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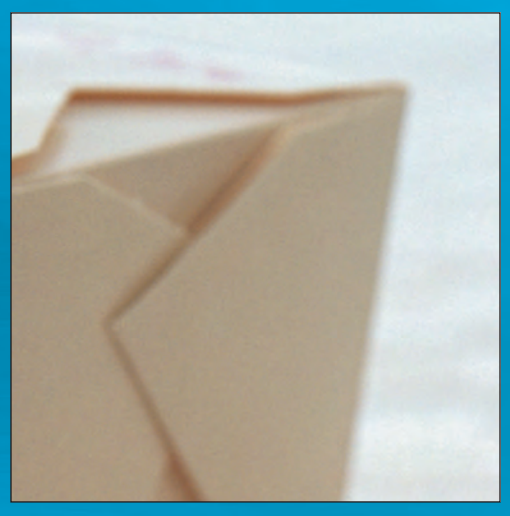

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Late News

Insurers dispute disability policy probe

Insurers last week filed suit against the California Department of Insurance in response to a department examination of disability policies that could lead to the withdrawal of all previously approved policy forms that it determines contain "unlawful" provisions. Insurers filing the suit in state court said the department's action could lead to rate hikes of up to 46% for group disability insurance and up to 33% for individual coverage. The lawsuit was prompted by an Oct. 3 letter from insurance department general counsel Gary M. Cohen, in which he said the department is concerned that there are provisions in disability income insurance products that "would not be approved if they were submitted to us today, and in many cases have not been approved for many years."

Former Benfield brokers barred over finite deal

Two former reinsurance brokers have agreed not to place business for two years following their connection to a deceptive financial reinsurance deal. The agreement, announced by the U.K.'s Financial Services Authority, bars Robert George Phillips and Isabel Rawlence, formerly employed by London-based broker Benfield Group Ltd., from "undertaking any regulated activity for two years." The two brokers were involved in

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Inside

JAIL TIME
Ex-Near North boss Segal sentenced to 10 years.
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STORMY QUARTER
Insurer results battered by hurricane losses.
PAGE 3

XL management under fire as more problems emerge

Analysts raise questions following insurer's costly loss in arbitration

By DAVE LENCKUS

WINTERTHUR, Switzerland—An arbitration loss that forces XL Capital Ltd. to add $830 million to loss reserves is another in a string of surprising financial setbacks this year that has some securities analysts questioning the capability of the insurer's management.

Even so, analysts agree that the Hamilton, Bermuda-based insurer is positioned to take advantage of an expected hardening in the primary insurance and reinsurance markets.

XL says that positioning reflects a carefully crafted acquisition strategy that has expanded the insurer's reach.

The arbitrator's Nov. 23 draft decision centered on loss development and unearned premiums on pre-2001 business written by Winterthur International, a former unit of Winterthur Swiss Insurance Co. that XL acquired in 2001.

Under the terms of the acquisition, XL and Winterthur agreed to review the reserves adequacy after three years. The two insurers disagreed, however, on the amount Winterthur should add to its former unit's reserves, and the dispute went to arbitration.

The arbitrator ruled that Winterthur Swiss, a Winterthur, Switzerland-based unit of Zurich-based Credit Suisse Group, owes XL about $575 million, including interest. XL had sought about $830 million more, or about $1.4 billion.

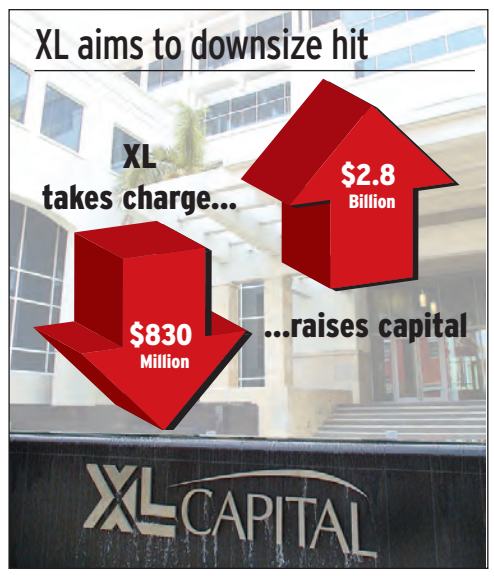

PHOTO: DAVID SKINNER

The draft decision is scheduled to be finalized Dec. 5 if the insurers do not uncover any calculation errors by the actuary.

As a result of the ruling, XL said it will have to take an $830 million pretax charge against earnings in its fourth quarter.

After the decision, Standard & Poor's Ratings Services downgraded XL to A+ from AA-.

The arbitrator's decision was the third big fi-

See XL / page 40

IRS guidance hampers firms with FSAs, HSAs

By JERRY GEISEL

WASHINGTON—Even if only a handful of employees at an organization opt for health savings accounts, all employees could lose their ability to fully utilize their flexible spending accounts during an FSA grace period.

That is the result, benefit experts say, that could occur under a newly issued Treasury Department and Internal Revenue Service notice that provides guidance on the integration of HSAs with FSAs that employers amend to add an IRS-authorized grace period.

Under that grace period, 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.

That modification was a Bush administration middle-ground response to years of congressional pressure to scrap a two-decades old FSA "use it or lose it" rule that requires plan participants to forfeit unused FSA balances at the end of a plan year.

But as soon as the grace period option was unveiled, benefit experts raised questions on how employers adopting HSAs could integrate such programs with an FSA grace period.

That question arose because, under law, FSAs cannot be used to cover health care expenses that fall under the deductible imposed by the health insurance plans to which the HSAs are linked.

By adding a grace period, FSAs potentially

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House, Senate differences won't kill TRIA

Lawmakers seek to map long-term solution, but disagree on best route

By MARK A. HOFMANN

WASHINGTON—U.S. House and Senate conferees should be able to resolve a key difference between two bills designed to extend the Terrorism Risk Insurance Act, say proponents of TRIA extension.

The difference is the way in which the bills approach providing a long-term answer to the question of how best to provide terrorism insurance.

TRIA, which provides a federal backstop for insurers facing catastrophic losses, is slated to expire on Dec. 31. Both bills would extend TRIA through 2007. Proponents acknowledge, though, that an extension beyond 2007 is doubtful, so they say finding a long-term alternative is critical.

The Senate's Terrorism Risk Insurance Act—S.467—calls for the President's Working Group on Financial Markets to "perform an analysis regarding the long-term availability and affordability of the insurance for terrorism risk," including group life coverage and coverage for chemical, nuclear, biological and radiological events. The bill, which the Senate approved last month, further directs the group to submit a report on its findings to the Senate Banking, Housing and Urban Affairs and House Financial Services committees by Sept. 30, 2006.

The House's Terrorism Risk Insurance Act—H.R. 4314—calls for the establishment of a broader commission that would have to report by Dec. 31, 2006, on "whether there is a need for a federal terrorism risk insurance program and, if so, shall make a specific detailed recommendation for the replacement of the program, including specific, detailed recommendations for the creation of a terrorism reinsurance facility or facilities or single or multiple pooling arrangements or both."

The bill spells out exactly who would sit on the Commission on Terrorism Risk—including one representative of policyholders. That bill, as amended, won the Financial Services Committee's approval on Nov. 14 and is expected to reach the House floor this week.

That it will do so is not guaran-

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BENEFIT MANAGER OF THE YEAR

CHRIS McSWAIN
Business Insurance's first annual Benefit Manager of the Year PAGE 10

Aon Focus
www.aon.com/focus

Aggressive methods enable the public sector to slow the rising costs of employee benefits.

DECEMBER 5, 2005

Ten strategies to control public sector health care plan costs

Lurline Craig-Burke is senior vice president and national practice leader for state and local government within Aon Consulting's government human capital services group. She can be reached at lurline_craig-burke@aon.com.

Federal, state and local governments continue to face the challenge of offering their employees valued and affordable health care coverage. The public sector has been forced to make some major plan design changes to reduce the ever-increasing costs of health care. Some strategies being used by government plan administrators include:

1. Adopting health care "consumerism." This strategy requires employees to be actively involved in the evaluation, selection and associated costs of their medical care. It is a growing trend in both the private and public sector. Consumer-driven health plans, including HRA and HSA designs, use plan design to engage consumers in medical service purchasing decisions.

2. Investing in medical plan data analytics and predictive modeling. Governments can manage medical benefits better if they understand financial and utilization dynamics. Predictive modeling is used to analyze the health status of populations, project future costs, identify likely high-cost members and compare the efficiency of competing health plans.

3. Pricing health coverage to better manage plan costs. Examples include providing premium discounts for employees who do not use tobacco products and applying premium surcharges when an employee covers a spouse when the spouse is eligible for coverage from his or her own employer but declines such coverage.

4. Implementing a broad-based health management program. This enables plan sponsors to identify and manage major health care cost drivers for their entire population, regardless of health status. In its broadest sense, health management covers the spectrum from Health Promotion/Wellness to prevent illness, Disease Management for the chronically ill and Case Management for the most serious and expensive medical situations.

5. Transitioning from co-payments to co-insurance. This strategy enables employees to see the true cost of their medical care and share in those costs on a predetermined percentage basis. By making them more aware of these costs and increasing their share of these costs, employees should become better health care consumers.

6. Adopting a value-based plan design. High out-of-pocket costs in some plans can unwittingly discourage chronically ill individuals on maintenance drugs from adhering to their medication. By lowering patient costs for certain drug classes, employers expect to avoid medical complications and achieve lower long-term costs.

7. Tiering plan premiums based on salary or years of service. This strategy may alleviate issues of "equity" among employees, as well as save hard-dollar costs for the plan.

8. Providing one-time eligibility amnesty. Eliminate medical costs associated with individuals who are not legally entitled to be covered by your medical plan by communicating a one-time eligibility amnesty period. During this period, allow employees to drop any ineligible dependents without penalty.

9. Investing in integrated absence management programs. A well-designed program manages total costs across the organization, including absenteeism, disability, workers' compensation, medical and drug expenditures and turnover, to improve financial results.

10. Effectively integrating the new Medicare Part D prescription drug benefit into the retiree medical program. Wraparound plans or an enhanced plan may be more financially advantageous than the plan sponsor subsidy option.

By implementing one or more of these strategies, the public sector will be better able to manage its health plans and moderate the expected relentless increases in health care costs.

Employers take steps to realize the benefits of advanced biotech medicines

Biotechnology-derived and injectable medications, known as biotech medicines, are the leading edge of medical treatment today. With more than 600 biotech medicines currently in development and several hundred scheduled to enter the market by 2010, employers must take steps to leverage this advanced technology. Specifically, employers can adopt strategies to eliminate benefit confusion for members and enhance member care and satisfaction by redesigning plan structures to improve performance and coordination of care and by eliminating administrative burdens and complexity from pharmacy claims billing. To learn more, visit **www.aon.com/focus**.

Section 409A changes offer businesses alternative planning opportunities

New Section 409A impacts the rules regarding taxation, design and administration of deferred compensation plans. The provisions include a broad definition of deferred compensation and may include excess plans, SERPs, separation plans, 401(k) "wraparound" plans, individual agreements and equity-based compensation programs. While many aspects of 409A are in effect now, the rules become fully active in 2006, so employers should evaluate deferred compensation plans as soon as possible in order to preserve any opportunities to maximize their tax effectiveness and ensure that executives will not experience any adverse tax consequences. For further insights, visit **www.aon.com/focus**.

Inside

Online poll - [11/28 - 12/02]

How confident is your organization that its health care cost increases will be lower in 2006 than this year?

Not confident	82.8%
Somewhat confident	6.9%
Confident	10.3%

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

Departments

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Michael Segal sentenced to 10 years

Judge cites ex-broker's 'bigheadedness'

By MEG FLETCHER

CHICAGO—Convicted Near North National Group Inc. owner Michael Segal was sentenced last week to more than 10 years in federal prison for his June 2004 conviction on charges of fraud, racketeering and mishandling more than $30 million in insurance premium trust funds.

In addition to the sentence of 10 years and one month, Judge Ruben Castillo of the U.S. District Court for the Northern District of Illinois ordered Mr. Segal to pay $831,528 in restitution to former Near North clients.

"It's a classic case of bigheadedness," Judge Castillo said during the sentencing hearing. "You thought you were above the law."

While expressing remorse, Mr. Segal, 63, said: "I fundamentally disagree with the verdict."

"I am not a bad person," he said. "I have never stolen a dime."

Mr. Segal plans to appeal the sentence, according to defense attorney Jeffrey Steinback.

During a six-week jury trial that began in May 2004, the prosecution alleged that, beginning as early as 1990, Mr. Segal took millions of dollars from the brokerage's premium fund trust account to expand his business and to finance a lavish lifestyle.

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

"Just because he had the wealth to cover the loss doesn't mean that he should be able to snub his nose at the (state-mandated trust fund) requirement," said Virginia Kendall, a deputy chief in the U.S. attorney's office for the Northern District of Illinois, during the sentencing hearing.

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

Mr. Segal was convicted on 13 counts of mail fraud, seven counts of making false statements, three counts of embezzlement and one count each of wire fraud, tax conspiracy and racketeering.

Late last year, Judge Castillo acquitted Mr. Segal of the seven counts of making false statements but upheld the other counts.

Since his conviction, Mr. Segal, who was considered a flight risk, had been held at a federal facility in Chicago. His sentencing was delayed twice this year in part due to psychiatric evaluations. In October, he was found mentally competent to be sentenced.

Ex-Near North owner Michael Segal was convicted of fraud and other charges in 2004.

In sentencing Mr. Segal, Judge Castillo accepted some defense arguments for mitigating factors, including Mr. Segal's attention deficit/hyperactivity disorder and charitable contributions.

Near North National Insurance Brokerage Inc., once the nation's 18th-largest broker of U.S. business, based on $199.9 million in 2002 brokerage revenues, also was convicted on similar fraud charges.

After two failed attempts to sell the brokerage, Mr. Segal eventually transferred what was left to Chicago-based Mesirow Insurance Services Inc. in August 2003.

Mr. Segal is not affiliated with The Segal Co., a New York-based employee benefit consulting company.

Aon corrects error, increases Connecticut settlements

HARTFORD, Conn.—More than 20 Connecticut municipalities, corporations and individuals will receive more money than they anticipated under Aon Corp.'s $190 million contingent commissions settlement after the Chicago-based brokerage rectified mistakes made in its original offers.

Connecticut Attorney General Richard Blumenthal said Monday that his office discovered Aon's miscalculations in the settlement shares owed to certain Connecticut policyholders and that Aon has corrected its mistakes and is notifying towns and other policyholders of their corrected settlement amounts.

According to Mr. Blumenthal's office, among the towns receiving higher-than-expected settlement shares are: Fairfield, whose settlement increased nearly $88,000 to $135,816; Enfield, whose settlement offer increased more than $62,000 to $79,778; Hartford, whose settlement offer increased nearly $41,000 to $44,776; and North Branford, whose settlement offer increased more than $25,000 to $33,997. In addition, the town of Portland, which was not initially included in Aon's calculations, has now received a settlement offer of $8,379.33.

Furthermore, the settlement offer for Windham Public Schools increased nearly $40,000 to $49,348 and Sterling Board of Education's settlement offer increased more than $4,000 to $5,313, according to the attorney general.

Eligible policyholders have until Nov. 30 to officially request their share of the settlement offer, which will be distributed in three installments—on Dec. 31, 2005; Sept. 30, 2006, and Sept. 30, 2007.

"We will ensure that every eligible policyholder is paid every penny of restitution—almost 6,000 Connecticut towns and cities, taxpayers, nonprofits and corporations," Mr. Blumenthal said in a statement.

An Aon spokesman said via e-mail, "We were happy to work with the attorney general's office and other parties to the settlement to make sure that all calculations are appropriate and accurate."

In March, Aon agreed to establish a $190 million compensation fund to be distributed among affected policyholders to settle charges with five agencies in three states, including Mr. Blumenthal's office, that it steered insurance to those insurers paying the highest contingent commissions, among other charges (*BI*, March 7).

—By Sally Roberts

Property/casualty insurers shaken but not toppled by 3Q hurricanes

By JUDY GREENWALD

Hurricanes aside, the U.S. property/casualty industry is doing pretty well, say observers.

While insurers are clearly feeling the impact of this year's hurricane season on their bottom lines, their underlying results remain strong as they continue to benefit from past years' rate hikes.

The 14 insurers surveyed by *Business Insurance* for the nine months ended Sept. 30 reported a 23.7% increase in net income, to $18.25 billion, a reduction by almost half of the 44.5% increase posted by the insurers in the first six months of the year.

The hurricanes will continue to exert an influence next year as well. Policyholders can expect rate hikes, particularly in lines affected by the storms, although observers disagree whether the momentum will spill over into casualty lines.

"Everyone's really focused now" on "the breadth and the durability of expected price improvements as a result of the catastrophe losses," said Mark Lane, a principal and research analyst with William Blair & Co. in Chicago.

Among other results from *BI*'s survey:

- The insurers reported a 98.2% average combined ratio for the first nine months of 2005 vs. a 98.6% combined ratio for the comparable period a year ago. They reported a 92% combined ratio for the first half.
- Net premiums written increased 4.5%, to $100.92 billion.
- Policyholder surplus for the 13 companies that report this data increased 14.6%, to $75.41 billion.

"The contrast of the third-quarter results in relation to the results of the first half of the year highlight the challenge of being in this industry," said Cincinnati-based independent insurance analyst John L. Ward.

"The first half of the year in the commercial sector, the results were outstanding," but the catastrophes "cast a whole new perspective on the condition of the commercial sector and the short-term outlook," he said.

But the insurers nevertheless did well, say observers. "Clearly, Katrina and Rita put a bit of a dent in the results for a lot of companies but I think, overall, we were pleased and pleasantly surprised that many of the primary companies were able to basically absorb those losses within that quarter's earnings" or over two quarters' worth of earnings, said John Iten, a director at Standard & Poors Corp. in New York.

Excluding the catastrophes' impact, during the third quarter there "was a continuing softening of commercial lines pricing, a slow-

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State may restrict health insurers' 'excess surplus'

Washington state regulator cites record profits, rising premiums in proposing study of reserve limits

By MEG FLETCHER

OLYMPIA, Wash.—Washington may become the third state to regulate "excess" surplus at health insurers, which, state officials say, are experiencing record profits while premiums increases outpace inflation.

"Excess surplus is an emerging issue which I believe deserves a closer look," Washington state Insurance Commissioner Mike Kreidler said in a statement. Mr. Kreidler described it as "one of my top policy priorities for 2006."

Insurers say, though, that they should not be prevented from holding sufficient resources to offer adequate security to plan members.

Mr. Kreidler is holding a public hearing on the issue Dec. 8.

He said his concern stems from the fact that "carriers are experiencing record profits, yet health insurance premiums continue to rise faster than the rate of inflation. We need to ask: 'How much is too much?'"

Historically, "regulators look at carriers' surplus to be certain it's sufficient to protect policyholders and the market," Mr. Kreidler acknowledged. While Washington state insurance law sets minimum financial requirements to ensure that insurers are financially solvent, it does not set a limit on the maximum an insurer can hold in surplus, nor does it stipulate how an insurer's surplus should be considered in regulating insurance rates.

Mr. Kreidler

Average 2005 rate increases in Washington state were 5.1% for large-group employers, 8.9% for the small-group market and 17.5% for the individual market, according to a spokeswoman for the state Office of the Insurance Commissioner.

Currently, Hawaii and Michigan have laws that regulate the maximum surplus held by health insurers, according to an OIC spokeswoman.

Neither insurance regulator in those states has ever had to enforce those laws, though, because health insurers covered by the laws have never exceeded the excess reserve threshold established by their respective state legislatures, a spokesman for each regulator said.

Specifically, Hawaii's 2003 law applies to managed care companies and is triggered when an insurer's net worth exceeds 50% of its combined annual health care expenditures and operating expenses.

In Michigan, the law was drafted to apply only to Blue Cross & Blue Shield's nonprofit operations since 1985. However, "they have never hit the maximum reserve amount," according to a spokesman for the Michigan Office of Financial & Insurance Services. The law stipulates that the surplus cannot exceed 1000% of risk-based capital requirements.

The purpose of the Washington hearing "is to gather facts and examine the pros and cons of regulating the amount of surplus," the OIC said in a statement. The hear-

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Employer held liable for contract worker's acts in harassment appeal

By JUDY GREENWALD

CHICAGO—An employer can be liable for sexual harassment committed against one of its employees even if the harasser is not an employee of the organization, says an appellate court.

The Nov. 17 decision by the 7th U.S. Circuit Court of Appeals in *Lisa Dunn vs. Washington County Hospital and Thomas J. Coy* focused on Dr. Coy, who was an independent contractor at the Washington, Iowa-based hospital.

Nurse Lisa Dunn had filed a sex discrimination claim against the hospital, contending that Dr. Coy, the head of its obstetric and emergency services, had "made life miserable for her and other women on the staff."

A lower court granted the hospital summary judgment in the case, with the judge ruling that the hospital was not liable because, as an independent contractor, it could not control Dr. Coy's conduct.

But the appellate court disagreed. It makes no difference that Dr. Coy was an independent contractor, says the decision. "Ability to 'control' the actor plays no role. Employees are not puppets on strings; employers have an arsenal of incentives and sanctions (including discharge) that can be applied to affect conduct."

"It is the use (or failure to use) these options that makes an employer responsible—and in this respect independent contractors are no different than employees," says the decision.

"Indeed, it makes no difference whether the actor is human," the opinion continues. "Suppose a patient kept a macaw in his room, that the bird bit and scratched women but not men and that the hospital did nothing. The hospital would be responsible for the decision to expose women to the working conditions affected by the macaw, even though the bird (a) was not an employee, and (b) could not be controlled by reasoning or sanctions."

"It would be the hospital's responsibility to protect its female employees by excluding the offending bird from its premises," says the ruling.

There was a 2-1 ruling in the case. The dissenting judge agreed with the majority's decision on the independent contractor issue but disagreed with its rulings on other claims brought by Ms. Dunn.

The appellate court remanded the case to the district court to determine whether Dr. Coy's conduct justified liability.

Lisa Dunn, plaintiff-appellant, vs. Washington County Hospital and Thomas J. Coy, defendants-appellees; 7th U.S. Circuit Court of Appeals, No. 05-1277.

Errors & Omissions

● A Nov. 28 article, "Cyber privacy rules challenge employers," included an incorrect location for the law firm Cozen O'Connor. The law firm is based in Philadelphia.

Cayman attracts its first reinsurer

Brokers question domicile's ability to be major player

By SALLY ROBERTS

GEORGETOWN, Grand Cayman—With the formation last month of its first open-market reinsurer, Greenlight Re, the Cayman Islands is poised to become a major player in the reinsurance market, according to its insurance supervisor.

As one of the world's largest financial centers, with well-developed banking, accounting, legal and captive insurance industries, Cayman has the infrastructure in place to achieve such a goal, local insurance specialists say.

Indeed, the formation of Greenlight Re and the potential for other reinsurers in the future would provide a one-stop-shop environment for Cayman captive owners, who would be able to meet and have access to reinsurance coverage locally, they note.

But because the island is not a well-established open-market reinsurance center like Bermuda, some reinsurance brokers are concerned about conducting business on the island.

Last month, New York-based hedge fund Greenlight Capital Inc. launched Greenlight Re on Cayman with more than $220 million in capital (*BI*, Nov. 21).

The reinsurer specializes in structured property/ casualty reinsurance on a global basis and also plans to work with local insurance managers to provide reinsurance for Cayman-licensed captives.

With Greenlight Re now up and running, Cayman's insurance supervisor hopes others will soon follow suit.

"Cayman has never really aggressively targeted the reinsurance market—traditionally these have gravitated towards Bermuda," said Mary-Lou Gallegos, head of insurance for the Cayman Islands Monetary Authority, in an e-mail. "However, given that Greenlight has now established and the fact that we are currently reviewing the insurance law, now is an opportune time to ensure that legislation is in place to facilitate the formation of the larger

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Multiemployer plans struggle to establish health accounts

But expert advises how to introduce other consumerist elements

JOANNE WOJCIK

HONOLULU—The lack of U.S. Treasury Department guidance on the use of consumer-driven health plans in multiemployer environments makes it difficult, though not impossible, for multiemployer plans to offer health reimbursement arrangements and health savings accounts in conjunction with high-deductible health plans, according to one expert.

But it should be relatively easy for multiemployer plans to introduce elements of consumerism to help curb future cost increases, suggested Kathy Linton, senior manager of the integrated health group for Deloitte Consulting L.L.P. in Seattle.

Many multiemployer plans governed by the Taft-Hartley Act have had in place for several years personal care accounts that function much like health reimbursement arrangements. But such accounts are fully funded and held in trust, unlike the HRAs that are established by individual employers and funded as needed, according to Phyllis C. Borzi, of counsel at O'Donoghue & O'Donoghue L.L.P. in Washington.

Coverage of the IFEBP annual conference continues on page 38

Numerous obstacles prevent multiemployer plans from simply converting those fully funded Taft-Hartley accounts into health savings accounts, Ms. Borzi explained during a conference session on designing consumer-driven health plans in the multiemployer environment at the 51st annual meeting of the International Foundation of Employee Benefit Plans, held Nov. 12-17 in Honolulu.

In particular, Internal Revenue Service rules governing such accounts apply only to single-employer plans, not multiemployer plans governed by collective bargaining agreements, she noted.

For example, the IRS has made HRAs subject to the health care continuation requirements of the

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Wal-Mart suing hospital to recoup payout on workers comp claim

By ROBERTO CENICEROS

SALINAS, Calif.—In what some observers say is part of a growing trend of employers filing subrogation suits, Wal-Mart Stores Inc. is suing a hospital to recoup workers compensation benefits it paid to an employee who allegedly contracted so-called flesh eating bacteria while receiving treatment at the facility.

The retailing giant alleges that the hospital was negligent in it sterilization procedure and that it should bear some of the benefit and indemnity costs. Wal-Mart was self-insured at the time.

While employers have previously filed third-party subrogation claims alleging negligence and have sought workers compensation expenses, such claims are infrequent compared with other property/casualty lines, industry observers say.

Wal-Mart is among of a growing number of employers that are filing subrogation suits to recover the costs of workers comp and other claims.

But workers comp-related subrogation is a growing area, especially in cases brought by self-insured employers, said Jeff Baill, a partner at Yost & Baill in Minneapolis. Mr. Baill is also founder of the Minneapolis-based National Assn. of Subrogation Professionals.

Currently, more self-insured employers are helping fuel a trend in workers comp subrogation as they increase their sophistication for countering losses, he said. Such suits against hospitals, however, remain a small part of the business.

Employer lawsuits against hospitals are not frequent, agreed Michael Evans, senior vp and chief risk and compliance officer for Sutter Health, a Sacramento, Calif.-based group of hospitals and physician organizations. "It happens, but it is not very common," Mr. Evans said.

To help reduce Sutter's exposure, the company's risk management staff collects data on potentially compensable events and looks for trends, such as infections occurring in its facilities, Mr. Evans said. Risk

See WAL-MART/page 36

PAUL WINSTON

Editorial Director

Unpredictability holds intrinsic industry lure

Many people in the insurance industry have wondered why they have stayed in this business so long.

They think of their childhood, when they held unflattering perceptions of people who worked in insurance. They recall how their first job in the business was accompanied by thoughts of, "This is only temporary until the longshoreman's union processes my application." They look back at the past 15 years of anguishing over when they'd ever be able to charge a higher rate again. They look to the future and wonder how, after changing employers 10 times in as many years, they will ever accrue a pension that would allow them to retire before age 105.

They think these dark, doubting thoughts, and yet they remain in the insurance industry, instead of quitting to pursue a more glamorous and fulfilling career like day-trading Amazon.com futures. Sometimes, they are bound to shake their fists at the sky, or at their blinking computer screens, or at the bartender at the far end of the bar and ask, "Why? Oh, why didn't I listen to my mother and enter dental school?"

Scientists now have found the answer. Researchers at Emory University in Atlanta have published a study that shows that more than sex, more than food, the human brain craves a good surprise. See? You're delighted already!

The scientists subjected a group of men and women to simple tests in which they received drops of water or fruit juice in a repetitive, monotonous pattern and tracked the response of each of their pleasure centers. It quickly became clear that no one was very excited by getting water, water, juice, juice, water, water—especially in such tiny quantities. Then, they began to vary the routine to see what happened. A simple disruption in the routine—such as water, water, juice, water, juice, water, juice—made the test subjects sit up and take notice. They were surprised! And, what's more, they were delighted by the experience. The images of these brains began to light up like the $1,000,000 slot machines at Bally's after someone hits a jackpot. Can you imagine the response if the study group had been given water, water, juice, juice, bourbon and water? Wow.

From this simple experiment, scientists deduced that people are bored by droplets of water and fruit juice in general, but if delivered in an unpredictable manner, the they can be very stimulating. In short, people enjoyed being surprised.

And what industry is more full of surprises than insurance?

What is insurance other than trying to prepare for and minimize the effects of unexpected events, while hoping that they never occur? Surprises, which come in all areas of insurance, can be the pleasant variety or the unpleasant variety—and that in itself can be a surprise.

Imagine the risk manager of a major corporation who challenges a spurious third-party claim in court, only to have a jury return a multimillion-dollar verdict, with a punitive damages award that is five times greater? His bleeding ulcer may tell him otherwise, but his brain is delighted by the outcome.

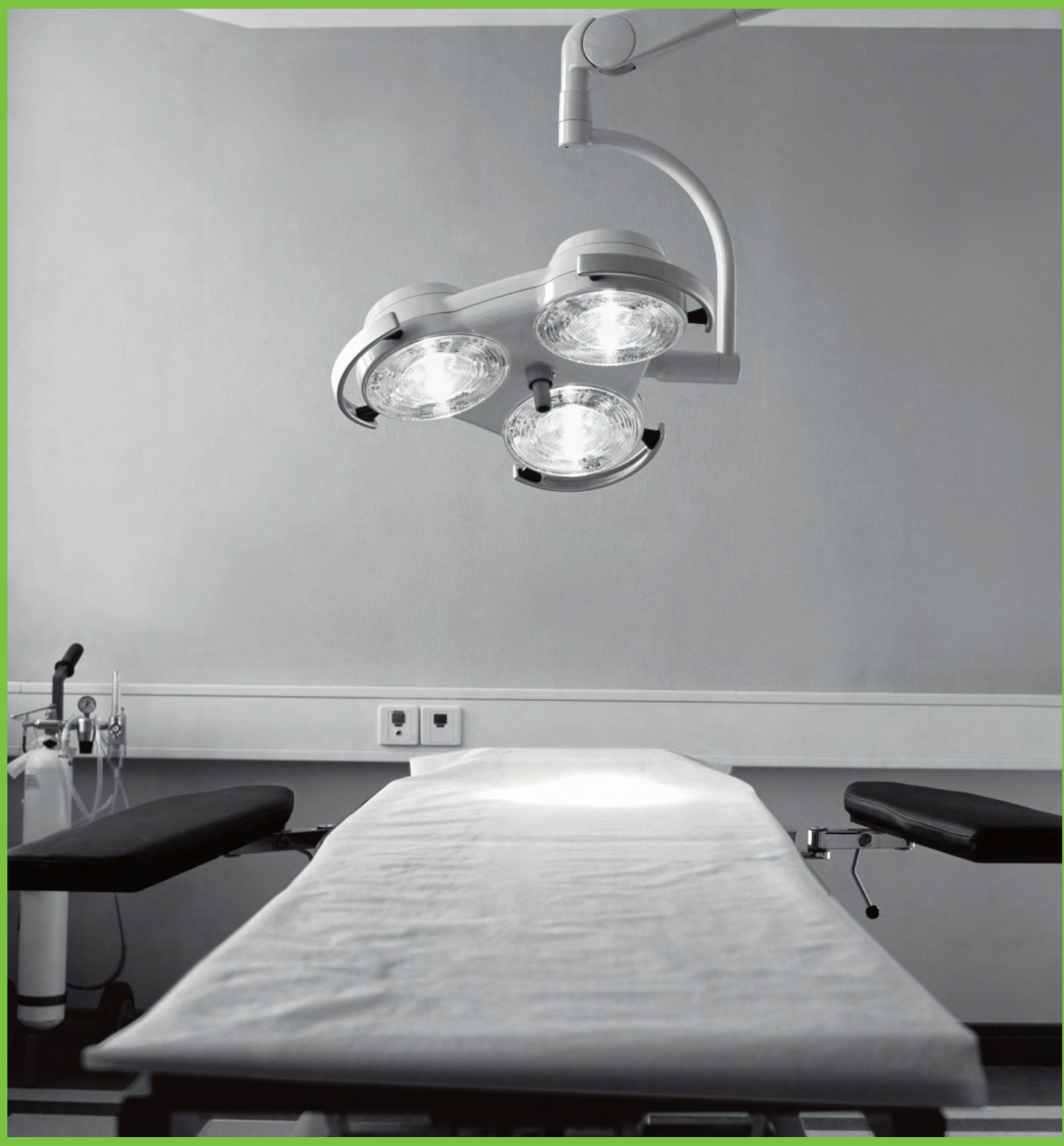
Consider how much more pleased he will be on a neurological level if he then forwards a claim to his company's insurer for coverage, only to have the claim denied on some technicality after paying premiums to that insurer for years. That risk manager is a surprise addict by now—he is hooked!

Or, take the perspective of the insurance underwriter, who year after year cuts her rates because investment returns are so strong that the business is profitable even without big underwriting gains. Then, the bottom drops out of the stock market and investment returns plunge. Surprise! And then, five once-in-a-lifetime catastrophes strike the industry in a row, resulting in millions of claims costing millions of dollars. Surprise!

Or, how about the broker who faithfully works the market to get his client the lowest possible price year after year, but has to jump through hoops in annual reviews to keep the business and one day loses the account over 0.05% worth of commissions. Surprise! And the next year, his firm is swallowed up by that competitor, and he gets the account back. Surprise!

If scientists are correct about how much people crave a surprise, it's easy to see why people stay in insurance. While on an intellectual level, people may question their sanity, on a biological level, they can never leave. Surprised?

Editorial Director Paul Winston is on vacation. This commentary from the BI archives was originally published on April 23, 2001.



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Editorial

Winner of benefit award sets example for others

TURNING AROUND health care cost trends is easy to say but hard to do. Still, an innovative benefit professional has managed to do it.

That accomplishment, among many others, helped to make him the 2005 Benefit Manager of the Year. In this issue, *Business Insurance* profiles Chris McSwain, the inaugural winner of the magazine's new annual competition to recognize excellence and innovation in employee benefit administration.

Mr. McSwain, the director of compensation and benefits at Columbia, S.C.-based SCANA Corp., was chosen by a panel of independent judges representing benefit consultants, brokerages, business groups, managed care companies and other benefit service providers. As the stories beginning on page 10 demonstrate, Mr. McSwain has had a major impact at SCANA in only two years.

In the three years before he joined, SCANA's health care costs went up by a combined 201%. He was able to make it a minus 5% trend, reversing years of soaring costs.

How did he do that? Through a well-thought-out program that got the attention—and support—of upper management. Mr. McSwain led SCANA to institute health and wellness initiatives and gather data on all facets of the company's health care benefits.

The saying, "If it can be measured, it can be managed," succinctly summarizes the approach he took. And it's paying off.

What's also remarkable is SCANA has managed to cut expenses not by slashing benefits but through a caring philosophy focused on treating "the whole person," as Mr. McSwain aptly puts it. At the heart of this is SCANA's LiveWell Resource Center, a facility open to any member of SCANA's benefit plans—employees, retirees and dependents. LiveWell aims to raise participants' awareness and teach them to lead healthier lives. A big help in this area is a staff "health coach," who assists plan members with diet and exercise.

Another innovation Mr. McSwain introduced is an in-house pharmacy to dispense many of the drugs SCANA benefit plan members use. This accomplishes several goals at once: it offers convenience, reduces cost by enabling SCANA to buy drugs at wholesale prices and provides utilization data to spot areas to further wring out expenses.

Controlling benefit costs is one of the biggest challenges employers face today. Leaders such as Mr. McSwain are developing creative solutions to this problem. *Business Insurance* is proud to recognize him as our first Benefit Manager of the Year.

Washington should think twice about surplus limits

THE STATE OF WASHINGTON plans to hold a public hearing this week on health insurers' "excess" surplus as a possible first step toward regulating the maximum amount of surplus insurers may maintain. We hope that the state considers the matter very carefully before it takes any further steps.

As we report on page 4, state officials say the action comes in response to health insurers' earning "record profits" at a time that premium increases outpace inflation. We can understand regulators' concern—health care costs, already high, are rising, and consumers are feeling the pinch. In that kind of situation, there's always pressure to "do something," even when no one's sure exactly what that "something" ought to be.

Burdening insurers with yet another regulatory requirement strikes us as a "something" that has to be approached with extreme caution. After all, despite the connotations of its name, "surplus" isn't the equivalent of windfall profits or profiteering—it means the pool of capital an insurer has to meet obligations. To limit the size of that pool through government fiat—no matter how well intentioned—strikes us as counterproductive.

After all, one of the chief tasks of insurance regulation as currently practiced is to ensure solvency. We'd much rather see insurers have more than enough capital to meet current obligations than to find themselves with shortfalls thanks to government intervention.

Schillerstrom

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

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Industry Focus: Rodd Zolkos, Rupal Parekh

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Risk securitization/capital markets risk financing: Carolyn Aldred

Runoffs/receiverships: Douglas McLeod

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Tort reform: Mark A. Hofmann

Work/life benefits and EAPs: Sally Roberts

Workers compensation: Roberto Ceniceros

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Disaster preparedness pays dividends

By Eileen Gardner

I concur with Paul Winston's Sept. 12 article "Cities paying a high price for their unpreparedness." It is vital to take the necessary steps before your catastrophe exposure becomes reality.

Earlier this year, Hurricane Ophelia raked the coast of North Carolina, causing $2.4 million in damages in Brunswick County, which is located just south of Wilmington, and was the largest county in the path of Ophelia.

In Brunswick County, we knew we had to act in a timely fashion to minimize our losses, and our emergency management preparedness plan was our boilerplate for success. Emergency Management Director Randy Thompson ensures that the plan is a living, working document. The plan, which works like a desktop tool, requires regular tweaking to be sure it continuously adapts to people and the environment.

Our experience, compounded by the recent losses along the Gulf Coast, forced all eyes wide open. We knew wireless communications were going to be affected and roads were going to be impassable. Moving residents to shelters was one of the initial challenges we faced.

But long before the disaster was upon us, we had undertaken exercises and met annually to help us through such potential challenges. The exercises included local emergency planning sessions, disaster plan reviews, safety inspections and incident re-enactments. We also knew the importance of maintaining an up-to-date statement of property values in case of an unplanned weather event.

Early on, as soon as the location and projected path for the hurricane was outlined, we got busy taking protective action. We got in step with the local branch of the National Weather Service and developed several potential scenarios. We then opted to anticipate the worst-case scenario, which provided latitude and longitude for our plan.

Here is what should be called for in a county emergency management preparedness plan:

- Determine the county's vulnerabilities and identify the resources required to secure them. Such determinations can be made through the property inspection process.
- Maintain good communications, including conference calls on a regularly scheduled basis, with all the county's key players. Key players include individuals who have influence over the resources of such entities as the local municipalities, the local school boards, major utilities, local hospitals, the department of transportation, the sheriff, the highway patrol, the U.S. Coast Guard, the Red Cross and the local media.
- Determine potential needs such as food, shelter, transportation, medical care and law enforcement. Identify isolated areas in the county.
- Network resources to meet needs through law enforcement, traffic control and medical response; evacuation may include transportation, military resources and the distribution of supplies.
- Execute a recovery plan to facilitate the transition back into a workable daily routine.
- After any disaster, incorporate the overall experience into the emergency management preparedness plan.

Reviewing the county's response can better position it for future success. Such reviews are part of the continuous work that goes into crafting the best possible risk management plans.

Our storm packed winds of 85 mph and brought 15 inches of rain. It caused power outages for more than 20,000 people and left more than 500 people without telephone communication. While our Category 1 storm in no way compares to the deadly hurricanes that struck along the Gulf Coast this season, we continue to learn from the experience.

What would your city or county do in light of these events? Having an emergency preparedness plan is crucial to the success of your community.

Asking some pertinent questions now can prepare you for disaster later. When do you issue a mandatory evacuation? When is it safe to perform bridge inspections? When do you resume mass transit and school schedules?

These are just some of the tough questions that require answers in order to plan for a disaster before it strikes. That way, when the emergency is over, you will have successes to share.

Eileen Gardner is risk manager of Brunswick County, N.C.

Far from standard, political risk coverage is tailored to meet specific customer needs

By Michael Bond

Many companies seeking business opportunities in the emerging markets are faced with unusual and unfamiliar risks, especially the political risks that can arise from volatility in those countries. While these occurrences are not frequent, expropriation of assets, confiscation, nationalization, currency inconvertibility and political violence can be catastrophic for a business. A single event may permanently derail plans to realize the opportunities available in these fast-growing economies.

Many companies are turning to political risk insurance to protect themselves against some of the unpredictability of emerging markets.

For these companies, the most desirable outcome of a political risk insurance policy may not be the payment of a claim. Rather, the real value in political risk insurance may come from an insurer that can help prevent or minimize the loss of assets so operations remain viable and profitable.

How can a risk manager, often located continents away, be an effective participant in this loss mitigation effort?

1. Ensure early insurer intervention.

The sooner a risk manager recognizes a potential political risk event, the earlier the insurer can set the wheels of loss mitigation turning. Admittedly, recognizing such an event may not be easy.

Decades ago, when it was not unusual for local governments to take over a foreign-owned plant or expropriate foreign assets by decree, problems were immediately obvious. Today, when developing markets want to maintain goodwill in the global economy, warning signs are more difficult to detect.

"Creeping" expropriation is now the norm. Rather than seizing assets, a host government may turn to discriminatory fees or punitive regulations that favor locally owned companies. The end result is the same–the foreign-owned entity can no longer function. The process is simply more subtle and gradual.

Still, a risk manager should recognize and be prepared to act on some warning signs:

- Increased visits to a facility by local authorities.
- A change in government leadership to those who have stated that they are less receptive to foreign investment or will consider canceling agreements entered into by prior governments.
- Regulatory changes, particularly where regulators are also owners of local enterprises.
- Populist uprisings.

2. Understand the scope of the political risk coverage.

Unlike many insurance coverages, political risk policies are far from standard. Each policy is tailored to meet the specific requirements of the asset and the customer. The risk manager should understand precisely what loss events the political risk policy will cover, what types of losses are excluded and what conditions may apply. For example, a political risk policy is unlikely to cover loss due to a commercial dispute or new legislation that is legally enacted and broadly applied. Conversely, political risk policies can extend coverage to events such as the forced abandonment of a facility due to civil war or the capricious cancellation of a legal export license.

3. Participate rigorously in claims and negotiations.

Once the insurer is alerted to a potential loss event, the risk manager should collaborate closely with the insurer and broker on a strategy to protect the insured company's interests and attempt to prevent or minimize the impact of a loss event.

Even before a claim is filed, the risk manager should be prepared to work in close cooperation with a loss mitigation team assembled by the insurer. The team could include U.S. and local attorneys, as well as other specialized professionals such as accountants and engineers with prior emerging-markets experience. At this stage, loss mitigation efforts typically focus on investigation of the situation and the development of a local network to advocate on the policyholder's behalf.

Claims-paying ability will always be pivotal in selecting an insurer. When choosing a political risk insurer, though, a risk manager should be equally cognizant of the importance of the insurer's experience, relationships and global reach. Mitigating losses in emerging markets requires an insurer with strong ties to multilateral organizations and public agencies. These relationships dramatically enhance the insurer's ability to work with host governments on a policyholder's behalf in the face of a potential loss. The insurer also must be able to mobilize experienced professionals who can respond effectively to the unique challenges of emerging economies.

When a risk manager works hand in hand with an experienced political risk insurer, it is possible to head off imminent losses and meet the insured's ultimate objective–keeping operations in emerging markets on course.

Michael Bond is senior vp and director-political risk for Zurich Financial Services in Washington.

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

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A caring approach to solving problems

Focus on health and service helps utility achieve fast results

By JOANNE WOJCIK

COLUMBIA, S.C.—Chris McSwain has accomplished more in his brief, two-year tenure as director of compensation and benefits at Columbia, S.C.-based SCANA Corp. than most benefit managers can hope to achieve in a lifetime.

Though most would say his most significant accomplishment has been to reverse the electric and gas utility company's upward spiral in health care costs, which rose a total of 201% over the past three years, Mr. McSwain, who was a chemist before he entered the human resources field, is more proud of SCANA's new health resource center and in-house pharmacy.

As a result of a health and productivity improvement initiative that included medical management, integrated absence management, a lower-cost provider network and higher copayments for use of hospital emergency rooms and specialists, SCANA's health care tab for 2005 is running 5% below that of 2004. In addition, the average short term disability duration has fallen 15% to 3.7 weeks from 4.7 weeks—saving the company approximately $500,000 annually—and cardiac and diabetes inpatient claims are down 5% to 18.2 per 1,000 covered lives.

To preserve those cost reductions, and perhaps generate additional savings down the road, SCANA's health resource center, which opened in July 2005, is promoting wellness by providing health education and health coaching as well as "life assistance" to address the many serious health conditions that have behavioral roots.

Located in the company's down-

Continued on next page

Continued from previous page

town Columbia, S.C., headquarters, the LiveWell Resource Center also is home to a company-owned and operated pharmacy that is saving SCANA even more money by bypassing the middleman in the prescription drug purchasing chain and buying directly from a wholesaler. SCANA employees who use the in-house pharmacy share in the savings because they don't pay the dispensing fees that retail pharmacies charge. And to make using the in-house pharmacy even more convenient, particularly for employees in outlying areas, SCANA offers its own mail-order prescription drug delivery service via intercompany mail.

Both SCANA's in-house and mail-order pharmacy dispense both generic and brand-name drugs. However, they do not handle controlled substances, injectibles or any drugs that must be refrigerated. Payment can be made by credit card or debit card. No cash is accepted.

The next item on Mr. McSwain's agenda is to identify—and hopefully mitigate—the company's future health care exposures. As part of this endeavor, he has been working with the University of South Carolina and a data aggregator to build a data warehouse that will be used to analyze the health status, claims and risks of SCANA's 15,000 benefit plan participants and develop appropriate interventions (see story, page 28).

He also is revamping the company's retiree health benefits in light of the fact that it has reached its cap under Financial Accounting Standard 106 and has decided to accept the federal subsidy that is available, starting next year, to employers that maintain prescription drug benefit plans that are at least equal to what Medicare will provide through its new Part D program. Under FAS 106, which took effect in 1995, companies can no longer account for their retiree benefit costs on a pay-as-you-go basis; they must accrue the present value of all future retiree health care liability on their financial statements. In response, many employers, including SCANA, implemented caps to limit their retiree health care liabilities and annual expenses (*BI*, Sept. 29, 2003).

Business impact

"HR has a 'fluffy' feel to it. But I wanted to demonstrate that this is about business," said Mr. McSwain, who was selected *Business Insurance's* first Benefit Manager of the Year for 2005.

"We were presented with business problems and business challenges. We jumped in and changed our trend line dramatically in less than two years in a coordinated and intentional manner by combining the best of what everybody can do and putting it together in one place," he said.

> "HR has a 'fluffy' feel to it. But I wanted to demonstrate that this is about business."
>
> **Chris McSwain**
> **SCANA Corp.**

"Every $1.8 million is worth a penny to our stock," Mr. McSwain estimated. "When I can turn what was headed north and change its slope, imagine how much electricity and gas we don't have to generate and pump to make that kind of profit. So these are in very real ways adding money to our bottom line."

While it would be easy to bask in his accomplishments, Mr. McSwain is unassuming, sharing the credit with his staff and SCANA's upper management, who backed him 100%, virtually giving him full authority to make the necessary benefit plan changes and investments in health promotion, the resource center and pharmacy.

"What is striking about Chris is that he is relatively quiet, very modest and self-effacing. Yet he has great vision, knows how valuable it is to help SCANA's families choose healthy lifestyles and understands how to get things done," said Helen Darling, president of the National Business Group on Health in Washington. Ms. Darling spoke at the Health Care Summit Mr. McSwain organized in August 2005 to present the business case for benefit management program change to SCANA's leadership, winning their support.

Ms. Darling was one of 10 independent judges of this year's Benefit Manager of the Year award (see story, page 30).

"He gives everybody else credit, but he keeps working away, making things happen that are to the benefit of the entire company. He has brought new ideas and tremendous leadership to a company that is very important in South Carolina. The depth of his support at SCANA is testimony to his vision and skills," she said.

What is also notable is the fact that even though he was the new kid in town, Mr. McSwain was able to effect significant change in a 159-year-old utility company that has provided employment to numerous generations of South Carolinians since 1846.

Liz Borkhuis, a principal at Towers Perrin in Atlanta who nominated Mr. McSwain for *Business Insurance's* Benefit Manager of the Year competition, says his outsider status may have actually been more of a help than a hindrance.

"I think his approach was a bit different than perhaps some of his predecessors. He was an outsider. He didn't know any better. He started out by getting senior leadership on board. You have to have the mandate from senior management to make changes. He did that very astutely and very well," she said.

"Then he involved a group of people within the organization to get broader buy-in. He didn't try to shove things down people's throats. The more you dictate, the less effective you'll be."

"He's a great collaborator," said Joe Bouknight, senior vp of human resources, and Mr. McSwain's direct supervisor. "To work as a collaborator, you have to be willing to accept results that might be somewhat different if you had to do it only, if you were running solo, and we've all had to make certain adjustments to what we think would be the best way to do something. And we've had to make it consistent with the culture of a 150-year-old company."

Moreover, "he consciously makes an effort to involve the finance function. In previous instances where they have changed benefits, the design people have gone through the whole process of designing the benefit package they wanted before telling the finance people how much it will cost," recalled Ms. Borkhuis, who has worked with SCANA for about 20 years.

"By involving people, making it a team effort, he's managed to energize a lot of people in the organization," she said.

"We have a team. Chris is a member of a team, and he has peers who head up workforce planning and development, the HRIS side, and safety, and none of those things were in particularly good shape, but as a team, we have dealt with them all," Mr. Bouknight said.

Despite the stereotype of stubbornness often placed on old-guard companies, SCANA has always supported innovation, a necessity for survival in the energy industry, according to Mr. Bouknight.

"We had the right culture to facilitate the changes Chris has made," he said. "The issue that we dealt with was we needed to make progress in the administration of our benefits before we could reinvent ourselves."

"So much of the trouble we have in benefits today is because we're mired in the day-to-day tactical administration and we don't get our heads up above the smoke to see what's ahead," Mr. Bouknight observed.

Mr. McSwain "has been able to balance the strategy with the tactics, and we've been able to fix most of the administrative issues while at the same time nurturing a strategy for change," he said.

In addition, "he cares. He cares about people. He cares about the company. He cares about doing the very best that he can do personally," Mr. Bouknight said. "I don't think he could have done everything that he has accomplished if he were focused purely on the numbers."

Conversely, "I don't think if he weren't able to be focused on the numbers he could have pulled together a strategy," he said, pointing to Mr. McSwain's background as a chemist.

Powering change

Since joining SCANA Corp. only two years ago, Chris McSwain has radically retooled the utility company's benefit management program.

September 2003:
Chris McSwain is hired as director of compensation and benefits at SCANA Corp.

February 2004:
Selected wellness vendor.

July 2004:
Revamped and stepped up benefit communications.
Established wellness council.

August 2004:
Held Health Care Summit.

October 2004:
Introduced HealthSmart with decision support tools.
Began working with South Carolina Pharmacy Board for approvals to use intercompany mail to deliver prescriptions to employees.

November 2004:
Began remarketing EAP as "life assistance."

January 2005:
Changed to lower-cost provider network.
Increased copayments for ER, specialist and urgent care visits.
Fine-tuned disease management, providing free generics as incentives to increase compliance with prescriptions and improve generic/brand ratios.
Instituted spousal surcharge.

February 2005:
Introduced clinical review of all STD/LTD and FMLA claims.
Integrated short- and long-term disability management and FMLA.

March 2005:
Branded and service-marked SCANA Benefits as "LiveWell Life Counts."

May 2005:
Hired health coach.

July 2005:
Opened LiveWell Resource Center containing SCANA Pharmacy, wellness and life assistance.

October 2005:
Introduced LiveWell credit as incentive to complete health risk assessment.
Conducted all-online open enrollment.
Introduced new three-year retirement medical strategies to active employees and retirees.

Reforms built on legacy of innovation

COLUMBIA, S.C.—Chris McSwain's groundbreaking efforts to address the company's health care cost crisis are the latest examples of SCANA Corp.'s 159-year history of innovation and resilience.

Though the holding company known as SCANA wasn't officially formed until December 1984, its predecessor companies date back to 1846, when local business leaders came together to form the Charleston Gas Light Co. in Charleston, S.C.

In 1894, Columbia Water Power Co. supplied power to the world's first electrically powered textile mill. In 1946, South Carolina Electric & Gas became the first South Carolina corporation to be listed on the New York Stock Exchange. And, in 1963, SCG&E joined with three neighboring utilities to build the first nuclear power generating station in the Southeast.

The company also has proved its resilience when faced with natural disaster: When Hurricane Hugo struck Charleston, S.C., in September 1989, it took SCANA just 17 days to restore a 100-year-old electric delivery system that had been virtually destroyed, leaving some 300,000 customers without power.

"We foster innovation based on the needs of our constituents, whether it's our employees, or our shareholders or our customers," observed Therese Griffin, SCANA's manager of corporate communications. "It's always driven by the best interests of the people who make the company successful."

Today, SCANA has grown to become an $8 billion Fortune 500 energy-based holding company whose business units run the gamut from regulated utility operations engaged in the generation, transmission, distribution and sale of electricity and natural gas, to telecommunications and other non-regulated energy-related operations, including providing management and maintenance services for a synthetic fuels production facility.

Among its subsidiaries are: South Carolina Electric & Gas Co.; South Carolina Generating Co. Inc.; South Carolina Fuel Co. Inc.; Public Service Co. of North Carolina Inc.; South Carolina Pipeline Corp.; SCG Pipeline Inc.; SCANA Energy Marketing Inc.; SCANA Energy; ServiceCare Inc.; SCANA Communications Inc., SCANA Communications Inc.; PrimeSouth Inc.; SCANA Resources Inc.; and SCANA Services Inc.

Altogether, SCANA subsidiaries provide electricity to about 592,000 customers in South Carolina and natural gas to more than 1 million customers in South Carolina, North Carolina and Georgia.

SCANA also provides self-insured health care benefits to 15,000 individuals, including 5,500 employees and 1,900 retirees.

For more information about the Columbia, S.C.-based company, visit *www.scana.com*.

—By Joanne Wojcik

PHOTO: MICHAEL MARCOTTE

Benefit Manager of the Year Chris McSwain, right, reports to Joe Bouknight, senior vp of human resources at Columbia, S.C.-based SCANA Corp.

Winner's indirect career path rounds out benefit experience

By JOANNE WOJCIK

COLUMBIA, S.C.—Like many benefit managers, Chris McSwain didn't enter the field directly.

After graduating from Emory University with a master's degree in chemistry, he worked for two years in the pharmaceutical division of Ciba-Geigy in New Jersey, later transferring to Greensboro, N.C., to work in a crop protection lab of the Swiss-based chemical/life sciences company.

It was about a year after that when the opportunity arose to change the direction of his career.

"I think I felt as though I was in a bit of a closet in the sense that, in the lab, I was only getting a slice of the overall picture of what was going on in a business," Mr. McSwain explained. "I wanted to know about how the business worked, and I liked working on projects that affected the lives of people, and HR had this open position. It was the first time they had opened it to someone who did not have an HR background. And I was their successful applicant."

Mr. McSwain started in employee relations, training and recruiting and then went into compensation. He also worked on implementation of a new PeopleSoft human resource information system and was introduced to benefits management.

Mr. McSwain said the best advice he ever received was from a compensation mentor.

"She said, 'If you really want to be good, you have to leave. If you stay here, you're only going to know how compensation is done here. If you go other places, you'll see how it's done elsewhere,' " Mr. McSwain recounted.

> "I think I felt as though I was in a bit of a closet in the sense that, in the lab, I was only getting a slice of the overall picture of what was going on in a business."
>
> **Chris McSwain**
> **SCANA Corp.**

Heeding that advice, Mr. McSwain left Ciba-Geigy and took a job at Oakwood Homes, which changed its name to Clayton after being acquired by Berkshire Hathaway Inc. of Omaha, Neb. But he left a year later, after installing a new performance management and compensation system, when he discovered an opening at Falls Church, Va.-based General Dynamics Corp.

"They were looking for someone to put in a bunch of new compensation programs," he recalled.

Eventually, he also became responsible for HRIS and benefits.

At that point, Mr. McSwain decided he needed some international HR experience to round out his resume and found a position in Mexico at Reichhold Inc., now a Triangle Park, N.C.-based coating and polymers manufacturer.

After just one month, he was promoted to global director of compensation.

"We were in the middle of a joint venture with Dow," he said. "I came in and helped put out a lot of fires."

Then, after a year, "my boss told me that the consultants said we needed to have someone in charge of the data, but we didn't know what that meant. It was a developmental assignment. We put in" enterprise software from Walldorf, Germany-based SAP "on a global

See CAREER/page 14

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Summit frames health care as business issue

Presentations, visual aids illustrate skyrocketing costs of coverage

By JOANNE WOJCIK

COLUMBIA, S.C.—Chris McSwain, SCANA Corp. director of compensation and benefits, knew almost instinctively that the only way he was going to win upper management's support of his plan for remedying the company's health care ills was to speak their language.

But he also knew he'd have to get them to see things his way.

Sneakers were the answer, he decided.

When SCANA's top 300 managers gathered in Columbia, S.C., for the company's biannual leadership meeting, he asked them all to wear sneakers. And they did.

There also was a distinct difference in the agenda. Instead of the usual litany of business issues, the daylong meeting focused on one: health care. For many, news of the company's spiraling health care costs came as a surprise.

"None of this was known," he said, when he joined as director of compensation and benefits.

But Mr. McSwain realized the problem after only about a month in the job. A short time later, he made a formal presentation to the company's senior leadership, including Bill Timmerman, SCANA's chairman, president and chief executive officer, to warn them about the impending crisis: Over the prior three years, health care claim costs had increased a total of 201%.

Then he also showed them the trend line if they took no action.

"Even with conservative projections based on historical trend, health care would become unaffordable," he said. "The day after that, the chairman went to the head of communications and said, 'I want a health care summit.' So they came to me."

Mr. McSwain worked with SCANA's corporate communications department to create an agenda for what would be the company's first health care summit. He also asked Helen Darling, president of the National Business Group on Health in Washington, to be a

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Career: Varied background hones expertise

Continued from page 12

basis."

In accepting the assignment, Mr. McSwain learned more about technology and implemented a data quality and information function.

Mr. McSwain's tenure at Reichhold was short-lived, though. After two years, a significant financial change in the business led to divestitures and workforce reductions.

"I was in Mexico and had people who reported to me from other countries. I was there to get the international experience. When I came back, I went to my boss and said that I didn't think the team was necessary based on the company's financial situation. The only thing I asked was that I stay long enough to find work for the members of my team."

Mr. McSwain was successful in placing everyone but himself and one other staff member.

After he left Reichhold, Mr. McSwain still had some contacts in the human resources field. "I called a contact I had met while looking for the Reichhold job, but he was no longer with the company," he recalled.

But the person who took his call suggested he apply for an opening at SCANA, which he did.

"I hadn't been to South Carolina for 20 years," Mr. McSwain said. But, being from Charleston, S.C., he found such a move attractive. He and his wife, Jemmy Lea, also had family in the area.

Mr. McSwain's introduction to SCANA turned out to be almost as tumultuous as his final days at Reichhold. He was interviewed by the senior vp of HR, who had already announced he was leaving the company. In addition, SCANA had not yet filled another position to which Mr. McSwain was to report.

Starting in September 2003, Mr. McSwain had a total of three bosses before Joe Bouknight was hired six months later as senior vp of human resources.

Mr. McSwain said that, in some ways, the lack of direct management oversight may have worked in his favor, because it gave him the freedom to act autonomously.

In fact, SCANA's management structure is somewhat flat, with little corporate hierarchy, he said. Mr. McSwain reports to Mr. Bouknight, who reports directly to William B. Timmerman, SCANA's chairman, president and chief executive officer.

"We are large enough to matter, but we're small enough to where I'm much more like a cruiser in the water than a battleship or an aircraft carrier like employers 10 or more times my size," Mr. McSwain said.

Mr. McSwain also said he believes the speed of the changes at SCANA demonstrates just what can be done when corporate culture fosters ingenuity. "We are walking evidence that you can do some pretty innovative things in a short period of time," he said.

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Summit: Numbers-driven message connected with senior management

Continued from page 14

speaker. It was one of the few times in the company's history that an external speaker was permitted to address a leadership team meeting.

Sara Delk, wellness program administrator, put together numerous health fair type displays, including a plastic food pyramid, a rubber blob that represented five pounds of fat, a scale, a blood pressure monitor and brochures on various health topics.

In addition, she spent about a week researching informational cards that would be placed on the buffet table listing the nutritional content of all of the food that was to be served at the meeting.

The health care summit was divided into two parts, the first describing the current state of SCANA's health care cost situation, and the second showing what the future could look like if they intervened.

Mr. Timmerman spoke first, while Joe Bouknight, senior vp of human resources, followed. They both were armed with visual aids created under the direction of Mr. McSwain.

Among the charts Mr. Timmerman used to address the group was one listing the top 25 drugs being taken by SCANA employees, retirees and dependents, which he read from top to bottom, stopping to talk a little bit about each medication.

> "Chris saw this 'perfect storm' that was brewing out there. If we didn't do something, we would have had to make some really hard calls, cutting health care or cutting some other things because we simply could not afford it."
>
> **David N. Simmons**
> **SCANA Corp.**

"He went over by 45 minutes," Mr. McSwain recalled. "He used every chart we gave him."

"Our CEO really made it a challenge, just as he might with a new operational project or a new plant," said Therese Griffin, manager of corporate communications, who collaborated with Mr. McSwain on SCANA's health care summit. "He made health care and the importance of living a healthy lifestyle a business issue. In the past, it was more of an HR issue."

The health care summit was "a turning point for us as a department and an organization to have that kind of support. And from that point forward, every leadership meeting has had a lot of the things that are going on in this department as part of that agenda," said David N. Simmons, manager of Total Rewards, who reports to Mr. McSwain.

"Chris saw this 'perfect storm' that was brewing out there. If we didn't do something, we would have had to make some really hard calls, cutting health care or cutting some other things because we simply could not afford it," Mr. Simmons said. "Being a regulated business, it would require us going into our rate commission and asking them for more money so we could pay for health care, and that was unacceptable."

But, more importantly, Mr. McSwain knew how to translate what was happening into dollars and cents.

"Chris put it in terms that management could really appreciate and take action on," Mr. Simmons said.

Talking the talk

For example, when describing the amount that SCANA spends annually on compensation and benefits, Mr. McSwain describes it as being equivalent to the cost of building "a dam and a half."

"He was able to communicate that to senior management so that they could appreciate the magnitude of what we were talking about," Mr. Simmons said.

"You look at your senior staff, and they're very numbers-driven. When they know it's affecting their bottom line, that brings it to the forefront," Ms. Delk agreed. "Chris was successful in persuading senior staff to look at the numbers and see what poor health was costing the company, not only in terms of benefit costs but in lost productivity."

"HR has a 'fluffy' feel to it. But I wanted to demonstrate that this is about business," explained Mr. McSwain. "We were presented with business problems and business challenges. We jumped in and changed our trend line dramatically in less than two years in a coordinated and intentional manner by combining the best of what everybody can do and putting it together in one place."

"Every $1.8 million is worth a penny to our stock," Mr. McSwain estimated. "When I can turn what was headed north and change its slope, imagine how much electricity and gas we don't have to generate and pump to make that kind of profit. So these are, in very real ways, adding money to our bottom line."

Although no other health care summits are planned, health care is now a regular topic at the leadership team meetings, Mr. McSwain said.

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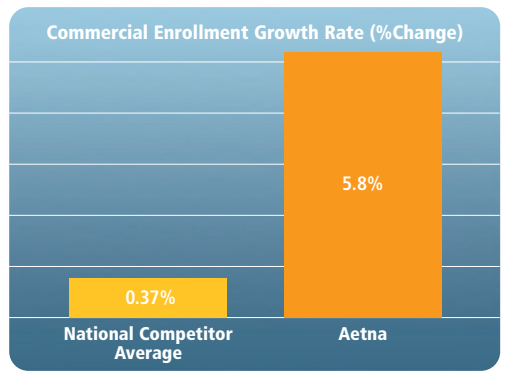

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-2005125

Consumerist incentives yield savings for SCANA

Surcharge on working spouses and retirees is unpopular but effective

By JOANNE WOJCIK

COLUMBIA, S.C.—To curb its spiraling health benefit costs, SCANA Corp. made several plan changes that it hopes will encourage its employees to become more careful consumers of health care.

The Columbia, S.C.-based utility company also introduced a care management program that integrated and lowered the cost of the company's short- and long-term disability programs by returning employees to work quicker after non-occupational illness and injuries.

"Our engagement is by offering a carrot, using the incentive as a positive reinforcement of the behavioral change we want to see come back from our people," explained Chris McSwain, director of compensation and benefits.

For example, one of the consumerist incentives—forgoing an increase in the premium contributions for employees who took an online health risk appraisal—was offered in the hopes of making employees take better care of their health.

"It's all about awareness, education and change," observed Joe Bouknight, senior vp of human resources.

"We've done all this to get everybody's attention," said Mr. Bouknight, who predicted that the health risk assessment will "raise everybody's awareness." The company must then be prepared to provide the education and support to help its employees make lifestyle changes, he said.

More than 85% of SCANA's employees took the health risk assessment, which was offered during open enrollment this fall. The employees who did not take the health risk assessment will see their 2006 premium contributions increase 12% from what they were in 2005.

Another consumerism-oriented change, though, has been less popular: a surcharge of $45 per pay period for employees whose working spouses have the opportunity to enroll in their own employers' health plans but choose to enroll in SCANA's instead. Retirees are charged $100 per month for the same privilege.

"It's been very difficult for employees to accept," said Teresa L. Brown, supervisor of compensation administration, who noted that she gets at least two calls each week from employees asking for refunds.

"This was probably the biggest change we did," acknowledged Mr. McSwain. But, based on research he conducted, Mr. McSwain found that the surcharge had the potential of reducing SCANA's benefit plan costs significantly.

Carrots...and sticks

SCANA Corp. has achieved big cost savings through consumer-oriented incentives, including:

- Freezing the level of health care premium contributions for employees who take an online health appraisal.
- Levying a $45 per pay period surcharge on employees whose working spouses have access to another employer's health plans.
- Placing a similar $100 per month surcharge on retirees.

"It's been well documented," he said, pointing to Ford Motor Co. as an example. "Ford did plan audits and pulled 50,000 people out of the medical plan that weren't eligible."

SCANA offers its employees a choice of four plans, all of which are self-insured and administered by Bloomfield, Conn.-based CIGNA HealthCare: a catastrophic plan with a $1,700 individual deductible and a $2,200 family deductible; a traditional indemnity plan with 80/20 coverage above an $800 individual deductible and a $1,400 family deductible; and two preferred provider organization plans with either a $25 or $15 co-payment. In addition, employees receive prescription drug coverage, also administered by CIGNA.

A change in the prescription drug co-insurance that takes effect in January 2006 will provide an incentive to use SCANA's in-house pharmacy, which already has been saving the utility company money by eliminating the middleman in the drug purchasing chain (see story, page 22).

Beginning next year, employees who take their prescriptions to retail pharmacies will pay 20% of the cost for preferred drugs and 40% of the cost for nonpreferred drugs, based on SCANA's formulary.

Because the co-insurance will be based on the price charged for the individual medications, "it will behoove employees to shop around

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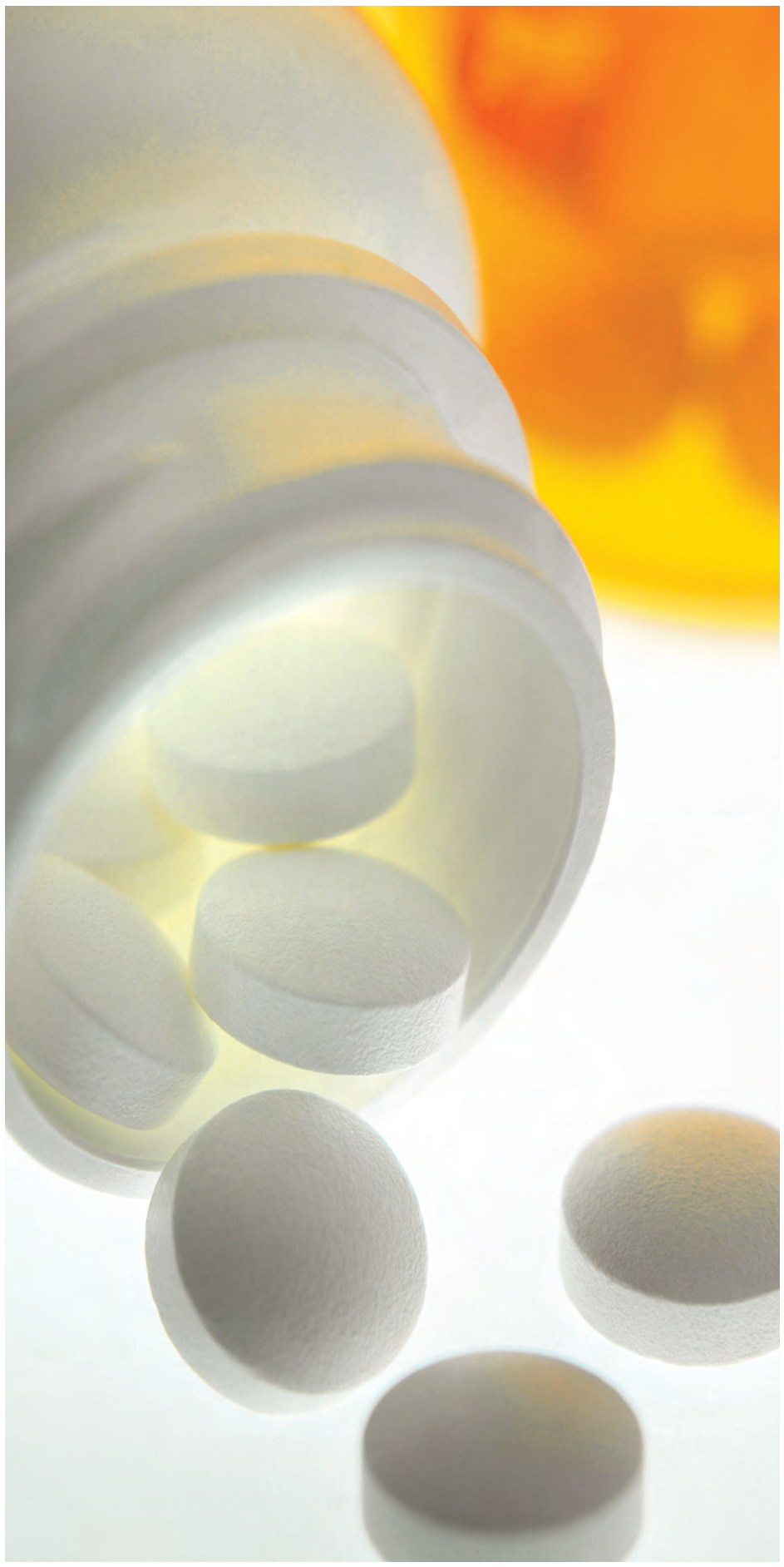

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Medicare eligibility sets options for retirees

COLUMBIA, S.C.—Like many companies that offer retiree health benefits, SCANA Corp. faces the challenge of keeping those costs in check.

"There are two driving forces," explained Chris McSwain, director of compensation and benefits for the Columbia, S.C.-based utility services company, which provides health benefits to approximately 1,900 retirees and their dependents. The Medicare prescription drug plan is scheduled to go into operation in January 2006, Mr. McSwain explained, and SCANA has reached the cap it had placed on contributions to retiree health benefits to help it comply with Financial Accounting Standard 106.

Under FAS 106, which took effect in 1995, companies can no longer account for their retiree benefit costs on a pay-as-you-go basis; they must accrue the present value of all future retiree health care liability on their financial statements. In response, many employers, including SCANA, implemented caps to limit their ret health care liabilities and annual expenses (*BI*, Sept. 29, 2003).

Between November 2004 and June 2005, Mr. McSwain worked with a team of SCANA directors and officers to develop a multiyear strategy that addresses benefits for current Medicare-eligible retirees as well as current employees who will be eligible for health care benefits after they retire.

The strategy, which goes into effect on Jan. 1, 2006, will give Medicare-eligible retirees three choices: a traditional preferred provider organization-style plan, a catastrophic plan and a prescription drug-only plan. Retirees who are not yet eligible for Medicare have two choices: the PPO or the catastrophic plan.

—By Joanne Wojcik

Changes: Generics linked to disease management

Continued from page 18

for pharmacies with the best prices," explained Rachel Bourke, supervisor of benefits administration. "Employees will have to know the retail costs of both preferred and nonpreferred drugs," she said.

But employees who use SCANA's pharmacy will pay only a 15% coinsurance charge for preferred drugs, 35% for nonpreferred drugs and tiered dollar amounts for generics. In cases where the generic costs less than the co-payment, the retail price applies.

Because SCANA's pharmacy charges less than retail pharmacies, it is hoped that more employees will use it, as well as the intercompany prescription drug mail order service.

SCANA also offers free generic drugs for some chronic conditions to encourage employees with those conditions to participate in disease management programs.

Mr. McSwain said he got the idea for the program from Pitney Bowes Inc., the Stamford, Conn.-based mailing and document technology company. Pitney Bowes conducted a study that found compliance with treatment protocols was very low among its diabetic employees. "To encourage compliance, they made generics free," Mr. McSwain explained. And it worked.

PHOTO:MICHAEL MARCOTTE

In-house pharmacist Catherine Peebles works with SCANA employees, who can receive some generic drugs for free by taking part in wellness programs.

So, in 2005, SCANA launched its own targeted generics program, in which diabetics who enroll in a disease management program receive their insulin, oral generic prescription drugs for diabetes and diabetic supply kits free.

In its cardiac care disease management program, SCANA gave coupons to participants to receive a free 30-day supply of an ACE inhibitor for hypertension to encourage individuals to switch to generic from brand-name medication. Participants were also offered a free generic alternative for cholesterol management.

To determine which disease management programs to invest in, Mr. McSwain worked with CIGNA and his benefit consultant, Paul Goldbeck, senior vp at Aon Consulting in Winston-Salem, N.C.

"We wanted to use the budget in the most effective way," Mr. McSwain said. "We found that making the diabetic supplies free, it would cost a certain amount. But we didn't have enough money in the budget to make all generics free for the blood pressure problems."

"We had 867 people enrolled in the diabetics Well Aware program, but only 654 in the cardiac Well Aware program. There were more people I could impact positively in the diabetics program," he explained.

Two other changes that SCANA implemented in 2005 to reduce its health benefit costs were to switch to a lower-cost provider network and adjust co-payments for emergency care.

After conducting some analysis, Mr. McSwain found that switching to a different network that provided the same quality of care but offered deeper discounts would save the company a considerable amount without forcing it to make radical changes in plan design. "It was just money laying on the table that nobody ever went after," he said.

The changes in co-payments for the use of emergency care and specialists was intended to make SCANA's employees "think more like consumers," Mr. McSwain said. "We looked at the data and saw that, by making a few minor modifications, we could gently influence people's behaviors," he said.

Among the changes: The co-payment for using a hospital emergency room was set at $100; for a specialist visit, $50; for a primary care physician office visit, $25; and for the use of an urgent care clinic, $75. Previously, the co-payment for the use of any of these services was $50.

Mr. McSwain determined it was necessary to integrate SCANA's short- and long-term disability management programs after conducting a clinical review of the company's disability claims.

"We wanted to introduce care management, but our plans were in disarray," he said. "Short- and long-term disability were disintegrated. Nonoccupational disability wasn't being managed. Approvals for STDs were done by a clerk without any clinical background, and virtually everything was approved." Furthermore, he said, "supervisors and the safety community were involved when they shouldn't be."

The New York office of the Westminster, Colo.-based Reed Group was selected to manage and integrate SCANA's short- and long-term disability benefit programs as of last February.

The new process ensures that employees receive appropriate, high-quality care and return to work as soon as possible, while preserving the face-to-face communication between employee and supervisor.

The Reed Group will become the central authority for managing the non-occupational illnesses and injuries requiring time off. In addition to monitoring medical protocol, Reed will keep in regular contact with the treating doctors and maintain communication with the employee. "Reed was selected because they're very good at a high-touch model," Mr. McSwain explained.

The change went virtually unnoticed by those who really needed the benefits, he noted. "We've defined everything that we're doing in benefits around total health and productivity," he said. "Everything falls into one of three buckets: health management, plan management or vendor management."

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SCANA's plan members value onsite resource center

Open-access facility aims to treat 'whole person'

By JOANNE WOJCIK

COLUMBIA, S.C.—The LiveWell Resource Center is the manifestation of the improvements SCANA Corp. has implemented to help its employees, retirees, as well as their dependents, better manage their health.

Housed in a 2,000-square-foot converted computer server room in the electric and gas utility company's downtown Columbia, S.C., headquarters, anyone who is covered by SCANA Corp.'s benefit programs is welcome to use the facility, which is open during regular business hours.

The LiveWell Resource center offers wellness education programs, life assistance services, behavioral health counseling, health coaching, a lactation room for nursing mothers and a pharmacy. It also has two computer kiosks set up to access HealthSmart, both of which have their monitors built into the desktops facing up to ensure that only the user can view the pages that are displayed. And a ceiling-mounted television set plays a regular stream of health videos similar to those often shown in doctors' offices today.

Creating the resource center was like "building a house," said Christina Rice, benefits analyst and resource center project manager. "There was no map" to use as a guide.

The entrance to the center is marked by a slate wall fountain that bears the company name but also is indicative of the sense of calm that awaits those who enter.

"Everybody loves the resource center. They love the mood. It's so quiet down there. The lights are dimmed," says Crystal Smith, administrative assistant in the resource center. In addition to manning the reception desk, she also responds to e-mail queries sent to the center and tracks the usage of all of the health resources it provides.

One service that has become more and more popular since the resource center opened in July 2005 is the corporate owned and operated pharmacy, which, in addition to dispensing most brand and generic medications also serves as a mail-order pharmacy, packing and shipping prescription drugs to other SCANA offices via inter-company mail. The pharmacy also provides one-on-one pharmacological counseling (see related story).

But perhaps the resource center's greatest objective is to encourage people to use the former employee assistance program, which has been renamed "Life Assistance."

"We are setting our model up so we have pharmacy, wellness and life assistance all in one place so that it becomes more acceptable by the employee base. Much of our medical and pharmacy costs are rooted in behavioral issues," explained Chris McSwain, director of compensation and benefits.

Unfortunately, "people are so skeptical of that particular area, and it's very confidential, and having it in the resource center we've had a hard time getting people to use that particular area. They don't want to be seen using Life Assistance," said Sara Delk, wellness program administrator.

As of the end of October, 1,861 employees made a total of 6,054 visits to the resource center.

It is Ms. Delk's job to de-stigmatize Life Assistance among SCANA's largely middle-aged male workforce. She meets regularly with CIGNA Behavioral Health to address this challenge.

Ms. Delk also meets regularly with staffers from SCANA's corporate communications department to develop programs to try to achieve that objective.

Instead of a fitness center as its centerpiece, as at many corporate health centers, the LiveWell Resource Center has a "multipurpose room" that can be used to hold health education classes and meetings. The room has a wall of windows that bring in outside light. Below the windows are cabinets that contain items that are used for certain health demonstrations, such as a Lucite food pyramid containing plastic replicas of healthy food items, a blood pressure monitor and rubber blobs of fat and lean muscle.

In addition to on-site counseling, the pharmacist and health coach also travel to remote locations to provide in-person counseling.

Because SCANA's workforce is scattered throughout three states, "our model had to be more of a traveling model," Ms. Delk said.

PHOTO: MICHAEL MARCOTTE

SCANA's LiveWell Resource Center is popular among workers. The facility offers behavioral health services, a pharmacy and other services.

SCANA has more than 60 locations of varying sizes. One has only three employees.

Another reason a fitness center wasn't included in the resource center was the fact that SCANA already has fitness centers in seven different locations, and one more is planned for next year. In addition, Mr. McSwain is seeking board approval for funds to add one fitness center each year. Though employees in the headquarters don't have their own onsite fitness center, they receive a discount to use the YMCA across the street.

"We want to treat the whole person," Mr. McSwain said of the LiveWell Resource Center.

"We hold employees accountable for certain aspects, like taking health risk appraisals, using positive reinforcement. The health assessment data is essential to understand the risk across the enterprise," he said.

"At the end of the day, we think good health is free, and part of the message is that we were building into this for our employee base is that this is a win-win," he said. "The company has taken extraordinary measures consistent with our values, caring for each other, doing what is right."

In-house pharmacy delivers results

By JOANNE WOJCIK

COLUMBIA, S.C.—Chris McSwain, director of compensation and benefits at SCANA Corp., thought he would meet some resistance when he approached three state pharmacy boards for permission to open an in-house pharmacy.

Surprisingly, the boards liked the idea.

And when Mr. McSwain suggested that SCANA also might implement an intercompany prescription drug mail-order service for its employees in those states, the boards gave the green light to that idea as well.

"Probably the single most important piece of that puzzle was getting approval from the pharmacy boards in three states to be able to deliver the meds through the company mail," said Joe Bouknight, senior vp of human resources, who is Mr. McSwain's direct supervisor.

But "they liked the clinical counseling piece, they liked the fact that it was in-state, and that there would be a local pharmacist hired to run it," he said.

"They said, 'This is far better than most of the mass-merchant models where the money's all going out of state, the pharmacist never makes eye contact with the patient. You're actually doing a good thing,' " he recounted.

In fact, the South Carolina board even recommended someone to

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Pharmacy: In-house facility helps cut drug costs while improving care for workers

Continued from page 22

run it: Daniel Bundrick, a licensed pharmacist with 21 years' experience.

Sheila Young, compliance manager for the South Carolina Board of Pharmacy, said she recommended Mr. Bundrick because he agreed with her philosophy about the role pharmacists and pharmacies should play in the medical delivery system.

"Pharmacies shouldn't be like a fast-food place. It should be concerned with counseling patients on drugs and disease states. Daniel had the same idea," she said. "We should push back the clock 20 years so pharmacy is like it used to be."

In the past, before pharmacies evolved into giant retail chains, people often went to their local pharmacies to ask medical advice before they would make an appointment with a doctor, she explained.

Ms. Young also said she recommended that Mr. Bundrick be hired before the pharmacy was built so that he would be involved in the project from the beginning.

Mr. Bundrick agreed. "It's a unique model. This is pharmacy the way it was meant to be practiced. I'm not just dispensing medicines like an assembly line," said Mr. Bundrick, who joined SCANA in February 2005 to help build and run the pharmacy project.

Mr. Bundrick's office, which is connected to the rear of the pharmacy itself, has a separate entrance accessible from the resource center so that he can provide in-person counseling. He also offers phone counseling and responds to online queries via SCANA's AskaPharmacist Internet portal. He estimates he spends about 2 hours doing phone counseling, an hour doing AskaPharmacist and about 4 hours doing face-to-face counseling.

Among other things, Mr. Bundrick advises plan participants on the availability of generic equivalents for high-cost brand-name drugs, whether they can split pills to save money and, in some cases, even notifies them when generics become available for the higher-cost drugs.

Because of the change in prescription drug coverage taking place in January 2006, the most popular queries generally involve pricing—how much employees will be paying next year for the drugs they currently use.

"The biggest thing I've found here, and this is a very educated workforce— engineers, that sort of thing—what I've found is a lot of people do a lot of research on some things, but their health care, sometimes they don't," Mr. Bundrick observed. "The other comment I hear is, 'I've never talked to a pharmacist this long.'"

Mr. Bundrick's staff includes a pharmacy technician, Jackie Kelly, and a 20-hour-a-week pharmacist, Catherine Peebles. They are in the process of hiring another full-time technician and receive occasional help from pharmacy students at the University of South Carolina.

Since the pharmacy opened in July 2005, the volume of prescriptions has increased steadily.

Only two months after opening, the pharmacy was "filling 53 prescriptions per day....That's great for a new pharmacy. I know of a new pharmacy in Camden (a town near Columbia), and they're only filling about 15 a day," Mr. Bundrick said. As of last month, SCANA's pharmacy was averaging more than 100 prescriptions per day.

Chris McSwain, SCANA director of compensation and benefits, said he got the idea for the pharmacy after making a site visit to Caesars Entertainment Inc.'s resource center in Las Vegas—now part of Harrah's Entertainment Inc.—which has a pharmacy that dispenses generic drugs only free of charge to company employees, Messrs. McSwain and Bundrick decided their cost savings would be even greater if SCANA's pharmacy dispensed both brand and generic drugs.

Mr. McSwain also decided that rather than subcontracting with a prescription benefit management company, as Caesars did, that SCANA would own and operate the pharmacy itself, thereby eliminating the middleman that can add to the cost of prescription drugs. SCANA also contracts directly with a prescription drug wholesaler.

"There's a lot of money in the pharmaceutical supply chain," and by eliminating the middlemen, SCANA is filling some prescriptions for as little as 60 cents, Mr. McSwain said.

PHOTO: MICHAEL MARCOTTE

Pharmacist Catherine Peebles, left, and pharmacy technician Jacqueline Kelly work at SCANA's in-house pharmacy.

But "although we are saving money by purchasing closer to the source, it is the counseling that is the greater opportunity," he said. "We believe behavior change probability increases when there is face-to-face counseling than by telephone or e-mail."

Initially, instituting intercompany mail-order was somewhat challenging, said Mr. Bundrick. "When we found out some of the mailboxes at some of the locations were outside, we had them moved inside. So there was a lot of work upfront," he said.

But this ended up providing a side benefit.

"I think it helped our overall mail system. It got them more staff. It made it more secure," he added.

"There was no hurdle there that was without a solution," said Mr. Bouknight. "We ended up buying another car and hiring another courier. We just staffed up a little bit to make sure we could get the meds within 24 hours to almost everybody in the company, and, with few exceptions we were able to accomplish that."

A rigid system of checks and balances was established to track the mail-order service, Mr. McSwain said.

"There is a bar-coded label on each prescription that is scanned by hand-held computer and distributed via interoffice mail, where it is scanned again" when it arrives at its destination, he described. "At the end of each day, the handhelds are then read to determine how many prescriptions were filled."

And to use the intercompany prescription drug mail-order service, employees first must complete several privacy and permission forms. But the service is voluntary; those who are not comfortable with it can continue using either their local pharmacy or a mail-order program through CIGNA HealthCare.

About 75% of intercompany mail-order prescriptions are for employees; the remainder are for dependents. However, in some rare cases, retirees who have a relationship with a co-worker at their former plant also use the service, Mr. Bundrick said.

SCANA health site helps employees stay informed, crunch numbers

COLUMBIA, S.C.—The health information Web site that SCANA Inc. provides to its employees, retirees and their dependents is a virtual health resource center in itself.

"HealthSmart," which was developed by Aon Consulting, hosts the utility company's health risk assessment tool, taps into online information source WebMD to access information on health conditions and treatment options, including various types of medications that may be prescribed, and has several built-in calculators to help employees manage their health care spending.

An employee can plug in his or her projected health care utilization over the year—such as the anticipated number of in-network and out-of-network doctors' office visits and the likely number of prescriptions and whether they will be generic or brand name-to estimate the cost of care to determine how much to put in a flexible spending account. Then, if the employee also inputs his or her annual income, the calculator will estimate the potential tax savings from using an FSA.

Another calculator allows an employee to compare his or her potential out-of-pocket costs in each of SCANA's health plan offerings to help determine the plan best suited to the individual.

"You can take your 2005 medical needs and, for example, you went to the doctor 15 times, and you took your kids two or three times, and the system will help you figure out which plan is the most cost effective for you and your family," explained Rachel Bourke, supervisor of benefits administration.

HealthSmart also has a tool to compare the cost of generic with preferred brand name and nonpreferred brand name medications. Usage of that tool is expected to increase after SCANA's change in prescription drug coverage takes effect next year (see story, page 20).

"If you go to Google and put in 'diabetes,' you get 2 million hits. This is one place where people could go where they or a family member can look up more specific information about their health condition or to track their health if they are setting goals," explained Chris McSwain, SCANA's director of compensation and benefits.

—By Joanne Wojcik

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SCANA health coach helps plan members get in shape

By JOANNE WOJCIK

COLUMBIA, S.C.—Weight loss is the most popular reason for SCANA Corp. employees to seek the help of Health Coach LaTonya Davis in the LiveWell Resource Center.

It's also a topic near and dear to her heart.

"I have a lot of family members who are obese and have health issues and I want to help them, and I need to know how, first, and also I don't want to end up the same way," she said.

Ms. Davis is eager to help SCANA employees, and tries to be sympathetic despite her own youthful state of physical fitness. This is only her second full-time job since graduating from Berea College in Kentucky, though part of her degree program required her to work 10 hours per week in a field related to her discipline. During college, Ms. Davis worked as a personal trainer on campus. Before coming to SCANA as an independent contractor on May 31, she worked at the University of South Carolina. She officially became a SCANA LiveWell Resource Center employee in August.

Often, SCANA employees ask Ms. Davis about the value of diet pills and other products on the market.

"We call it nutritional quackery," she said, adding that much of the time she finds herself having to dispel diet and exercise myths, such as concerns among women that they will become "bulky" if they lift weights or that a low-carbohydrate diet will enable them to keep weight off permanently.

To increase her visibility, Ms. Davis takes to the road and visits other SCANA locations two to three days each week.

She said it is usually more challenging to recruit severely obese people because often they may overeat because of emotional issues. In those cases, she refers them to SCANA's Life Assistance program so that the cause of the problem is addressed in conjunction with her diet and exercise coaching.

After an initial consultation, if an employee decides to use Ms. Davis' services, he or she must first complete a questionnaire, called "Healthtrac" to gauge their current health status. So far this year, 88 people have had consultations with Ms. Davis, and 4,107 have completed Healthtrac assessments.

The form includes questions on current physical activity readiness, such as whether the employee has a heart condition, bone or joint problems that may require limitations. Employees also list any medications they are taking and for what conditions. It also asks whether an individual is over the age of 45 and not currently exercising, whether the person is pregnant, uses tobacco products and whether there is any history of cardiovascular disease in anyone under the age of 50 in their immediate family.

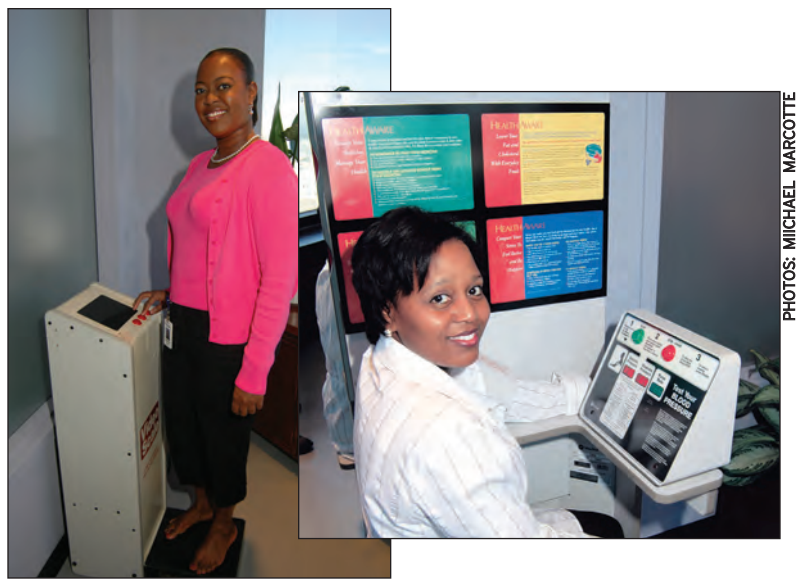
The questionnaire also covers nutrition and other health behaviors, such as which meals people generally eat as well as how many servings of fruit and vegetables, red meat, fish, poultry, water and alcoholic beverages they have each day.

The health behavior form goes so far as to ask how the individuals prepare meals, what their favorite snack foods are and how often they snack each day.

After reviewing the responses, Ms. Davis works with the employee to create a lan that works for their individual lifestyle and helps them reach their goals, which also are worked out together.

If it is needed, Ms. Davis encourages the employee to receive approval and instructions from their doctor, which she also uses in tailoring the program.

Like the other members of the LiveWell Resource Center team, Ms. Davis also has metrics to track and report back to Chris McSwain, director of compensation and benefits. They include the number of consultations, Healthtrac assessments completed, presentations she conducts, referrals she makes to the pharmacy and referrals she makes to Life Assistance.



PHOTOS: MICHAEL MARCOTTE

Taranda Frost, senior benefit analyst, demonstrates the weigh-in scale at SCANA's LiveWell Resource Center. Inset, Rachel Bourke, benefit administration supervisor, tries out a blood pressure machine in the health center.

Benefit 'dashboards' aid SCANA's drive to cut costs

By JOANNE WOJCIK

COLUMBIA, S.C.—As a scientist, it was only natural that Chris McSwain, director of compensation and benefits at SCANA Corp., would develop his own system for measuring the performance of the various company benefit programs.

Mr. McSwain's team is taking a running tally of everything from how many employees, retirees and their dependents visit the LiveWell Resource Center, to how many referrals are made to the health coach and even how many pill splitters are issued.

Crystal Smith, administrative assistant in the LiveWell Resource Center, has perhaps the largest number of metrics to collect. Among them are: the number of speakers' bureau requests and number of presentations given; the number of employees attending the presentations; the number of video, book and brochure requests; the number of e-mails to AskLiveWell, the resource center's e-mail address, which Ms. Smith is responsible for monitoring; the number of appointment requests through AskLiveWell; and the number of total phone calls to the resource center.

She also tracks usage of the HealthSmart Web site, using reports provided by the vendor that include such information as the number of unique site visits; number of registered users; the most popular areas of the site visited, such as weight, blood pressure control, cholesterol, men's health, women's health, etc.; and how many visitors are using the medical cost comparison tools, plan comparison tools and/or medication comparison tools.

"It tells me every page they went to—say, 10 people went there; five went there," she said.

On a monthly basis, Ms. Smith also is responsible for obtaining the pharmacy metrics collected by SCANA Pharmacy Manager Daniel Bundrick; the wellness metrics from Health Coach LaTonya Davis; and Life Assistance metrics from Sara Delk, the wellness program administrator.

Careful measuring

The metrics Mr. Bundrick collects include the total expenditures for prescriptions as well as the number of: prescriptions filled; generics; consultations and/or interventions provided by the pharmacy; AskAPharmacist queries, which he is responsible for answering; prescriptions switched from preferred/nonpreferred to generic; pill splitters issued; seminars conducted; referrals to the health coach, Life Assistance or to the CIGNA PBM; and drug interactions found.

> "If some senior exec asks, 'How do we know this is actually making a difference?' I've got data."
>
> **Chris McSwain**
> **SCANA Corp.**

Among the metrics Ms. Davis collects are the number of: consultations; Healthtrak assessments completed; presentations conducted; and referrals to either the pharmacy or to Life Assistance.

Ms. Delk collects metrics on the number of: Life Assistance consultations; referrals to CIGNA Behavioral Health counselors; calls to the toll-free assistance line; and referrals from Life Assistance to either the pharmacy or the health coach.

All of these metrics are assembled into a single, color-coded chart that is presented monthly to SCANA's top management, with a running tally of the services used, benefit costs and any other measurable information.

In fact, these monthly "dashboards," as they have been dubbed, are what led Joe Bouknight, senior vp of human resources, to write the letter nominating Mr. McSwain for the *Business Insurance* Benefit Manager of the Year competition.

That's how he and other members of senior management discovered that the 201% increase in health care spending that had occurred over the three years before Mr. McSwain joined SCANA was reversing itself, Mr. Bouknight said.

"When I first heard about the opportunity (to nominate Mr. McSwain), my initial reaction was maybe we're a year early. But when we put together a list of everything that was accomplished," that provided the impetus, Mr. Bouknight said.

"If I were not really comfortable that this stuff is going to work, I wouldn't have written the nomination letter. But we're getting so much positive feedback within the company. The volume in the pharmacy is steadily increasing. The health coach is engaging people. We were absolutely amazed by how many people have already gone online and did the health risk assessment (85% by late October), and they're doing it candidly, because there is a high percentage of people at risk," he said.

Evidence of success

Indeed, tracking the volume of people going into the resource center, as well as the services they are using, and health care costs, is making it easier to demonstrate the value of the changes to SCANA's management, Mr. McSwain said.

"So if some senior exec asks, 'How do we know this is actually making a difference?' I've got data.

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Data warehouse to sharpen analytical tools

By JOANNE WOJCIK

In a rare public/private partnership, SCANA Corp. is working with the University of South Carolina to build a health and disability claims data warehouse that will be used to develop interventions to keep SCANA's workforce healthy and productive.

Chris McSwain, SCANA's director of compensation and benefits, said inspiration for the project came from a program he had read about at Pitney Bowes Inc. in which diabetics received access to free generic medications after data mining showed that many were not following standard treatment protocols.

"That's the sort of key learning that we expect to get from this. Data operates in silos. Certain patterns won't be seen until the data is put in one place, such as the state of individual health, risk factors and the claims associated with them," he explained.

"Turning data into knowledge, into information, into action. That's our plan. The next step is to take all the health and productivity-related data and put them in one place. Analysis of the data will tell us where we need to go."

With the University of South Carolina virtually "in our backyard—I can literally throw a rock and hit their campus," Mr. McSwain said, it was only natural that SCANA take advantage of what the school had to offer. He said SCANA will also work with the university to apply for grants to fund much of the research.

The data warehouse is expected to be completed and ready for use during the next cycle of benefit contract negotiations, according to David Hoke, manager, total health and productivity at SCANA and the data warehouse project manager.

"Our goal is to get everything done so that the first quarter of next year we'll have all the data to analyze for the '07 benefit year. Our planning cycle is the first quarter to middle of the second quarter," he explained.

The data warehouse will include all of SCANA's medical and pharmacy claims data, the results of the health risk assessments taken during this year's open enrollment,

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Metrics: Usage study leads to surprising find

Continued from page 26

It's important to demonstrate the value this adds, and there are so many new things that we're doing, we want to measure how things are working so we know where to make adjustments and direct changes."

Mr. McSwain also is using the findings of his data collection project as leverage to improve the service provided by the company's various benefit plan vendors, which ultimately should produce even more improvements in the health and well-being of SCANA's employees.

For example, when Mr. McSwain compared the pharmacy metrics with the usage of behavioral health care services in the resource center, he found a discrepancy.

"Of all the areas that we measure in the LiveWell Resource Center metrics, the least-performing is behavioral health. But when we look at the top drugs dispensed by the pharmacy, No. 5 and 6 are antidepressants," he said.

Armed with this data, Mr. McSwain approached CIGNA Behavioral Health, SCANA's mental health care vendor, and asked the company to improve its service model.

"The best of their thought leaders will figure out what they need to do to their service model to change it so we can tap more effectively into the demand that we know exists by our pharmacy data," he said.

"That is how measuring things in one area has helped me more effectively partner and manage the vendor on another side. I never would have known that if hadn't been looking at my pharmacy spend and measuring the utilization of the behavioral side of the resource center," Mr. McSwain said.

Powerful message empowers employees

Marketing strategy seeks to highlight positive changes

By JOANNE WOJCIK

COLUMBIA, S.C.—After getting the green light from SCANA Corp.'s upper management, Chris McSwain, director of compensation and benefits, knew he would also need an employee mandate for the benefit program changes he was implementing to be effective.

So he worked with SCANA's internal corporate communications department to develop a marketing strategy that would make employees feel like the benefit program changes and additions were being made in their best interest.

"Communications was a really big thing for us," he said. "We wanted our people to be better consumers, take control, feel responsible, we're all in this together, not the company's problem to figure out, it's all of our problems to figure out."

It was also important "to help people understand that these things that we're doing are things that we're doing *for* them, not *to* them," he added.

"Those simple words have just been so powerful for us as we go about the things that we are doing and the culture change that we're in the middle of," Mr. McSwain said.

Using SCANA's internal communications and marketing people also helped to reinforce that message, according to Therese Griffin, manager of corporate communications.

"We really felt if we could participate on the front end and get an understanding of what the goals and objectives were for the health and productivity strategy we would be able to support his needs," she said. "It also lends some credibility to what we're doing. The message is coming from within the company rather than from the outside."

The communications team that Mr. McSwain has assembled is headed up by Ms. Griffin and Nicole McLean, a communications specialist who also supports human resources. To develop strategy, the two meet regularly with the benefits team and any vendors that may be necessary for addressing particular topics. SCANA also uses SCANA's internal group of creative services to handle printing and other production.

To enlist the participation of employees' dependents in the company's new health and productivity management programs, a bimonthly newsletter was created with content specific to all constituencies—even children. And the newsletter is sent home to attract dependents as readers.

"The newsletter in its current state was established in March 2005. We had previously published a newsletter for the 2004 enrollment period. As we got out of the enrollment period and were focused more on lifestyle changes, the content of the newsletter changed to address health and productivity," Ms. Griffin explained.

PHOTO: MICHAEL MARCOTTE

A bimonthly newsletter was created with contents specific to all plan members—even children. The newsletters focus on lifestyle changes.

"On the back, there's always a highly visible piece about children or directed toward children, something that if a child walks by and sees it, they'll pick it up. It will be of interest to them. We're trying to get a younger audience also engaged in learning more about health care and the importance of being healthy," she said.

The March 2005 issue, for example, contains an article about the "10th Annual Kick Butts Day," which was started by Tobacco-Free Kids to persuade the tobacco industry to stop targeting children in their advertising. On the back of the newsletter, there's a "Kick Butts Day Wordfinder," a word search puzzle that contains hidden words within rows of seemingly unrelated letters.

The next issue of the newsletter, which is currently in production, will focus on encouraging people to use their preventive health care benefits.

"We want people who don't get their annual physical to know that's not necessarily a cost savings because what you don't know can get out of control. And so we're trying to encourage people that haven't been to the doctor in several years to reacquaint themselves with the medical community," Ms. Griffin said.

And to make those physician consultations more productive, the communications team has created the "Healthy, Wealthy Wallet Card" for employees that lists "Questions to ask your doctor" and "Questions to ask your pharmacist." The cards, about the size of a typical business card when folded in half, are printed on thick paper stock. They also contain contact information for the SCANA employee benefits department, the health plan administrator, the LiveWell resource center and other related vendors.

"We wanted to equip our people with the information so that at the point of service they would be equipped to ask very basic questions of their treating physician or pharmacist," Mr. McSwain explained.

Prior to the July opening of SCANA's LiveWell health resource center, the communications team developed a "mini campaign" to promote it, using postcards mailed to employees' homes featuring somewhat provocative questions such as: "Is your best friend the furry (four-legged) kind?" and "Who said making ends meet is easy?"

"Because sometimes there's a stigma attached to counseling services, we were trying to point out that there are other things you can use life assistance for," Ms. Griffin explained. "So it's not just about counseling, although counseling is a very important part of it. You can also get financial planning assistance, or you can use it if you need a pet sitter. I've done that. I've called and got referrals for pet sitters."

See **WORD POWER/** next page

PHOTO: MICHAEL MARCOTTE

Chris McSwain's team at SCANA includes, seated left to right: Colette Wines, senior benefits representative; Rachel Bourke, supervisor, plan administration and customer service; Mr. McSwain; Lisa Jones, senior benefits representative. First row, from left: Chris Bennett, senior benefits analyst; Carrie Hilton, administrative assistant; Shannon Payne, senior benefits representative; Crystal Smith, administrative assistant-LRC; LaTonya Davis, health coach; Christina Rice, benefits analyst; Teresa Brown, supervisor, compensation administration and customer care. Seated on credenza, from left: Karen Frownfelter, compensation analyst; Karen Walters, junior compensation analyst; Catherine Peebles, part-time pharmacist. Back row, from left: David Hoke, manager, total health and productivity; Matt Stanton, senior compensation analyst; Sara Delk, wellness program administrator; Patricia Gayle, junior benefits analyst; Jacqueline Kelly, pharmacy technician; Taranda Frost, senior benefits analyst; David Simmons, manager, total rewards. Not pictured are Daniel Bundrick, pharmacy manager; Vivian Carlson, part-time pharmacy technician; Eve Hisel, senior compensation analyst; Lenora Gerald, senior compensation representative; and Linda Moore, part-time pharmacist.

Data: 'Open universe' weds practical, policy, vendor and environmental issues

Continued from page 27

both occupational and non-occupational disability data and other pertinent information drawn from SCANA's human resource information system.

Special precautions will be taken to ensure the security of the data to prevent violations of the Health Insurance Portability and Accountability Act, according to Mr. Hoke, who has been working closely with SCANA's legal department and information technology security departments on the project.

"The data aggregator that SCANA selects will host the data on their system in a de-identified format," he explained. "We'll run our standard ad hoc and custom reports, but what we really want to do is to take that data in a de-identified format and ship it to the university. That's where it will start to get interesting."

Mr. Hoke explained that the epidemiologists in the university's School of Public Health will use SCANA's data to perform population health analyses much like they traditionally have done using government data, only this time the population will be much smaller.

"They are used to doing analyses using population-wide data sets, but why can't an organization or a company be viewed as a small world unto itself?" he queried.

Some of the information that is culled and analyzed will be used to help shape future benefit plan design, or in negotiations with vendors, such as to develop a specialty provider network for certain conditions found to be prevalent among SCANA's employees, retirees and/or their dependents.

"We may use some of the findings to make changes to how our health risk assessment and wellness programs are designed to build interventions to guide people to disease management," Mr. Hoke continued.

Or if the analysis finds that certain types of claims are occurring in geographic clusters, that information will be used to develop high-performance provider networks in those areas to address those conditions, according to Mr. McSwain.

Other uses may be to change co-payment and co-insurance structures to encourage consumerism, Mr. Hoke suggested.

"We might even change some corporate policies," he said. "You've got environmental issues to reckon with, you've got policy issues, you're going to have practical day-to-day issues as well as your vendor issues."

"The idea is to start with an open universe. So many times, we put barriers on ourselves before we start. We want to start with an open universe and see what the options are, and then, based on organizational culture, where we are, what's on our list otherwise, and how this reinforces our other messages, choose those things that we think will have the greatest impact on improving the health of the workforce," Mr. Hoke explained.

Colleagues, family and friends honor McSwain's achievements

By JOANNE WOJCIK

COLUMBIA, S.C.—The drive and passion that Chris McSwain, director of compensation and benefits at SCANA Corp., has for his work may come from within, but it also reflects the culture of his company.

At a luncheon and award ceremony held in Mr. McSwain's honor last month in Columbia, S.C., his co-workers, staff and even SCANA's upper management all confirmed their commitment to the health and productivity programs he has introduced and continues to foster.

The inaugural *Business Insurance* Benefit Manager of the Year award was presented by Editor Regis Coccia. Also present were Publisher Martin J. Ross, Editorial Director Paul Winston, Editor-at-Large Jerry Geisel and Senior Editor Joanne Wojcik.

The fact that Mr. McSwain won the *BI* Benefit Manager of the Year award "says a lot about us," said Bill Timmerman, SCANA's chairman, president and CEO, during the Nov. 28 event attended by 52 of Mr. McSwain's colleagues, family members and friends.

"We're not a utility company, we're a customer service company," Mr. Timmerman asserted. "You can't do customer service well if you don't care for people. That says more about our company than our stock price or our S&P ratings."

Mr. Timmerman also said that all of SCANA's employees—from the top down—live by six key values, one of which is "to respect diversity and care for each another."

SCANA's corporate values are: "Serve our community. Achieve. Communicate openly and honestly. Respect diversity and care for each other. Excel in customer service and safety. Do what is right."

The first letter of each statement makes the word "sacred."

"None of this would be possible if we didn't work for a company that has solid leadership," Joe Bouknight, senior vp of human resources, said during the award ceremony.

Mr. Bouknight said when he first joined SCANA and saw the company's values statement posted on a

See LUNCHEON/next page

PHOTO: MICHAEL MARCOTTE

Among the executives of Columbia, S.C.-based SCANA Corp. at the Benefit Manager of the Year luncheon were, left to right, Joe Bouknight, senior vp of human resources; Bill Timmerman, chairman, president and chief executive officer; and Chris McSwain, director of compensation and benefits.

Word power: Empowering employees

Continued from previous page

The communications team also helped create some of the many health- and productivity-related brochures that employees, retirees and dependents are welcome to take when they visit the resource center.

To ensure continuity, the entire communications program has been color coded and branded with the "LiveWell Life Counts" service mark.

Green represents wellness, blue is for pharmacy and orange is life assistance, Mr. McSwain explained.

SCANA's benefit communications program won a 2005 Award of Excellence from the South Carolina Chapter of the International Assn. of Business Communications, the highest category of recognition in the Palmetto Awards.

The next project on the drawing board for the communications team is to develop a new benefits Web portal that will bring together all benefits related to an employee's health, wealth and career onto the corporate intranet, Ms. Griffin said.

Currently SCANA's Web-based benefit communications are being handled by Aon Consulting via its HealthSmart Internet portal (see story, page 24).

As part of this year's open enrollment process, employees are also being surveyed about the newsletter and other components of the communications program. The findings will be used to develop SCANA's future benefit communications strategy, according to Ms. Griffin.

Luncheon: Friends, family, colleagues honor McSwain's achievements

Continued from page 29

wall, he thought that, like most companies, the wall was where those values would remain. On the contrary, Mr. Bouknight said, "we have a company that lives by those values."

"It's within that environment that you were able to excel," he said, looking directly at Mr. McSwain.

Celebrating at the Benefit Manager of the Year luncheon were Daniel Bundrick, SCANA Corp.'s pharmacy manager; Mr. McSwain; and Sheila Young, compliance manager at the South Carolina Board of Pharmacy.

Mr. Bouknight added that SCANA doesn't seek recognition, yet "recognition comes to us."

He said the company also is the recipient of the 2004 South Carolina Family Friendly Workplace award, given by the South Carolina Chamber of Commerce, the Governor's Office and the South Carolina Department of Commerce and the U.S. Secretary of Labor's 2003 Opportunity Award for establishing and instituting comprehensive workforce strategies to ensure equal employment opportunities.

Mr. McSwain was also lauded by longtime friend and college classmate Richard Feigl, who traveled from Maryland to participate in the award ceremony at Columbia's Capital City Club.

During an emotional acceptance speech, Mr. McSwain mentioned his late father and father-in-law, both of whom still inspire him several years after suffering fatal heart attacks.

"We have Charlies and Jimmys climbing power poles every day at SCANA," he said, adding that many of the programs the company has introduced to improve the health of its workforce could prevent others from suffering similar fates.

Mr. McSwain also acknowledged his mother, Evelyn; his mother-in-law, Dorothy Butler; and his wife, Jemmy Lea; all of whom were present as he accepted the award.

In keeping with his modest nature, Mr. McSwain shared credit for his success with his staff, SCANA's management and several business mentors, including Dr. David Whitehouse, the former medical director at CIGNA Behavioral Health who now is medical director at United Behavioral Health; and Gary Earl, former vp of benefits and corporate human resources at Caesars Entertainment Inc. prior to its merger with Harrah's Inc. earlier this year. Mr. Earl, now a senior vp at CIGNA HealthCare in Hartford, Conn., has been assigned to the SCANA account.

PHOTO: MICHAEL MARCOTTE

Mr. McSwain, second from the left, was joined at the Benefit Manager of the Year luncheon by, from left: David N. Simmons, SCANA's manager of total rewards; Elizabeth M. Borkhuis, principal at Towers Perrin; and Chris Neal, consultant at Towers Perrin HR Services.

"I am flattered that anyone would call me mentor, particularly given that someone like Chris not only knew the answer to the question in his heart but has demonstrated that he can take it to a new level, raising the bar for future Chris McSwains to follow and gain upon," said Mr. Earl in an earlier interview.

Mr. McSwain's energy and devotion have rubbed off on members of his staff.

"The more he works, and the more he wants to get things done, the more it motivates me," said Carrie Hilton, Mr. McSwain's administrative assistant and the person he credits with helping him juggle his busy schedule. "I like working in a department where we're doing something for the employees."

Busy benefit manager engages in unique activity to relieve on-the-job stress

COLUMBIA, S.C.—Chris McSwain, director of compensation and benefits at SCANA Corp., knows how to swim with sharks.

He slips out of his office around 3 p.m. every Wednesday and heads over to the nearby aquarium, where he helps clean a tank filled with sharks, moray eels and other potentially dangerous saltwater fish.

"I have special rocks," he said, which he scrubs with a brush for about an hour one day each week.

Although it is considered volunteer work, Mr. McSwain views the Zen-like task as a way to relieve stress.

"I need to do a better job of being balanced," he said. "I really put a lot of myself into what I do. I probably work, honestly, about 70 hours a week."

Mr. McSwain's wife, Jemmy Lea, would say that's an understatement.

Despite his long hours, though, Mr. McSwain still manages to make the time to be active in the Lexington Baptist Church, and both he and Mrs. McSwain are godparents to five children.

The couple also worked together to help form the DayStar Baptist Church in Greensboro, N.C., where they lived before Mr. McSwain joined SCANA in 2003.

Mr. McSwain also has a black belt in Tae Kwan Do.

"If he has a weakness, it is that he works too hard," acknowledged Joe Bouknight, senior vp of human resources, to whom Mr. McSwain reports. "My coaching to him has been to have a good work-life balance. It's his nature to be so much a part of what he's doing."

But as dedicated as Mr. McSwain is to his job, it is unlikely he will lighten his workload any time soon.

"I have been in other places and not had the stars lined up, the opportunities, for a really special thing to happen, like it has here," he said of SCANA.

"When we were building the resource center, there was a drive to get it done before something could change. I really care about the people here. I know that what we were building would change people's lives. It has been a passion to really drive this thing to the end and to see it deliver the things that I've had faith that it would do," Mr. McSwain said.

—By Joanne Wojcik

Independent panel of judges selected top benefit manager

CHICAGO—*Business Insurance* assembled an independent panel of employee benefit experts as judges for the inaugural Benefit Manager of the Year award.

The panelists represented top benefit consulting firms, insurance brokerages, managed health care companies and other benefit service providers. Judges reviewed and scored nominations for the award on seven criteria reflecting innovation and leadership (see box). The candidate receiving the highest overall score was named Benefit Manager of the Year.

The judges were:

- Brent Bannerman, chief strategy officer of HighRoads Inc., formerly known as IE-Engine, a benefit technology services company based in Woburn, Mass. HighRoads specializes in streamlining employee benefit procurement and cost management for large employers.
- Monica M. Burmeister, leader of the global benefits practice at Lincolnshire, Ill.-based benefit consulting company Hewitt Associates Inc.
- Helen Darling, president of the National Business Group on Health. The Washington-based group represents more than 200 of the nation's largest employers on national health care policy concerns. Ms. Darling previously was a senior benefit consultant at Watson Wyatt Worldwide and before that directed health care and disability benefits at Xerox Corp.
- Richard A. Elliott, president and chief executive officer of Willis Benefits of North America in Atlanta, a unit of Willis Group Holdings Ltd.
- Alan Glickstein, national retirement practice leader for policies and processes at benefit consulting company Watson Wyatt Worldwide in Dallas.
- Cynthia Keaveney, national practice leader, account management, at Aon Consulting, a unit of Chicago-based Aon Corp. Ms. Keaveney, based in Conshohocken, Pa., previously was senior vp and national practice leader of Aon Workforce Strategies, a division that provides health, absence and productivity management solutions.
- Dan Klein, U.S. client development leader at Mercer Human Resource Consulting. Mr. Klein is based in the Chicago office of Mercer, a unit of Marsh & McLennan, and helps large, global employers develop benefits, human resource and compensation programs.
- David A. North, president and CEO of Sedgwick Claims Management Services Inc., a Memphis, Tenn.-based third-party administration company. Sedgwick CMS serves employers nationwide in providing claims and productivity management solutions.
- Noël Obourn, president of the National Account Segment at CIGNA HealthCare in Bloomfield, Conn. Ms. Obourn leads the delivery and servicing of CIGNA medical and dental benefits, behavioral health programs and prescription benefits for large U.S. employers.
- Virginia M. Olson, a principal at benefit consulting company Towers Perrin. Based in Atlanta, Ms. Olson works with employers in a broad range of industries in all aspects of employee benefits and total rewards programs.

Criteria for award

An independent panel of judges scores nominees on a scale of one to 10 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 manages benefit programs to control costs.
- Exhibits leadership in achieving change within his or her organization.
- Established an effective system for communicating benefit programs to employees.
- Skillfully administers benefit programs through the application of technology.
- Develops in his or her career and promotes advancement of the benefit management profession.

2006 Benefit Manager of the Year

Business Insurance's Benefit Manager of the Year competition seeks to recognize excellence and innovation in employee benefits management. Any full-time employee of a corporation, nonprofit organization or government entity who handles benefits is eligible for the award. A nominee need not manage benefits as a sole responsibility but must be a full-time employee of the organization. For nomination forms, please visit *www.BusinessInsurance.com/BMOY* or request forms from Regis Coccia, *Business Insurance*, 360 N. Michigan Ave., Chicago, Ill. 60601; *rcoccia@businessinsurance.com*.

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COMMENTARY

Senior Editor Dave Lenckus

Anesthesia belongs in specialist hands

Hospital risk managers have to question whether gastroenterologists—the physicians who specialize in stomach and related disorders—are team players in mitigating medical malpractice losses.

It does not appear so. Gastroenterologists are trying to boost their income at the expense of patient safety and additional risk to hospitals and a drugmaker that has acted responsibly in marketing a drug that already has financially benefited the physicians.

The drug is the general anesthetic propofol, which AstraZeneca P.L.C. markets as Diprivan. The drug label warns that the anesthetic should be administered only by anesthesiologists or nurse anesthetists.

But the American College of Gastroenterology wants the U.S. Food and Drug Administration to remove the drug's warning label so physicians would be free to use nurses to administer propofol with impunity. The ACG argues that nurse-administered propofol sedation is safe and much less expensive for patients. Many gastroenterologists already ignore the label and have nurses with varying levels of training in anesthesiology administer the drug.

No one is arguing that propofol is unsafe. Compared to other general anesthetics, it is more beneficial in several respects—for physicians and patients. It acts more quickly, so physicians can perform more procedures daily; it does not last as long; and its aftereffects are more moderate.

Still, pulling the warning label would be like yanking seatbelts from a car that scores highly in crash-safety tests. It would be an unwise gamble.

The ACG's own petition to the FDA clearly spells out the drug's risks, though the organization tries—unconvincingly—to rationalize them away.

The drug decreases blood pressure and depresses respiration, which can lead to partial airway obstruction. In addition, because of propofol's short duration, sedation may require additional reinforcement doses. That makes managing a patient's sedation a more demanding task than if a longer-lasting sedative were used.

Compounding those risks is a nearly 20-fold variation in how the drug metabolizes in patients. That means two patients with nearly identical physical characteristics may have completely different reactions to identical doses of the drug.

On top of all that, there is no antidote to the drug.

Clearly, an anesthesiology specialist should be the only medical provider administering this drug.

Still, the ACG wants the FDA to focus on the drug's good safety record and the cost savings from pushing anesthetists out of the operating room.

Regardless of the drug's safety record, its risks speak for themselves. And the economics argument has gaping holes.

First, many gastroenterologists already ignore the warning label. How would those physicians reduce their patients' medical costs?

Second, many health insurers do not consider that most procedures performed by gastroenterologists warrant a sedative as strong as propofol, notes the American Society of Anesthesiologists. So those insurers do not cover the cost of an anesthesiologist for those procedures, the ASA says.

Hospital risk managers also should consider this: Some attorneys say that if the warning label is removed and a propofol-sedated patient has a bad outcome—a likely problem if inadequately trained nurses continue to administer the drug—the hospital where the procedure was performed could be a bigger med mal target than the physician. The theory is that a physician who made no errors during a procedure could escape liability. But a jury would look for accountability somewhere, and the drugmaker and hospital, which could have imposed stricter patient-safety protocols on physicians, would be the perfect foils.

While the FDA could issue a decision within weeks, risk managers have time to comment. But whatever the FDA decides, risk managers should wrestle back control of patient safety and their hospitals' med mal risk. Hospital protocol should require anesthesiology specialists to administer propofol. Given the drug's warning label, this policy already should be in place.

If hospitals get on the same patient-safety page, then gastroenterologists could not play facilities against each other for the physicians' business.

Senior Editor Dave Lenkus can be reached at dlenckus@businessinsurance.com.

PRODUCTS & SERVICES

BISYS general liability insurance offering added

MELBOURNE, Fla.—BISYS Specialty Programs, a division of BISYS Commercial Insurance Services, has added a monoline general liability coverage program to its line of products.

The general liability program intends to protect business owners against incidents that can occur on the grounds of where they conduct business and allows them to continue operations while facing real or fraudulent claims, such as negligence or wrongdoing.

The program's eligible classes of business include apartments, condo associations, hotels, restaurants and taverns, and artisan and specialty contractors, among others.

Limits are available up to $1 million, with a $1,000 minimum deductible and $5,000 minimum premium.

For more information, contact Robert DeVries, business development manager, at 877-247-9772 or at *standalonegl@bisys.com*.

IRMI issues updated 'Defective Construction'

DALLAS—International Risk Management Institute Inc. has released the second edition of "Insurance for Defective Construction."

The book analyzes the legal trends and theories of commercial general liability claims involving defective workmanship, and it explains policy form changes.

It is written by Patrick J. Wielinksi, a Dallas-based attorney for Cokinos, Bosien & Young, a Houston-based law firm. The print edition of the book is available for $72.

To order the book, contact the IRMI's customer service department at 800-827-4242 or visit *www.irmi.com/products*.

MetLife alliance offers long-term care program

WESTPORT, Conn.—MetLife is offering a long-term care insurance program available through the workplace for California employees.

The product, MetLife/California Partnership Long-Term Care Insurance Program, is endorsed by the California Partnership for Long-Term Care, an office that was created by the state's Department of Health to oversee long-term care initiatives.

The MetLife offering is geared to small and midsize businesses and can be offered as an employer-paid or a voluntary benefit. It also offers a variety of options, which allow employees to customize their plans. It intends to help provide financial protection for employees by allowing them to access funds to help pay for their long-term care services when needed.

For more information, contact the company at 888-422-7526 or visit *www.metlifecaplan.com.*

Lighthouse adds BOP to entertainment program

ANNANDALE, Va.—Lighthouse Underwriters L.L.C. has enhanced its entertainment insurance program, Take1, by adding a business owners policy.

The Take1 program is an all-lines package available to audio and visual dealers, equipment dealers and multimedia production companies. The BOP provides actual loss sustained business income and extra expense coverage, valuable-paper and crime coverage, and per-location aggregate coverage, among others.

More information can be obtained by contacting Brian Cropp, Take1 program director, at 703-770-3700 or *bcropp@lighthouseunderwriters.com*.

MedAmerica adds group long-term care

ROCHESTER, N.Y.—MedAmerica Insurance Co. has added a group long-term care offering to its CareDirections Simplicity product line.

The Group Simplicity product is available to companies with 50 or more employees. The program has no restrictions on how policyholders use their cash benefit. Once group members are eligible, they can submit a request for payment each month and they will receive a monthly cash benefit.

More information about this offering can be obtained by contacting Steve Whalen, director-group sales, at 800-544-0327.

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

Pension reform gets mixed review

U.K. employers differ on proposal to mandate plan contributions

By SARAH VEYSEY

LONDON—Employer groups expressed mixed reactions to proposals that would radically overhaul the pensions system in the United Kingdom and require compulsory employer contributions to a new national savings plan or automatic enrollment in more-generous occupational plans.

An independent commission on pension reform last week proposed the introduction of a nationwide, low-cost pension savings plan, into which all employees would be automatically enrolled, that would be funded by default contributions from employees of 5% of gross pay and from employers of 3% of gross pay.

In its final report last week, the Pensions Commission, which was set up by the British government in 2002 to "keep under review the regime for U.K. private pensions and long-term savings," proposed plans for a National Pension Savings Scheme aimed at increasing pension saving.

While the commission's proposals are not binding, Britain's government has said it will consider the commission's findings and will likely introduce reform legislation in spring 2006.

Lord Adair Turner, chairman of the Pensions Commission and a former director general of the Confederation of British Industry, said the proposed NPSS likely would not be implemented before 2010.

Employers that provide occupational pension plans that are judged to be more generous than the NPSS would be exempt from compulsory payments into the nationwide plan, provided that all employees are automatically enrolled in employer-sponsored plans unless employees expressly opt out.


PHOTO: NEWSCAST

Lord Turner

According to the commission's report, any employer that provides defined benefits that are assessed by the Government Actuary's Department to be "worth more than the expected value of the default contributions to the NPSS would be free of the requirement to auto-enroll any employees into the NPSS," provided it automatically enrolls employees into its defined benefit plan and provided that all employees would be eligible to join that plan.

In addition, employers that sponsor defined contribution plans would not be required to automatically enroll employees into the NPSS "if the employer's contribution is at least the same level or greater than the minimum compulsory match in the NPPS, if the combined employer and employee contribution exceeds the combined lev-

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Lloyd's hurricanes losses add up

Katrina	Rita	Wilma
$3.27 billion	$920.4 million	$830.9 million

Hurricanes deliver blow to Lloyd's profit hopes

By SARAH VEYSEY

LONDON—Lloyd's of London will likely report a loss for 2005 as a result of losses from hurricanes Katrina, Wilma and Rita, Lloyd's said Wednesday.

Lloyd's said that marketwide losses from Hurricane Katrina are now expected to reach £1.9 billion ($3.27 billion), up from a previously announced estimate of £1.4 billion ($2.41 billion). That preliminary estimate, given in September, was based on "the very limited information available at the time," Lloyd's said in a statement.

In addition, Lloyd's announced that the market's net loss from Hurricane Rita is expected to be £535 million ($920.4 million), while the net loss from Hurricane Wilma is estimated at £483 million ($830.9 million).

"The market expects to be able to meet all its liabilities with immaterial impact on the Central Fund," Lloyd's said in the statement. The Central Fund, to which all syndicates in the market contribute, is intended to meet the liabilities of syndicates that cannot pay all of their losses.

"Fu rther, there is nothing to suggest that any syndicate will be unable to trade forward as a result of the hurricanes," the statement said.

When Lloyd's announced its half-year results—a pretax profit of £1.38 billion ($2.47 billion)—in October (*BI*, Oct. 10), the market's chief executive officer, Nick Prettejohn, said that while Hurricane Katrina would have a significant bearing on profits for 2005, the market likely would make a profit for the year barring any other major catastrophic loss.

In its statement Wednesday, however, Lloyd's said that given the development of loss figures for Hurricane Katrina and the impact of Hurricane Wilma, which occurred after the announcement of Lloyd's half-year results, "the chances of the market making a profit in 2005 are now small."

Lloyd's also announced that underwriting capacity for 2006 will likely be about £14.7 billion ($25.29 billion), 7% higher than capacity for 2005, as a result of several syndicates revising their business plans to take advantage of increased rates in catastrophe-related classes of business.

Supply chain risks require thoughtful managing: Experts

By BARBARA COCKBURN

LONDON—Outsourcing can save companies money, but the increased risk associated with relying on outside help must be carefully managed or those savings could evaporate, several experts say.

In particular, the risk of a loss at one supplier affecting several other links in a supply chain must be addressed, they said.

Simply purchasing a business interruption policy is not a sufficient response to the risk.

Companies that outsource must have a detailed business continuity plan, said Geoff Taylor, director of risk management at Nike Europe, Middle East and Africa, in Hilversum, Netherlands.

Nike outsources almost all of its work to Asia "because it's cheaper," he said, and, in doing so, it faces a number of external risks including natural catastrophes, accidents, operational risks and industrial actions.

Mr. Taylor said, "It's important to understand the supply chain end to end. When you're delivering to customers you need to be aware of the risks."

"There's a lack of vision in the supply chain that can hinder external risks. Europe doesn't suffer earthquakes or tsunamis, but Asia does. But there will be a loss of sales if there's a fire in a factory anywhere in the world," Mr. Taylor said. He was speaking at the annual symposium of broker Jardine Lloyd Thompson Risk Solutions Ltd., in London.

And though business interruption insurance coverage is relatively cheap, business continuity planning is a more effective tool for dealing with outsourcing risk because it ensures continuity in the face of unforeseen or difficult circumstances. He added that risk managers should encourage a full risk assessment and "make sure that what you do provides a system and basis if something goes wrong. Will your business be around next year?"

> "Europe doesn't suffer earthquakes or tsunamis, but Asia does. But there will be a loss of sales if there's a fire in a factory anywhere in the world."
>
> **Geoff Taylor**
> **Nike Europe, Middle East and Africa**

He suggested that organizations get basic risk management principles down to one page and develop a statement of principles "in the context of a contract."

Mr. Taylor said the document should explain that "you understand who is taking on the risk at

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Updates

Beazley to form third Lloyd's syndicate

Beazley Group P.L.C. is setting up a third Lloyd's of London syndicate to underwrite property insurance, property reinsurance and marine energy business. Beazley, which manages two Lloyd's syndicates and a U.S. operation, said several investors were interested in a syndicate to take advantage of hard-market conditions in property and energy business lines. Beazley said in a statement that the proposed syndicate–3623–would have capacity of up to £200 million ($343.1 million) for 2006, and that it intends for the syndicate to be operational in time for the year-end renewal season.

Watson Wyatt forming branch in Shanghai

Watson Wyatt Worldwide plans to set up an insurance and financial services consulting branch in Shanghai, China, early next year. The Washington-based human resources firm's Shanghai insurance and financial services consulting team will be led by Michael Ross, who previously worked in the firm's Hong Kong office. Watson Wyatt has operated a representative office in Shanghai since 1995.

Creechurch to set up takaful syndicate

Lloyd's of London managing agency Creechurch Underwriting Ltd. plans to set up a Lloyd's syndicate that would underwrite takaful business–insurance and reinsurance business that complies with Islamic principles. Bruce Graham, chief executive officer of Creechurch, which operates syndicate 1607, said the company has approached Lloyd's about setting up the takaful syndicate and is now awaiting regulatory approval. Takaful insurance, which spreads losses and liabilities across a mutual pool, complies with principles of Islamic law.

JLT taps Burke as group chief executive

London-based Jardine Lloyd Thompson Group P.L.C. has named Dominic Burke group chief executive. He previously was a director and chief operating officer at JLT. JLT has been searching for a new chief executive since November 2004, when Steve McGill resigned. Since then, JLT Chairman Ken Carter has served as executive chairman. In addition, JLT said Mike Hammond, chief executive of its JLT Risk Solutions Ltd. division, has resigned and the division's chairman, Dominic Collins, has assumed executive responsibility. Mr. Carter will retire in April 2006 and be replaced by Geoffrey Howe, joint deputy chairman and senior independent director of JLT.

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LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re: **SEFTON PARK INSURANCE LIMITED**
(Petition of Malcolm L. Butterfield)
Case No.: 02-12934 (BRL)

PLEASE TAKE NOTICE that on November 22, 2005, the Bankruptcy Court entered an order continuing the Preliminary Injunction Order (the "Order") pursuant to 11 U.S.C. § § 105 and 304(b) originally entered in this case on November 7, 2002. The Order shall remain in effect pending a hearing scheduled for May 24, 2006 at 10:00 a.m. before the Honorable Burton R. Lifland, in the Alexander Hamilton Custom House, One Bowling Green, New York, New York. Any person wishing to obtain a copy of the Order should contact Theresa D'Agostino at (212) 610-6300.

ALLEN & OVERY LLP
1221 Avenue of the Americas
New York, New York 10020
Tel: (212) 610-6300, Fax: (212) 610-6399
Attention: Ken Coleman, Stephen Doody

For 2006 *BI* Rates or Editorial Calendar

e-mail tvasilakis@BusinessInsurance.com

REQUEST FOR PROPOSALS

REQUEST FOR PROPOSALS
NEW YORK CITY TRANSIT
OWNER CONTROLLED INSURANCE PROGRAM
2005 - 2009 Capital Program

The Metropolitan Transportation Authority's Risk and Insurance Management Department is soliciting Requests for Proposals (RFPs) from qualified brokers/agents to provide Program Administrative and Insurance Marketing Services for a New York City Transit Owner Controlled Insurance Program (OCIP) for the 2005 - 2009 Capital Program.

Brokers/Agents must demonstrate:

- a clear understanding of the objectives and constraints of an OCIP;
- experience as Broker of Record handling OCIPs in the transportation industry, with construction values of at least $250 Million for an individual OCIP program;
- that principal staffing is in a location readily and easily accessible to MTA Service Area and;
- commitment, capability and experience of key personnel proposed to manage these programs.

The OCIP will require an MBE/WBE goal participation. The MBE/WBE goal is yet to be determined.

The contract term of the OCIP is eight years. Information concerning the projects to be included in this OCIP will be available on or about December 7, 2005. Please fax request for an RFP to 212-878-1203. Responses to the RFP are due by 5:00 p.m. on Friday, January 27, 2006. Please submit ten (10) copies to Ms. Laureen Coyne, Director, MTA Risk and Insurance Management Department, 347 Madison Avenue (341/18), New York, New York 10017.

Metropolitan Transportation Authority *Going your way*

REQUEST FOR PROPOSAL

Michael T. McRaith, Director of the Illinois Division of Insurance, announces that Illinois' high risk pool, the Comprehensive Health Insurance Plan (CHIP), is beginning a competitive bid process designed to result in the selection of a plan administrator for a five-year term beginning January 1, 2007.

CHIP will be releasing in February, 2006 a Request for Proposals (RFP) that solicits proposals for various administrative and support services of the CHIP program from January 1, 2007 to December 31, 2011.

Insurers or administrators who are interested in participating in this process, and who wish to receive a copy of the RFP, should, by January 15, 2006, send a letter of interest to :

Executive Director
Comprehensive Health Insurance Plan
320 W. Washington Street, Ste. 700
Springfield, IL 62701-1150
E-mail: **director@chip.state.il.us**

Fax us your ad 312-649-7937

REQUEST FOR PROPOSALS

LEGAL NOTICE
CITY OF NAPERVILLE
REQUEST FOR PROPOSALS
RFP 06-118
Workers' Compensation Third-Party Administrator

The City of Naperville is seeking proposals for the administration of our self-insured workers' compensation program for a period beginning March 1, 2006. The City will accept multi-year or single-year contract proposals.

Proposals will be received at the City of Naperville, Procurement Services Team Office, 400 S. Eagle Street, Naperville, Illinois 60540 until **3:00 P.M., local time, on January 3, 2006**, at which time they will be publicly opened.

Those desiring to propose may obtain copies of the specifications and other information between the hours of 8:00 A.M. and 5:00 P.M., Monday through Friday, in the Procurement Services Team Office, at the above address, or download the document via the City's web site (**www.naperville.il.us**).

The City reserves the right to reject any or all proposals.

LEGAL NOTICE

LEGAL NOTICE
Notice of Final Substantive Closure Distribution
ANGLO AMERICAN INSURANCE COMPANY LIMITED ("ANGLO")

The Scheme Administrators have set the Final Substantive Closure Distribution as set out below and, subject to the cap of 100% on aggregate Scheme and Amending Payments applicable under Clause 8.6.2 of the Amending Scheme of Arrangement, the increased payments due will be paid to creditors on the Final Substantive Closure Distribution Date of 27 January 2006.

Payments of interest in full under Clause 3.3.2 of the Scheme of Arrangement are also expected to be made to Scheme Creditors on 27 January 2006.

	Existing Payment Percentage	Final Substantive Closure Distribution Percentage
Anglo	90%	100%

2 December 2005

A J McMAHON and J M WARDROP
Scheme Administrators

Address for correspondence:
CMGL, Ibex House,
42-47 Minories,
London EC3N 1HN
Tel: +44 (0) 20 7680 6600
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So take a look at the menu of issues to watch for in 2006, and get ready to dig in:

Jan	23	Retiree Benefits: Health Care*
Feb	27	Voluntary Benefits
Mar	13	Health Care Coalitions*
Apr	17	Health Care Cost Control*
May	29	Regulatory & Legislative Developements
Jun	19	Work & Life Benefits*
Jul	10	Benefits Market Forecast
Aug	14	Consumer-Driven Health Plans*
Sep	18	Benefit Financing Strategies
Oct	16	Technology & Online Solutions*
Nov	27	Retiree Benefits: Pensions & Savings Plans*
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Pensions: Overhaul proposal gets mixed review

Continued from page 33

el in the NPSS…and if auto-enrollment is applied," the report said.

If employers operate occupational pension plans that have restricted access, such as a minimum waiting period before an employee could become part of the plan, they would be required to automatically enroll employees not eligible for the employer-sponsored plans into the NPSS, according to the commission's proposals.

Among other proposals in the commission's report was the recommendation that the state pension age be raised gradually between 2020 and 2050—to 67 to 69 years old, depending on demographic trends, Lord Turner said.

In addition, the commission proposed that measures be introduced to allow more flexibility for those working beyond retirement age.

The London-based labor union, the Trades Union Congress, welcomed the proposals allowing more flexible retirement and backed the move to make employer contributions to the NPSS compulsory.

"The TUC has been at the forefront of those arguing for compulsion on employers," Brendan Barber, general secretary of the TUC, said in a statement.

"Government should listen to those employers…who have backed compulsion as the best way to stop good employers being undercut by the bad," he added.

The London-based Confederation of British Industry, which represents employers in Britain, said it welcomed the report, but said compulsory employer contributions could greatly increase some employers' costs--particularly smaller companies'.

Sir Digby Jones, director general of the CBI, said in a statement that "compulsory employer contributions may well not impact on large employers, who are already contributing generously to their employees' pensions, whatever their type."

"But make no mistake, compulsion would be a step too far for smaller firms who simply cannot afford such a hike in the cost of employment," he said.

"Automatic enrollment would help overcome inertia and increase take-up of private pensions. The CBI agrees that it should not be compulsory for employees—so by the same token it should not be compulsory on employers," the statement noted.

Martin Temple, director general of the Engineering Employers' Federation, called for a phased approach.

"We support the idea of soft compulsion for employers and employees but recognize that some smaller companies will find this problematic," Mr. Temple said in a statement. "Government must address their concerns by providing them with some initial assistance to meet the additional costs and phase the implementation over a realistic period so they can gradually adjust to this new pensions environment."

Some pension experts said the proposed NPSS and the requirement that employers offering alternative occupational pension plans must automatically enroll employees could increase employers' pension costs and prompt some to stop offering occupational pension plans.

Automatic enrollment will increase take-up of employer-sponsored pension plans and will, therefore, increase costs for employers running such plans, noted Paul McGlone, head of employer propositions at Aon Consulting in London.

"In the face of increased cost pressures, many employers may cease offering an occupational scheme and opt for a lower-quality NPSS instead," Christine Farnish, chief executive of the London-based National Assn. of Pension Funds, said in a statement.

Because the NPSS is intended to be a low-cost plan—where the collective power of member funds would be used to bargain for low fees from fund managers, according to Lord Turner—some employers may decide that paying default contributions into the NPSS is cheaper than and preferable to continuing to offer occupational pension plans, noted Tim Keogh, a worldwide partner at Mercer Human Resource Consulting in London.

"When you introduce a form of compulsion, there is a risk that employers will go down to the lowest level," and pay contributions equal to NPSS default contributions, noted Jonathan Gainsford, a pensions consultant at Hewitt Associates in London.

"The NPSS may simply crowd out attractive defined contribution" plans, he said.

"That contagion effect is very real," said Andrew Power, a partner in the financial services practice at Deloitte Touche Tohmatsu in London.

Employers in industries where there is high staff turnover—for example the retail industry—may decide to cease offering occupational plans as an employee incentive and, instead, opt to pay into the NPSS, he said.

But some employers will continue to offer generous occupational pensions as a recruitment and retention tool, noted Hewitt's Mr. Gainsford.

Copies of the report, "A New Pension Settlement for the Twenty-First Century," can be viewed at *www.pensionscommission.org.uk*.

Cayman: Attracts first reinsurer

Continued from page 4

reinsurance companies" on Cayman, she said.

"As a first-class financial center, Cayman already has the infrastructure in place to support this market, and we see this as a great opportunity to become a major player in the reinsurance market," she said.

"The pure fact that such a company would choose Cayman is a testament to their confidence in the strength and stability of the financial service industry within Cayman," said Seamus Tivnan, managing director of Marsh Management Services Cayman Ltd. and chairman of the Insurance Managers Assn. of Cayman, in an e-mail. "It also highlights (Greenlight Re's) confidence in Cayman's infrastructure, its ability to expand, and for the financial service provider community being able to absorb and deal with that growth," he said.

> "Most brokers…would not do cartwheels or be thrilled to be placing business (in Cayman). They seem to be comfortable with more established marketplaces like Bermuda."
>
> **Rod Thaler**
> **Willis Re Inc.**

Cayman's existing infrastructure indeed played a part in the decision to launch Greenlight Re on the island, according to Len Goldberg, the reinsurer's chief executive officer.

"Cayman has a wonderful regulatory environment—one that is mature and certainly one that understands our business," he said. It also is home "to some of the best captive managers in the world."

Cayman is the world's second-largest captive domicile, with 694 captives under management at the end of 2004. (*BI, March 7, 2005*) The captives generated $5.6 billion in written premiums in 2004 and had $22.2 billion in assets under management.

At the same time, by locating in Cayman rather than Bermuda, Greenlight Re is differentiating itself, Mr. Goldberg said. "We aren't looking to be the same as everybody else. It doesn't make any sense for us to be the 52nd reinsurer in Bermuda."

While existing and potential captive owners may find doing business on the island a little easier with the establishment of Greenlight Re, reinsurance brokers have their own concerns in regard to the open market.

Cayman "is just not a well-known and respected domicile," said Steven K. Bolland, president of New York-based reinsurance brokerage Gill & Roeser Inc. "Basically, when you're looking at security, part of the review you give it is who's supervising the company—who's the watchdog? I think over the years, people obviously are comfortable with the supervision in the U.S., and they've become comfortable with the supervision in Bermuda. I don't know what the supervision in the Cayman Islands is like."

Rod Thaler, executive vp and national director of Willis Re Inc. in New York, added: "Most brokers…would not do cartwheels or be thrilled to be placing business there. They seem to be comfortable with more established marketplaces like Bermuda."

But as Marsh's Mr. Tivnan points out, being the first is not always the easiest.

"Once Greenlight demonstrates that their decision was the right one, others will follow. It takes strength to be a leader, and we admire Greenlight for showing that strength. Few wish to be the first, and we strongly believe that their pioneering will be rewarded."

South Dakota court strikes countersign law

PIERRE, S.D.—A U.S. district court has struck down South Dakota's countersignature law that required out-of-state agents to pay resident agents a fee to countersign policies sold in the state.

The Nov. 29 ruling by Judge Charles B. Kornmann in *Council of Insurance Agents & Brokers and James T. Joyce vs. Gary R. Viken and Gary Streuck* voided, at least temporarily, the last state countersignature law. Messrs. Viken and Streuck are South Dakota's secretary of revenue and regulation and director of insurance, respectively. The state had argued that the countersignature law was necessary to assure agent competence, as well as agent accessibility and accountability.

But Judge Kornmann wrote that "the countersignature laws and discrimination practiced do not bear a substantial relationship to any legitimate objectives of South Dakota law." He added that "there is no valid reason" to treat resident licensed agents and nonresident licensed agents differently and agreed with the Washington-based CIAB that the law was unconstitutional.

South Dakota may appeal the ruling, as Nevada has a similar ruling that struck down its countersignature law in 2004.

The CIAB has challenged countersignature laws in court for years, holding that they are nothing more than protectionist measures that do nothing to benefit policyholders. Joel Wood, the CIAB's senior vp-government affairs, hailed the latest decision as overturning "a particularly venal form of one of the last vestiges of protectionism."

—Mark A. Hofmann

Supply: Risks need managing

Continued from page 33

the different stages of your supply chain by asking what you can do for your outsourcing company, what that company will do for you, what's going to be done and who is going to do it."

The details of risks need to be first on the agenda. "When pricing and service is done first and then things go wrong, all fingers point to everyone else. Sorting out the risks and the costs to mitigate it should come first. You need a clear process in place."

Phil Morris, consultancy director at London-based outsourcing consultants Morgan Chambers P.L.C, advocated more communication and transparency among risk managers and suppliers. "You need to ask, 'What do you deliver? Who are your customers?' And you have to meet those commitments to external organizations. If you take a piece out of the chain, you may be impacting the next loop of the chain. Everyone has to work together," he said.

Mr. Morris said that relationships break down when organizations walk away after a contract has been signed, leaving the external supplier to have to deal with a problem that occurs.

"The problem will always come back to the original company, so there needs to be transparency. You need to keep in mind what the deal was set up to do and has it met its objectives," Mr. Morris said.

Wal-Mart: Subrogating claim

Continued from page 6

management can assist the hospitals' infection control specialists, he said.

In its lawsuit against Salinas Valley Memorial Hospital in Salinas, Calif., Wall-Mart seeks compensatory damages to recoup workers compensation benefits paid on behalf of its injured worker Joseph Salarzon, court records show.

Wal-Mart was self insured for workers comp exposures in Calif. during September 2004, when Mr. Salarzon obtained treatment at the Hospital, court records state. The Bentonville, Ark.-based retailer no longer appears on a roster maintained by California's Self Insurance Plans office, which approves employers to self insures workers comp risks in the state.

Wal-Mart's lawsuit, filed Nov. 2, in Monterey County Superior Court, alleges that necrotizing fasciitis, a flesh eating bacteria, harmed Mr. Salarzon's right forearm and other body parts.

Necrotizing fasciitis can be a deadly infection, working its way rapidly through layers of soft tissue.

Wal-Mart alleges the hospital was negligent in cleaning and sterilizing equipment, and provided faulty products, which allowed the bacteria to infect Mr. Salarzon.

The lawsuit does not provide details about the injury Mr. Salarzon suffered while working for Wal-Mart and the employer did not return telephone calls. The attorney representing Wal-Mart declined to comment.

Salinas Valley Memorial Hospital maintains Mr. Salarzon did not contract the infection at its facility. "It is our feeling that any work comp expense should come from Wal-Mart," a hospital spokeswoman said.

CDHP: How to inject consumerist elements into multiemployer health care plans

Continued from page 4

Consolidated Omnibus Budget Reconciliation Act. But it would be hard for a multiemployer plan to determine what premium should be charged for COBRA coverage, Ms. Borzi said, because employer contributions to multiemployer plans vary from month to month based on the number of hours a participant works.

A group of lawyers representing Taft-Hartley plans has been meeting with federal regulators to come up with a way to make HSAs work in a multiemployer environment, she added. So far, the IRS has suggested using the average number of hours worked over the year as a gauge, she said.

Despite these obstacles, it may be possible for a Taft-Hartley plan to offer a high-deductible plan as an option, allowing participants who choose that option to establish their own HSAs, Ms. Borzi suggested.

The Northern California General Teamsters Security Fund is offering a high-deductible plan to its participants, and the participating employers have agreed to fund the HSAs that are being offered in conjunction with them as part of a collective bargaining agreement, she acknowledged.

Even though it would be difficult to replace a multiemployer health plan with a consumer-driven health plan with a high deductible and either a health reimbursement arrangement or a health savings account, it is still possible to introduce some elements of consumerism to plan participants, according to Ms. Linton.

> "It's an area that's ripe for it, because the information is available on prescription drugs."
>
> **Kathy Linton**
> **Deloitte Consulting L.L.P.**

For example, prescription drug co-payments could be replaced with percentage-based co-insurance, she suggested. If the retail prices of prescription drugs are made more transparent to participants, they might choose to use those that cost less, she said.

"This is probably one of the biggest opportunities from a cost savings perspective to make a change that gets immediate results," Ms. Linton said. "It is an area that's ripe for it, because the information is available on prescription drugs. You can go out and compare the cost of drugs relatively easily."

Plan sponsors also should find out what consumerism tools their current vendors have to offer, such as Internet-based health care and prescription drug cost calculators, provider quality reports, health-based newsletters, toll-free help lines staffed by nurses and health advocate services, she suggested.

Other ways to introduce consumerism are to provide incentives for plan participants to take health risk assessments and to participate in disease management programs when chronic conditions are found.

But Ms. Linton warned that adding a high-deductible health plan as an option rather than a full replacement could result in adverse selection against other plans.

"You want to make sure not just your young, healthier participants are going into your consumer-driven health care plan," she said. "You would see a decrease in the plan costs for that group; however, your other health care programs might experience an increase."

Peter J. Kaehler, president and chief executive officer of Compre Healthcare Solutions in St. Paul, Minn., moderated the session.

Plan trustees advised to join the bankruptcy process early

By JOANNE WOJCIK

HONOLULU—To avoid having a bankruptcy court judge decide the fate of employee benefit plans in a corporate bankruptcy, plan trustees should make certain they get a seat on the creditors' committee, a bankruptcy expert warns.

Otherwise, the benefit plans could be relegated to the status of "general unsecured claimant," the second-lowest category of claimant under the U.S. Bankruptcy Code, just above shareholder, according to Andrew E. Staab, president and managing partner of the law firm of Rosene Haugrud & Staab Chartered in St. Paul, Minn.

"If you find out in a multiemployer plan that you've got an employer that's filing bankruptcy, you go to the creditors' meeting, which is usually 60 days after they file," Mr. Staab said. He offered advice to benefit plan trustees attending a session on bankruptcy and employee benefit plans during the 51st Annual International Foundation of Employee Benefit Plans Conference, which was held in Honolulu on Nov. 13-16.

Then, when the other creditors ask the trustees who they are, they should identify themselves as representing either the union or the benefit plan and indicate that they are there to find out whether the company is going to assume, modify or reject the collective bargaining agreement, Mr. Staab recommended.

"Make them say they're going to assume it, and ask them when they're going to do the assumption; otherwise, you're going to set a motion (in bankruptcy court) for them to assume it," he said, "because once they do, you get a 'superpriority' of the benefits that are delinquent."

"Otherwise, you become a general unsecured claimant, the second-lowest form of life in bankruptcy. The lowest form of life is being a shareholder," Mr. Staab described. "As a general unsecured claimant, you basically file your proof of claim, and you hope and you pray."

The primary reason that plan trustees should get involved as early as possible in the bankruptcy process is because bankruptcy judges are not familiar with labor law and often rule against preserving benefit plans in a reorganization if their cost would make it difficult for the company to emerge from bankruptcy, according to Mr. Staab.

Only a few sections of the bankruptcy code directly address employee benefits, he noted.

> "The bankruptcy judges are making decisions over collective bargaining agreements. They're replacing the NLRB."
>
> **Andrew E. Staab**
> **Rosene Haugrud & Staab Chartered**

Section 1114 was created in response to the bankruptcy of steel giant LTV Corp., which resulted in the elimination of its retiree health benefits, he explained.

Section 1114 permits "authorized representatives," who usually are retired union presidents, to negotiate retiree health benefits in bankruptcy.

"This used to be the hot topic for companies that wanted to file bankruptcy," Mr. Staab said. "Pensions are now taking a lot of that area up."

But, ultimately, the bankruptcy judges still determine whether the negotiated package "will contribute to a successful reorganization of the company," he warned.

"This is where it gets really controversial, because you have bankruptcy judges making employee benefit plan decisions," he said. "If they hear somebody say, 'We're going to lose our retiree health,' and they hear the company say, 'We want to reorganize,' they're going to side with the reorganizing argument."

Two other sections—365 and 1113—address collective bargaining agreements, Mr. Staab explained.

In a bankruptcy situation, the debtor company has three options—assume, modify or reject the collective bargaining agreement, he explained.

The modification option was added as a result of a 1984 decision by the U.S. Supreme Court in *National Labor Relations Board vs. Bildisco & Bildisco*, in which the company filed a motion in bankruptcy court to reject its collective bargaining agreement and the judge, having no background in labor law, allowed it, according to Mr. Staab.

As a result of this decision, Congress passed legislation to add a provision to Section 1113 of the bankruptcy code similar to that pertaining to retiree health benefits, which gives companies the ability to reopen negotiations of collective bargaining agreements, he explained.

This provision also limits the amount of time that can be spent renegotiating, which could be detrimental to the benefit plan, he said.

"This is what's going on right now in the airline industry," Mr. Staab said. "They are in the middle of the 1113 negotiations process. The pressure's on for them to reach agreement, because the unions know in these situations that if they can't reach agreement in the time period, all the company has to do is say, 'We've bargained in good faith. We couldn't reach agreement. We'd like to either modify by cutting back the health benefits or by cutting back the accrual rates on our defined benefit plan.' "

"Then the bankruptcy judges say, 'As long as you negotiated in good faith, that this fits the business judgment rule for successful reorganization, it's in.' Once again the power goes to the bankruptcy judges. The bankruptcy judges are making decisions over collective bargaining agreements. They're replacing the NLRB," he said.

"This is the fear of pension plans, of health plans, of union officials," Mr. Staab said.

For the benefit plan to be protected in bankruptcy court, "there is a formal act of assumption that is required. You have to get the bankruptcy court's blessing," he asserted. And the place to seek that commitment is at the creditors' table, he said.

Any interested parties—a union, a pension plan, a health plan, anybody affected by a collective bargaining agreement—can pursue the issue, according to Mr. Staab.

However, "if you're going to sit around and wait for the debtor to move the court to assume the contract, you will get burned," he warned.

Trustees converge at conference

HONOLULU—More than 5,000 trustees of multiemployer health plans attended the 51st Annual U.S. Employee Benefits Conference of the International Foundation of Employee Benefit Plans, held Nov. 12-16 in Honolulu.

In addition to plan trustees, more than 500 plan administrators and 600 public employee representatives attended. The conference is the largest annual gathering of multiemployer and public-sector trustees and administrators, attorneys, accountants, actuaries, investment managers and others who provide services, manage or administer benefit trust funds. A total of 1,156 trust funds and 1,112 pension funds were represented. The conference also featured exhibits of 175 vendors.

Next year's conference will be held Oct. 8-11 in Las Vegas. For more information, visit the Brookfield, Wis.-based organization's Web site at *www.ifebp.org*.

Property/casualty insurers' 2005 nine-month results

Ranked by net income. All amounts are in thousands of dollars.

	Corporate			Property/casualty operations					
Company	Net income	Percent increase 2005-2004 (decline)	Consolidated revenues 2005	Combined ratio 2005 [1]	Combined ratio 2004 [1]	Premiums written 2005	Percent increase 2005-2004 (decrease)	Policyholder surplus 2005	Percent increase 2005-2004 (decrease)
American International Group Inc.	$10,023,000	20.9%	$81,542,000	99.1%	96.6%	$31,740,000	3.9%	N/A	N/A
The Hartford Financial Services Group Inc.	1,807,000	20.9	19,346,000	91.2	97.1	7,897,000 [2]	4.9	$6,900,000	16.9%
The St. Paul Travelers Cos. Inc.	1,443,000	121.3	18,184,000	97.9	108	15,092,000	9.3	17,738,000	23.4
Chubb Corp.	1,211,500	12.1	10,379,500	93.3	92.9	9,185,300	2.4	8,650,000	17.7
ACE Ltd.	792,000	(9.5)	9,900,000	98.9	93.5	9,164,000	3.5	10,229,000	3.9
Liberty Mutual Group Inc.	774,000	13.8	15,647,000	105.5 [2]	106.5 [2]	10,516,000 [2]	4.4	9,570,000	21.1
SAFECO Corp.	500,400	30.8	4,756,800	91.7	92.4	4,428,000	3.5	3,619,600	13.9
CNA Financial Corp.	469,000	230.3	7,450,000	106.2 [2]	101.7 [2]	5,190,000 [2]	(1.9)	7,330,000	11.1
Cincinnati Financial Corp.	419,298	7.1	2,800,579	91.0	92.3	2,348,835	3.3	4,659,921	1.6
Old Republic International	408,288	22	2,779,939	91.4	90.7	1,402,503 [2]	9.9	2,141,488	10.0
Ohio Casualty Corp.	135,373	89.4	1,274,951	101.1	99.5	1,112,457 [2]	0.1	937,003	0.6
American Financial Group	118,100	(55.8)	3,019,400	101.8	96.2	1,901,900	12.5	2,293,100	17.3
RLI Corp.	89,029	104.3	433,543	81.5 [2]	96.0 [2]	376,068 [2]	(3.6)	686,083	10.0
Argonaut Group Inc.	55,100	20.8	573,800	99.4	101.6	567,200	12	653,900	13.8
Cumulative	**$18,245,088**	**23.7%**	**$178,087,512**	**98.2%**	**98.6%**	**$100,921,263**	**4.5%**	**$75,408,095**	**14.6%**

1 Includes dividends 2 Statutory N/A Company did not provide data
Source: *BI* survey

Surplus: Wash. eyes reserve cap

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ing will also consider what should happen to any surplus amounts that are determined to be excessive and how the regulation will affect the marketplace, the OIC said.

Several insurers and other industry participants have been invited to participate in the hearing.

Among them is Regence BlueShield, a nonprofit provider of health, dental, vision and life insurance for more than 1 million Washington residents who purchase coverage as members of groups or as individuals. The insurer has an A- rating from A.M. Best Co.

"State statutes refer to reserves as 'surplus,' which makes them sound excessive or unnecessary," a Regence spokeswoman said in an e-mail response.

"In fact, these reserves are an essential safety net for our members. Any effort to reduce capital reserves will reduce our members' health security. These reserves protect our members from disasters, pandemics and unexpected claims that exceed premiums," the Regence spokeswoman said.

A spokesman for Premera Blue Cross in Mountlake Terrace, Wash. said in an e-mail response, "We do think placing limits on capital is a bad idea."

Steve Leahy, president and chief executive officer of the Greater Seattle Chamber of Commerce, said, "It's appropriate for Mr. Kreidler to study this, but we urge him to do a fair and complete review."

Results: Hurricane Katrina seen pushing up reinsurance prices

Continued from page 3

down in premium growth, but still very, very good margins, which have benefited from the compound effect of rate increases the past four years, tighter contract terms and conditions and also relatively benign claims inflation," said Mr. Lane

Results were "not unexpectedly strong, but strong," excluding the catastrophes, said John D. Gwynn, managing director at Morgan Keegan in Memphis, Tenn.

"It's amazing, isn't it?" he said. If the estimated $70 billion to $90 billion in hurricane losses had happened five years ago, "we'd have all assumed there'd be a couple of dozen failures," said Mr. Gwynn. That they have not materialized, "just speaks to the excess capital, at least on a reported basis, that's built up in the industry."

As for the rest of the year, Mr. Iten said, "We think absent any more unforeseen events, like another catastrophe in the fourth quarter, there should be a rebound back to the strong results that we saw in the first half of the year. So overall, we're expecting a reasonably good year for the industry," although not as good as 2004 because of Katrina.

Unique commercial loss

James B. Auden, senior director at Chicago-based Fitch Ratings, said, though, "overall, our expectation for industry earnings is down quite a bit for this year." Katrina's loss distribution "was a lot different than past hurricanes. A much greater percentage of the loss was in commercial vs. personal lines."

However, with loss estimates for Katrina alone still ranging between $30 billion to $60 billion, "There's a lot of uncertainty about what the ultimate results will look like" for year end, said Daniel Ryan, vp at Oldwick, N.J.-based A.M. Best Co.

Next year, assuming a normalized catastrophe year, is "likely to be a pretty good year in terms of profitability for the industry," said Mr. Ryan. But because rates had been decreasing, insurers will not have the benefit of the rate hikes from the hard market that were reflected in 2005 results.

Furthermore, "there's a good bet that pricing for reinsurance is going to go up substantially and be passed on to the primary companies" because of the capacity lost as a result of the hurricanes, said Mr. Ryan.

"I think results will be strong for next year," said Mr. Ward, however. "I think a lot of the discipline is still in place," although catastrophes and the issues related to modeling are wild cards.

Michael Dion, senior equity analyst at Sandler O'Neill & Partners L.P. in New York, said, though, "Premium growth will still be somewhat difficult to obtain, excluding any benefit from price increases, because you're still grappling with basically a lot of capacity in the industry looking to basically write a lot of the same business, and that competition, I think, is going to keep rates still at competitive levels."

James Inglis, managing director at Stamford, Conn.-based Philo Smith & Co., an investment banking firm, said the strong underlying results for the nine-month period "gives one pause for concern about where the cycle may go further down the road" and if competition may increase.

Disagreement on casualty

Observers disagree about the hurricanes' impact on casualty business. "I don't think we're seeing Katrina having a lot of impact there," said S&P's Mr. Iten. "We expect to see a continuation of the modest rate decreases that we've seen in 2005," he said.

"I know there was some speculation that there might be a spillover from Katrina in the casualty sector, but we don't see a lot of evidence of that at this point," said Mr. Iten.

Mr. Ward agreed. "I think there will be a minimal effect on casualty rates resulting from the hurricanes," he said. "The pricing that was in effect before the catastrophes will largely be in effect after the catastrophes" for casualty business.

Fitch's Mr. Auden said, however, there "might not be a hardening effect, but at least a stabilizing effect."

Best Vp Andrew Colannino agreed. "We're still in the downward slope of the pricing cycle, but there may be a flattening for the time being," he said.

Peter C. Streit, an analyst with Williams Capital Group in New York said he anticipated that casualty lines of business, which would have been down 5% to 10% next year without the hurricanes, would be flat to slightly up in the United States.

"There's been change in the marketplace, and the level of capacity is not the same as it was six months ago…so therefore pricing should reflect those changes in capacity," he said.

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Issue of December 5

Rules: HSA guidelines hamper FSA grace period use

Continued from page 1

could be used to cover expenses falling under a high-deductible plan, making employees ineligible to contribute to an HSA until the end of the grace period.

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

In their most recent notice, the IRS and Treasury Department adopted this approach. But regulators say, in the notice, that this curtailment on how FSA money accumulated from the prior year can be spent during the grace period would apply to all FSA participants, not just those opting for HSAs.

Even if, for example, just 20 workers out of 1,000 FSA enrollees signed up for HSAs, all FSA participants would be limited to applying the rolled over funds to non-medical core expenses or expenses above the deductible during the grace period.

Such a restriction will pose yet another communications challenge to employers, who would have to explain the limitations employees would face in tapping their FSAs during any grace period.

Some employers with HSAs may decide the hassle of explaining the restrictions and administering an FSA that can be used for certain expenses at some point in the year, but not for others, is not worth it and opt not to offer an FSA grace period.

"It's like oil and water. They don't mix," said Andy Anderson, of counsel in the Chicago office of law firm Morgan, Lewis & Bockius L.L.P.

Even before the latest government notice on integrating HSAs with an FSA grace period, many employers had been questioning whether or not to adopt the grace period.

> "It's like oil and water. They don't mix."
>
> **Andy Anderson**
> **Morgan, Lewis & Bockius**

For example, just one third of employers surveyed by Deloitte & Touche USA L.L.P. and the ERISA Industry Committee earlier this year said they intended to modify their FSAs to accommodate the grace period.

"A lot of people have said the grace period is more bother than it is worth. This (HSA issue) adds to that perception," said Jeff Munn, a consultant in the Falls Church, Va., office of Hewitt Associates Inc.

"A grace period doesn't really add that much. You still are probably going to have about the same amount of FSA forfeitures," said Scott Keyes, a health care consultant in the Stamford, Conn., office of Watson Wyatt Worldwide.

Others, though, caution against blowing the HSA-FSA grace period integration issue out of proportion, noting that only a small percentage—typically about 15%—participate in FSAs, and that FSA forfeitures tend to be low.

"You are talking about a small number of people," said Fran Bruno, an attorney in the New York office of Mercer Human Resource Consulting. Additionally, the Treasury-IRS notice still would permit employees to tap FSAs balances that were rolled over to pay expenses incurred during the grace period, like vision or dental care, that could be substantial, Ms. Bruno said.

In a special transition rule, regulators are carving out an exception for FSA plan years ending June 30, 2006, that would allow employees to make regular contributions to an HSA during a grace period even though the employer offered a health care FSA to all employees during the grace period.

To qualify, under one option, the employee would have to exhaust his or her account balance by the end of the prior year.

"This is something employers will want to communicate to employees opting for HSAs. Spend your FSA balance down now," said Jay Savan, health and group welfare leader with Towers Perrin in St. Louis.

BI Stock Index [11/28 - 12/2]

Up-to-the-minute data for all 85 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**	
2,891.21	0.54%
Dow Jones	
10,877.51	-0.49
S&P 500	
1,265.08	-0.25

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

Largest gains

Gainsco, Inc.	12.35%
Meadowbrook Insurance Group Inc	9.85%
SCOR S.A	6.60%
AEGON N.V.	5.42%
Harleysville Group Inc.	5.29%

Largest losses

Endurance Specialty Holdings Ltd.	-6.78%
IPC Holdings Ltd.	-5.14%
PartnerRe Ltd.	-4.00%
NYMAGIC Inc.	-3.72%
Everest Re Group Ltd.	-3.17%

Weekly change by market segment

Brokers	37.41%
Insurers/Reinsurers	18.86%
Managed Care Organizations	27.85%

Late News

Continued from page 1

designing and placing a loss portfolio transfer agreement for Chiyoda Fire and Marine Insurance Co. (Europe) Ltd. in 2001.

California court rules for quake policyholders

An insurance broker acted as the California Fair Plan Insurance Co.'s representative for purposes of the Northridge earthquake revival statute, which gave policyholders another year to file lawsuits against their insurers in connection with the 1994 quake, a California appeals court ruled, overturning a lower court decision. The focus of the ruling was a California law that extended the statute of limitations to Dec. 31, 2001, for claims and lawsuits related to the quake provided the insured had contacted an insurer or an insurer's "representative" before Jan. 1, 2000, regarding potential damage.

Unions file suit to strike comp bill

More than 70 labor organizations filed a lawsuit last week seeking to strike down workers compensation reform legislation that Missouri Gov. Matt Blunt signed into law in March. Among several allegations, the lawsuit states that Senate Bill 1 so severely limited the types of injuries that are compensable under Missouri's workers compensation statute that the law "no longer serves as an adequate substitute for injured workers' tort remedies."

PBGC increases maximum benefit

Participants in pension plans taken over and terminated in 2006 by the Pension Benefit Guaranty Corp. will be guaranteed a maximum annual benefit of $47,659.08, a 4.5% increase from the 2005 maximum. In fiscal 2005, the PBGC paid about $3.7 billion in benefits to more than 682,000 participants in terminated plans, up from a $3 billion benefit payout to nearly 518,000 participants in fiscal 2004.

Bally Fitness insurers seek to rescind policies

Two excess directors and officers liability insurers for Bally Total Fitness Holding Corp. have asked a federal judge to allow the insurers to rescind their policies or deny coverage for losses stemming from securities class action litigation filed over the company's restated financial reports. The insurers, Travelers Indemnity Co. and ACE American Insurance Co., allege that Bally included materially false and misleading financial information in its applications for coverage during the 2003-2004 policy year.

Calif. comp insurers continue rate cuts

Workers compensation insurers in California continue to slash their rates and cite a favorable environment created by the state's workers compensation reforms. The State Compensation Insurance Fund announced last week that it will reduce rates 16% for policies incepting Jan. 1. Also, Woodland Hills, Calif.-based Zenith National Insurance Corp. said it has filed for an average 13.1% reduction from rates in effect since Jan. 1, 2005.

Medical group wins SCIF suit

A jury awarded $1.13 million to a medical group alleging that California's State Compensation Insurance Fund unfairly excluded it from its network of medical providers. Palm Medical argued that by excluding the group, SCIF violated the common law doctrine of fair procedure. That doctrine applies only when a business has substantial economic power in a market. SCIF argued that it excluded Palm Medical because the medical group mishandled claims and provided poor patient care.

XL forms E&S unit

XL Capital Ltd. has formed an excess and surplus lines unit to provide primary casualty coverage to midsize and large companies. John M. DiBiasi, who most recently served as executive vp of underwriting for Scottsdale, Ariz.-based Nautilus Insurance Co., will serve as president of the unit. The E&S policies will be underwritten through the insurer's Indian Harbor Insurance Co. subsidiary. The new unit, to be based in Exton, Pa., will focus on primary casualty business but also offer property and umbrella coverages.

At BusinessInsurance.com

New **Online Poll:** For 2006, do you think your organization's risk management department budget will:

a) increase; **b)** decrease; **c)** stay about the same; **d)** don't know.

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.

XL: Management's capability questioned following string of financial setbacks

Continued from page 1

nancial hit XL has taken in recent months. In October, XL reported $1.47 billion of catastrophe losses during the third quarter. In July, the insurer announced a $182.9 million increase in reserves for the North American reinsurance operations it acquired in its 1999 takeover of NAC Re Corp. XL has had to boost reserves on that business several times in recent years.

As analysts said they expected, XL management has moved quickly to shore up its balance sheet. The company announced plans late last week to sell at least $2.15 billion of ordinary shares and raise about $650 million of additional capital through a debt and equity offering.

Credibility hurt

The financial surprises, though, have taken a toll on XL management's reputation, say analysts.

The $830 million hit to capital "comes at absolutely the wrong time" for XL, as it already faced a capital crunch because of third-quarter catastrophe losses that were too large "in relation to its size," said Paul Newsome, a vp and senior equities analyst with A.G. Edwards & Sons Inc. of St Louis. "It also casts a cloud over management's ability."

Mr. Newsome explained that investors thought XL management would be in a better position than Winterthur Swiss management to analyze the loss development on the Winterthur International business, because XL has been managing that business for several years.

Brian R. Meredith, an analyst with Banc of America Securities L.L.C. in New York, agreed that the arbitration loss hurt XL management's "already damaged credibility." Management "was confident that they would win the arbitration and spent a lot of time and money on consultants to come up with their estimate," he said.

Mr. Newsome noted that if the loss development on the Winterthur International business eventually turns out to be close to the arbitrator's determination, then XL would be vastly overreserving for those losses now.

"It's just that this event (of losing the Winterthur Swiss arbitration) is one of a series of mishaps over the last few years" and several just this year, including the third-quarter catastrophe losses that were too large for XL's size and diversification said Mohammed Ashab, a, director and credit analyst with S&P.

"The loss to Winterthur raises questions surrounding some of XL's risk management capabilities, including areas such as the reserve setting processes, data quality and systems issues. Accordingly, we will be meeting with XL to ascertain its risk-management capabilities within the context of our new enterprise risk management criteria," Mr. Ashab noted.

"What we want to see is this company really perform and deliver consistent earnings without any significant negative surprises," he said.

But one analyst said the arbitrator's decision was not a big surprise.

Adam Klauber, a managing director with Cochran, Caronia & Co. in Chicago, said he had thought that there was an even chance that the decision could go either way. Mr. Klauber noted that, in these kinds of situations, insurer management cannot provide an adequate amount of data that would allow analysts to make a reasonable judgment on a likely outcome.

Still a good deal

Despite XL's arbitration loss, analysts said they believe that Winterthur International will turn out to be a good acquisition for XL. For XL, which paid a relatively low-priced $330 million for Winterthur International after several re-evaluations, the acquisition will help the insurer expand its commercial primary insurance business, they said.

But factoring in the NAC Re acquisition, which analysts characterized as "pricey," XL management's record on acquisitions is "mediocre" at best, the analysts said.

Mr. Klauber, though, said more time is needed to judge the wisdom of the NAC Re acquisition.

He noted that ACE Ltd.'s 1999 acquisition of CIGNA Corp.'s property/casualty insurance operations "looked bad at first" for ACE. Now, the CIGNA business is "the core of the franchise" at ACE, he said.

Over the next few years, XL management has to show it has "gotten on top of all the problems at NAC Re," and it must make Winterthur International a bigger primary market player, he said.

A spokesman for XL noted in an e-mail response that XL adopted an acquisition strategy in 1997 that included not only NAC Re and Winterthur International but also several other acquisitions that have expanded the company's size and reach.

The Winterthur International acquisition, in particular, "was critical to our development as a global company. It gave us the reach and competitive advantage of a global insurance network, strong customer relationships and intellectual capital and positioned us for the growth opportunities we have enjoyed over the last four years," he said. "This was no accident but part of a plan to become a major insurance and reinsurance player."

The analysts noted XL is well positioned—if it can raise adequate capital—to take advantage of an expected market hardening after the huge hurricane losses this year.

For example, Mr. Ashab said that, despite the downgrade, S&P viewed XL as an insurer with a "very strong competitive position and global market presence, diversified earnings stream, very strong investments, liquidity and financial flexibility, and negligible asbestos and environmental exposure."

Turbulent times for XL

FEBRUARY 1999: XL merges with NAC Re Corp. in a deal valued at $1.2 billion.

OCTOBER 2000: XL exits several lines of business, including the pooled aviation and medical stop-loss business written by NAC Re. XL eventually will not renew more than 60% of the business it acquired with NAC Re.

JULY 2001: XL enters international primary insurance with $600 million acquisition of Winterthur International from Winterthur Swiss Insurance Co.

JANUARY 2002: XL announces $60 million fourth-quarter 2001 loss, partially due to a boost in reserves for NAC Re business written prior to 1999.

JANUARY 2002: Winterthur International sets up a large-account excess casualty underwriting unit in New York.

FEBRUARY 2003: XL takes $30 million charge in its fourth quarter for 2002 to boost reserves for pre-1986 asbestos liabilities it acquired.

OCTOBER 2003: XL's third-quarter 2003 profits are reduced by $184 million for losses from its North American reinsurance casualty business, which NAC Re had written in the late 1990s.

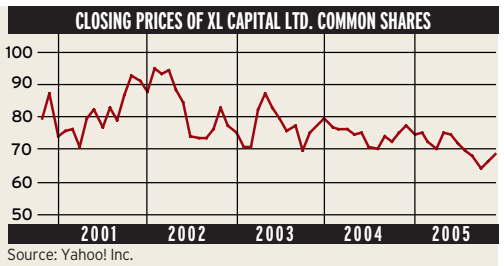
JANUARY 2004: XL takes $663 million pretax charge against fourth-quarter 2003 earnings to bolster reserves on business NAC Re had written before its acquisition. The charge spurs rating agency action against XL. Management promises the boost will resolve all NAC Re reserving questions.

JULY 2005: XL boosts reserves on its North American reinsurance business by $186.3 million on an aftertax basis.

OCTOBER 2005: XL reports more than $1.47 billion of natural catastrophe losses in third quarter, equal to 18% of second-quarter shareholder equity.

NOVEMBER 2005: An arbitrator rules XL is owed only $575 million for loss development and unearned premiums on business Winterthur International wrote before its 2001 acquisition. XL had sought about $830 million more.

CLOSING PRICES OF XL CAPITAL LTD. COMMON SHARES



Source: Yahoo! Inc.

TRIA: Differences in House and Senate extension bills appear surmountable

Continued from page 1

teed, though. Late last week, rumors arose that the House Judiciary Committee could exert jurisdiction over the bill because of the bill's potential tort implications. That would slow its progress and perhaps delay its consideration until 2006. In the meantime, TRIA would expire on Dec. 31, leading to market dislocations.

"Bringing in tort reform issues on TRIA is an act designed to eliminate the chances for TRIA extension, and I'm confident that House leaders will appropriately address that position," said Joel Wood, senior vp-government affairs for the Council of Insurance Agents & Brokers in Washington. "There's no bill with tort reform provisions in it that will ever be accepted in a conference setting with the Senate."

If that is avoided and the House approves its TRIA extension bill, House and Senate conferees would have to iron out differences between the measures, which are considerable but not insurmountable, say observers. The differing approaches to studying the long-term issues surrounding terrorism insurance should be resolved with relative dispatch, say some TRIA advocates.

"Everybody wants to negotiate renewals that have terrorism coverage intact on Jan. 1," said the CIAB's Mr. Wood. "That's been everyone's priority. However, it is very difficult for me to envision that two years from now we'll successfully petition Congress for yet another extension. There needs to be some sort of pathway toward a permanent and private solution," he said.

"It's not too difficult to see how you could reconcile those two approaches. But, arguably, it is the most important long-term issue. If all we get is TRIA with more industry participation and it ends in two years, then this entire effort is just a stopgap. We like the construct in the House, but there's every reason to believe" the House and Senate can work out their differences, Mr. Wood said.

"Either or both bills could get you to a long-term solution. We're just very pleased that both the House and the Senate have acted and acted very responsibly to create bills that can work in the marketplace," said Carl Parks, senior vp-government affairs in the Washington office of the Property Casualty Insurers Assn. of America.

"We're trying diligently not to pick favorites between the two bills, but on that particular provision, PCI has worked very hard on finding a long-term solution all along," he said. "We're very supportive of the House provision that creates what we would say is a bridge to a long-term solution. Either bill could produce that, but the House seems to be more of an umbilical cord to a real long-term solution."

"I think they can be ironed out," said Leigh Ann Pusey, senior vp-government affairs for the American Insurance Assn. in Washington. "The good news is both bills recognize the need to explore a long-term solution. The House bill has a little more detail to that."

David Winston, senior vp-federal affairs for the National Assn. of Mutual Insurance Cos. in Washington, agreed that the differences could be overcome. "Clearly, there has to be long-term public/private partnership. At the end of the day, there will be a resolution of the two approaches, and it's certainly not a deal killer," he said.

Risk managers like the commission idea as well but want more buyer representation.

"I'd like to see a little more representation of the policyholder community, maybe a little more balance there," said Bradley R. Wood, senior vp-risk management for Marriott International Inc. in Bethesda, Md. "You've got one slot here for policyholders," he noted.

"It's an opportunity for government to dispel the notion that it's an insurer bailout by ensuring that there's the appropriate balance of policyholder interest on the commission," said Marriott's Mr. Wood.

Terry Fleming, a member of the New York-based Risk & Insurance Management Society Inc.'s board of directors with responsibility for external affairs, said, "We would prefer a risk manager be named" to the commission. This could be done by either replacing the policyholder spot with one specifically for a risk manager or adding an additional position to be filled by a risk manager, explained Mr. Fleming, who is also director-division of risk management for Montgomery County, Md., in Rockville.

One prominent extension advocate holds that the House approach is the only acceptable way to go.

"It's a step back for the Senate," said Ronald R. Robinson, chair of the Chicago-based Defense Research Institute's TRIA subcommittee and a partner in the Los Angeles law firm of Berkes Crane Robinson & Seal L.L.P. "The original S.467 had a much broader mandate for the presidential working group, and they stepped back from that."

Mr. Robinson recently joined Don Goodrich, chair of the Families of Sept. 11 organization, in sending a letter to leaders in both houses of Congress urging that a final TRIA extension bill contain the House bill's commission rather than the narrower Senate proposal.

"The real crux of the matter is the full participation and the forward-looking recommendations," Mr. Robinson said in an interview last week. "The commission is a fair attempt to include all of the stakeholders."

Another attorney specializing in insurance and reinsurance agreed.

"I think its critical to have something in place as a backstop for the extraordinary catastrophic exposure of terrorism in the United States now, so I would view a long-term solution to include some government backup at an appropriate exposure, rather than a short-term temporary solution that will leave these types of risks basically uninsured over the long term," said Christopher Kende, who is vice chair of the reinsurance practice group at Cozen O'Connor in New York. "I don't think the industry is capable of absorbing these types of losses. We've been incredibly lucky that nothing horrible has happened. I would prefer the commission and a solution that would improve government backup at an appropriate level based on an in-depth study by a broad-based commission."