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Late News

Merck to appeal Vioxx award

Merck & Co. Inc. plans to appeal a $253.4 million jury award to the widow of a man killed by the drugmaker's painkiller Vioxx. A Texas state court jury on Friday made the award, $229 million of which is punitive damages. The jury concluded that Vioxx was to blame in the man's 2001 death from a heart arrhythmia. Merck maintains that it acted responsibly in researching Vioxx prior to its regulatory approval, monitoring the medicine while it was on the market and eventually voluntarily withdrawing it.

PBGC terminates plans at WestPoint Stevens

The Pension Benefit Guaranty Corp. has terminated severely underfunded pension plans sponsored by failed textile manufacturer WestPoint Stevens Inc. that covered the company's hourly and salaried employees. The WestPoint Stevens plans, which have about 32,500 participants, are 46% funded, with $260 million in assets and $566 million in liabilities. The

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Inside

Grace period complicates FSAs

Employers weigh pros and cons of easing 'use it or lose it' rule

By JERRY GEISEL

WASHINGTON—On the surface, giving employees more time to use their flexible spending account balances looks simple.

Through a plan amendment, employers can incorporate an FSA design option proposed by the U.S. Treasury Department to mitigate the two-decade-old "use it or lose it" rule, which requires FSA participants to forfeit unused account balances at the end of a plan year.

Under the modification, plan participants can apply unused account balances to pay for health care and dependent care expenses incurred in the first two and a half months of the following plan year.

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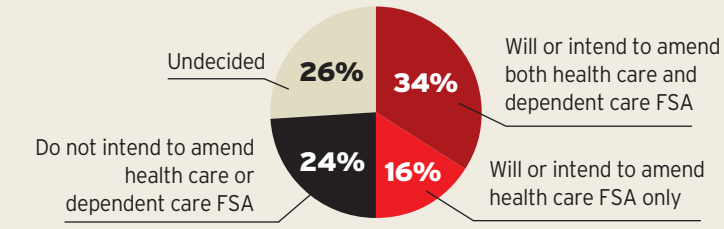
State of grace periods

Are employers going to amend their flexible spending account programs to add a grace period?



Source: Deloitte & Touche USA L.L.P./ ERISA Industry Committee survey

PHOTO: AFP/GETTY IMAGES

Greek police officers examine the wreckage of a jet that crashed near Athens Aug. 14. The Helios Airways jet was one of four large commercial aircraft losses this month.

Series of plane crashes won't force rate hikes

By SARAH VEYSEY

Aviation insurance rates will likely fall during the upcoming renewal season, despite the four commercial plane crashes in the past month, underwriters and brokers say.

Though the size of the liability losses from the four accidents is yet unknown, only one of the four incidents is likely to result in hull losses approaching or surpassing $50 million, sources say.

In addition, insurers have faced relatively few large aviation losses since 2001 and the decline in rates that policyholders have experienced over the past three years will likely continue in 2005, they say.

See AIR/page 17

Tort reformers cheer class action ruling in Illinois

State Farm claimants rejected

By MARK A. HOFMANN

Tort reform advocates are hailing as a significant victory last week's Illinois Supreme Court ruling that a lower court erred in granting class action status to a diverse group of State Farm policyholders who claimed the insurer used inferior replacement parts to repair damaged autos.

"This case was really a classic example of class action abuse; this case was the poster child."

Robin S. Conrad
National Chamber Litigation Center Inc.

The case—*Michael Avery et al. vs. State Farm Mutual Automobile Insurance Co.*—involved an aggregation of about 4.7 million claims from policyholders in more than 40 states who sought relief under Illinois consumer fraud law. The 1998 lawsuit was a challenge to the use of so-called nonoriginal equipment manufacturer–or non-OEM–replacement parts rather than original manufacturers' parts to repair crash damages. The suit alleged consumer fraud and breach of contract, and a lower court certified the class in a suit that ultimately resulted in a $1.18

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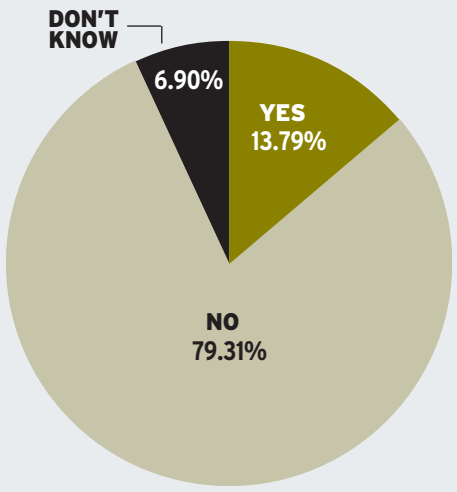
NEWSPAPER

INTERNATIONAL NEWS

Inside

Online poll - [8/15 - 8/19]

Has the issue of discrimination based on religious beliefs or national orgin become a bigger issue for your organization over the past five years?



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

Departments

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Nursing homes welcome fire code

Sprinkler standards expected to save lives, cost $1 billion


PHOTO: AP

New sprinkler requirements are intended to prevent nursing home fires like a 2003 blaze in Hartford, Conn., that killed 10.

By MARK A. HOFMANN

Even though complying with new safety codes requiring that all nursing homes install fire sprinklers could cost the industry more than $1 billion, the long-term care industry isn't complaining.

In fact, the Washington-based American Health Care Assn., which represents long-term care providers such as nursing homes, was the chief proponent of the standards, which were prepared by the Quincy, Mass.-based National Fire Protection Assn.

The nursing home standards were one of three sprinkler codes and standards that went into effect Aug. 18. Another would require sprinklers in new one- and two-family dwellings, while the third requires sprinklers in all new nightclubs as well as in all existing nightclubs and similar facilities with a capacity of more than 100 occupants.

The new standards emerged from an ongoing process, explained Gary Keith, vp-building and life safety for the NFPA. "In general, our major codes such as fire code, life safety codes, national electrical code" are updated on a three-year cycle, Mr. Keith said. Volunteer committee members develop the codes, he said.

The codes, though, must be adopted by the relevant jurisdictions; the NFPA cannot enforce them on its own, Mr. Keith explained. The governing jurisdictions range from local bodies to federal agencies, with states playing a critical role. "Each state is set up differently," he said, noting that some states do not have statewide code adoption.

"We work very closely with the states; we're very active in helping jurisdictions through the adoption process," Mr. Keith said.

The provision mandating sprinklers in existing as well as new nursing homes came in re-

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Health care funding design may aid smaller employers

Law permitting HRAs also lets employers form hybrid plans

By JOANNE WOJCIK

As health insurance premiums continue to soar, some small and midsized employers that may not otherwise be candidates for self-insurance are turning to hybrid health plans that blend self-funding with fully insured coverage.

The programs are permitted under Section 105 of the Internal Revenue Code—the same section of U.S. tax law that the originators of the consumer-driven health plan concept used to develop health reimbursement arrangements.

But instead of creating individual HRAs, these hybrid arrangements use a single, employer-controlled account to self-fund claims that fall below a high-deductible health plan purchased by the employer and above lower deductibles assumed by individual employees.

As with HRAs, any funds remaining in Section 105 accounts at year end are carried over into subsequent years to pay future medical expenses. However, unlike HRAs, the balance in the Section 105 account is not allocated to individual employees; rather, the employer retains ownership and control of the account.

While some health care financing experts welcome this approach as an alternative to traditional self-funding arrangements for some small and midsize employers, others warn that it may not be feasible for employers with poor claims experience.

Still, advocates say the design is an innovative way for smaller employers to self-fund health care benefits.

> "What the 105 program does is basically take a self-funded concept. . . and bring it down to smaller employers."
>
> **Gregg Dennis**
> **Investment Insurance Services Inc.**

"What the 105 program does is basically take a self-funded concept that employers with 5,000 employees have been using and bring it down to smaller employers," explained Gregg Dennis, president of Investment Insurance Services Inc., a benefits broker in Las Vegas.

IIS, which has been selling the programs for five years in Nevada, recently introduced an affinity group version of the program for members of the Better Business Bureau of Southern Colorado. The broker also is opening offices to market the programs in Palm Springs and Sacramento, Calif.

How it works

"Say an employer has a fully insured plan with a $250 calendar-year deductible, $20 office visit copayments, 80/20 coinsurance in network, and a $1,500 out of pocket max. The employee sees no change in out of pocket. But the employer takes on a higher deductible and picks up the difference, less the employee coinsurance," said Steve Hicks, regional manager for IIS in Colorado Springs, Colo.

The employer also continues to collect premiums from employees calculated at the lower deductible rate, leaving sums in excess of the high-deductible plan premiums in the Section 105 account to pay claims as they come in, he added.

Depending on the size of the deductible the employer is willing to assume, premium savings can range from 30% to 50% or more, said Mr. Hicks. Some of those savings, though, could be offset by the employer's increased exposure to claims falling within the self-insured retention.

For example, first-year premium savings amounted to 55% for the University of Nevada School of Medicine Multi-Specialty Group Practice South Inc. in Las Vegas, according to Craig Seiden, fiscal officer.

"We were getting double-digit increases annually," he said.

See SECTION 105/page 16

Readers, voice your choices

Which companies are the best in the industry? Who's tops in terms of service, value, quality and innovation? If you read *Business Insurance*, we want to know what you think.

With our inaugural Readers Choice Awards, *BI* readers will choose the top companies in 11 categories relating to risk management and employee benefits. The winners will be announced and profiled in the Oct. 10 issue.

Voting is completely confidential but must be completed by the end of Wednesday, Aug. 24. To complete a ballot, please visit *www.BusinessInsurance.com/ReaderAwards*.

Voting is open to *BI* subscribers, who can fill out an interactive online ballot if they are registered users of the Web site. Subscribers who are not registered or do not wish to register may submit paper ballots, which can be downloaded at the site but must include their subscription number. All ballots will remain confidential.

Visit w*ww.BusinessInsurance.com/ReaderAwards* today to cast your vote.

New York City Council passes grocer benefit mandate

By JERRY GEISEL

NEW YORK—Legislation overwhelmingly approved last week by the New York City Council would require grocery stores and other retailers that sell groceries to make substantial contributions toward their employees' health insurance coverage costs.

The legislation, approved on a 46-1 vote, would apply to all grocery stores with at least 35 employees and to all other retail stores with at least 10,000 square feet of food products.

Covered employers would be required to contribute an amount equal to the prevailing employer contributions that New York City grocers now pay toward their employees' health insurance coverage. New York would conduct surveys to determine this amount. The Brennan Center for Justice, a public policy think tank in New York, estimates that amount currently is about $2.50 to $3.00 per hour per employee.

Employers covered by the mandate would have broad flexibility in how they could make their contributions. For example, employers could choose to contribute the funds to employees' health savings accounts or to reimburse employees for their medical claims.

It is not known if New York Mayor Michael Bloomberg will sign the bill, believed to be the first of its kind. A spokesman for the mayor's office did not return a call for comment.

Paul Sonn, deputy director of the Brennan Center's Poverty Program, said he believes the measure was drafted in such a way that it could survive legal challenges that the federal Employee Retirement Income Security Act pre-empts the measure.

Grocery store employers in New York City may soon have to make mandatory contributions to workers' health insurance.

Use teamwork to add benefits to captive

By MICHAEL BRADFORD

BURLINGTON, Vt.—While employers may have varied reasons for funding employee benefits through captive insurers, they all need skilled coalition builders to get the job done, according to those who have blazed that alternative risk financing trail.

The motivation for putting benefits into captives will vary, they say, but the expertise required is the same for each parent company.

"Every company is going to have different reasons" for funding benefits through a captive, said Nick Parillo, president of The MollyAnna Co., a Vermont captive owned by the Netherlands-based food retailer Royal Ahold. A company's culture, its appetite for risk and its bureaucratic structure are key factors that must be considered when determining whether to finance benefits through a captive, he said.

Mr. Parillo's knowledge of the process comes from his efforts while he was with the Columbia Energy Group to help establish one of the first single-parent captives owned by a public utility and arrange for it to fund long-term disability benefits.

Speaking as a panelist during an educational session at the Vermont Captive Insurance Assn.'s 20th Annual Captive Insurance Conference in Burlington, Vt., earlier this month, Mr. Parillo told attendees that "there's a little bit of a recipe that we can give you, but you all know your organizations best."

At Columbia Energy, which later was acquired by NiSource Inc. of Merrillville, Ind., the motivation to put benefits into the company's captive came from the top, Mr. Parillo said. When deregulation ramped up competition among utilities in the mid-1990s, Columbia Energy's senior management wanted all departments to look at ways to operate more efficiently, he said.

That edict led Mr. Parillo and others to realize that the company was not effectively managing its long-term disability claims. An integrated disability management program was put in place and, with those cases aggressively managed, it made sense to fund that benefit in the captive, he said.

"At Alcoa, our situation was slightly different," said Thomas C. Mordowanec, manager, people benefits services, at Alcoa Inc. in Pittsburgh.

In Alcoa's case, managers of the company's captive came up with the idea that it could reinsure a portion of the parent's $60 million in employer- and employee-paid life insurance programs. An arrangement was completed last year that allows the Alcoa captive to provide reinsurance on a portion of those risks.

An arrangement was completed last year that allows the Alcoa captive, Vermont-domiciled Three Rivers Insurance Co., to provide reinsurance on a portion of those risks.

Even though their motivations for funding benefits in their captives differed, Mr. Parillo and Mr. Mordowanec found their approaches to getting the job done were similar in many ways.

Douglas J. Ley, Milwaukee-based vp and director of the national actuarial practice of Willis of Wisconsin and moderator of the discussion, pointed out that such projects involve "divergent pieces" of an organization, including risk management, human resources, finance and other departments.

VCIA For more coverage, turn to **page 10**

"Sometimes they share goals, and sometimes they don't share goals and there are some cross-purposes," said Mr. Ley. "And if you're going to be looking at putting benefits coverage in a captive," he added, those departments are going to have to work together.

Mr. Mordowanec said the first move toward avoiding turf battles and building a coalition was "we got all the parties together up front."

"We became convinced it was the right thing for the corporation to do overall," he said, "and then we brought the interests of the various parties onto the table" before determining how to move forward and "getting as close to a win-win as possible."

Forming that team from various departments, "with a lot of mutual respect for the roles and responsibilities of each member," was important in moving the project along, Mr. Mordowanec said.

"That's a critical issue," concurred Mr. Parillo. Making that team as broad as possible and working out the details so that each department can participate allows the person spearheading the effort to "break down barriers" that could impede

See **BENEFITS**/page 10

Zurich on hook for excess coverage

Ruling hinges on 'prior loss' definition

By DAVE LENCKUS

NEW ORLEANS—An excess fidelity insurer must cover all of a loss that exceeded years of primary coverage for the risk, even though none of the loss exceeded primary coverage in any policy period, a federal appeals court has ruled.

In its 3-0 ruling, which reversed a lower court's summary judgment, a 5th U.S. Circuit Court of Appeals panel also rejected the excess insurer's argument that its policy did not cover losses that occurred before the coverage was written.

As a result of the Aug. 15 ruling, The Times-Picayune Publishing Corp. in New Orleans will be able to recover nearly $1.2 million of excess insurance from Zurich American Insurance Co. in Schaumburg, Ill.

The case centers on the interpretation of coverage language found in standard-form crime policies.

> "Zurich's duty to pay is triggered by...the exhaustion of the underlying primary policy."
>
> **5th U.S. Circuit Court of Appeals**

Coverage under those policies typically is triggered when a loss is discovered. Under the "prior loss" clauses in those polices, the coverage will respond even if the losses occurred in prior policy periods, as long as the policyholder had been continually insured between the time of the theft and its discovery.

At the Times-Picayune, an employee embezzled about $2.2 million between January 1995 and December 2000, when the theft was discovered.

From January 1995 until July 2001, the company purchased $1 million of primary fidelity limits annually from Federal Insurance Co., a unit of Warren, N.J.-based Chubb Corp. It also bought $1.5 million of excess limits from Federal from July 1996.

The Times-Picayune switched

See **TIMES**/page 18

Health care cost increases expected to remain stable

Managed care plans seeing profits from pricing, M&A

By GLORIA GONZALEZ

Commercial health care premium increases are expected to remain consistent in the second half of 2005, with managed care companies continuing to price their products at or near cost trends.

The major managed care companies reported that medical cost increases were stable in the first half of 2005, mostly in the range of 8% to 10%, down from the double-digit increases seen in previous years. For example, Indianapolis-based WellPoint Inc., the largest managed care organization in terms of membership, reported a medical trend of less than 9%.

"The big thing that surprised us is that cost trends are decelerating a little bit more than expected, driven by pharmacy trends," said Bradley Ellis, director at Fitch Ratings in Chicago.

With medical cost trends predicted to remain within a stable range, employer premium rate increases also are expected to be relatively steady for the rest of the year, analysts say.

"I think what we're going to see is consistent pricing," said Stephen Zaharuk, vp and senior analyst for Moody's Investors Service in New York.

For the first half of 2005, all the major managed care companies reported higher net income, which they attributed to several factors, including strong financial performances from acquired businesses, moderating cost trends and disciplined pricing (see chart, page 17).

In terms of merger and acquisition activity in the managed care sector, the highlight of 2005 thus far is UnitedHealth Group Inc.'s $8.1 billion acquisition of PacifiCare Health Systems Inc. The announcement came as something of a surprise to analysts, who expect large managed care organizations to focus on smaller niche companies. The transaction, which is expected to close in late 2005 or early 2006, though, has been viewed favorably because it will give UnitedHealth a strong market share in the West Coast re-

See **MANAGED CARE**/page 17

Know a great benefit manager? *BI* seeking nominees for award

Business Insurance is seeking nominations for its first Benefit Manager of the Year™ award to recognize excellence and innovation in employee benefits management.

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

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

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

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

2005 Benefit Manager OF THE YEAR™

- Develops in his or her career and promotes the advancement of the benefits management profession.

The value or generosity of specific benefits will not be judged; the award is intended to honor outstanding performance in managing and administering benefit programs overall. The highest-scoring candidate will be named Benefit Manager of the Year™.

The independent panel of judges comprises 10 representatives of leading employee benefit consulting firms, brokerage firms, managed care organizations and benefits industry vendors (*BI*, Aug. 8).

"At a time when benefit programs are becoming a strategic challenge for employers, and with *Business Insurance* covering benefit issues closely since the magazine's inception, we think it's a great moment to give special recognition to leaders in the benefits field," said *BI* Editor Regis Coccia.

"We invite all our readers to help us identify the top benefit managers by submitting nominations."

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

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

Asbestos illnesses not 'by accident'

5th Circuit ruling favors comp insurer

By ROBERTO CENICEROS

NEW ORLEANS—Contracting an asbestos-related disease is not an "accident" under the terms of a workers compensation policy, the 5th U.S. Circuit Court of Appeals ruled earlier this month.

The case involved a coverage dispute between Graphic Packaging International Inc. and Employers Insurance of Wausau, which wrote the company's workers comp and employers liability policies between 1974 to 1984.

In 2000, numerous current and former employees of Graphic Packaging—formerly known as Riverwood International Inc.—sued the company, seeking damages for asbestos-related disease, court records show.

Riverwood settled with 260 employees for $1.5 million. The employer then notified its insurers about settling the asbestos claims. Riverwood's insurance claims eventually led to litigation with Wausau over ambiguous policy language and whether an asbestos-related disease is a "bodily injury by disease" or a "bodily injury by accident," court records show.

The distinction is significant because Wausau, Wis.-based Wausau's policies excluded coverage for "bodily injury by disease" for claims filed 36 months or more after the policy period.

A district court rejected Riverwood's argument that its claims should be construed as arising out of a single accident. The court found Riverwood lacked evidence that all the claimants were simultaneously exposed to asbestos through one specific accident, occurring at a common location.

Exclusion applies

The court also found that the underlying claims involve bodily injury by disease and, therefore, the 36-month exclusion applies. The court noted that other courts considering the same issue had ruled similarly.

Riverwood appealed, and the New Orleans-based 5th Circuit concluded that "the district court properly determined that the policies are subject to only one reasonable interpretation—that an asbestos-related injury is not a 'bodily injury by accident' under the policies in question."

A ruling against Wausau would have opened a new avenue for employers to tap workers comp policies sold before 1985 for coverage of asbestos claims, according to the American Insurance Assn., which filed an amicus brief in the case. Insurers tightened their policy language in 1984.

Representatives of Marietta, Ga.-based Graphic Packaging could not be reached for comment.

Graphic Packaging International Inc. vs. Employers Insurance of Wausau, 5th U.S. Circuit Court of Appeals, No. 04-30608; Aug. 4, 2005.

MMC settles with D.C. attorney general

By SALLY ROBERTS

WASHINGTON—Marsh & McLennan Cos. Inc. recently reached a settlement with District of Columbia Attorney General Robert J. Spagnoletti to resolve his investigation into potential antitrust violations at the world's largest insurance brokerage.

The agreement, reached Aug. 11, allows Mr. Spagnoletti to directly monitor New York-based MMC to ensure it is complying with the national business reforms it agreed to under the settlement reached earlier this year with New York Attorney General Eliot Spitzer.

The settlement with Mr. Spagnoletti does not call for any restitution to clients of MMC's brokerage arm, Marsh Inc. In January, MMC agreed to pay $850 million in restitution to clients to settle fraud and bid-rigging charges leveled by Mr. Spitzer.

Under the latest agreement, Mr. Spagnoletti's staff will have ready access to Marsh employees and business records, which would show whether the brokerage is adhering to its promised reforms.

The district's antitrust investigation focused on whether Marsh improperly engaged in bid-rigging, depriving clients of the benefits of unfettered competition, according to a statement from the attorney general's office.

"Although the agreement does not resolve any private claims, which district-based companies may have against Marsh, the settlement gives my office the tools it needs to determine whether Marsh clients here in D.C. are receiving the pro-competitive benefits of the business reforms negotiated by Attorney General Spitzer," Mr. Spagnoletti said in the statement.

Under the settlement agreement, Marsh also agreed to pay $25,000 to the District of Columbia Antitrust Fund as compensation to the district for the past costs of its investigation. Mr. Spagnoletti agreed to not file any complaint or initiate any other proceedings against Marsh for any violation that is within the scope of the investigation.

An MMC spokeswoman declined to comment on the settlement.

Illinois: State high court holds that class wasn't certifiable

Continued from page 1

billion judgment—which included $600 million in punitive damages—against State Farm. That award was later reduced to slightly more than $1 billion.

State Farm appealed to the state's high court, which ruled Aug. 18 that the class never should have been certified in the first place. The insurance policies involved varied significantly from state to state, thus creating such differences among the class members that they did not constitute a class, the court ruled.

The court also held that the Illinois Consumer Fraud Act did not apply to plaintiffs whose vehicles were "not assessed and repaired in Illinois."

Tort reformers applaud

Tort reform advocates found much to like about the decision.

"The court was respectful of Illinois legislators and regulators, lawmakers in other states and, especially, the public at large," said Sherman Joyce, president of the American Tort Reform Assn., in a statement issued shortly after the court issued the decision. "The court took a common-sense approach to the Illinois consumer protection statute and showed its respect for the rule of law."

"It's an extraordinarily significant decision," said Robin S. Conrad, senior vp for the National Chamber Litigation Center Inc. in Washington. The center, which handles litigation on behalf of the U.S. Chamber of Commerce, had filed an amicus brief favoring decertification of the class.

"This case was really a classic example of class action abuse; this case was the poster child," said Ms. Conrad. "It was huge class. It applied Illinois consumer fraud law beyond the state borders in an extraterritorial fashion." She noted that four of the five representative plaintiffs who led the complaint had nothing to do with the state of Illinois.

Ed Murnane, president of the Illinois Civil Justice League in Chicago, called the ruling "very encouraging." He said the ruling is "a good sign that the court system, which has been highly criticized—justifiably—for many years is turning around."

"The public has certainly indicated that it wants to see a change in the system, and the judges are getting the message," Mr. Murnane said, noting that the ruling was bipartisan, supported by four of the court's seven justices with two others concurring in part. The seventh justice did not take part in the ruling. He also noted that Chief Justice Mary Ann G. McMorrow, who wrote the opinion, had written an earlier opinion that had overturned Illinois' comprehensive tort reform law.

The decision "is another instance where an appeals court has had to rein in aggressive trial lawyers and the judges who agree to allow them to proceed with questionable cases," said Quentin Riegel, vp-litigation and deputy general counsel of the National Assn. of Manufacturers in Washington.

"We're relieved to see that the Illinois court has put a stop to this in this case, but we continue to be very concerned about attempts by the trial bar to regulate business through litigation," said Mr. Riegel. "Courts must insist not only that plaintiffs prove that they have actual injuries caused by someone else but that the class action process strictly follow court rules. The size of this one case alone shows that the stakes are too high to be controlled by overly permissive judges," he said.

"The court also rejected the plaintiffs' attempt to create a new theory of law that allows damages to be awarded for repairs that were made properly," said Mr. Riegel. "It rejected the theory of 'specification damages,' which would have allowed the class to recover simply because the repair shops estimated the cost of repairs using non-OEM parts, even if actual OEM parts were installed during the repairs. The NAM has been fighting for years to prevent such innovative legal theories from being adopted by judges. We are gratified that the Illinois Supreme Court recognized that there must be actual damages in order to file a lawsuit. Novel legal theories must be adopted by the legislature, not by the courts," he said.

Philip Morris seeks relief

Meanwhile, Philip Morris USA will ask the Missouri Supreme Court to review a decision last week by a Missouri appeals court to allow a lawsuit against the cigarette maker to proceed as a class action.

The Missouri Court of Appeals for the Eastern District upheld a lower court ruling last year that a class was appropriately certified in a lawsuit accusing Philip Morris of misleading smokers about the health risks of its "light" cigarettes.

"For a variety of reasons, the company believes the law doesn't allow cases like this to be treated as a class action," William S. Ohlemeyer, vp and associate general counsel at Philip Morris, said in a statement.

Michael Avery et al. vs. State Farm Mutual Automobile Insurance Co., Illinois Supreme Court, No. 91494.

Michael Bradford contributed to this report.

Editorial

Grocer benefit mandate a recipe for big problems

WHILE WELL-INTENTIONED, a grocery industry health care contribution mandate passed last week by the New York City Council would cause far more problems than it would solve.

As we report on page 4, the measure would require grocery stores—except very small ones—and other retailers that devote at least 10,000 square feet to grocery products to make contributions toward employees' health expenses that would be equal to the average prevailing contribution made by grocers that now provide coverage. If implemented today, the required contribution for employers in New York's grocery industry would be about $2.50 to $3.00 for each hour an employee works.

To be sure, we understand the mandate's appeal, especially to those employers already providing coverage to their employees. On one level, a contribution mandate would reduce the competitive cost advantage that employers that do not offer health care plans enjoy over those that do.

On a broader level, we acknowledge that increasing the number of people with health insurance will decrease the uncompensated care incurred by providers, reducing cost-shifting to patients with health insurance.

That said, we see obvious and serious problems with the mandate.

The mandate makes no distinction in how demographics differ from one grocer to another. Consider a grocery whose workforce is comprised primarily of teenage part-time employees who receive coverage through their parents' group health insurance plans. Such an employer would be forced to make contributions, at perhaps the cost of reducing other benefits, that really were not needed by its employees.

Or, take the case of an entrepreneur who wants to enter the grocery business. Perhaps in the first year, such a startup could not afford to make the contribution and thus couldn't enter the business. That could deprive the neighborhood where a grocery store would have been located of a new place to shop and new jobs for its residents.

For these reasons, New York City Mayor Michael Bloomberg would be wise to veto this well-intended but flawed proposal.

Commission acts admirably

IN SEEKING TO PROTECT the interests of consumers, regulators in many markets are frequently criticized, and sometimes rightly so, for imposing well-intentioned but stifling requirements on businesses. So, it is refreshing to see one of the most criticized of regulators, the European Commission, stepping in to try to prevent a European Union member state from inadvertently worsening a situation it is trying to improve.

As we report on page 13, the commission has warned the Irish government over its proposals to introduce measures that would require recent entrants into the private health insurance market in Ireland to pay what amounts to compensation to the country's long-standing state-owned private health insurer. Such payments are designed to offset the costs of treating higher-risk members that the state insurer has taken on.

The intention behind the proposals is to ensure that all insurers can operate in a market where members of the plans are not charged differing premiums depending on their age, gender or health status. And, given the limitations on free health care within the public system in Ireland, it is understandable that the government would want to ensure that Irish residents have access to affordable private insurance coverage.

As the commission points out, though, the so-called "risk equalization" proposal would impose financially crippling charges on the newer entrants that would likely drive them out of the market. Such a result would restrict consumers' choices and would likely lead to higher premiums, making the coverage less affordable for employers and employees.

While the mesh of public and private coverage in the Irish health care system may need more careful handling that a purely market-driven approach might provide, the commission's interjection into the dispute is a welcome example of regulatory common sense.

Schillerstrom

Letters

Big health plans' attempt at consumerism falls short

To the editor: I was afraid of this. Gloria Gonzalez writes in the Aug. 15 issue that the big health plans—UnitedHealth Group, WellPoint Inc., CIGNA HealthCare and Aetna Inc.—are including "consumerist elements" in all their products and fitting top-down incentive programs "under the banner of consumerism."

Offering the bells and whistles of consumer-driven health care without giving employees the power to make their own judgments is empty rhetoric. Having a "health plan" (the new euphemism for "insurance company") decide which providers are worthy and driving employees to them through the use of differential co-pays is a continuation of the paternalism that consumer-driven health is trying to get away from.

And it won't work. Consumers no longer trust insurers to make judgments that are in the best interests of the patients, rather than the best interests of the insurer. That is part of what is driving this movement in the first place.

This "banner of consumerism" development shows how reluctant insurance companies are to cede even a little bit of their power to the health care consumer. Let's hope employers aren't fooled.

Greg Scandlen
Founder
Consumers for Health Care Choices
Hagerstown, Md.

Write Us

Business Insurance welcomes letters to the editor. The section is intended to be a forum for readers' opinions and comments. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters.

Please send your letters to:
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Perspectives

States fumbling on regulation

Evolution of insurance business calls for federal oversight

By Felton Newell

The business sections of America's newspapers have been full of stories this year about investigations by state regulators and the Securities and Exchange Commission into finite risk reinsurance contracts. While the business press has done an admirable job of explaining these fairly complicated transactions, the stories have not explained how insurers came to use these arrangements. Nor has the press offered a comprehensive approach to solving the problems that the occasional misuse of these transactions may pose.

Although the historical evolution and potential misuse of finite risk reinsurance arrangements is a complicated issue, the solution to this and many other problems facing the insurance industry is quite simple: Congress must take the regulatory reins away from ill-equipped and sometimes-inexperienced state regulators and give them to the federal government, which will provide uniformity of laws and enforcement.

In an era in which the worldwide insurance industry has consolidated with alacrity, only uniform federal regulation can effectively balance the need to provide the adequate protection of consumers with the need to promulgate and enforce clear rules for the industry.

Over the past 60 years, the regulation of the insurance industry has been largely a state concern. In 1945, Congress enacted the McCarran-Ferguson Act, which precluded the application of any federal statute in the face of state law "enacted. . .for the purpose of regulating the business of insurance" if that federal measure did not "specifically relate to the business of insurance" and if it would "invalidate, impair or supersede" the state's law. Congress' delegation of regulatory authority over insurance to the states made sense in the 1940s, given the way the insurance market functioned at that time—small local insurance companies insured individuals and businesses in local communities. Congress concluded that the states were best equipped to regulate this localized market.

Changed landscape

It is simply beyond dispute that the world has changed since the 1940s. There no longer exists a "local" insurance market or even merely a national one. The insurance market—like the financial markets—has become an international playing field. The existing system of 50 different states enforcing burdensome, duplicative and sometimes-conflicting rules and regulations is both anachronistic and anticompetitive. Small insurance companies have been gobbled up by larger national insurance companies, which have been swallowed by even larger international insurance conglomerates. The remaining transnational companies are required to make duplicative wasteful filings and to attempt to wade though the bureaucracies of 50 states, while the insurance commissioners and state attorneys general are ill-equipped to effectively regulate insurers operating across state borders.

> Uniformity of state rules is no substitute for the type of coordinated effort necessary to tackle this global, complex and essential industry.

Furthermore, state regulators—particularly those who are elected—often lack the sophistication and industry knowledge necessary to fairly and effectively regulate the insurance industry. For example, finite risk reinsurance arrangements have been in use since at least the early 1990s. State regulators have long known about these arrangements and sometimes actively encouraged insurers to enter into them to strengthen their balance sheets. We are now seeing, though, that these arrangements were sometimes abused. As New York Attorney General Eliot Spitzer testified before Congress last year, "It is clear that the federal government's hands-off policy with regard to insurance, combined with uneven state regulation, has not entirely worked. . . . Many state regulators have not been sufficiently aggressive in terms of supervising this industry."

Coordination needed

Now, following Mr. Spitzer's recent foray into insurance regulation, many of the same state regulators who in the past tacitly approved finite transactions have jumped on the bandwagon with Mr. Spitzer as if they were unaware that reinsurers had been entering into these transactions for years. Federal regulation conducted by professional and experienced financial regulators would be less likely to engage in schizophrenic law enforcement that leaves the insurance industry in the dark as to what constitutes compliance with the law in any particular jurisdiction or situation.

Not surprisingly, state regulators—eager to protect their own turf and the huge and costly bureaucracies they manage—are the first to oppose the federal regulation of insurance. Critics of federalized regulation have proposed legislation requiring states to develop uniform standards for regulating the industry. House Financial Services Committee Chairman Michael Oxley, R-Ohio, introduced legislation last year that would have established uniform standards, and he is drafting similar legislation for the current session of Congress.

The National Assn. of Insurance Commissioners has drafted model rules for states to consider in order to increase uniformity. This "uniformity" approach—sought to prop up the status quo—is too little, too late. Even if this approach were to harmonize regulatory requirements successfully—and that is a big "if"—the expertise of state regulators would continue to vary widely. Uniformity of state rules is no substitute for the type of coordinated effort necessary to tackle this global, complex and essential industry.

Felton Newell is a litigation associate in the Los Angeles office of Milbank, Tweed, Hadley & McCloy L.L.P.

TRIA uncertainty puts premium on assessing exposures

By Mark Bunim

The Terrorism Risk Insurance Act was enacted in 2002 as a three-year temporary program to provide a safety net for commercial property insurance, obligating insurers to offer terrorism insurance coverage to their customers that they might otherwise be reluctant to make available. Now, the original legislation is clearly about to expire at year end, despite extensive lobbying to extend TRIA past 2005. In view of the U.S. Treasury Department's June 30 report, which recommended that TRIA not be extended, Congress will undoubtedly not extend the current guarantee of governmental sharing in terrorism coverage.

Without TRIA in place to provide a safety net, insurers will be reluctant to offer terrorism coverage or will exclude terrorism from standard property policies, especially in vulnerable, high-density parts of the country such as major cities.

With the likely expiration of TRIA, what steps can commercial property owners take? Clearly, rates will go up, and it is unlikely that lenders will allow owners of vulnerable property in major cities to go bare on terrorism. By engaging in concerted risk management programs and conducting vulnerability assessments for all properties, though, owners can put themselves in a stronger position to negotiate fair rates with insurers. In view of the federal government's belief that market forces should govern terrorism coverage, property owners and tenants that may be required to have terrorism coverage in place would do well to engage in a process to try to make rates somewhat reasonable.

For example, owners might call in third-party firms to examine all their properties and make written recommendations as to how to better secure the properties themselves and their perimeters, such as the parking lots, from possible attacks. Because suicide terrorist attacks are not unlikely, as we saw on 9/11 and in other parts of the world, proper precautions must be undertaken. A property owner that uses a risk assessment analyst should demand an extensive written report with a set of recommendations and a time frame to enact those recommendations. That report, and the sincere undertaking of those recommendations, can then be presented by the broker to insurers to assist in procuring post-TRIA terrorism coverage at a more reasonable cost. Property owners should also run extensive background checks on their employees and on the employees of contract vendors that regularly come onto the premises, such as those that provide cleaning, trash removal and delivery services.

Clearly, property owners that have undergone this process will be in a better bargaining position than those that have not, and the insurance industry will have to take notice of the difference between those that are and are not committed to reducing risk. Given that Dec. 31, 2005, is not far away, preparations need to be made now to deal with this deadline.

Mark Bunim is vp-risk management at Fortress Global Investigations in New York.

Submitting a Perspectives article to *Business Insurance*

Business Insurance accepts articles from experts in commercial insurance, risk management and employee benefits management for publication in its Perspectives section.

The section is intended to be a forum for readers' opinions as well as a forum for the discussion of technical topics that do not lend themselves to a news story. Therefore, Perspectives articles should take a point of view, offer advice and/or explain a technical subject.

They should not present case studies or promotional information.

All articles for the Perspectives page should address the concerns of the corporate buyer of insurance; i.e., the risk management or employee benefits manager. Material written for only the concerns of brokers or underwriters is not appropriate.

To submit an article for the Perspectives section:

- Send us a letter describing the topic you would like to address. You might want to suggest alternative topics. For each topic, briefly describe what you want to say and accomplish in the article.
- You will receive from us an acceptance or declination of your article idea.
- If accepted, we will respond with comments and request the full article, which generally should be no more than 800 words in length.
- All articles are to be accompanied by a black-and-white photograph of the author or authors as well as a brief biography.
- We will notify you of any questions we have about your article or any substantial editing we think is necessary.

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For the same reason, we will not run more than one article in a calendar year from the same author.

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Reinsurers' improved lot may benefit captives

By MICHAEL BRADFORD

BURLINGTON, Vt.—Captives soon may have access to a reinsurance market stocked with players earning an underwriting profit for the first time in more than a quarter-century, a reinsurance company executive contends.

"You may be about to witness history," Anthony Kuczinski, the president of Munich-American RiskPartners in Princeton, N.J., told captive owners and others at the Vermont Captive Insurance Assn. conference in Burlington, Vt., earlier this month. "It's been greater than 25 years since a reinsurer has earned an underwriting profit," Mr. Kuczinski noted. "That's absolute fact."

Speaking during a panel discussion, Mr. Kuczinski said 2005 could be a watershed underwriting year for the entire reinsurance market. "It's possible that '05 will be the first year that reinsurers—the whole industry—returns a profit," he said, providing that there are no major catastrophes and that not all reserve deficiencies are addressed this year.

That doesn't mean that reinsurers are completely out of the woods, Mr. Kuczinski stressed. He noted that unusual market cycles have created some problems.

The last soft market "absolutely was one of the deepest and most severe," Mr. Kuczinski said. By contrast, "the hard market that we have recently experienced…was clearly the least restorative as hard markets go," he added.

Having had a tough go of it

Reinsurers need sufficient hard-market pricing to make up for the soft-rate underwriting years, and "I'm not so sure that has happened this go-round," Mr. Kuczinski said.

And reinsurers have yet to prove they can turn an underwriting profit, he pointed out. Through 2004, their combined ratios are greater than 100%, Mr. Kuczinski said. Many reinsurers, he said, "are still paying for the sins of the past."

"I won't dispute the statistics that show that reinsurers have had a tough go of it," acknowledged Robert J. Cooney, president and chief executive officer of Bermuda-based Max Re Ltd. and moderator of the panel discussion. But he stressed that there are reinsurers who have "fared better in certain lines of business" than the marketplace as a whole.

Among them are newer players with a lack of "legacy issues," Mr. Cooney explained. Those reinsurers are "in a position to perhaps be a little more responsive based on the assessment of the risk today, as opposed to factoring in some payback or adjustments for underwriting decisions made in prior accident years that weren't profitable," he said.

> "I believe the alternative market is a place where reinsurers will continue to be."
>
> **Anthony Kuczinski**
> **Munich-American RiskPartners**

The reinsurance market is healthy enough to provide a "well-thought-out" placement with keenly structured and priced coverage, Mr. Cooney emphasized.

There are trouble spots, though. Mr. Kuczinski said he expects pro-rata reinsurance deals are going to be among those hard to come by in current market conditions. He also predicted that reinsurance coverage for workers compensation and professional liability risks will "continue to be difficult in all market segments."

Marketplace volatility and the complex nature of the reinsurance business means captives' relationships with reinsurers and specialty excess insurers "can be invaluable, particularly in difficult markets," Mr. Cooney pointed out.

The reinsurance business is "becoming more and more technical," and a captive's position in the underwriting process can make things easier, Mr. Cooney said. Employers "having a captive, taking a risk, being in the market—as opposed to being two or three steps removed in a traditional placement from the ultimate risk taker—can benefit the buyer significantly," he said.

Market cycles are here to stay, Mr. Cooney predicted, and captives will continue to play a role in smoothing some of the market volatility. "The net result is, I think, over time the use of a captive in a reinsurance program for large corporations or an association or group can ultimately lower costs," he said.

The importance of alternative risk transfer vehicles means they will be around for a long time to come, Mr. Cooney said. "I, for one, believe the alternative risk transfer market—which is a broad catch-all phrase—is alive and well and is a critical part of our industry and won't go anywhere," he said.

Thriving amid scrutiny

While there may be some increased "accounting rigor" and more attention paid to "the appropriate amount of risk transfer" because some methods of alternative risk funding have come under scrutiny, the alternative market will continue to be "of great value to buyers and their brokers in terms of getting coverage in place at the most efficient and economical terms," Mr. Cooney said.

"I agree completely," Mr. Kuczinski said. "I believe the alternative market is a place where reinsurers will continue to be."

Also on the panel were Timothy Demetres, chief financial officer at Nonprofits' Insurance Alliance of California in Santa Cruz, Calif., and Dan Meyer, senior vp with Guy Carpenter & Co. in New York.

Poll reveals who evaluates captive performance and how

By MICHAEL BRADFORD

BURLINGTON, Vt.—Senior management at organizations that own captives are paying close attention to how the insurers operate, a recent poll at an industry conference suggests.

Poll respondents also indicated that treasurers and chief financial officers are often interested in monitoring the performance of their organizations' captives, while one-third of the respondents said that chief executive officers are inclined to be uninterested.

Using hand-held instant polling technology, an audience of around 200 at the Vermont Captive Insurance Assn. conference held in Burlington, Vt., earlier this month registered their opinions on several issues raised during an educational session covering the financial performance of captives.

When asked to rate the level of interest in the performance of captives from treasurers and CFOs, 69% said those executives are "very interested." In response to a separate question, though, just 26% of respondents said CEOs were "very interested," and 33% responded that those executives are "not interested" in the performance of their organizations' captives.

The audit committees of the parent organizations' boards of directors were said to be very interested in how the insurer performed by 32% of voters, while 37% said the boards are moderately interested.

"The last several years have seen unparalleled growth in the captive and risk retention group industries," partly because of hard-market conditions and the increasing sophistication of risk managers, said Thomas F. Heim, national practice director, risk finance and transfer, at Hilb, Rogal & Hobbs Co. in Glen Allen, Va.

The growth in captives has come at a time when "governance has begun to take hold in the business communities," said Mr. Heim, who moderated the conference session. And, as corporate governance has become more important, "it becomes incumbent upon us, as an industry, to establish, monitor and evaluate best practices in the areas of both governance and financial performance," he said.

The informal poll also shed some light on how captive owners and their business partners feel about the importance of tracking the performance of captives.

Financial ratios are useful in evaluating a captive's performance, according to 60% of those polled at the opening of the session. Of those ratios, the combined ratio was reported to be most important by 48% of the voters. The loss ratio garnered 22% of the votes as most important, while the reserve-to-surplus ratio received 18% and the premium-to-surplus ratio got 13% of the votes.

72% of those casting votes said senior managers at their organizations have increased their scrutiny of captives as a result of industry events such as the investigations by New York Attorney General Eliot Spitzer and the passage of stricter corporate governance controls.

That question was asked again after attendees had heard presentations on how financial performance is evaluated by consultants and captive owners. After the presentations, 63% of the respondents gave the nod to the combined ratio as the most important ratio in tracking performance.

Twenty-three percent of the voters said the reserve-to-surplus ratio was most important, while the loss ratio and the premium-to-surplus ratio each took 7% of the vote.

Of respondents that own or manage captives, 63% said they measure and evaluate the financial performance of their insurers quarterly. Eighteen percent indicated that they conduct evaluations annually and 6% semi-annually. Thirteen percent of the respondents said they have no formal policies in place for evaluating performance.

Participating in the session were John Yonkunas, principal at Tillinghast Towers Perrin in Weatogue, Conn.; Mitch Melfi, senior vp and chief risk officer at Catholic Health Initiatives in Erlanger, Ky.; and G. Terry Hawkins, general manager-warranty management and consumer home services risk with General Electric Co.'s GE Consumer & Industrial unit in Louisville, Ky.

Vermont governor addresses group

BURLINGTON, Vt.—Vermont's captive business has a big supporter in the statehouse.

Gov. James Douglas told attendees at the 20th Annual Captive Insurance Conference, sponsored by the Vermont Captive Insurance Assn. in Burlington, that the alternative insurance market makes a significant contribution to the state's economy.

Captive business is "essential" to the state's fiscal strength and is responsible for $21 million that goes to Vermont's general fund, Gov. Douglas pointed out at the conference, held Aug. 9-11. The employment of 1,400 people in captive-related jobs translates into a "significant economic impact," he said. The governor noted that if the captive market were considered a single employer, it would rank as around the state's 10th largest.

The recent conference's contribution to the Vermont economy came from around 1,300 attendees, who were scattered among several Burlington hotels and met for educational sessions and social activities at the Sheraton Burlington Conference Center.

Industry experts covered a number of captive-related issues in the sessions, from basic topics such as captive formation to more-advanced matters related to the financial workings of the insurers.

Information on next year's conference is available from the VCIA at One Lawson Lane, Suite 320, Burlington, VT 05401-8445; telephone: 802-658-8242, fax: 802-658-9365. The association's Web site is *www.vcia.com*.

Benefits: Teamwork required

Continued from page 4

the success of the project, he said.

Tax, legal and accounting are among other departments that should participate, said Mr. Parillo. With everyone on board, senior management gets a consolidated recommendation as the project moves along rather than disparate views and concerns, he said.

Once the plan is in place, getting an exemption from Employee Retirement Income Security Act regulations from the U.S. Department of Labor is not as time-consuming as it once was, according to P. Bruce Wright, a partner with LeBoeuf, Lamb, Greene & MacRae L.L.P. in New York.

While it took Columbia Energy 13 months to gain the exemption, an expedited process now in place means that, "theoretically, an exemption can be granted within 75 days," explained Mr. Wright. He noted, though that, realistically, it is likely to take around three months.

The expedited exemption is available to companies that submit proposed plan arrangements that are similar to those at other companies that already have gained approval. A plan that does not meet the requirements for the expedited process can expect an answer from the Labor Department within three to six months, Mr. Wright said.

Between the Lines

Compiled by Joanne Wojcik

Death, taxes and life insurers

It's almost as if the life insurance industry is in a fight for its life.

Life insurers, which, among other things, sell annuities and other insurance products that can provide financial shelter from federal estate tax, stand to lose billions if pending legislation is passed repealing the so-called "death tax" after 2010.

Under current law, estates worth more than $1.5 million are subject to a 47% tax rate. That threshold increases annually until 2010, when it is scheduled to drop back down to $600,000. One way to avoid paying the tax is for the owner of the estate to purchase an annuity with the assets, naming his or her heirs as beneficiaries.

The Assn. for Advanced Life Underwriting has gone as far as posting an "Action Alert" on its Web site urging members to lobby their senators to vote against the proposed legislation. But instead of acknowledging the threat it poses to its members' business, the organization claims it opposes the legislation because it would add to the federal budget deficit.

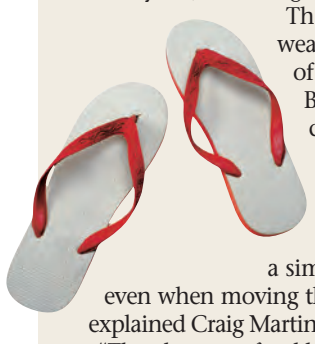
"It's kind of like oncologists lobbying against an actual cure for cancer because it would destroy their business," analogized Harold Apolinsky, general counsel for the Washington-based American Family Business Institute, which is pushing for repeal of the federal estate tax.

"AALU supports permanent, sustainable estate tax reform that will help families and businesses plan with certainty," countered Tom Korb, vp of policy and public affairs at the Falls Church, Va.-based organization.

The estate tax repeal bill, H.R. 8, passed the House in April, and is slated for a Senate vote after Labor Day.

Auto insurer warns against risky footwear

Few people would probably consider flip-flops—that universal fashion essential throughout the hot summer months—as road hazards, but they are, according to Norwich Union Motor Insurance in London.

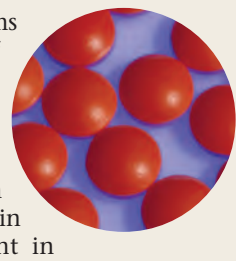


The insurer is warning policyholders to avoid wearing them while driving, after a recent survey of 1,000 motorists found that nearly 75% of the British public admits they find it difficult to drive when wearing flip-flops, with almost a quarter of drivers admitting to driving in such footwear regularly.

"Footwear such as flip-flops are dangerous, as the sole can get caught under a pedal during a simple gear change, when applying the brake or even when moving the foot from the clutch to brake or vice versa," explained Craig Martin, motor marketing manager at Norwich Union.

"The absence of ankle support can lead to the foot slipping off the pedal altogether," Mr. Martin added, advising drivers to wear "sensible shoes," especially on long trips.

Oregon law aims to counter meth abuse



Employers in Oregon could see a spike in claims for doctors' office visits following the passage of legislation mandating that over-the-counter cold and allergy remedies containing pseudoephedrine become prescription medications.

Gov. Ted Kulongoski signed the measure into law last week, hopeful that the new prescription requirement will slow the growth of meth labs in the state. Pseudophedrine is a key ingredient in methamphetamine.

The law makes Oregon the first state to place such restrictions on of common over-the-counter drugs such as Sudafed and Claritin D.

Oregon and several other states already require a consumer to show identification and sign a log when obtaining over-the-counter cold and allergy medicines from pharmacies, and the U.S. Congress is moving toward similar restrictions.

Hard times for hard drives

How frustrating it must have been for computer users affected by the Internet worm last week when they tried to download the software patch that Microsoft put up on its Web site to remedy the problem. The attack, which was directed at the Microsoft 2000 operating system, caused computers to crash repeatedly.

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

COMINGS & GOINGS - INDUSTRY

Insurers:

Mr. Robinson

Bob Robinson is the new syndicates underwriting and claims counsel for Liberty Syndicates in London. Before joining Liberty, Mr. Robinson was an equity partner at Lord Bissell & Brook L.L.P.

Greenwich, Conn.-based W.R. Berkley Corp. has appointed **William Robert Berkley Jr.** executive vp. Previously, he was senior vp, specialty operations.

OIL Group of Cos. in Hamilton, Bermuda, has named **George F. Hutchings** senior vp and chief operating officer of Oil Casualty Insurance Ltd. Most recently, Mr. Hutchings was executive vp of Risk Intermediation Structured Capital (Bermuda) Ltd.

Ohio Casualty Insurance Co. has named **Ralph S. Michael** president and chief operating officer. Before joining the Fairfield, Ohio-based insurer, he was executive vp and manager of U.S. Bank's private asset management division.

ACE INA in Philadelphia has named **Bruce Kessler** chief underwriting officer and executive vp. Previously, he was a senior vp, global reinsurance, for ACE Tempest Re USA.

Also at ACE, **Steven J. Reiss** has been named senior vp and regional executive, mid-Atlantic region, for ACE USA in Philadelphia. Most recently, he was a managing director and client executive team leader for Marsh & McLennan Cos. Inc.

The Domestic Brokerage Group of American International Group Inc. has made four senior-level appointments:

- **Robert S. Schimek** has been named senior vp and chief financial officer. Previously, he was a partner at Deloitte & Touche L.L.P.
- **Charles E. Williamson** has been named president of the AIG WorldSource division in New York. Previously, he was a senior vp of sales and marketing for DBG.
- **John T. O'Brien** has been named executive vp and chief operating officer of the AIG environmental division. He had been executive vp of commercial and middle markets.
- **James C. Roberts** has been named senior vp, workers compensation. Previously, he was divisional president of specialty workers compensation of American Home Assurance Co.

Brokers:

Marsh Inc. in New York has made two appointments at FINPRO, Marsh's financial and professional liability practice:

- **Robert A. Parisi Jr.** has been named a senior vp and leader of the technology and telecommunications industry practice for errors and omissions. He previously was senior vp and chief underwriting officer for the eBusiness risk solutions division of American International Group Inc.
- **Larry Goanos** has been named a senior vp and senior client development advisor in the United States. He previously was a senior vp and financial services industry practice leader for ACE USA.

Mr. Loepp

Marsh Ltd. in London has named **Simon Collings** leader of its U.K. employers liability practice. Before his promotion, Mr. Collings was employers liability practice placement leader.

Bruce Slayter, managing director, risk management services for Mesirow Financial Services Inc. in Chicago, has been named chair of the loss control practice group of RiskProNet International Inc., a network of 28 independent brokers.

Daytona Beach, Fla.-based Brown & Brown Inc. has appointed **Michael J. Gill** executive vp and profit center manager of its Villari & Associates division in Fort Lauderdale, Fla. Previously, he was president of General Electric Specialty Insurance Co.

Willis Group Holdings has appointed **David Wynstra** executive vp of its national health care practice in San Francisco. Previous, he was a division president of Arthur J. Gallagher's Healthcare First unit.

Also at Willis, **Edward Breedlove**, formerly a senior vp, has been promoted to executive vp of the South Carolina operation.

Willis Re, the reinsurance unit of Willis Group Holdings in New York, has named **Samuel L. Dutcher** senior vp in the San Francisco office. He joins Willis from Benfield Inc., where he was a senior vp.

Aon Corp. has named **Peggy Cullen** director of syndication in the company's New York-based environmental practice. Before joining Aon, she was senior vp of AIG Environmental.

Acordia Inc. has named **Barbara Gubitose** senior vp for the risk finance group. Before joining Acordia, she was a senior vp for Marsh FINPRO.

Managed care:

Detroit-based Blue Cross Blue Shield of Michigan has given its chief executive officer-designate, **Daniel J. Loepp**, additional duties, naming him executive vp during the transition. Mr. Loepp will assume the CEO position when Richard E. Whitmer retires in 2006. Previously, Mr. Loepp was a senior vp.

Other providers:

Buck Consultants has named **Linda Konarik** principal in its retirement consulting practice in Houston. Previously, she was a principal in the client management practice for Mercer Human Resource Consulting.

Irish 'risk equalization' plan criticized

Health insurer revenue-sharing proposal draws E.U. body's concern

By BARBARA COCKBURN

DUBLIN, Ireland—The Irish government could be in breach of European competition rules if it introduces a controversial health insurance revenue sharing system, which critics say will increase costs and reduce choices for employers, Europe's top regulator has said.

The introduction of "risk equalization" would force existing private health insurers out of the Irish market and discourage other private insurers from entering the market, according to a letter sent by the European Commission to the Irish government last week.

While the Commission is not averse to the principle of one insurer with lower-risk members making payments to another insurer that has taken on higher-risk members, any payment should be "proportionate," the regulator has said.

The Commission letter is the latest twist in a nearly decade-long debate over fair ways to expand the private health insurance market in Ireland, which has recently resulted in a court fight over the issue.

BUPA Ireland, a Cork-based unit of the British United Provident Assn. Ltd. in London, filed suit against the Irish government in May, alleging that the planned introduction of risk equalization would breach European anticompetition laws.

Under risk equalization proposals, BUPA Ireland would have to pay VHI 34 million euros ($41.96 million) to ensure that VHI is "adequately compensated for the higher-risk individuals that it insures."

BUPA says that such a payment would equate with double its 2005 profits and have a "potentially catastrophic impact" on its business.

In its letter to the Irish government, the European Commission, which had previously stated that it does not oppose risk equalization in principle, said that the payment proposed for BUPA was "disproportionate," a Commission spokeswoman said.

The letter from the Commission went on to invite the Irish authorities to comment on the statement and to submit any "useful" information within one month.

A spokesman for the Department for Health and Children said, "The Department will consult its legal and insurance advisors and respond to the E.U. in due course."

Although BUPA Ireland has not yet seen the letter, it said in a statement, "Our opposition to risk equalization has always been based on the fact that it kills competition. It is not, and never has been, about community rating, which is fully protected in law. We welcome, therefore, any initiative which would preserve and promote competition in the Irish health insurance market."

BUPA Ireland was established in

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DB pension plans better funded in U.S. than U.K.

Defined benefit plans sponsored by large U.S. employers are typically much better funded than plans sponsored by big United Kingdom-based companies, a study concludes.

The study, conducted by Aon Consulting, found that, on average, plans sponsored by U.S. companies were 91% funded at the end of 2004. By contrast, plans sponsored by big U.K.-based employers were just 85% funded during the same period.

Additionally, 20% of the plans sponsored by U.S. employers were fully funded, compared to just 5% of U.K. plans.

The study is based on information drawn from annual reports of 80 Fortune 100 companies sponsoring defined benefit plans and disclosures of 200 of the largest companies in the United Kingdom with pension plans.

One of the reasons that big U.S. employers' pension plans are better funded is because plan sponsors have made larger cash contributions, on average, to their pension plans over the last few years than their U.K. counterparts, according to Aon.

For example, over the last two years, U.S. employers have made cash contributions equal to more than 10% of plan assets, while U.K. employers' cash contributions have amounted to just 7% of plan assets.

Additionally, the decline in bond yields and the design of pension plans in the United Kingdom have exacerbated funding problems for British employers.

"The fall in bond yields has had more of an effect in the U.K. than the U.S.," said Andrew Claringbold, a principal at Aon Consulting in London.

"This is because benefits for most leavers and retirees in the U.K. have to be increased each year in line with the retail price index. Therefore, the amount of money required in the pension plan to meet these benefits is more susceptible to longer-term interest rates. This is not a standard pension requirement in the U.S.," Mr. Claringbold said in a statement.

Copies of the study are available at *www.aon.com*.

—By Sarah Veysey

PHOTO: CORBIS

During their recent trip to London, students of insurance and risk management from Indiana State University toured the headquarters of several market participants, including the Lloyd's of London building, left, and the Swiss Re Tower.

Trips bring London market home to insurance students

Programs abroad offer exposure to the industry

By MARA LAZDINS

As students at U.S. colleges and universities prepare to start their fall semesters, some who are studying risk management and insurance are looking forward to field trips to London, where they'll learn about one of the world's most important insurance markets.

Several schools have programs abroad to expose insurance majors to various facets of the insurance industry.

During spring break this year, for example, students in a class on "International Insurance: The Lloyd's Market" at Indiana State University in Terre Haute, Ind., didn't head for the beach. Instead, they spent the week exploring Lloyd's and the London market.

ISU Professor Mary Anne Boose took 11 students to London, the second such trip for ISU's Insurance & Risk Management Program, according to Ms. Boose. A third trip is currently being planned for 2006, during ISU's spring break.

In Ms. Boose's elective Insurance 449 course, students studied the financial elements of insurance, claims and aspects of the surplus lines market. They also covered material from the Associate in Surplus Lines Insurance professional designation. Visiting Lloyd's was helpful in this regard, because most of the U.S. business placed at Lloyd's is written on a surplus lines basis.

In addition, students heard from principal consultant Bill McGannon of Risky Business, a privately owned risk management firm for small businesses in Calgary, Alberta. Mr. Mc-

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Updates

Lloyd's queried over finite deals

The U.S. attorney's office of the Southern District of New York and the U.S. Securities and Exchange Commission have asked Lloyd's of London for information about finite reinsurance transactions entered into by syndicates in the Lloyd's market. A spokeswoman for Lloyd's said the market was cooperating with the requests. Earlier this year, John Oxendine, insurance commissioner for Georgia, subpoenaed Lloyd's for information about finite reinsurance.

Zurich reports profits increase

Zurich Financial Services, the Switzerland-based insurer, reported net income of $1.8 billion for the first half of 2005, a 21% increase over restated profits for the first six months of 2004. The group restated its 2004 figures for comparability under International Financial Reporting Standards and said the improved profit was the result of strong underwriting performance and tighter expense controls, among other factors. Gross written premiums for nonlife insurance increased 1%, to $18.6 billion, Zurich said.

Aon captive unit offers terror coverage facility

White Rock Insurance (Europe) PCC Ltd., an Aon Corp. unit, has set up a protected cell company in Gibraltar intended to help corporate insurance buyers to self-insure terrorism retentions in the protected cell company and manage their terrorism coverage. The company has been licensed by the Gibraltar insurance regulator, the Gibraltar Financial Services Commission, to write all classes of insurance business—except automobile liability and life insurance business—within the European Economic Area.

Acquisitions help fuel QBE profit growth

QBE Insurance Group reported a profit of $491 million Australian ($374.04 million) for the first half of 2005, a 43% increase over the restated figures for the comparable period last year. The group restated its 2004 figures to comply with the Australian Accounting Standards Board's equivalent standards to International Financial Reporting Standards, which all Australian companies must use for 2005 results. QBE said the improved profit was due to premium growth from acquisitions, favorable market conditions and better investment results, among other factors.

London: Students gain exposure

Continued from page 13

Gannon, formerly of NOVA Corp., a Calgary-based petrochemical company, came to speak to students and helped establish connections with the industry in London. He had previously worked with students at the University of Calgary to establish a course similar to the one offered at ISU. Mr. McGannon met Ms. Boose at an American Risk & Insurance Assn. conference, where she approached him about coming to Indiana to speak with her students.

"I shared with them how the market works and the amount of personal contact that is so important," Mr. McGannon said. "I told them you have to be as honest as you can be, that it takes a long time to gain the trust of the market and told them about the fact that the market measures you very carefully."

Ms. Boose said Mr. McGannon introduced contacts who provided valuable information and networking to her students.

"In this course, we connect with the insurance and risk management community," Ms. Boose said. "We're always trying to do something that's relevant to today's industry."

Other U.S. colleges and universities also have sent students to London this past year. They include the School of Risk Management, Insurance & Actuarial Science at St. John's University in New York; and the Katie School of Insurance & Financial Services at Illinois State University at Normal, Ill.

Anticipating lessons

The goal of the trip, according to Ms. Boose, was for students to see the London market and to help them learn more about surplus lines insurance, as well as to give them a cultural experience.

"All of these students will go into the industry. These are their career aspirations," she said. "They won't all have positions where they have contact with the London market, but this will help them see how the market works. You learn by doing more than by listening."

On the trip, students spent time at several insurance companies, where they went on tours and attended seminars. At Newman, Martin & Buchan Ltd., a Lloyd's broker that specializes in energy, marine and reinsurance, students met with its director, Simon Pringle, who briefed them on the industry and the functions of a broker.

Some schools offering programs in insurance and risk management have turned to Lloyd's and the London market as a hands-on classroom.

At the London offices of actuarial consulting firm Tillinghast, students learned about Lloyd's reconstruction and renewal plan, which reorganized the market after a series of huge losses in the late 1980s. David Powell, a head actuary for Tillinghast, spoke about the financial reconstruction of Lloyd's and its success as a market.

The students also toured Swiss Re International, the London operations of the Zurich, Switzerland-based reinsurance giant. There, students learned about nonadmitted markets and risk management for the petrochemical industry.

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Ireland: Plan finds criticism

Continued from page 13

1996 after the Irish government opened up the private health insurance market in compliance with European Union directives. Prior to that move, private health insurance in Ireland was provided solely by VHI Healthcare, a Kilkenny-based state-owned insurer.

VHI, BUPA Ireland, and other private insurers offer coverage that supplements the public health care system in Ireland, which provides free health care for individuals with low incomes and imposes limited charges on other residents.

VHI is attempting to intervene in BUPA Ireland's suit against the government and plans to appeal a ruling made earlier this month by the High Court in Dublin that it could not be named as a party in the suit.

The Irish government has been considering when to introduce risk equalization since 1996. The measure is intended to ensure the maintenance of "community rating" whereby premiums are not affected by a member's age, gender, or health status.

London: Market field trip

Continued from page 14

Alan Taylor, claims manager for energy onshore for Swiss Re, spoke about the ramifications of the March 23 explosion at a British Petroleum refinery in Texas City, Texas–the accident occurred while the students were on their trip–and explained to students about losses and how they could be avoided.

Students said they enjoyed their visit at Swiss Re, commenting that it communicated to them a variety of issues from different perspectives of the industry.

"Swiss Re was my favorite. They brought in underwriters, risk managers, all different people from the insurance world," said Halee Cork, a senior mass education major with a minor in insurance at Indiana State. "Each person spoke about what they did, and they gave a great presentation."

"I researched Swiss Re and did a project that I presented to the class," said Jocelyn Gohman, a junior insurance and risk management major in Ms. Boose's class. "I expected to learn a lot, but I didn't know what to expect from the companies we were going to. Swiss Re went through a lot of preparation for us; once we were there, they gave us a lot of information we could use in the future."

The trip culminated with a visit to Lloyd's. Tours at Lloyd's are not open to the public and are conducted on a controlled basis. Ms. Boose said the students were fortunate to take the tour and attend seminars.

Students also viewed some of Lloyd's historic elements, such as the Adam room, a conference room that has been dismantled and reassembled throughout several moves, and the Lutine bell, a recovered ship's bell that tolls significant news. In recent years, the bell has been rung to signal the Sept. 11, 2001, terrorist attacks and the December 2004 Indian Ocean tsunami.

Throughout the course of the trip, students took extensive notes during the briefings and gained information useful for their schooling as well as their future careers.

"I really got a sense of how everything works together and how business is done elsewhere," Ms. Gohman said. "I was surprised at the amount of things that are the same in insurance. Things we learned in class, we heard about while we were here and it linked them together for me very well."

Inspiring careers

Ms. Boose said she hoped students would learn more about the insurance industry and would also be more excited about their career aspirations as a result of the trip.

"I want students to say, 'Insurance is exciting!' I want to attract and prepare students for the industry through this experience," Ms. Boose said.

ISU's Insurance & Risk Management program focuses on connection with the industry and gives students a variety of opportunities to work for, visit and learn from insurance companies in the real world.

"There is a lot of personal involvement in planning for students while they're here," said Ronald Green, dean of the School of Business at ISU. "We're pleased with our ability to work individually with students to get a jumpstart on their careers before they leave."

Students can gain self-assurance from their travel experience to London.

Mr. Green assisted in organizing the trip and in seeking financial aid. Students paid most of their travel costs, he said, but ISU was able to supplement their payments through the Networks Financial Institute, an organization funded by Indianapolis-based Eli Lilly & Co. that recruits students to connect with industry.

Not only do these students get a headstart on their career plans from the opportunities the program offers but they also gain self-assurance and are able to further develop personal goals from experiences such as the trip to London, said Ms. Boose.

"I want students to develop confidence to accept different cultures and different environments; this is my personal goal," she said. "My business goal is that in their careers they will have confidence that they understand what surplus lines markets are, that they are less naïve and more knowledgeable about how the industry works."

Court denies damages in Executive Life sale

By JUDY GREENWALD

SAN FRANCISCO—The California Supreme Court has restricted California Attorney General Bill Lockyer's pursuit of damages in connection with the 1991 sale of now-defunct Executive Life Insurance Co.

The court ruled in *State of California vs. Altus Financial S.A.* that Mr. Lockyer could not pursue civil remedies under the California False Claims Act because the assets in question are not state funds within the meaning of the law. Mr. Lockyer had sought treble damages under the CFCA.

The unanimous decision is an apparent victory for Insurance Commissioner John Garamendi over Mr. Lockyer, although Mr. Garamendi was not a direct party in this latest litigation, said defendant attorney James Clark of Gibson, Dunn & Crutcher L.L.P. in Los Angeles.

The opinion said that "the 'state funds' necessary to state a claim under the CFCA only include funds that are in some sense part of the public treasury," but when the insurance commissioner takes title to an insolvent insurer's assets, "he holds them as a trustee for the benefit of private parties, and they never become part of the public treasury."

The court did rule that, under the state's unfair competition law, Mr. Lockyer could pursue civil penalties but not restitution, and that the record is unclear as to whether he can seek injunctive relief.

Mr. Lockyer had originally filed suit in the case in federal district court, but the court ruled that the insurance commissioner has exclusive authority to litigate the issue. After the attorney general appealed, the 9th U.S. Circuit Court of Appeals in San Francisco asked the California Supreme Court to issue a decision on the matter.

"They basically tried to sue the same defendants based on the same facts, seeking the same relief...and the Supreme Court said they can't do that and the proper party is the commissioner of insurance and not the attorney general," said Mr. Clark.

In July, a federal jury in Los Angeles awarded $700 million in punitive damages, but no compensatory damages, in a lawsuit filed by the California Department of Insurance that accused French billionaire Francois Pinault's holding company, Artemis S.A., of fraud in the Executive Life sale.

In May, the jury found Artemis liable on three counts—conspiracy to commit fraud, intentional misrepresentation and concealment—but only the conspiracy count was accompanied by a finding of harm to the ELIC estate.

Mr. Clark said the punitive damages award is being appealed on the grounds that punitive damages cannot be assessed without compensatory damages.

State of California vs. Altus Financial S.A., Supreme Court of California, No. S119046, Aug. 15, 2005.

Section 105: Design approach may aid smaller employers

Continued from page 3

"Premiums reached over $300 per employee per month."

With the medical group picking up 100% of the tab for employee-only coverage for its 150 employees, that came to a sizable sum, he noted.

But by switching from a $500 annual deductible plan to a $7,500 annual deductible plan, the medical group's premiums fell enough that in the second year of the program the employer dropped its employees' individual deductibles to $250 and added fully paid vision coverage, Mr. Seiden said. "Our savings to date exceed six figures," he said, declining to be more specific.

When told about this new twist on the use of Section 105 accounts, Tony Miller, president of Minneapolis-based Definity Health, the company that used the same part of the tax code to develop the HRA concept, welcomed this innovation in the health care financing marketplace.

"We think it's great that people are awakening to the opportunities created by Section 105," he said. "This is an innovative concept in terms of setting the price point lower for the consumer in terms of deductible and buying reinsurance above that and having the employer run that Section 105 between those two layers. It's an innovative way of actually taking advantage of that actuarial cost curve," he said. "I'm a big fan in that it's more innovation in the marketplace."

But while the switch to partial self-insurance so far is working for the University of Nevada School of Medicine, it may not be appropriate for all employers, Mr. Seiden acknowledged.

"IIS helped us in getting the claims history from our current carrier on our employees. If you don't have that, then you're really flying blind, because you need to see what the risk is on your employees. If you have an unhealthy employee population, it's going to be unfavorable in terms of cost," he said.

However, "you don't necessarily need an entirely healthy employee base, but you need to have a mix, a balanced mix," he added.

Some are skeptical

"I think it's an idea that's been tried before and, in general, has not been very successful," said Bill Sharon, a senior vp with Aon Consulting in Tampa. "If an employer wants to self-fund, those advantages can be accomplished through traditional self-funding arrangements, the purchase of stop loss and minimum premium plans."

A minimum premium plan is somewhat similar to the Section 105 approach in that the employer pays a premium to cover fixed administrative costs and the cost of excess coverage, and then pays the claims as they come in, up to the excess coverage attachment point, he explained.

> "You don't necessarily need an entirely healthy employee base, but you need to have a mix, a balanced mix."
>
> **Craig Seiden**
> **University of Nevada School of Medicine**
> **Multi-Specialty Group Practice South Inc.**

Another skeptic, Eric Raymond, president of Corporate Synergies Group Inc., a Mount Laurel, N.J.-based employee benefits consultant, warned that good claims experience may not last for some employers.

"When you first start a self-funded program, you have what's called 'the lag.' The first few months, it's artificially low. It takes a few months before anyone submits claims. So there's a big, distorted savings up front," he explained.

"The truth is, you have to fully analyze the options and the implications," Mr. Raymond said. "There might be some examples that look fantastic. But insurance companies price it so they don't lose money."

Switching to a layered health program also is harder to administer, Mr. Sharon pointed out.

"It's more complicated administratively because you still have to figure out whether it's a reimbursable claim between the $250 and the $5,000" or whatever deductible the employer has selected, he said. "It's a cumbersome process as opposed to having the carrier do it all themselves."

Indeed, when the medical group's employees use their health benefits, they first must file a claim with the insurer, which reviews it, and if it falls below the employer's $7,500 deductible, it sends a zero-pay correspondence to both the employee and the provider, Mr. Seiden explained.

The employee would send this correspondence to the self-insured portion of the plan's third-party administrator, Southern Nevada Benefit Administrators, which is a subsidiary of Investment Insurance Services. Then the claim is adjudicated and IIS receives an explanation of benefits and a check drawn on the Section 105 account, which the employer then forwards to the provider.

A few downsides

Another downside to the arrangement is the fact that the plan technically is still a fully insured plan, making it subject to state benefit mandates, Mr. Dennis acknowledged.

In addition, the plan is not individually underwritten, making it subject to general rate increases regardless of how good its claims experience may be, he added.

But because those future rate increases are based on a smaller premium to begin with, the annual rate increases will also be a fraction of what they had been, Mr. Dennis points out.

"Our clients are still going to get the same renewal increases," he said, "but it's on a number that was 50% less."

Major managed care organizations' first-half 2005 results

Ranked by net income. Dollar figures in millions.

Company	Net income H1 2005	Percent increase (decrease)	Revenues H1 2005	Percent increase (decrease)
UnitedHealth Group*	$1,600.0	27.6%	$22,000.0	23.0%
CIGNA Corp.	1,200.0	52.3	8,600.0	(9.7)
WellPoint Inc.	1,200.0	3.0	22,400.0	8.0
Kaiser Permanente	915.0	8.3	15,500.0	10.3
Aetna Inc.	833.7	21.8	10,900.0	11.3
Coventry Health Care Inc.**	242.1	34.6	3,200.0	19.3
Humana Inc.	193.9	23.4	6,900.0	3.1
PacifiCare Health Systems Inc.	178.3	19.8	7,000.0	14.3
WellChoice Inc.	145.5	14.3	3,200.0	9.7
Health Net Inc.	74.9	24.7	5,900.0	1.5

*Includes net income and revenues for Oxford Health Plans Inc., which merged with UnitedHealth on July 29, 2004.

**First-half 2005 figures include results from Coventry's acquisition of First Health Inc. as of Jan. 28, the date the transaction closed.

Source: Company reports

Managed care: Stable pricing seen

Continued from page 4

gion while also providing it with a foothold in the Medicare market.

The government segment, because of new opportunities created by the Medicare Modernization Act, is one of the few markets with organic growth potential, unlike the commercial market, which Joseph Marinucci, credit analyst with New York-based Standard & Poor's Corp., described as "mature to somewhat stagnant."

"The reason (for consolidation) is because organic growth opportunities are limited, particularly on the commercial side," Mr. Marinucci said.

Analysts were somewhat divided on the question of whether another merger of two top-10 managed care companies would put pressure on the other major companies to do comparable deals.

"On the for-profit side, there probably is a certain measure of wanting to keep pace," Mr. Marinucci said. "When you're dealing with a mature market…you're going to do deals to grow."

Mr. Zaharuk, though, said he does not see this deal as putting pressure on the other managed care companies to explore mergers. The sector will continue to consolidate, he said, but he predicted, "I don't think we're going to see any knee-jerk reactions because of PacifiCare/UnitedHealth."

While there is a point at which consolidation in a marketplace can result in a few players holding most of the market share, most analysts agree that the managed care sector is not at the place where this is a concern. Analysts note, in fact, that the strong earnings experienced by the managed care companies have made them more expensive to acquire, which could serve as a deterrent against any major M&A activity going forward. "There's going to be a natural limitation," Mr. Marinucci said.

The managed care industry, though, will continue to consolidate, with analysts viewing smaller deals the size of Hartford, Conn.-based Aetna Inc.'s $390 million purchase of HMS Healthcare Inc., a regional health care network, as most likely. That transaction is expected to close during the third quarter of 2005.

> "When you're dealing with a mature market…you're going to want to do deals to grow."
>
> **Joseph Marinucci**
> **Standard & Poor's Corp.**

Nonetheless, a blockbuster deal the size of UnitedHealth/PacifiCare always remains a possibility, analysts say.

Los Angeles-based Health Net is being mentioned as a possible acquisition target despite its recent problems. That's because the company is a powerhouse in California, explained Fitch's Mr. Ellis. "It depends on what company thinks they can solve the problems Health Net has been experiencing," he said.

Mr. Ellis said that UnitedHealth, given its PacifiCare acquisition, and other companies with a substantial presence in California, are unlikely suitors for Health Net because of possible antitrust issues. He noted, though, that one of the East Coast managed care players might be seen as an appropriate match for the company.

Health Net is making good progress in its turnaround efforts, analysts say. The company reported net income in the first half of 2005 of $74.9 million, up 24.7% from the prior-year period due to positive results from its commercial and government businesses. The company also settled a lawsuit regarding its claims payment practices.

Health Net officials also said the membership declines that negatively affected its results last year are stabilizing, with total membership down 7% from a year ago but down only 1% from the first quarter of 2005.

"Health Net's results were encouraging," Mr. Zaharuk said.

On the negative side, the company is still dealing with the ramifications of an adverse jury verdict in Louisiana stemming from a lawsuit related to its 1999 sale of three health plan subsidiaries. The jury returned a verdict of $117 million, which the company intends to appeal. Health Net took an after-tax charge of $15.9 million for litigation costs related to the case in the second quarter. "It will be interesting to see how that turns out," Mr. Ellis said.

Meanwhile, Philadelphia-based CIGNA Corp., which also has struggled to retain members in the past year, saw enrollment remain virtually flat at the end of the second quarter vs. the first quarter. Analysts say the company appears to have resolved the service issues that contributed to its membership problems.

"If the trend is any indication, things are starting to look up for them," Mr. Zaharuk said.

Air: Aviation claims so far not squeezing market

Continued from page 1

About 80% of all airline insurance premiums renew in the last quarter of the year.

The first major loss of 2005 occurred on Aug. 2, when an Air France Airbus A340-300 en route from Paris to Toronto skidded on landing and burst into flames at Toronto's Pearson International Airport. The plane, valued at $131 million, according to sources, had 297 passengers and 12 crew on board.

There were no fatalities, but 43 people were injured, and two class action lawsuits seeking millions of dollars in damages have been filed in the Ontario Superior Court (*BI*, Aug. 15).

Hull and liability coverage for the plane was led by the Paris-based aviation insurance pool La Réunion Aérienne.

On Aug. 6, a Tunisair turboprop plane crashed into the sea near Sicily after encountering engine trouble on its way from Bari, Italy, to Djerba, Tunisia. Thirteen of the 39 people on board died. The plane was valued at $12.5 million, and the insurance coverage was spread throughout the international aviation insurance market, sources say.

Then, on Aug. 14, a Helios Airways Boeing 737-300 jet crashed into a mountainside north of Athens on its way from Larnaca, Cyprus, to Prague, Czech Republic, killing all 115 passengers and six crew.

Insurance coverage for the jet was led by London-based Global Aerospace Underwriting Managers Ltd. The value of the hull is about $30 million, and the liability limit is about $600 million, sources say.

And on Aug. 16, a Colombian passenger jet crashed in Venezuela, killing all 160 people on board. Insurance coverage for the plane, which was valued at about $3.5 million, was led by Lloyd's of London syndicate 318, which is managed by Beaufort Underwriting Agency Ltd., sources say.

The McDonnell Douglas MD-82 aircraft, owned by West Caribbean Airways, was en route from Panama to Martinique when it crashed near to the town of Machiques, Venezuela.

Rates on decline

Although the losses have come in a "raft," the combined effect is unlikely to be market-changing, according to Steven Doyle, aviation and aerospace practice manager at Aon Ltd. in London.

Rates have been declining steadily since a hike following the Sept. 11, 2001, terrorist attacks in the United States, he said.

The past three years have been the safest on record, Mr. Doyle noted, and have not been costly for aviation insurers.

In 2002, there were two crashes where hull and liability losses totaled more than $50 million, in 2003 there was one, in 2004 there were two, and so far in 2005 only the Air France loss is expected to top that figure, he said.

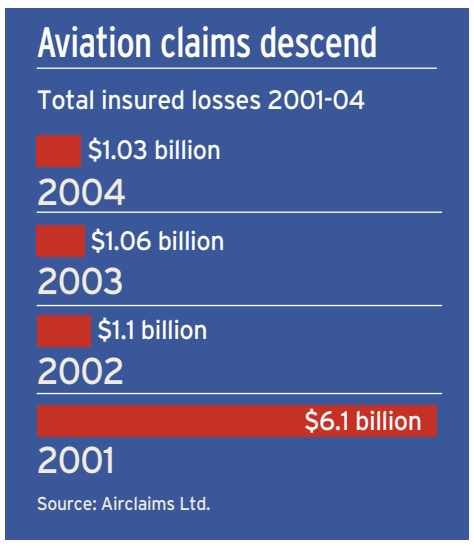
Rates for aviation insurance have been declining steadily since a roughly threefold hike in prices following the Sept. 11, 2001 attacks, according to David Whiter, senior aviation underwriter at Aspen Insurance Holdings Ltd. in London.

And the recent losses will likely not lead to reduced capacity for aviation risks or marketwide rate increases, he said.

The potential size of the Air France hull loss has "got everybody's attention," according to Nigel Weyman, head of the direct aviation unit at Jardine Lloyd Thompson Group P.L.C. in London.

Losses won't roil market

But although class action lawsuits are seeking court approval in Canada, liability losses from the crash will likely not be large because only minor injuries were sustained by passengers involved in the accident, Mr. Weyman noted.



"These losses will not wipe out premium; we are not anticipating that the losses that have happened will derail the rate reductions that we have been expecting," he said.

Since rates peaked following the Sept. 11, 2001, terrorist attacks, rates have been declining at about 10% to 15%—and, in some cases, 20%—each year, he said.

These reductions have been achieved because of a lack of large losses and a profitable aviation insurance marketplace, Mr. Weyman said.

Unless a large loss occurs, the recent losses will likely not temper similar-sized rate reductions at the forthcoming renewal, he predicted.

Nor will the losses for the four crashes likely affect the reinsurance market, said Ulrich Loessl, deputy class underwriter at Limit Underwriting Ltd.'s Lloyd's of London syndicate 566. The losses will likely be contained within primary insurers' retentions, he said.

"On the reinsurance side, rates are likely to remain stable with increases for loss-affected accounts," Mr. Loessl said.

FSA: Grace period rules cause confusion for some employers

Continued from page 1

By giving them more time to spend down account balances, employees' worries about the use-it-or-lose-it rule should lessen, proponents say. In turn, that should boost both the percentage of eligible employees who contribute to FSAs and the average amount of the contributions, generating additional tax savings for employees and employers, they say. Currently, about 15% of eligible employees contribute to health care FSAs, with employees contributing on average between $1,100 and $1,200 a year, consultants and FSA administrators say.

While it is not known yet if the adoption of a grace period will boost employee FSA participation, it is clear that, three months after the Treasury Department announced its approval of the so-called FSA grace period, employers are finding that implementing the new design is anything but simple. Sticky and complex issues to wade through include:

- Adding the grace period may, ironically, result in situations in which employees could lose their ability to obtain reimbursement from their FSAs for prior-year claims that would have been covered had the grace period not been added.
- Adopting a grace period could prevent employers from implementing high-deductible health insurance plans linked to health savings accounts due to government restrictions.

It is possible that the Treasury Department, which is examining the interaction of an FSA grace period with HSA programs, could ease this problem, but the direction regulators will take is unknown.

Additionally, there are FSA designs that could be used to mitigate the problem, but those designs could be complicated to explain and would reduce the value of FSAs to employees.

- Adopting a grace period could reduce the forfeitures that many employers count on to help offset the costs of running their FSAs. Those forfeitures revert to employers, which often use the money to cover the expense of running FSA programs.

After examining these and other issues, some employers have decided against adopting an FSA grace period, saying the administrative problems outweigh the benefits that might be realized by only a handful of employees.

"The more we looked into it, the more nitty-gritty problems came up," said Nicki Gustin, employee benefits manager at Aquila Inc., a Kansas City, Mo.-based natural gas and electricity distributor that has opted not to add the grace period.

Consultants say some of their clients, after conducting cost-benefit analyses, have decided against adopting the grace period, at least for now.

"Some employers have been saying that the juice is not worth the squeeze," said Jay Savan, health and welfare group leader in the St. Louis office of Towers Perrin.

Others predict that many employers will adopt a grace period, but not until 2006 at the earliest, to give them more time to work out problems, establish administrative procedures and communicate the new design to FSA participants.

"Employers are saying, 'Let's wait until 2006 and announce the change during open enrollment,' " explained Barry Barnett, a principal in the HR Services unit of PricewaterhouseCoopers L.L.P. in New York.

To be sure, many employers are considering adding a grace period, believing it would be a benefit to employees and to themselves.

"It will make the plan more attractive to employees, increase participation and generate tax savings for the company," said Michael Pikelny, benefit consultant and corporate actuary with apparel manufacturer Hartmarx Corp. in Chicago. The potential tax savings would accrue if employee FSA contributions, which reduce employees' wages for payroll tax computations, increase.

"This is a win-win situation. It reduces employees' fears of losing funds, which should boost participation. And that means tax savings for the company," said Dennis Nirtaut, vp-compensation and benefits for Chicago-based Aon Corp., which, Mr. Nirtaut said, is likely to add a grace period.

"We intend to analyze this in the months ahead," said Kathy Dupree, insurance risk/benefits manager in the Orlando, Fla., office of Ocwen Financial Corp., a loan servicing company.

One of the most basic—but significant—issues facing employers is deciding on an "ordering" procedure to determine whether claims incurred during the grace period are allocated to the prior year's account balances or to the account balances in the current year.

Indeed, there could be situations in which employees—because of the claims-ordering system their employers adopted—could lose FSA reimbursements for claims incurred the prior year but submitted during the current year. Typically, employers close off FSA reimbursement

> "Some employers have been saying that the juice is not worth the squeeze."
>
> **Jay Savan**
> Towers Perrin

three months after the end of the plan year.

Take the situation of an employee who ends the year with a $500 balance in his or her FSA. On Jan. 15 of the next plan year and during the grace period, the employee incurs a $500 uncovered medical claim and files the claim to get reimbursement from the FSA. The employer, in this case, has set up its ordering allocation so that unused FSA balances carried over from the prior year are automatically tapped first to pay claims.

Then, one month later, the employee discovers a $100 dental claim from a service provided during the prior year. Because his prior-year account balance was exhausted by the $500 medical claim incurred in the grace period, it can't be used for reimbursement for the $100 dental claim. And because the $100 dental claim was for a service incurred the prior year, the employee's FSA account balance for the current year also can't be used.

Ironically, in this situation, had the employer not adopted a grace period, the employee would have received FSA reimbursement for both the $500 and $100 claims.

"There are some real-world problems," said Henry Saveth, an attorney with Mercer Human Resource Consulting in New York.

Administrators say there are approaches to prevent such situations from developing. One approach, Towers Perrin's Mr. Savan said, would be to apply claims to the plan year in which they were incurred. At the end of the claims submission period for a plan year, the employer then would look back to see if there were a remaining balance from the prior plan year and reallocate claims incurred during the grace period to the prior year until the prior account balance was exhausted.

Such an approach likely would pass regulatory muster, provided the reallocation was administered consistently, said Bill Sweetnam, a principal at the Groom Law Group in Washington and the former benefits tax counsel at the Treasury Department. Plan administrators say they would be able to implement such a procedure, but it likely would increase overhead.

"We could do this, but it would not be a standard offering," said Scott Halstead, chief executive officer of WageWorks, a San Mateo, Calif.-based FSA administrator.

Transition problems

The grace period also poses transition problems for employers that plan to implement HSA programs. The problem arises because of regulatory requirements that an FSA cannot be used to cover expenses that fall within the deductible of the high-deductible plan linked to the HSA.

If employers add a grace period, the FSAs would be covering expenses that had fallen within the health plan's deductible, making employees ineligible for the HSA.

One way around this problem would be to limit FSA reimbursement for claims during the grace period to nonmedical core expenses such as for dental or vision care or for health care expenses after the deductible in the high-deductible plan had been met.

But that approach, severely limiting the reach of the FSA during the grace period, would increase the likelihood that employees would have to forfeit unused FSA balances from the prior year.

Some regulatory relief is possible, though by no means certain. The Treasury Department is examining this issue and intends to provide clarification soon, a spokesman said.

Additionally, experts note that there could be a cost to employers if grace periods reduce employees' FSA forfeitures. Employers now often use forfeitures, which revert to them, to offset the administrative expenses of offering FSAs.

"There could be a 50% reduction in forfeitures, and employers should be prepared for that reduction," said Jeffery Lanzet, a senior vp with SHPS Inc., an FSA administrator in Louisville, Ky.

But Mr. Lanzet said such a reduction likely would be more than offset by the greater payroll tax savings employers would rack up if grace periods were to boost employee FSA participation. For every $100 an employee contributes to an FSA, an employer generally saves $7.65 in payroll taxes.

And administrators say the grace period, along with technological advances such as debit cards that eliminate the need for employees to file reimbursement forms for many claims, are bound to significantly increase FSA participation.

"This is absolutely going to increase participation and the size of the average election," said WageWorks' Mr. Halstead.

Others are more cautious. "We may see some modest increases, perhaps a few ticks up," said Karen Frost, a consultant with Hewitt Associates Inc. in Lincolnshire, Ill.

"I don't think this is enough to cause a widespread change in employee behavior," said Randy Abbott, a senior consultant with Watson Wyatt Worldwide in Wellesley Hills, Mass.

Fire: Sprinkler systems needed

Continued from page 3

sponse to two major nursing home fires in 2003, noted Thomas Jaeger, president of Jaeger & Associates in Great Falls, Va., and a fire safety consultant to the AHCA. A fire at a Hartford, Conn., facility killed 16 people; another at a Nashville, Tenn., facility killed 15.

The federal government has required that facilities receiving Medicare and Medicaid payments follow the NFPA's Life Safety Code, which has called for the installation of sprinklers in new facilities since 1991, said Mr. Jaeger, speaking on behalf of the AHCA. While some states required sprinklers in all nursing homes, others did not.

"The nursing home industry basically said, 'What is the one thing we can do to eliminate multiple death fires?' " The answer, he said, was to require sprinklers across the board.

"It was actually the nursing home industry that was the proponent for this, not the federal government," said Mr. Jaeger. "We were the proponent of it because we felt that the one protection feature that could significantly reduce or even eliminate multiple-death fires was sprinklers."

About 4,200 nursing homes were not sprinklered in 2003, said Mr. Jaeger.

He noted that the AHCA had estimated that sprinklering those 4,200 nursing homes would ultimately cost about $1 billion, although that figure will probably be higher because the cost of construction materials has significantly increased since 2003.

Times: Prior loss covered

Continued from page 4

its excess coverage to Zurich in July 1998, when Zurich wrote a $1.5 million three-year policy for the newspaper company.

While the Zurich policy did not contain a "prior loss" clause, it followed the Federal policies, which did contain those clauses.

Before Zurich wrote its coverage, the Times-Picayune unknowingly had incurred slightly more than $1 million of its loss. Overall, the embezzlement losses did not exceed $563,000 in any year, according to court papers.

After Federal covered the newspaper for $1 million of the $2.2 million loss, Zurich agreed to cover only about $166,000.

Zurich argued that under Federal's "prior loss" clauses, the excess insurer was not responsible for any losses that occurred before the excess insurer's policy inception date, because losses did not exceed Federal's $1 million limit in any earlier policy period.

But in its decision, the appeals court ruled that the lower court erred by not taking into account the insuring and "drop down" provisions in Zurich's policy. "When these clauses are properly understood in light of the excess policy as a whole, the scope of Zurich's liability clearly expands in favor of the Times-Picayune," the panel ruled.

"Zurich's duty to pay is triggered by a single condition: the exhaustion of the underlying primary policy by actual payment of benefits," the panel ruled.

Times-Picayune Publishing Corp. vs. Zurich American Insurance Co., 5th U.S. Circuit Court of Appeals, No. 04-30602; Aug. 15, 2005.

ADVERTISER INDEX

Issue of August 22

Employer-provided health cover declining in California, study says

As costs rise, fewer get health insurance from their employers

By JOANNE WOJCIK

A study by the UCLA Center for Health Policy Research shows that job-based health insurance coverage is declining in California due to cost.

With cost increases for employees enrolled in employer-sponsored family coverage averaging 79.1% over the three year period between 2001 and 2003, enrollment of adults dropped 2% and dependent coverage dropped 4%, according to the UCLA study, released last Tuesday.

Among children, these losses were balanced by a 5% increase in children's enrollment in government programs like Medi-Cal and Healthy Families, leading to an actual increase in children's insurance overall, the study found. Many adults, meanwhile, shifted to privately purchased health plans, including many high-deductible plans.

"We are seeing a shift to government programs, like Medi-Cal and Healthy Families, as employers fail to provide affordable health insurance for working families," said E. Richard Brown, director of the UCLA Center for Health Policy Research and a professor in the School of Public Health, in a statement.

> "The data show that California's health insurance system is increasingly unstable and unable to provide for the basic medical needs of millions of residents."
>
> **E. Richard Brown**
> **UCLA Center for Health Policy Research**

"The data show that California's health insurance system is increasingly unstable and unable to provide for the basic medical needs of millions of residents," he said.

Other trends identified in "The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey" include:

- More than 6.6 million Californians younger than age 65 (more than one in five nonelderly residents) went without insurance for at least part of 2003.
- More than 3.7 million lacked health coverage for the entire year.
- Nonelderly Latinos and American Indian/Alaska Natives reported the highest rates of uninsurance.
- Three out of four uninsured are in working families. Two-thirds of children in Medi-Cal or Healthy Families had at least one employed parent.
- The main reason the uninsured give for not having coverage was that they couldn't afford it.
- Those without health insurance were much less likely to have seen a doctor, gotten preventive screenings for cancer or taken medication for high blood pressure.

The report was funded by grants from The California Endowment and The California Wellness Foundation. Findings are based on data collected in the 2003 California Health Interview Survey.

To access the full report, visit *www.healthpolicy.ucla.edu*.

Beecher Carlson adds to practice

ATLANTA—Beecher Carlson Holdings Inc. has expanded its fledgling national health care practice across the country with the addition of seven industry executives from competing firms, the Atlanta-based brokerage said last week.

Blake Kirk, Kristin Klug, Joseph Mack and Randy Pizer have joined Beecher Carlson's national health care practice in Irvine, Calif., from Aon Corp. Messrs. Kirk and Mack are now a senior vps, while Ms. Klug and Mr. Pizer are vps.

Colleen Murphy joined Beecher Carlson's health care practice in Nashville, Tenn., as a senior client services manager. She was formerly with Willis of Tennessee.

Carl Phillips, former managing director for Aon's national managed care practice, has joined Beecher Carlson's health care practice in Minneapolis as a senior vp. And Marc VanDusen, a former senior vp with Marsh, joined Beecher Carlson's New York office as a senior vp.

The health care practice, which Beecher Carlson formed in May, focuses exclusively on providing comprehensive risk management, human resources and benefits services to the health care provider and payer industry, including physician groups, clinics, hospitals, long-term care facilities and managed care organizations.

—By Sally Roberts

BI Stock Index [8/15 - 8/19]

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

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

***BI* Stock Index**	2623.93	-0.68
Dow Jones	10559.23	-0.39
S&P 500	1219.71	-0.87

Largest gains

Clark Inc.	9.72%
Harleysville Group	5.67%
Meadowbrook Insurance Group	4.05%
Health Net Inc.	3.92%
Torchmark Corp.	2.95%

Largest losses

Two Group Inc.	-6.23%
Unitrin	-4.82%
ING Groep N.V.	-4.17%
AEGON N.V.	-4.05%
Vesta Insurance Co.	-3.94%

Weekly change by market segment

Brokers	1.84%
Insurers/Reinsurers	-0.38%
Managed Care Organizations	.06%

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

Late News

Continued from page 1

PBGC estimates it will be liable for $286 million of the $306 million funding shortfall.

Unum unwinds finite risk deal

UnumProvident Corp. said it will unwind a 1996 finite risk transaction between Unum Life Insurance Co. of America and Bermuda-based Centre Life Reinsurance Ltd. An Unum spokesman said the move, under which the insurer will recapture a closed book of individual income protection business, was not sought by regulators. The business includes about $1.6 billion in invested assets and $185 million of annual premiums. The insurer said it expects the move to have a minimal impact because it already provides claims and service administration on these policies.

Aetna providing info on service fees

Aetna Inc. is launching a pilot program that will allow customers to determine what the cost of medical services will be prior to their appointments. Under the program, consumers can gauge their out-of-pocket health care expenses through online access to the actual discounted rates for up to 25 of the most common office-based services offered by their own primary care and specialist physicians. The program initially will be piloted in Cincinnati, Dayton and Springfield, Ohio, northern Kentucky and southeast Indiana.

Number of tort trials sees big drop: Report

The number of tort trials concluded in U.S. district courts fell by 79% between 1985 and 2003, according to a report by the U.S. Department of Justice's Bureau of Justice Statistics. The bureau found that 768 tort cases—primarily involving personal injury—were decided by trial in U.S. district courts in 2003, the most recent year for which statistics are available, compared with 3,604 such cases in 1985—the peak year to date. The bureau notes that the growing use of alternative dispute resolution is frequently cited as a factor behind the falling trial rate.

Oregon governor signs mental health parity bill

Oregon health insurers will be required to provide coverage for mental illnesses and substance abuse disorders on the same basis as other medical conditions, under a bill signed last week by Gov. Ted Kulongoski. The bill will take effect Jan. 1, 2007, and will apply to policies issued or renewed on or after that date. More than 30 states have passed various forms of mental health care parity legislation.

Goshawk issues profit warning

Goshawk Insurance Holdings P.L.C. has issued a profit warning for the first half of 2005 after earlier predicting a profit of $4.6 million. The company is now "expecting to report a small loss" for the first half, according to a spokesman. The expected loss was due, in part, to worsening losses from Hurricane Ivan. Goshawk, which operates Bermuda-based Rosemont Re, also reported losses from windstorm Erwin in Scandinavia and the explosion at Suncor Energy Inc. in Alberta, Canada.

Guy Carpenter names president

Guy Carpenter & Co. Inc. has named David Spiller as president of the reinsurance brokerage, effective Jan. 1, 2006. Mr. Spiller, who most recently was chief executive officer of the international division of London-based Benfield Group Ltd., will be based in the company's New York headquarters. The position of president was previously vacant.

Best upgrades two ACE units

A.M. Best Co. has raised to A+ from A its financial strength ratings of ACE Westchester Specialty Group and ACE American Pool, U.S. subsidiaries of Bermuda-based insurer ACE Ltd. Best said the upgrades are based on ACE's strong capitalization, excellent earnings generating capability, disciplined underwriting culture and consistent management strategies, among other things.

Florida's Citizens plans levy

Florida property owners are expecting a one-time 6.8% premium charge to make up a $515.5 million deficit in the state's insurer of last resort. Pending regulatory approval, Citizens Property Insurance Corp. will levy the assessment on Florida insurers, who will then seek authority to pass the charge along to policyholders, a spokesman for the insurer confirmed. The charge will apply to commercial and residential policies written by companies participating in the state-run insurer.

Briefly noted

Larry Mirel, the insurance commissioner for the District of Columbia, will leave the post at the end of September to join the Washington-based law firm of Wiley Rein & Fielding L.L.P....A U.S. district court judge has dissolved the temporary restraining order recently won by **Guy Carpenter & Co. Inc.** against five former members of its medical malpractice reinsurance practice who left to join competitor John B. Collins Associates Inc.

At *BusinessInsurance.com*

Online Poll: Do you intend to modify your health care flexible spending account program to offer enrollees a grace period?

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