.aetna.com	Aetna HealthFund HRA, Aetna HealthFund HSA	1,400,000	10,800	Dental, FSA, HMO, HRA, HSA, indemnity, PPO, prescription drugs, vision	Ronald A. Williams, chairman/CEO
3	CIGNA HealthCare 900 Cottage Grove Road, Hartford, Conn. 06152	860-226-6000 www.cigna.com	CIGNA Choice Fund	925,000	721	Dental, FSA, HRA, HSA, indemnity, PPO, prescription drugs, vision	Tom Richards, senior vp-product
4	Humana Inc. 500 W. Main St., Louisville, Ky. 40202	502-580-1000 www.humana.com	CoverageFirst, High Deductible Health Plan, Personal Care Account, SmartSuite, SmartExpress	636,000	9,600	Dental, FSA, HMO, HRA, HSA, indemnity, PPO, prescription drugs, vision	Michael B. McCallister, president/CEO
5	Meritain Health 300 Corporate Parkway, Amherst, N.Y. 14226	800-828-6922 www.meritain.com	-	150,000	131	Dental, FSA, HRA, HSA, indemnity, PPO, prescription drugs, vision	Elliot Cooperstone, CEO
6	Principal Financial Group 711 High St., Des Moines, Iowa 50392	800-986-3343 www.principal.com	-	145,362	16,786	Dental, FSA, HRA, HSA, PPO, prescription drugs, vision	Dave Shafer, senior vp-health division
7	Medica 401 Carlson Parkway, Minnetonka, Minn. 55305	952-992-2900 www.medica.com	Definity by Medica	143,343	3,172	Dental, FSA, HMO, HRA, HSA, indemnity, PPO, prescription drugs, vision	David Tilford, president/CEO
8	Choice Care Card 76 McNeil Road, Waterbury Center, Vt. 05667	888-244-2000 www.choicecarecard.com	-	125,000	2,700	Dental, FSA, HMO, HRA, HSA, indemnity, PPO, prescription drugs, vision	Jay Hunter, president/CEO
9	Flexible Benefit Service Corp. 10275 W. Higgins Road, Suite 500, Rosemont, Ill. 60018	847-699-6900 www.flexiblebenefit.com	Flex125, FlexHRA, FlexHSA	100,790	5,470	FSA, HRA, HSA	John DiVito, president
10	Harvard Pilgrim Health Care 93 Worcester St., Wellesley, Mass. 02481	888-888-4742 www.harvardpilgrim.org	Best Buy HSA/PPO, Best Buy HMO/PPO	85,000	3,000	FSA, HMO, HRA, HSA, PPO	Charles D. Baker, president/CEO

*If different from company name

Source: BI survey

Researched by Karen Tucker

Visit www.businessinsurance.com/directories for more information and to access the full searchable Directory of Consumer-Driven Health Care Providers. Business Insurance now offers the option to purchase the entire online directory as an Excel file or as a PDF.

Growth: CDHP enrollment growing fast

CONTINUED FROM PAGE 9

costs are less than traditional health care plans.

"We see a 10% to 12% savings on claims experience in the first year" in moving to a CDHP, said Will Giaconia, vp of CIGNA's Choice Fund product. "There's a dividend in future years because the population is more engaged."

These lower-cost plans have boosted employee enrollment year after year.

"Initially, a 10% enrollment rate was considered good," recalled Meredith Baratz, vp-market solutions at UnitedHealthcare in New York. Today, "at companies with 3,000 or more employees, we see an average 22% enrollment with the HRA model and 45% with the HSA model. Employers that offer both models get 48% enrollment rates," she said.

By comparison, about 39% of midsize employers enroll in a CDHP linked to an HRA while CDHPs linked to HSAs average about 21%. When both are offered, enrollment climbs to 69%, Ms. Baratz said.

"Depending on how the plan is structured, you may see a 12% to 15% median enrollment in HSAs vs. 20% to 25% in HRAs," said Mr. Domaszewicz, citing data from Mercer's annual survey. This compares with 2008 median enrollment rates of 11% for HSAs and 23% for HRAs, he said.

"Since it's gone up for 2009, we could see another big jump for 2010" in HSA-linked CDHPs, he said.

Often, financial incentives offered by employers are driving growth.

"If all health plans are being offered at a 20% employee contribution, they may offer a CDHP at 15% to make it more attractive," Mr. Domaszewicz said.

In addition, most CDHPs provide first-dollar coverage of preventive care, such as mammograms and annual checkups. In some cases, employers are taking advantage of a U.S. Treasury Department letter allowing certain drugs to be treated as "preventive" and therefore exempt from the deductible, said Kathy Campbell, head of product development at Aetna in Hartford, Conn.

At Black & Decker Corp. in Towson, Md., the employer made HSA contributions sizable enough to eliminate the difference between the PPO deductible and the CDHP, said Raymond Brusca, vp of benefits. As a result, its enrollment grew from 4% to 8%, but Mr. Brusca said he expects an even bigger jump in 2010 because of incentives that will make family coverage payroll contributions \$2,000 less than Black & Decker's traditional PPO plan.

"It's clear that the economy has accelerated a lot of the movement toward consumer-driven health plans and consumerism in general," said Michael Thompson, a principal with PricewaterhouseCoopers L.L.P. in New York.

Although only about 6% of employers make CDHPs their sole health plan, "what you're starting to see is employers using the CDHP as the benchmark or core plan; and

while they might offer other options, they require employees to pay more for them," Mr. Thompson said.

"We're seeing a lot of employers that may have been on the fence either coming to us and talking about it or moving into (CDHPs) because of cost pressure," said CIGNA's Mr. Giaconia. "The economy is putting a kick start into the product."

Scott Keyes, a senior consultant at Watson Wyatt Worldwide in Stamford, Conn., said two things are driving CDHP popularity: They've been around for more than five years, so they're gaining acceptance. Meanwhile, deductibles on PPO

plans have grown significantly, narrowing the gap between the average PPO deductible and CDHP deductibles, which, by law, must be at least \$1,150 for individuals and \$2,300 for families in 2009.

According to Mercer's National Survey of Employer-Sponsored Health Plans, the median deductible for individual coverage in PPO plans is \$1,000.

"I never thought I'd say making the other plan look bad would make (CDHPs) look more attractive, but PPOs are looking less attractive," said Tom Lerche, senior vp at Aon Consulting in Chicago.

Greg Scandlen, senior fellow and

TOP CONSUMER-DRIVEN HEALTH PLANS WITH HSAS

Total lives covered for CDHPs linked to health savings accounts as of Jan. 1

UnitedHealth Group Inc.	3 million
WellPoint Inc.	2 million*
Aetna Inc.	1.8 million
CIGNA Corp.	1 million

Source: Insurer estimates
*BI estimate



director at the Heartland Institute's Consumers for Health Care Choices in Hagerstown, Md., described the CDHP situation this way: "In the early days, the satisfaction was not

very high because people had to learn a whole new way of doing things, and they were suspicious of it. Over time, they've become more accustomed to it."

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Emerging models aim to boost allure of medical tourism

Rising costs, economy factors in employers' effective-care efforts

By LOUISE ESOLA

Medical tourism—an idea thousands of years old that has gained fresh traction amid rising health care costs—remains something that only a tiny minority of employers and individuals use.

Particularly for medical tourism that would take U.S. residents abroad, experts say more employers are considering the idea. But for individuals, at least one survey indicates interest in going abroad for medical care may actually be waning.

"A growing minority of employers are looking at medical tourism as a viable way to provide cost-effective care," said Steve Wojcik, vp for public policy for the Washington-based National Business Group on Health.

Internal Revenue Service rules allow individuals to use pretax dollars, either set aside by employees and/or employers in health savings accounts or provided by employers in health reimbursement arrangements, to cover procedures and necessary travel costs as long as the money linked to high-deductible health care plans is not used for personal vacations.

While medical tourism was again brought to the forefront in the 1990s mainly as a way for image-

conscious Americans to save money on elective plastic surgery, it has evolved since then as more medical travel companies have formed to arrange major, necessary surgeries and travel for individuals seeking the same care at a lower price.

But medical tourism is far from a mainstream medical option for most employer-sponsored health care recipients, experts say.

While there is no official data on number of insurers and employers offering medical tourism, WellPoint Inc. and Swiss Reinsurance Co.'s Commercial Insurance line are among insurers offering medical tourism as an option.

Employers are giving the idea greater consideration, consultants say.

"(Employers) are starting to look at medical tourism more seriously now, with costs going up," said Sharon Cohen, Washington-based benefits counsel for the group health care practice with Watson Wyatt Worldwide. "This is definitely on the table right now."

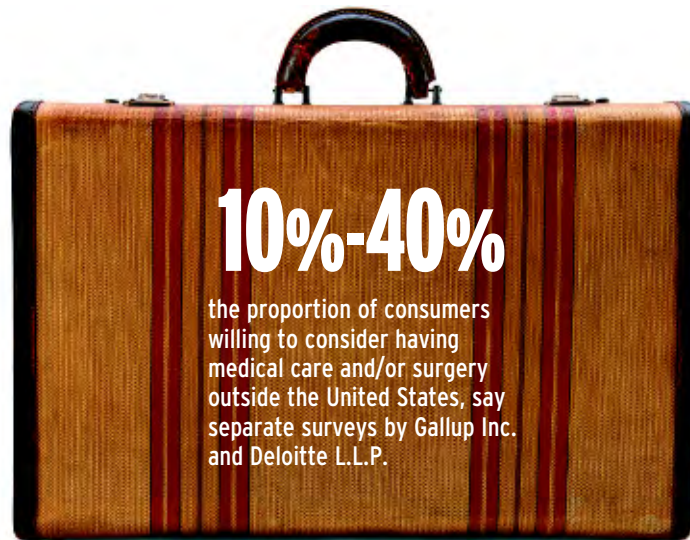
It's the obvious next step after employers' plunge into CDHPs, said Renee-Marie Stephano, chief operating officer for the West Palm Beach, Fla.-based Medical Tourism Assn. Inc.

However, when it comes to diseased or injured employees facing costly surgeries with five- to six-figure price tags in the United States, employers still are footing much of the bill aside from deductibles and copays. Workers also are feeling the brunt, as copays generally increase

year to year.

That's where medical tourism kicks in, Ms. Stephano said. As a way to make the option attractive to workers, some employers and insurers are offering to waive deductibles and copays if a covered individual insured agrees to have surgery abroad. Under this model, employers can save tens of thousands of dollars on one procedure alone.

For example, a worker in need of hip replacement surgery can turn to his local hospital for the estimated \$80,000 procedure, pay his \$2,000 deductible and copay, with insurance covering the rest. However, if the employer and insurer offer to waive the worker's deductible in exchange for having the procedure done instead in India for \$20,000 instead, the insurer and the



"We for the first time have started to put the pieces together," said Steve Lash, the company's president and chief executive officer.

The IRS has no limits on how much an employer can contribute to an HRA, making such a model an employee retention tool, Mr. Lash said.

Jim Williams, president of Newport Beach, Calif.-based Integrated Healthcare L.L.C., which administers CDHPs, said Satori's model is just one way companies can enrich their benefits offerings.

"People know they are paying more for health care, so they want these options," Mr. Williams said. "Whereas people would have never considered (medical tourism) in the past, they are starting to look at this now."

But individual interest is not firmly established.

An April Gallup poll of 5,000 adults found that up to 29% of U.S. residents would consider traveling abroad for medical procedures such as heart bypass surgery, hip or knee replacement, cancer diagnosis and treatment or alternative medical care.

In 2008, a Deloitte L.L.P. survey found that nearly 40% of consumers would consider having elective surgery done outside the United States if they could save 50% or more and be assured that the quality would be equal to that in the United States. However, in a May update, only 10% said they would consider receiving health care services outside the United States. While there was no explanation of why there was a decline in overall interest, the 2009 Deloitte update did note far greater interest in medical tourism among younger adults than those at or near retirement age.

employer pay far less.

"I don't see how, in this economy, with health costs going up, that we cannot (consider) medical tourism as a way to get health care," Ms. Stephano said.

Building on growing interest, San Diego-based Satori World Medical formed in 2007 and has established a patent-pending business model centered on linking company HRAs to medical tourism.

Satori's medical tourism program, which is free to companies that sign up, offers employees a package deal that includes the cost of the medical care, air fare and accommodations for the patient and a companion. The procedures take place at Satori facilities, with Satori-controlled quality measures, around the globe, the company says.

What makes Satori's business model unique, it says, is depositing a percentage of the amount saved to be deposited into an employee's HRA to be used to cover future medical expenses.

Disease management thrives on education

Waiving deductibles, personalized plans enhance outcomes

By LOUISE KERTESZ

Making disease-management programs available is just the first step in encouraging members of high-deductible consumer-driven health plans to use them, health care experts say.

"The real punch line is that for members in a CDHP, a couple of things are going on that increase engagement. They are financially engaged, so they have a heightened awareness of cost and quality, which drives them to be more aware of chronic disease-management programs," said William Giacomia, vp of consumer-driven products at CIGNA Corp. in Bloomfield, Conn.

enrolled in CDHPs, which combine a high-deductible health plan with a health savings account or health reimbursement arrangement, are eligible to receive certain wellness and preventive services—including disease management—without having to meet their deductible.

Experts say CDHP members tend to use those services more than members in traditional health care plans.

"What we have found is that because the preventive care programs are exempt from the requirement to meet the deductible, the use of those programs, including disease management, is slightly above those in other groups," said Carl Mowery, managing director at SMART Business Advisory and Consulting L.L.C. in Chicago. That is the result of an emphasis on "spending the time educating (CDHP members) about the bene-

Employees and dependents

Continued on next page



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CONTINUED FROM PREVIOUS PAGE

fits," he said.

Reaching out to CDHP members may be the biggest factor in encouraging members to use disease-management programs, observers said.

"I would say that for some of the (consumer-directed) plans, the intensity of outreach seems to be better" than for members of traditional plans, said Scott Keyes, senior consultant for Watson Wyatt Worldwide in Stamford, Conn.

For pioneering CDHPs Definity Health Corp. and Lumenos Inc., "the consumer experience and the education was as important as anything in the account." Those priorities are being mainstreamed into traditional health care plans as well, Mr. Keyes said.

While "some of the largest employers have been doing disease management for a long time...for many employers, awareness of disease management came with seeing CDHP plans and how they work. The light bulbs went on," Mr. Keyes said.

'Some of the largest employers have been doing disease management for a long time...for many employers, awareness of disease management came with seeing CDHP plans and how they work. The light bulbs went on.'

Scott Keyes,
Watson Wyatt Worldwide

Minnetonka, Minn.-based UnitedHealthcare Inc., which acquired Definity in 2004, "took the initial toolkit pioneered by Definity, supplemented by clinical support and management from United, and made those available to all members," said Meredith Baratz, vp of market solutions at UnitedHealthcare in New York. "CDHP members are probably more likely to make use of the decision-support tools," she added.

"One of the wonderful things Definity brought to United was creating and delivering highly personalized health messages based on a member's individual characteristics, plan use and needs," Ms. Baratz said.

For example, a message to a member with diabetes would direct him or her to a health coach. United tracked the messages and found that they result in a high percentage of employees taking appropriate action, she said. For example, women who did not have a mammogram were 68% more likely to get the test in the three- to six-month period after they received a personalized message. The same high percentages occurred after messages for cervical cancer and prostate screenings.

Employees of UnitedHealthcare's large-employer clients get personalized messages no matter what type of plan they have, but the messages are not yet available for all business segments, Ms. Baratz said. United hasn't yet rolled out the program to all of its business segments, she said.

CIGNA's CDHP plan features the Health Advisor program, a phone-based resource that allows members to speak with a nurse at any time about their health. "That's an engagement point for us to counsel people" with asthma or another chronic condition and remind them that CIGNA has a disease-management program that would benefit them, said Mr. Giaconia. While Health Advisor is included in CIGNA's CDHP, employers offering

traditional health care plans must purchase use of the program.

A CIGNA study showed its CDHP enrollees were far more likely to take advantage of preventive care than individuals enrolled in traditional plans. In the renewal year 2007, there were 413 preventive care visits per 1,000 CDHP plan members, vs. 367 visits per 1,000 members in traditional plans.

Aetna Inc. was the first insurer to clarify with the IRS that certain drugs prescribed for CDHP members with established chronic conditions are not subject to the deductible, said Kathy Campbell, head of product development at Aetna in Hartford, Conn.

"We actually encourage our plan sponsors to do this because we

think it's a positive to offer first-dollar coverage to prevent a condition from worsening," Ms. Campbell said. Most large employers have adopted the policy, but smaller groups tend not to, she said. Large employers tend to offer more generous benefits, she said.

Covering medications without requiring the deductible is a "pretty common enhanced benefit" for employers that have value-based plan designs that include consumer-driven plans, Ms. Baratz said. But not all large employers cover those medications for CDHP enrollees prior to the deductible, she said.

In a concept it calls "population health management," Irving, Texas-based Advanced Plan for Health

analyzes an employer's population and designs plans tailored to employees' needs and the employer plan's cost drivers, said Rich Williams, chief executive officer.

Advanced can design plans that provide first-dollar coverage for CDHP enrollees who take drugs for chronic conditions and who agree to participate in a disease-management program, Mr. Williams said.

"It's important to have a very focused environment related to each individual employer," he said.

He said the effort appears to be reducing costs.

Clients of Advanced Plan for Health saw their medical cost trends last year decline 1% vs. nationwide increases that averaged 8% to 12% last year, Mr. Williams said.

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Variety of tech tools in demand for using CDHPs

By **GEORGE SWEENEY**

As insurers and employers turn to consumer-driven health plans to cut benefit costs, they also look to technology to engage employees in their health care decisions, leading to an array of software as diverse as the challenges CDHPs pose.

"It's to no one's advantage for people not to know" how their health care benefits are structured, said Michael Wolf, director of the Center for Communication in Healthcare at Northwestern University's Feinberg School of Medicine in Chicago.

He cited a 2007 study by the University of Connecticut that estimated the cost of low health literacy is between \$106 billion and \$238 billion annually.

It's a drain on employers, patients and insurers that can be plugged only by keeping patients aware of healthy habits, when and how often they need to use health care services, and how to find the cheapest care.

It's especially important to keep CDHP patients informed because of the greater independence they have in making decisions about their care, Mr. Wolf said.

A variety of software has been developed to help CDHP users navigate their plans—some to be offered through employers or insurance companies; some directly to the consumer. Some are meant to

be used at home; others at work; and some, for mobile devices.

Still, more diversity exists in the programs' emphases—with some focusing on point-of-care decisions and others on preventive care, some focusing on health literacy, others purely on cost reduction.

RedBrick Health Corp. Chief Executive Officer Kyle Rolfing said his company aims to improve patients' habits.

Mr. Rolfing, a veteran of Definity Health Corp. and UnitedHealth Group Inc., said he started RedBrick to provide a system that rewards preventive care and healthy habits.

His Minneapolis-based company offers online health assessments and education, and sets up an infrastructure to reward employees for good habits like quitting smoking or losing weight.

Though he admitted some programs depend on the honor system, he said it's important to provide incentives to reward healthier lifestyles to reduce health care costs.

Other programs aim to synchronize data necessary for doctors and patients to make good decisions. Philadelphia-based CIGNA Corp.'s Cost of Care Estimator takes information about all costs associated with a treatment, considers features in a patient's plan and relevant factors from their health assessment, and makes treatment recommendations for the patient

Additional steps needed to communicate

When seeking to improve communication about health and benefits to employees, technology often is the answer—but not always.

"As antiquated as some things are, we do a lot of paper, multichannel communication," said Brenda Schmidt, chief executive officer of Diversity Wellness L.L.C., a Phoenix-based wellness program provider that helps companies teach hard-to-reach employees—such as those with limited English skills or infrequent Internet access—about benefit options and health-related issues.

For example, a Diversity Wellness survey of 200 Hispanic women found that fewer than 2% use the Internet for health information.

Beyond language or cultural issues, communication challenges vary by occupation. Ms. Schmidt said the challenge for truck drivers and oil rig workers is that they're geographically dispersed and working at sites that may have limited or no computer access.

For agricultural, food and auto workers, the typical lack of Internet access at work is compounded by the intensity of their jobs.

It's unrealistic to think most employees will put in the time necessary to research intricacies of dif-

ferent health plans, Ms. Schmidt said. "They go, 'Yeah, I want to pick what I had last year,' but they don't really know what they're doing."

Ms. Schmidt said she has found Spanish-only speakers and some American Indian groups are particularly difficult to reach online.

Kay Griffin, co-founder of BeneCom Associates L.L.C., an Avon, Conn.-based benefit communications company, said most challenges associated with getting benefit information to employees are occupation-driven, not caused by language or cultural factors.

It's toughest to reach those in jobs that don't involve computers or those with large staffs, such as hospitals, with greatly varying responsibilities and benefit levels, she said.

In reaching employees, Ms. Schmidt said the company uses a whatever-it-takes approach. Diversity Wellness staff have been placed at factories and dairy farms to take employees aside and discuss health issues. The health program provider also has established a 24-hour nurse hot line for one American Indian group to ask benefits and claims questions and get health coaching and behavioral counseling.

—By George Sweeney

and doctor to consider.

Some help patients shop around.

San Francisco-based Canopy Financial, a self-described health care banking technology company, offers an iPhone application that enables patients to search procedures using keywords, and then find out where they're available and if they qualify for payment from health savings accounts. It also uses a patient's ZIP code to estimate costs. CEO Vikram Kashyap said the company plans to make similar software for all mobile devices.

The Consumer Choice Plan from Franklin Lakes, N.J.-based Medco

Health Solutions Inc. provides Web-based tools to compare plans and purchase prescriptions. It also provides benefit coaching and structures payments to encourage patients to use preventive medications.

And some companies aim to make confusing programs understandable. Charleston, S.C.-based Benefitfocus, which says it is the largest health care software provider in the United States, produces videos that answer health-related questions and helps users choose between complex benefit packages and how to navigate them afterward. It also offers software that incorporates expected health care costs to help users choose their health plan.

Boston-based Health Dialog Services Corp. offers 24-hour health coaching and online videos to patients through health plans, employers and providers.

"Many decisions in medicine are gray," said Dr. Lance Lang, the company's medical director. "How much it's going to cost is only part of (the decision)." Dr. Lang said information necessary to make a choice often is absent or more than one evidence-based treatment is available, making it tough to choose between options. The Health coach's role is to talk patients through these decisions, he said.

Additionally, Microsoft Corp. and Google Inc. have established health record management tools. Both allow patients to input information and doctors to upload records to set up the health profile. Google Health enables users to search physicians by specialty and location, and shows reviews aggregated from other sites. Redmond, Wash.-based Microsoft also has added a tool that lets users get health advice from physicians at Mayo Clinic.

While CDHPs and the technology developed to help them work more efficiently are more than five years old, the insurers, consultants and tech-sector giants that built them remain challenged to get people to use them.

While experts in health literacy and employee behavior agree the technology shows the potential to improve health care decisionmak-

ing, it has not taken the place of long-trusted sources of health information.

According to a nationwide survey in May 2007 by Watson Wyatt Worldwide Inc., 57% of employees listed "friends and family" as their regular source of information about doctors and hospitals, while only 36% listed their health plan's Web site.

As for why this trend exists: "People don't trust their health plans," said Barbara Flitsch, senior consultant for Watson Wyatt in Minneapolis.

"People still tend to go with their gut," Northwestern's Mr. Wolf said. "The bottom line with health care in the past 20 years is that the average consumer knows very little about what they should be doing."

He characterized the technology options available to health plans as ranging from "Plymouth Neon to Cadillac." But their complexity, he added, makes it difficult to tell the difference—leading health plan members to make uninformed choices.

The lack of trust has continued even as companies rely more on health-administration technology.

A March Watson Wyatt survey found 19% of employers increased outsourcing of health and welfare benefits administration and 16% outsourced human resources and benefits services in the previous two years.

It also found 72% of companies surveyed report increased use of their intranet and 61% percent used more e-mail to communicate with employees during the same two-year period.

While more companies have come to rely on technology-driven means of reaching employees, it's also true that CDHP-technology industry has arrived in a climate of uncertainty for health care. With the prospect of health reform legislation looming, it's difficult to predict what CDHPs and CDHP technology will look like, or how common either will be, in the coming years, experts say.

Despite uncertainty about health care reform, Ms. Flitsch said she expects demand and innovations in health care software to continue.

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Contact Monique Murray at 212-210-0129 For Details

LEGAL NOTICE

IN THE HIGH COURT OF JUSTICE
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 No. 627 of 2009
NOTICE OF SANCTION OF A SOLVENT SCHEME OF ARRANGEMENT
 IN THE MATTER OF
THE MEADOWS INDEMNITY COMPANY LIMITED
 AND IN THE MATTER OF THE COMPANIES ACT 2006 OF GREAT BRITAIN

NOTICE IS HEREBY GIVEN that, by an Order dated 20 July 2009 made in the High Court of Justice in England and Wales, Chancery Division (Companies Court) in the matter of The Meadows Indemnity Company Limited (the "Company"), the solvent scheme of arrangement (the "Scheme") to be made between the Company and its Scheme Creditors as defined in the Scheme pursuant to Part 26 of the Companies Act 2006 which was made and approved by the Scheme Creditors during the meetings held on 27 May 2009, was sanctioned. A copy of the Order sanctioning the Scheme was filed with the Registrar of Companies on 20 July 2009, and the Scheme became effective on that date (the "Effective Date").

Scheme Creditors are required to submit completed Claim Forms together with the supporting evidence required by the Scheme in respect of their Claims as defined in the Scheme by 21.00pm (London time) on 31 January 2010 (the "Final Claims Submission Date").

Completed Claim Forms should be returned to The Meadows Indemnity Company Limited c/o Arham Limited, Lloyd's Avenue (House 5) Lloyd's Avenue, London, EC2N 2JY, United Kingdom or by fax to +44 (0) 20 7264 0801 or by email to meadowsenquiries@arham.com.

In the event that a Scheme Creditor fails to complete and submit a Claim Form to the Company on or before the Final Claims Submission Date, the Claim of that Scheme Creditor against the Company will be deemed to have been waived in full and that Scheme Creditor will not be entitled to receive any payment in respect of such Claim.

Notice of the Effective Date and the Final Claims Submission Date has been sent to all known Scheme Creditors for whom the Company has contact details which it does not believe are incorrect. Any person who believes it should or is entitled to be a Scheme Creditor of the Company who has not received notice of the Effective Date should contact Philip Grant of Arham Limited, the Scheme Administrator at the address above or by telephone on +44(0) 20 7264 0802 or by email to meadowsenquiries@arham.com.

Any Scheme Creditor who is unclear about or has any questions regarding the Scheme, or the actions it required to take, should contact the Scheme Administrator using the details set out below.

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Contact Monique Murray at 212-210-0129.

UP Comings & Goings CLOSE



TIM FARWARD

NEW JOB TITLE: Philadelphia-based nuclear client adviser for Marsh Inc.

PREVIOUS POSITION: U.S. Navy lieutenant; assistant engineering officer on a nuclear submarine; assistant professor of naval science at Florida A&M University.

RECOGNITIONS: Recipient of two U.S. Navy Achievement Awards; recognized as a Modern Day Technology Leader during the 2007 Black Engineer of the Year awards, U.S. Naval Academy graduate.

GOALS FOR NEW POSITION: My goals are to learn the new job, the insurance industry. It's something I haven't dealt with before. I want to focus on learning and obtaining the

knowledge to help improve the company. I want to also improve myself. Sometimes people look at a job as just a job and not as a way to learn and develop your character.

EXPECTATIONS: I am looking forward to moving up with the company. There is such a wide range of opportunity for me to work with Marsh.

INDUSTRY OUTLOOK: People like to call it a nuclear renaissance. There is going to be a lot of growth in the nuclear field. We are playing bigger roles in that and that is something I want to be a part of. It will be better for us.

MOST PASSIONATE ABOUT: My family. I have a 2-year-old son and a lot of the decisions I make are to help him have a better life...For me, family comes first.

Comings & Goings ONLINE

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Products & Services

Insential offers builder warranty

DALLAS—Insential Inc. is offering a warranty program for U.S. home builders to protect the market value of a new home.

Under the Home Value Warranty program, residential builders are able to transfer the risk from the consumer to the builder if the value of the home decreases below the original purchase price after seven to 10 years. The program transfers the warranty risk from the builder to an insurance policy through Insential, the Dallas-based brokerage said.

The program was established in response to the troubled housing market. When used as part of a builder's warranty portfolio, the program can help builders ease the concerns of prospective home buyers, Insential said.

The program is limited to Insential's partner agents.

For more information, contact Insential President Darwin Lucas at 972-535-6701 or visit www.insential.com.

Sedgwick CMS begins clinical consultations

MEMPHIS, Tenn.—Sedgwick Claims Management Services Inc. has rolled out a clinical consultation service to help organizations respond to workplace injuries and reduce workers compensation costs.

The clinical consultation includes a nurse triage service that is available by phone 24 hours a day. The nurse evaluates an injured worker's medical condition, recommends care and, if necessary, makes an appointment with a prequalified network medical provider.

The program aims to minimize the risk that care will be delayed or that serious conditions will go unrecognized. It also identifies alternatives to potentially costly emergency room trips and overtreatment of minor cases, Sedgwick CMS said.

The program can be integrated into an organization's workers comp claims reporting program, the company said.

For more information, contact Teresa Bartlett, medical director, at Teresa.Bartlett@sedgwickcms.com.

Travelers introduces D&O liability policy

ST. PAUL, Minn.—Travelers Cos. Inc.'s bond and financial products business has enhanced its Broad Form Plus directors and officers liability policy.

The policy offers coverage for nonindemnifiable claims against directors and officers for public and private companies, financial institutions and nonprofit organizations, Travelers said.

The policy offers several benefits, including a follow-form provision that offers uniformity of coverage in concert with the primary D&O liability policy.

In addition, if other insurance or indemnification from any source

doesn't respond to a claim within 60 days, this policy will respond upon request, Travelers said.

For more information, contact Cary Meiners, D&O product manager of bond and financial products, at (651) 310-8938 or cmeiners@travelers.com.

Eurobase rolls out organizational software

LONDON—Eurobase Insurance Solutions has released iSynergy, a software program to help organize insurance policy information from multiple sources.

Aimed at insurers and reinsurers, the software by London-based Eurobase identifies the user with a login and determines what infor-

mation to provide and how to present it based on the user's responsibilities and preferences.

It is meant to retrieve and convert real-time account information from insurers, reinsurers, brokers, underwriters and other sources.

For more information, contact Ian Forwood, insurance business development director, at ian.forwood@eurobase.com, or Maryann Fitzgerald, marketing director, at maryann.fitzgerald@eurobase.com.

Marathon Health offers worksite fitness programs

COLCHESTER, Vt.—Marathon Health Inc. is offering worksite fitness programs and related capabilities in its suite of onsite employee

health services.

The Colchester Vt.-based company—which sets up and runs onsite clinics, pharmacies and health screening programs—said it can help design fitness centers, manage them and promote the programs.

For more information, contact Jeff Seward, vp of sales, at 802-857-0400 or jseward@marathon-health.com.

TO SUBMIT ITEMS

BI's Products & Services column reports on new product offerings. Please send Product & Services news to Colleen McCarthy, 711 Third Ave., New York, N.Y. 10017 or e-mail cmccarthy@businessinsurance.com.

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Reform: Health care bills attract side issues, add-ons

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are attached to broader, high-priority legislation, such as that designed to bring the United States closer to universal health care.

The health reform bills, noted Gretchen Young, vp-health policy with the ERISA Industry Committee in Washington, are fast-moving measures.

The problem that can occur when unrelated provisions are attached to broader bills is that the provisions don't always get the attention and scrutiny they would if they were free-standing measures.

1980s example

One classic example occurred in the mid-1980s when legislators attached a free-standing bill—introduced by California Democratic Reps. Pete Stark and Henry Waxman to require employers to continue health care coverage for employees who quit or were let go, as well as dependents who otherwise would have lost group coverage due to death, divorce or marital separation—to a broader, must-pass budget bill.

When that budget bill later passed, few employers knew that it contained the health care continuation provision, which soon simply became known as COBRA, short for the Consolidated Omnibus Budget Reconciliation Act of 1985, the name of the broader bill. Many employers then had to scramble to comply with the COBRA provisions.

As for undetected benefit bombshells for employers and employees in the current health reform legislation, Ms. Young said: "Who knows what yet will be discovered?"

But given the size of the reform measures—the House bill is more than 1,000 pages—the odds are high that they contain potential benefit time bombs.

Some potentially troubling provisions and others unrelated to the core of the legislation already have been uncovered (see box).

For example, the House bill includes a provision that would bar employers with retiree health care plans from cutting benefits to current retirees unless they did the same for employees.

Employers would be locked into those arrangements and the net result would be a rush by employers, wherever possible, to terminate retiree health care plans before the provision took effect, experts say.

"It is a terrible provision. Effectively, employers would be locked in forever. Employers would have no incentive to offer the plans" and some would want to fold those plans as soon as possible, Ms. Young said.

"Employers would rush to get out of those plans," said Chantel Sheaks, a principal with Buck Consultants L.L.C. in Washington.

If adopted, other provisions in the House bill could have a huge impact on benefit programs. For example, the House Education and Labor Committee tacked on a provision—proposed by Rep. Dennis Kucinich, D-Ohio, that would remove a barrier that now blocks states from enacting single-payer health systems.

Under current federal law, ERISA preemption bars state laws that relate to employee benefit plans. The Kucinich amendment would exempt state single-payer laws from ERISA pre-emption.

Provision on plan design troubles employers

WASHINGTON—When President Obama said at a news conference last week that health care reform legislation would "keep government out of health care decisions," he may have been shading the truth, employee benefit lobbyists and others say.

In fact, tucked into the reform measure, H.R. 3200, passed by two House committees and awaiting action by a third, are provisions that could take away from employers their longstanding ability to design health care plans without government telling them what benefits they must offer and cost-sharing limitations they can impose.

The legislation not only would mandate a broad range of benefits "qualified" plans must offer, but it also would create a new Health Benefits Advisory Committee to make recommendations on benefit plan design.

The panel, whose members would be appointed by President Obama and Congress, would make recommendations on benefits that health care plans would have to cover and cost-sharing

requirements plans could impose.

Those recommendations would be sent to the Secretary of the Department of Health and Human Services, who would have the authority to impose them through regulations.

Nothing would require employers to amend their plans to meet the standards laid out in the regulations. But if they didn't, their health care plans wouldn't be considered qualified and they would be liable to pay a tax of 8% of salary for each employee not enrolled in a qualified plan.

No one knows what recommendations would be proposed, much less how those requirements could change in the future, resulting in continued uncertainty by employers on benefit plan designs that would pass muster and those that would not.

"This would be a real game-changer. Decisions now made by employers" would be turned over to the federal government, said Paul Dennett, senior vp-

health reform with the American Benefits Council in Washington.

"Employers need to take a look at this. You may think the legislation doesn't affect what you do, but it certainly does and in a huge way," said Chantel Sheaks, a principal with Buck Consultants L.L.C. in Washington.

More than 30 business groups, including the American Benefits Council, the ERISA Industry Committee, the National Assn. of Manufacturers, and the U.S. Chamber of Commerce, have signed a letter sent to all members of the House of Representatives urging the provision be stricken from the bill.

"Coverage decisions would...be set by a new Health Benefits Advisory Council that would have significant power but be highly unaccountable to the American people. We urge Congress to leave those decisions between providers, patients, insurers and plan sponsors—not to dictate them from Washington," the letter said.

—By Jerry Geisel

But the reason that some panel members—including 13 of the panel's 19 Republicans—voted for the amendment was not because they endorse single-payer systems, but because, benefit lobbyists said, is that the legislators believe the addition of the provision will reduce support for the overall bill, which Republicans oppose. So-called poison-pill amendments also are a tactic occasionally used to try to thwart legislation.

Like the budget legislation of the

mid-1980s, the House health care reform bill also packs a COBRA provision.

The most recent addition, introduced by Rep. Susan Davis, D-Calif., and added to the reform bill by the Education and Labor Committee, would allow COBRA beneficiaries whose coverage runs out to retain COBRA until they become eligible for group coverage under a new employer's plan or until they become eligible for coverage through new state health

insurance exchanges, which the legislation would establish starting in 2013.

As a result, COBRA beneficiaries could extend COBRA for years after their eligibility under current law expires. Under current law, employees who terminate employment are entitled to up to 18 months of COBRA coverage, while employees' dependents can obtain up to 36 months of coverage in situations involving death, divorce or marital separation.

Red flags: New rules causing confusion

CONTINUED FROM PAGE 3

not realize they are subject to the rule.

"Obviously, the financial institutions are on board, but other sectors are getting caught off guard," said Nicholas Economidis, an underwriter with Beazley USA's technology, media and business service team in Philadelphia.

He said retailers that issue private-label credit cards are particularly confused. "They think that because they have a financial institution handling the accounts, that they have outsourced the exposure and therefore are not subject to the rules." They are incorrect, he said.

Failure to comply with Red Flags could result in civil fines up to \$3,500 per incident. "More importantly, the regulation opens up the door to a wave of potential negligence claims, and companies that fail to comply could be exposed," Mr. Economidis said.

A number of high-profile, costly cases have boosted organizations' concerns about security and data breaches and many have taken risk-

mitigation steps. But the new rule should be a wake-up call that companies need to re-evaluate their programs in order to comply, experts say.

To identify red flags, companies should evaluate their potential exposures and examine the types of accounts they offer or maintain, as well as how access is provided to the accounts. In addition, companies should use identity verification methods for anyone opening up a new account. This could include using a credit reporting company, data broker or the Social Security Number Death Master File, to compare information, the FTC said.

Some firms already may have some procedures in place that can simply be implemented into the program, such as a "know-your-customer rule," Mohapatra said.

Combating data breaches and identity theft "actually has much more to do with human behavior than it does with technology," said Mark Pribish, vp and identify theft practice leader with Phoenix-based consulting firm Merchants Information Solutions Inc. He said, with

current or former employees often involved in such breaches, every business should consider using pre-employment screening.

Likewise, outsourcing is a risk and companies should review all provider contracts and include language to support security policies, he said.

Companies increasingly are turning to cyber liability and network liability insurance for additional protection, and observers say the Red Flags Rule likely will boost the market.

"We are seeing a huge uptick in both—people looking for coverage and people buying coverage," said Bob Parisi, national leader for the Tech/Telecom E&O and Network Risk practice at Marsh Inc. in New York.

Data security breaches can be costly. Last year, companies that experienced a data breach paid an average \$202 per record compromised, according to the Traverse City, Mich.-based Ponemon Institute L.L.C.

FTC guidance on the Red Flags Rule is at www.ftc.gov/bcp/edu/pubs/business/idtheft/bus23.pdf.

Manslaughter: Companies eyeing case under new law

CONTINUED FROM PAGE 3

interpreted by the courts, said Marc Spurling, a senior risk consultant in Marsh Ltd.'s Risk Consulting Practice in London.

If the case goes to trial, it will help Marsh advise its clients, but further prosecutions using the Corporate Manslaughter Act will be needed to give clarity for how the Act will be used to prosecute large, complex businesses, he added.

A key issue for large corporations with subsidiaries and local branches in the United Kingdom will be how judges interpret the act's definition of senior management, but this case is unlikely to clarify that issue, said Stefan Groch, partner at Manchester-based law firm DWF L.L.P. Cotswold Geotechnical, he said, is a small company with an uncomplicated management structure.

He said a trial would show how judges might interpret the act's definition of "gross breach" of a duty of care.

The case also may give an indication of likely future penalties. The fine in this case, should the company be found guilty under the act, will not "make waves" in terms of its size because Cotswold is small, but the judge may decide the penalty on the basis of a percentage of revenue, Mr. Groch said.

The case also could be one of the first prosecutions of a director to use the additional sentencing powers provided by the Health and Safety (Offenses) Act 2008, which was enacted in January, said Duncan Astill, associate at London-based law firm Mills & Reeve L.L.P.

The case shows the CPS's increased willingness, in the most serious cases, to prosecute individuals and the corporate entity, he said.

The Health and Safety (Offenses) Act increases the punishment available for individuals, including directors, who are found guilty of specific health and safety offenses, exposing them to higher fines and prison sentences, said Marsh's Mr. Spurling.

NYC fire department exams showed racial bias: Judge

Court says written exams violated Civil Rights Act of 1964

By JUDY GREENWALD

BROOKLYN, N.Y.—The New York City Fire Department's reliance on two written firefighter exams constituted employment discrimination against minorities in violation of civil rights law, a federal district court judge ruled.

The federal government; the Vul-

can Society Inc., a black firefighters organization; and three other plaintiffs had sued the fire department, claiming the city's use of the two tests had a disparate impact on black and Hispanic candidates in violation of Title VII of the Civil Rights Act of 1964.

Judge Nicholas G. Garaufis of the Federal District Court for the Eastern District of New York in Brooklyn last week agreed and granted summary judgment in favor of the plaintiffs. He noted in his 93-page decision that while 25% of the city's residents are black and 27% Hispan-

ic—as of 2007, when the litigation began—they accounted for just 3.4% and 6.7% of black and Hispanic firefighters respectively.

The judge said in his decision that it is “natural to assume that the best performers on an employment test must be the best people for the job. But the significance of these principles is undermined when an examination is not fair.” The city “did not take sufficient measures to ensure that better performers on its examinations would actually be better firefighters.”

The proceedings have been bifur-

cated, and Judge Garaufis said he will subsequently determine an “appropriate remedy.”

A New York City spokeswoman said the city will decide whether to appeal once the judge issues this second ruling in the case.

In addition, Georgia Pestana, chief of the labor and employment division of New York City's law department, said in a statement that she disagrees with the decision. She said the city since has developed a new test that was administered in 2007 and that, combined with an outreach effort, has resulted

in minorities now comprising 38% of the candidates on the passing list.

Judge Garaufis noted in his opinion also that the legal issue before his court was different than the one decided by the U.S. Supreme Court in *Frank Ricci et al. vs. John DeStefano et al.*, in which the city of Hartford, Conn., had rejected a promotion exam out of fear it would be sued for discrimination by minority candidates.

In June, the Supreme Court in that case ruled in favor of 17 white and one Hispanic firefighters who had brought the suit.

United: Some concerns on competition

CONTINUED FROM PAGE 4

financial analyst for the health insurance division at A.M. Best Co. Inc. in Oldwick, N.J., said the acquisition has the potential to expand UnitedHealth's regional membership in the three states, particularly if the commercial membership from Health Net moves to UnitedHealth upon renewal.

UnitedHealth currently has 2.6 million commercial members in the region, according to a company spokesman.

'When consolidation like this happens in the market, it always has a negative impact on competition in the region.'

Laurel Pickering,
New York Business Group on Health

“That said, the region is already very competitive, particularly in the New York City metro market, and UnitedHealth is already a formidable player in the commercial market with its UnitedHealth and Oxford Health operations, which have scale and a provider network across the area,” the spokesman said.

Though industry analysts didn't think the acquisition would pose a major threat to competition in the market, the employer community expressed some concern.

“When consolidation like this happens in the market, it always has a negative impact on competition in the region,” said Laurel Pickering, executive director of the New York Business Group on Health. “The number of health plans in our market is shrinking, and it is a concern to the business community. Less competition means less incentive to be the best in the market.”

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'Lean' process helps Boeing manage leaves of absence

Aerospace firm saves millions of dollars, hours of productivity

By ROBERTO CENICEROS

PORTLAND, Ore.—Boeing Co. applied a "lean" manufacturing process to improve absence management while merging its short- and long-term disability program administration with its leave-of-absence offerings.

Toyota Motor Corp. pioneered the lead philosophy that allows practitioners to simplify and become more efficient by identifying and eliminating waste, said panelist Jacqueline Coulter, program manager in the leave management services for Boeing, at the Disability Management Employer Coalition's annual conference.

Boeing's leave management program underwent the lean process beginning in 2007 because of several inefficiencies, Ms. Coulter said.

The company with 147,000 employees administers 11 different, complex leave programs, and its workers generate 59,000 intermittent Family and Medical Leave Act absences annually and 16,000 non-FMLA absences.

Poor administration of those cas-



Boeing Co. employees work on front landing gear on a 787 in Everett, Wash., in April. The company has begun a "lean" manufacturing process to improve absence management.

AP PHOTO

es was costing millions of dollars and lost productivity, she said.

"Not only were there significant costs and waste in the process, but we were not getting our employees back to work as quickly as we would have liked, so there was significant loss in productivity," Ms. Coulter said.

There was dissatisfaction all around, she said. Employees and managers were very dissatisfied

with the complexity of Boeing's cumbersome leave management administration; the company told its leave management services unit, "You guys are in a world of hurt and you need to fix it," Ms. Coulter said.

Past Boeing attempts to improve leave management services applied a "vertical-view" approach that focused on "single functional areas," Ms. Coulter said. In contrast, when Boeing used the lean philosophy,

the aircraft maker "zoomed out" horizontally to evaluate the entire leave process from "the point an employee requested to leave to the point where they are back to work behind the rivet gun or behind the computer," Ms. Coulter said.

That required examining the minutiae of every step in various leave processes to find improvement opportunities. It also allowed establishing an integrated absence-management program.

To do that, Boeing teamed with Aetna Inc., which has been "an integral part of our day-to-day operations for a number of years," providing short- and long-term disability support, Ms. Coulter said.

Aetna helped Boeing create a "current state map" of its leave processes. That required a "painstaking" look "where you go though and map out every single step along (a) leave and every organization, or every person involved, every single transaction, every system, and every handoff," Ms. Coulter said.

Then each step is quantified for the time it requires and a determination of whether that step can be removed.

"The lean process is really about breaking things down into its most minute function and recognizing which things can be removed," said panelist Ophelia Galindo, national

leader for absence and productivity solutions for Buck Consultants L.L.C. in Orange, Calif.

Savings and efficiencies result from removing a couple of minutes here and a couple of minutes there, and multiplying those by the tens of thousands of times Boeing employees seek a leave, Ms. Galindo said.

Boeing also made major changes.

Two service centers for leave-of-absence and short-term disability cases were consolidated into a single site, said Krista S. Moore, senior account executive for national accounts for Aetna in Seattle.

Paperwork and redundant communications to employees were combined or eliminated, among other changes. In all, 57,000 e-mails sent to employees a year were eliminated.

Among other improvements, the amount of employee time involved dropped 45% while back-office processing time dropped 29%, and end-user satisfaction increased to 87% from 80% when Boeing launched its improvement program.

There were financial savings as well.

"That is an awful lot of change and no small task," Ms. Coulter said. "But I can definitely say it was well worth the investment."

Harley: System keeps work comp at bay

CONTINUED FROM PAGE 4

measures specific job duties performed at the motorcycle company's facilities.

The POET system evaluates attributes such as range of motion, dexterity, grip strength, lifting ability and tolerance of certain positions. Employees are measured by pushing against a column, lifting weights and other efforts matched to specific job requirements that are recorded electronically.

Harley-Davidson turned to BTE after evaluating its workers comp, short-term disability and Family and Medical Leave Act claims and health care costs. It was looking to learn, among other things, how it could improve its hiring practices and reduce injuries, said Susanne Gartner, manager of corporate health services for Harley-Davidson, and another member of the DMEC panel at the July 19-22 conference in Portland, Ore. (see related box).

In 2008, the company tested 197 job candidates, 78% of which passed. Harley-Davidson estimates it has saved nearly \$260,000 in workers comp costs from claims it otherwise would have experienced from untested new hires. That does not include other savings, such as disability claims or return-to-work efforts, Ms. O'Connell said.

Only one workers comp claim, with a cost of \$879, resulted from the employees who passed initial testing last year.

One employee that failed the

DMEC conference held in Oregon

PORTLAND, Ore.—The Disability Management Employer Coalition held its annual conference July 19-22 in Portland, Ore.

More than 500 people registered to hear some 40 speakers, including large employers and their providers discuss benefits integration efforts, return-to-work strategies and disability management procedures, among other topics.

In 2010, DMEC's annual conference will be held in San Diego, Aug. 1-4.

More information is available at www.dmec.org.

—By Roberto Cenicerros

entry POET exam revealed later that he had undergone elbow surgery three months earlier, Ms. Gartner said.

"This is not someone we felt could manage the work environment," Ms. Gartner said. "Therefore, by doing our POET testing, we were able to keep the employee from coming in and filing another workers comp claim or getting injured. We don't want to put someone in a position where they are going to get injured."

The BTE system also plays a role in returning injured employees to work by helping company physical

therapists track and evaluate them to assure they have recovered sufficiently for certain roles.

"In the past, our (return-to-work) process was very, very cumbersome," Ms. O'Connell said. It could take a month to wade through jobs that might be satisfactory for workers whose doctors released them for duty with certain restrictions.

With physical demands required by various jobs now computerized in the BTE system, employees are matched immediately with jobs, Ms. O'Connell said.

Because the software system is Web-based, Harley-Davidson's workers comp and disability insurers, its third-party administrator and doctors all can use it to help make return-to-work determinations.

The testing system also allows Harley-Davidson to determine whether physical therapy received by injured workers is paying off. If not, treatment modifications can be made.

"You don't want to keep doing therapy on people if it is not helping," Ms. O'Connell said.

Because POET testing provides a base-line reading of a worker's physical abilities, it can also help rate future job-related disability claimants for compensation purposes, she said.

Because the testing is objective and electronically consistent for similar jobs at all Harley-Davidson facilities, it is "defensible" against legal claims, Connie Vaughn-Miller, vp of business development for BTE, told conference attendees.

South Carolina: Report finds captive concerns

CONTINUED FROM PAGE 3

because of budget cuts and staff departures, he said. "We said we're more worried about the public from an RRG standpoint than from a single-parent captive standpoint."

The audit report noted that of the 197 captive licenses South Carolina issued through September 2008, 60 were RRGs.

Mr. Richardson said the department will complete all outstanding examinations by mid-2010, contracting out most of the work.

Brady Young, managing director and president of Strategic Risk Solutions in Concord, Mass., agreed with South Carolina's approach. "If you have to do triage and you don't have adequate resources to do everything, spending the limited resources on RRGs...that's a prudent decision," he said. "Practically speaking, most captives are audited every year."

David F. Provost, deputy commissioner in the Captive Insurance Division of the Vermont Department of Banking, Insurance, Securities & Health Care Administration, took a similar view, though he noted, "We are not in the same position. We do have the resources."

Vermont's captive law allows the state to expand the examination period from three to five years if the captive has been audited, and the division has used that flexibility to smooth its examination load, Mr.

Provost said.

Mr. Richardson agreed that South Carolina's rapid growth as a captive domicile, making it the third-largest U.S. captive domicile in 2008, could have been a factor in getting behind on exams. "There's no question that that was probably an issue," he said.

The department has a captive staff of 15, and probably will add

'We said we're more worried about the public from an RRG standpoint than from a single-parent captive standpoint.'

Scott H. Richardson, South Carolina Department of Insurance

one or two more soon, the insurance director said.

Citing the loss of staff in the department, Garry W. Coulter, executive vp at USA Risk Group in Greenville, S.C., said, "I'm not surprised with the report." He added, however, that the South Carolina captive industry is strong and said, "The industry has offered to help any way it can to make the department more successful in the captive business."

ONI: Regulatory proposal includes Office of National Insurance

CONTINUED FROM PAGE 1

insurance industry," including gaps in existing regulation that could "contribute to a systemic crisis," according to the draft legislative language. The office could recommend to the Federal Reserve that it designate an insurer and its affiliates as a so-called Tier 1 financial holding company subject to heightened regulation.

The ONI also would oversee the federal terrorism insurance backstop program and coordinate federal international insurance matters. The office would have a limited ability to pre-empt state regulation under certain circumstances. In addition, the draft legislation also would grant the Treasury secretary power "to negotiate and enter into international insurance agreements."

Rep. Kanjorski's bill enjoyed support from most of the property/casualty insurance industry, and the administration's proposal received a generally warm welcome, although with some caveats.

The Risk & Insurance Management Society Inc. "supports the efforts of the Obama administration to establish an Office of National Insurance within the U.S. Treasury Department," said Nikolas Kapatos, chairman of RIMS' external affairs committee and senior vp and enterprise risk manager for Houston-based Sterling Bancshares Inc. "This important legislation represents a much-needed step forward in the process of financial services modernization."

The bill would "establish for the first time a repository for the collection and dissemination of informa-

THE PROPOSAL

The Obama administration's proposed Office of National Insurance would:

- Monitor all aspects of the insurance industry, including identifying issues or gaps in insurance regulation that could contribute to a systemic crisis in the insurance industry or the U.S. financial system.
- Be led by a director appointed by the Treasury secretary, with the power to recommend that the Federal Reserve designate an insurer and its affiliates as a Tier 1 financial holding company subject to heightened regulation.
- Oversee the federal terrorism insurance backstop program.
- Coordinate and establish federal policy "on prudential aspects of international insurance matters."
- Represent the United States in the International Assn. of Insurance Supervisors.
- Have the power to subpoena information from insurers.
- Have limited ability to pre-empt state regulation under certain circumstances, but no authority over state laws affecting rates, underwriting or sales practices.
- Have no jurisdiction over health insurance.

Source: U.S. Treasury Department

tion at the federal level, which would facilitate the federal government's development of much-needed expertise in insurance matters. It would also enable us to establish federal policy on international insurance matters," Mr. Kapatos said.

No one, though, expects Congress to deal with the issue until at least September.

"It's my understanding that it's going to be in the fall," said Ben McKay, senior vp in the Property

Casualty Insurers Assn. of America's Washington office. The PCI has not taken a position on the bill.

Mr. McKay said the Treasury Department "recognizes that the House wants to work on this over the recess," by getting staff work done and working out problems to get the bill ready to move in September.

"I expect broad regulatory reform issues to move in tandem later this year, and we probably won't see legislative introduction of the ONI

'This important legislation represents a much-needed step forward in the process of financial services modernization.'

Nikolas Kapatos, Risk & Insurance Management Society Inc.

until September," said Joel Wood, senior vp at the Council of Insurance Agents & Brokers in Washington. "I do think that of all the aspects of reform that involve pre-emption, this has the most legs...I expect the ONI to eventually be enacted in this session of Congress. I don't see any insurmountable political obstacles," Mr. Wood said in an e-mail.

Another supporter of the bill—Leigh Ann Pusey, president of the Washington-based American Insurance Assn.—said she found the fact the administration was issuing elements of the white paper in legislative language to be significant. The Treasury Department treats all of the elements of the white paper as being important, is not prioritizing among them and is moving them together, she said. "We take that as a good sign."

Lawmakers will "focus their attention on these proposals in the fall," said Ms. Pusey. "I think there's a chance something on insurance can get accomplished this Congress."

But the National Assn. of Mutual Insurance Cos. prefers the approach taken by Rep. Kanjorski's bill.

Rep. Kanjorski's bill is "a targeted approach that solves real problems without supplanting the state-based system" of regulating insurance, said Jimi Grande, vp in NAMIC's Washington office. He said NAMIC is concerned about the administration bill, particularly regarding privacy and data collection provisions. "I would encourage the administration to consider" the Kanjorski bill as its reform vehicle "because it has already been vetted and supported by most of the industry."

The Kanjorski measure is not as wide ranging as the Treasury proposal. For example, it does not give the Treasury secretary power to negotiate and enter into international agreements on prudential matters. It also does not specifically grant subpoena power to the office in its efforts to collect data, nor does it not grant the office the power to oversee the terrorism insurance program.

For his part, Rep. Kanjorski hailed the administration bill.

"The current economic crisis, including the meltdown of the American International Group, has poignantly shown that an office to provide a knowledge center within the federal government on insurance is urgently needed," Rep. Kanjorski said in a statement last week.

The larger legislative package focuses on systemic risk throughout the financial services industry. The proposed bill would provide for greater regulatory oversight of "all of the largest, most interconnected firms," according to a fact sheet released by the Treasury Department last week. It also would allow the federal government to wind down distressed financial institutions.

Piracy: Ransom dispute may alter response to pirates' demands

CONTINUED FROM PAGE 4

their proportionate share as beneficiaries of the ship being saved. A general-average adjuster determines how much each interest owes.

Maritime attorneys say numerous court cases have established that a pirate hijacking qualifies as a general-average act. But marine insurance experts say, in many piracy cases, those involved agree on their contributions without involving an adjuster, avoiding a potentially costly and lengthy process.

Navalmar paid \$25,000 in average adjuster fees and expenses for the Malaspina, according to court records.

"There is so far relatively little consensus or established practice," Jonathan Spencer, a New York-based average adjuster with Spencer Co., said during a June panel discussion at the Marine Money conference in New York. "A number of claims have been settled with (general-average adjustments)," he said. "A lot of incidents have also been settled on the basis of a more informal pooling of the ransom between the ship and cargo interests."

Some shipowners buy separate K&R insurance, which reimburses

the owner for the ransom and all related expenses. But that insurance can be expensive: between \$16,000 and \$20,000 for a single voyage through areas beset by Somali pirates, according to industry observers. It is impossible to know how many shipowners buy K&R cover because policyholders are not permitted to reveal that they have the insurance, but observers say many shippers rely on general-average contributions to help pay for ransom, instead of K&R insurance.

For the Malaspina hijacking, a general-average adjuster determined Hangzhou should contribute \$2.3 million—64% of total costs, according to Navalmar's complaint.

It is not known on what basis the Chinese cargo shipper is disputing that charge. It's possible the shipper is disputing only part of the charges; Mr. Spencer said he thought some of the expenses were not properly included in the general-average adjustment.

John Woods, a New York-based partner with law firm Clyde & Co. U.S. L.L.P. who has handled piracy cases, said he could imagine a cargo interest arguing its general-average obligation was nullified for a ship made "unseaworthy" by traveling



Norwegian-owned M.T. Bow Asir was released by Somali pirates on April 10 after owners paid ransom estimated at \$2.4 million.

through pirate-infested waters without proper safeguards.

"A year ago, it would have been clear-cut that shipowners were not expected to take steps like arming

their ships," Mr. Woods said. "Now the waters are a little murkier because more owners are in fact either hiring private companies or otherwise arming their ships."

Observers wonder if the Malaspina case could encourage more shipping interests to resist informal ransom agreements and, instead, push for a formal general-average adjustment or dispute a general-average adjustment in arbitration, as Hangzhou has done.

"If there start to be decisions that come from courts or arbitration panels holding that payment of ransom is not a general-average act, you can see cargo interests not stepping up and paying," said Bruce G. Paulsen, a New York-based attorney at Seward & Kissel L.L.P. "We haven't gotten to that point (yet). I don't know if this case will get us there. It could."

Even if the arbitration panel were to side with Navalmar, observers say the dispute underscores the risk of relying on general-average contributions to cover ransom costs. They say it could take a long time, and potentially a legal battle, before getting repaid.

It "could call into question those that are not buying K&R cover, but relying on recovery (through) general average sometime after the detention is over," Mr. Paulsen said. "They may want to think twice."

News In Brief

CONTINUED FROM PAGE 1

More big employers freeze pension plans

Of 607 employers on the 2009 Fortune 1000 list that sponsor defined benefit plans, 31.3% have frozen at least one of those plans, according to benefit consultant Watson Wyatt Worldwide. That's up from 2008, when 27.1% of 638 companies sponsoring defined benefit plans had frozen at least one plan. As the corporate drive to freeze defined benefit plans was gathering strength in 2004, just 7.1% of Fortune 1000 companies with defined benefit plans had frozen one or more plans. The survey was based on a review of companies' Securities and Exchange Commission filings.

PBGC to take over Delphi pension plans

The Pension Benefit Guaranty Corp. will take over the massively underfunded pension plans of financially troubled auto parts manufacturer Delphi Corp., a takeover that will cost the PBGC about \$6.25 billion—its second-biggest loss ever. The PBGC will take over six plans sponsored by Delphi, which is in bankruptcy. The \$6.25 billion loss to the PBGC is surpassed only by the agency's 2005 takeover of four United Airlines' pension plans, which cost the agency about \$7.5 billion. The PBGC estimates its takeover of Delphi's plans will increase its deficit—which stood at a record \$33.5 billion on March 31—by about \$3.5 billion. The agency had included the claim in its 2008 financial statements but at a much lower estimated amount.

SCOR unit to acquire XL U.S. life reinsurer

SCOR Global Life U.S., a subsidiary of French reinsurer SCOR S.E., has agreed to buy XL Re Life America Inc. in a €31.7 million (\$44.7 million) deal. The self-financed, cash deal is expected to close Sept. 30, subject to regulatory approval and normal closing conditions, SCOR said. XL Re Life America, a Stamford, Conn.-based unit of Bermuda's XL Capital Ltd., generated €22.1 million (\$31.2 million) in premiums in 2008, according to SCOR, which said the

deal will help it further develop its U.S. life reinsurance market position. Jamie Veghte, XL's chief executive of reinsurance operations, said in a statement, "Our planned sale of XL Re Life America Inc. is in line with our previous announcements regarding the strategic review of our life operations."

YKK seeks expansion of benefits in captive

YKK Corp. of America, the U.S. subsidiary of Japanese zipper manufacturer YKK Corp., is asking the U.S. Labor Department for authorization to expand benefit risks covered through its Vermont captive. In its filing, YKK Corp. of America wants to use its seven-year-old Vermont captive, YKK Insurance Co. of America, to reinsure supplemental life insurance and long-term disability policies. The supplemental life policies would be written by Minnesota Insurance Co. and the LTD policies would be written by Liberty Mutual Insurance Co. The insurers would reinsure up to 100% of the risk with YKK's captive. YKK last year received Labor Department permission to fund basic life insurance and accidental death and dismemberment policies through the captive.

Ex-Pru exec named interim N.J. regulator

Neil N. Jasey has been appointed as the interim commissioner of the New Jersey Department of Banking and Insurance. Mr. Jasey held a series of executive positions at Prudential Insurance Co. of America before retiring in 2004 as vp and deputy general counsel. In the interim post, Mr. Jasey succeeds former Commissioner Steve Goldman, who returned to private law practice earlier this year.

Noted

Average **commercial property/casualty rates** declined 4.9% in the second quarter compared with a 5.1% percent decline in the first quarter, according to the Council of Insurance Agents & Brokers' "Commercial Property/Casualty Market Index Survey."...Blue Cross & Blue Shield of Kansas City has become the first company in the nation to receive the National Committee for Quality Assurance's new **Wellness & Health Promotion Accreditation**. The program, launched by the Washington-based NCQA last fall, is designed to help employers and other health care purchasers compare wellness programs offered by insurers and other providers, said NCQA President Margaret E. O'Kane.

Space: Insurance cover on final frontier

CONTINUED FROM PAGE 1

Virgin Galactic says it could begin its flights in 2011, although the short history of the space tourism industry is beset with delays and setbacks. Still, the Federal Aviation Administration, which regulates private space flight in the United States, says space tourism could generate \$1 billion in annual revenue by 2021.

Brokers and other observers said it is difficult to speculate on the insurance market for private space flight because the space tourism industry is not yet a reality, but some said they believe the initial ventures would have difficulty buying cover for the risk.

"I imagine at first what you're probably going to see is a limited amount of insurance capacity to purchase on an asset and liability basis," said Jeffrey Polisenio, chief executive officer of International Space Brokers Inc., a Rosslyn, Va.-based division of Aon Risk Services. "You'll have a few (underwriters) in the beginning willing to take on more risk (on space tourism) than others, but they'll price accordingly."

One aerospace underwriter agreed, saying the history of private companies attempting to launch satellites suggests insurers could expect space tourism to produce at least one loss in its early stages.

"There are going to be very few markets willing to write that business," the underwriter said. "You're talking about people being placed on top of vehicles that are going to fail...It's a very volatile area."

Mr. Polisenio said space tourism presents a risk too different from satellite launches to compare the two. But he said he thought space tourism underwriters would want to see extensive test flights and demonstrations of reliability before putting capital at risk.

"In the beginning, it's going to be difficult for insurers to quantify what they're insuring—to quantify the risk," Mr. Polisenio said. "As you get a larger sample of flights and a reliability record and it's proven to be consistent and reliable, you'll find some support from the insurance market. But it'll take some time to get there...It's a prove-it-to-me market."

He and others said they think insurers would treat space tourism as aviation risks more than space risks, which to date have involved mostly satellites.

"It could become more of an aviation-related risk rather than a launch risk," said Mark Quinn, a Bethesda, Md.-based senior vp at Willis Inspace, a specialist space



AP PHOTO
Virgin Galactic founder Sir Richard Branson, left, and Scaled Composites L.L.C. founder Burt Rutan wave from an aircraft in Mojave, Calif., on July 28.

'As you get a larger sample of flights and a reliability record and it's proven to be consistent and reliable, you'll find some support from the insurance market. But it'll take some time to get there.'

Jeffrey Polisenio, Aon Risk Services

division of Willis Group Holdings Ltd. "A lot of the space tourism companies are talking about doing multiple flights a week—flying a lot more frequently than any of the (satellite) launch providers do."

Observers say the space insurance market focuses mostly on property cover with some third-party liability cover written by aviation underwriters. Mr. Polisenio said one of the major hurdles in getting underwriters to cover private-sector space flight, based on discussions he has heard, would be liability for the deaths of passengers, who—at least initially—are likely to be extremely wealthy. He said it would be important to have consistent legislation across all 50 states—seven of which have operational spaceports, with many more proposed—on this issue.

"That's going to be the real challenge because the assumption of liability is going to be enormous," he said. "These are obviously very

expensive assets carrying very high-net-worth individuals."

Mr. Quinn said for satellites, the launch licenses granted by the FAA have liability insurance requirements and he expects space tourism flights to work the same way. He said satellite companies and launch providers must carry third-party liability insurance to cover the maximum probable loss, up to \$500 million, but he said typically they need \$150 million to \$200 million or less. Mr. Quinn said he thought space tourism providers likely would need the same level of liability protection.

He speculated the market would have \$500 million in property and liability capacity for any single space tourism risk. He said there likely would be adequate capacity to write reasonably priced cover because private space flight companies and insurers are communicating as projects develop.

"I think it could be relatively affordable from the start, and it should be because all these ventures are either using heritage technology that has—if not actual flight success—some substantial test heritage which will validate its flight performance," he said. "And I think everybody does a very good job of keeping each other informed... Insurers are very clear about what they're going to need to see for them to be able to provide a valuable insurance product."

Mr. Polisenio agreed demonstrated reliability would attract insurers to the market and bring pricing down.

"This opens up a whole new potential revenue stream for insurers," he said. "Ultimately, when space tourism becomes routine, they are going to be very large supporters of it."

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Pez dispenses lawsuit over museum display

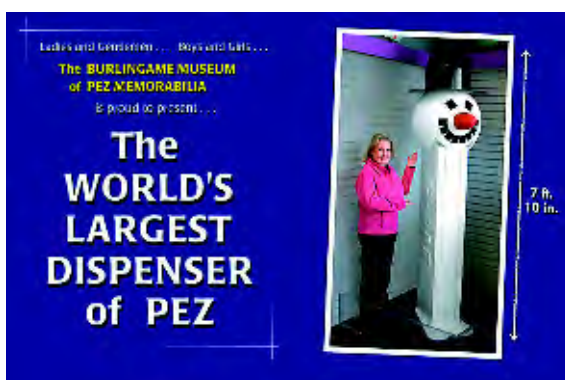
Sometimes, adulation is just not appreciated.

Patrafico A.G. and Orange, Conn., unit Pez Candy Inc. have slapped California's Burlingame Museum of Pez Memorabilia with a trademark infringement lawsuit.

The museum, which opened in 1995, features a 7-foot-10-inch Pez dispenser that its Web site says was certified in 2007 by Guinness World Records as being the world's largest candy dispenser.

Pez, however, is seeking destruction of the dispenser that the museum says is based on the retired Snowman B Pez dispenser.

For \$14.95, the gap-toothed



The world's largest candy dispenser is on display at the Burlingame Museum of Pez Memorabilia in California.

snowman puts out regular-size Pez dispensers and purchasers receive a certificate of authenticity.

The museum argues the dispenser is a work of art.

Pez also wants the museum, which says it features more than 550 Pez dispensers, to turn over all the profits it has made since its opening.

It is probably fair to say things are not so sweet these days for the California museum.

Business Insurance END PAGE

Contributing: Jeff Casale, Judy Greenwald, Mark A. Hofmann



HOT DOGS AREN'T SO HOT FOR HEALTH: CANCER GROUP

A hot dog a day will hurt your chances of keeping cancer at bay, a cancer prevention and survival advocacy group contends in a lawsuit against hot dog manufacturers.

The nonprofit Cancer Project filed suit last week on behalf of three New Jersey residents in Essex County Superior Court. The proposed class action takes aim at hot dogs as well as other processed meats.

The Cancer Project, an affiliate of the Washington-based Physicians Committee for Responsible Medicine, has urged the court to require meat processors to slap warning labels on their products sold in New Jersey to alert consumers that eating hot dogs can increase the risk of cancer.

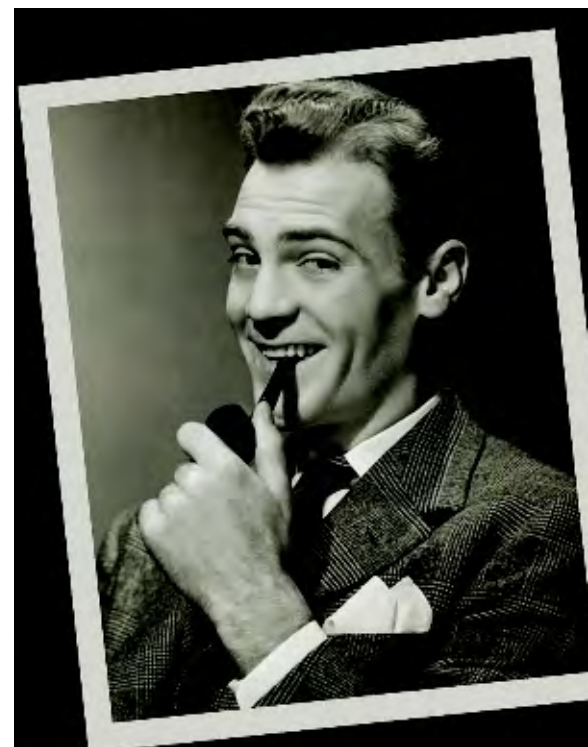
Five defendants named in the suit are Sara Lee Corp., which sells Ball Park Franks; Kraft Foods Inc., which sells the Oscar Mayer brand;

Nathan's Famous Inc.; Marathon Enterprises Inc., which makes the Sabrett brand; and even ConAgra Foods Inc., which sells kosher Hebrew National hot dogs.

"Just as tobacco causes lung cancer, processed meats are linked to colon cancer," Neal Barnard, president of the Washington-based Cancer Project, said in a statement. "Companies that sell hot dogs are well aware of the danger, and their customers deserve the same information."

The suit cited American Institute for Cancer Research data that just one 50-gram serving of processed meat—about one hot dog—consumed daily increases the risk of colorectal cancer an average of 21%.

It should be noted that on the day the suit was filed, the American Meat Institute celebrated National Hot Dog Month with a Capitol Hill hot dog lunch that drew about 1,100 attendees.



U.K. financial pros are spic and span

Mirror, mirror on the wall, who's the cleanest of them all?

According to a survey by the United Kingdom's largest dry cleaning and laundry company, financial services workers are the cleanest professionals in Britain.

The Johnson Cleaners-commissioned survey polled 100 professionals in northwestern England earlier this year, asking about their dry cleaning habits and attitudes toward workplace appearance. The survey included 20 representatives in each of five professions: property management, financial services, legal, management consultants, and public relations/marketing professionals.

Financial services professionals took the prize, with 95% saying they had their suits dry cleaned at least once a month. They edged out lawyers, 85% of whom made at least a monthly trip to the dry cleaners. Only 20% of each of the other sectors reported an equal devotion to dry cleaning.

In addition, 75% of the financial services professionals said they felt it's "imperative they dress smartly for work," according to a statement by Johnson Cleaners, a unit of Preston Brook, England-based Johnson Service Group P.L.C.

"I believe it has a lot to do with the 'dress to impress' pressures of recessionary times," Paul Ogle, managing director of Johnson Cleaners, said in the statement. "Many are struggling to retain jobs or secure new ones, and it's amazing how dressing smartly can boost confidence and make all the difference."

Given the state of financial markets, anything that boosts financial professionals' confidence is most welcome, particularly if it's only a dry cleaner away.

ACTOR HAS BIG MESSAGE ON LIFE

The life insurance industry hopes that Mr. Big has a powerful effect in its latest advertising campaign to raise awareness of the importance of life insurance.

Actor Chris Noth, who played Mr. Big on "Sex and the City" and Detective Mike Logan in "Law & Order: Criminal Intent," is the national spokesman for Life Insurance Awareness Month, an industrywide campaign organized by the nonprofit LIFE Foundation.

Mr. Noth will contribute his personal

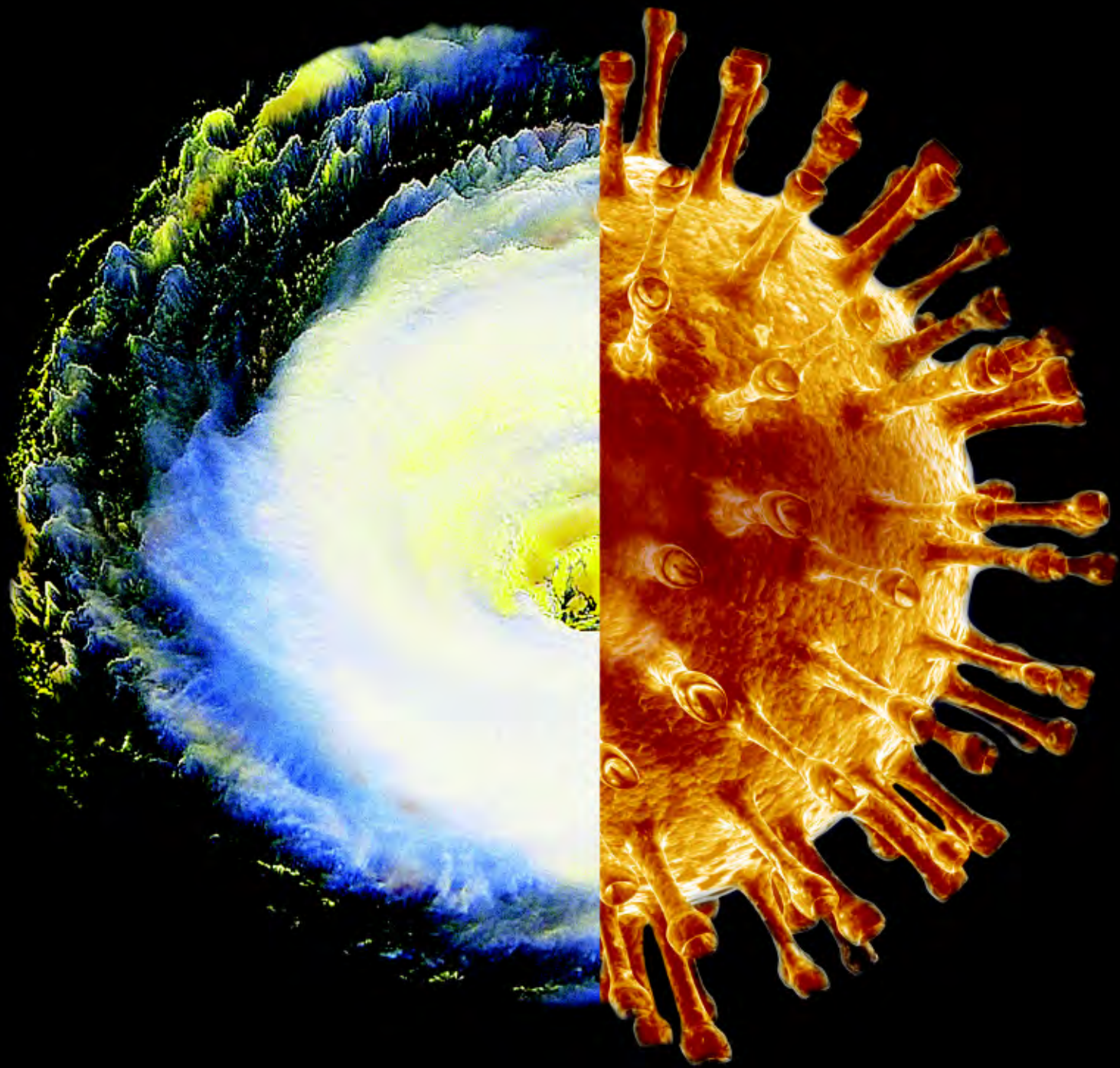
story while educating the public about the importance of having life insurance. While his grandfather and father were life insurance agents, Mr. Noth has another tie to the industry.

When Mr. Noth was 9, his father died in a car accident, leaving behind his mother to raise Mr. Noth and his brothers alone. Fortunately, Mr. Noth's father did have a life insurance policy, which allowed his mother to raise the three boys and put them through college.

"Life insurance can be that safety net that catches a family when tragedy strikes," Mr. Noth said in a statement. "I know from personal experience that life insurance can be the bedrock of a family's financial security."

His story will be broadcast in television and radio public service announcements starting this month, a prelude to Life Insurance Awareness Month during September.

For more information, visit www.lifehappens.org/liam.



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