Munich Re America
Munich Re Group

October 2008

# Munich Re America HealthCare **Newsletter**

## Healthcare Policy Reform

Will financial crisis push healthcare reform aside?

Click here for a variety of opinions.

**Also in this edition:**

October 2008

# Munich Re America HealthCare **Newsletter**

## Healthcare Policy Reform

## Will financial crisis push healthcare reform aside?

See these links for a variety of opinions.

***What I'm Telling the Health Care Business About the Future***
**by Robert Laszewski**
http://healthpolicyandmarket.blogspot.com/

"As the economy adjusts itself to this new reality, there will be no money for big health care reform plans--although what will likely be a growing number of uninsured will create an imperative for it to happen. An imperative that will be stymied by budget issues driven by the economic adjustment."

***Health Care and the Broader Economic Crisis*** **By BRIAN KLEPPER**
http://www.thehealthcareblog.com/the_health_care_blog/2008/10/health-care-and.html/

"The good news is that economic crisis favors approaches that drive down risk and cost. Organizations that focus on medical homes, Health 2.0, advancing clinical technologies (like minimally invasive procedures, or genomic tests that can often eliminate the need for certain treatments) and medical tourism should all do well in this environment."

***Health reform in the economic aftermath...*** **by Anthony Wright,**
http://www.health-access.org/2008/09/health-reform-in-economic-aftermath.htm

"We should remember that the major social programs and leaps--Social Security, Medicare--happened during similarly tumultuous times. And to those who argue that a new President will have other issues on his plate (two wars, the economy, housing, energy, etc.) to worry about, let's also remember that transformational moments in American history are not single-issue events.

"The New Deal, the Great Society did not only focus on one issue. When we argue that health reform needs to be a priority, it is not at the exclusion of other issues: rather, the change that comes will be on several fronts. It is our job to insure that health care is part of that wave."

**Business Development & Marketing**
Munich Re America
HealthCare

Table of contents

Picture credit
Shutterstock.com

© Copyright 2008
Munich Reinsurance
America, Inc.
All rights reserved.

Munich Re America
Munich Re Group

**The Actuarial Department**
Munich Re America
HealthCare

RATE THIS ARTICLE
★★★★★

October 2008

# MRAHC Newsletter
# Retiree Medical Solutions

As retiree medical costs continue to grow, some employers are dropping coverage. This article explores other solutions that can save employers money without eliminating these important programs.

**Retiree healthcare costs are becoming an increasing burden on employers.**

**Government agencies are beginning to feel the same pain from their retiree healthcare plans.**

Table of contents

In today's world of escalating healthcare costs and increasing life expectancies, the Financial Accounting Standards Board (FASB) 106 liabilities for retiree healthcare costs are becoming an increasingly onerous burden on commercial employers. With the recent creation and ongoing implementation of Governmental Accounting Standards Board (GASB) 43, governmental entities are beginning to feel the same pain from their retiree healthcare costs. The option being chosen by many employers is to simply drop coverage, but there are other solutions that can save money for employers without eliminating benefits that retirees may be counting on.

### Series 800 Part D Plans

Also called "Employer Group Waiver Plans" or EGWPs, these plans allow employers (usually self-funded companies) to shift the risk of Part D drug benefits to a fully-insured plan. These plans allow employers to gain the benefit of the Centers for Medicare and Medicaid Services' (CMS) subsidization of the Part D drug benefit without going through the administrative hassle associated with the Retiree Drug Subsidy (RDS) available to self-funded plans. For employers that currently offer a fully-insured Medicare Supplement plan that includes drug benefits, an EGWP may not be an ideal option.

### Group Medicare Advantage Plans

Employers can also choose to enroll their retirees in a Group Medicare Advantage (MA) Plan. Under this arrangement, the beneficiaries are no longer covered by two different plans (traditional Medicare and a Medicare Supplement plan), but are now covered by a single MA plan. The employer may realize some savings with these plans because of the potential for improved medical management, and the current CMS funding formula for these plans. However, because of recent legislative changes to the Medicare program (in particular the future requirement for contracted networks), and planned changes to Medicare reimbursements, this solution is likely to be attractive only if:

- The employer is willing to move the retirees into a network-based plan

**Retirees can be covered by a standard Medicare Supplement plan if they aren't covered by the MA network.**

with significant medical management components,
- The retirees are heavily concentrated in only a handful of metropolitan areas, and
- The employer is willing to offer a "dual-choice" option, so that the retirees can be covered by a standard Medicare Supplement plan if they aren't covered by the MA network.

**Individual-based Defined Contribution Plans**

Employers can set up either notional or funded Health Reimbursement Accounts (HRAs) for each employee, out of which the worker can purchase individual coverage (Medicare Advantage or Medicare Supplement). This plan has the advantage of reducing FASB and GASB liabilities, and removing the employer as the health plan sponsor. However, it does require retirees to find other coverage, which may not sit well with employers or retirees. It also does nothing to solve the problem of retirees under the age of 65 who aren't eligible for Medicare. Because many people would not be able to find affordable individual coverage, removing them from the active group population isn't a viable option.

**A VEBA trust will provide defined contribution funding for a group health plan and have the advantages of an individual defined contribution plan.**

**VEBA-funded Defined Contribution Plan**

Employers can also set up a Voluntary Employee Beneficiary Association (VEBA) trust that will provide defined contribution funding for a group health plan. This mechanism can have the advantages of an individual defined contribution plan. However, because coverage can be provided with a group plan, individuals don't need to find their own coverage and pre-65 retirees can be included, thus eliminating the disadvantages mentioned above. We are aware of at least one company that can help set up these types of trusts on a "turn-key" basis, and we believe there are others out there as well.

While this is not a comprehensive list of all possible solutions to the retiree health care problem, our hope is that understanding a little more about these options can benefit you in helping your clients get the most out of their healthcare dollar.

For more information contact Nick Potenza, Chief Actuary, Munich Re America HealthCare.

Table of contents

Picture credit
Shutterstock.com

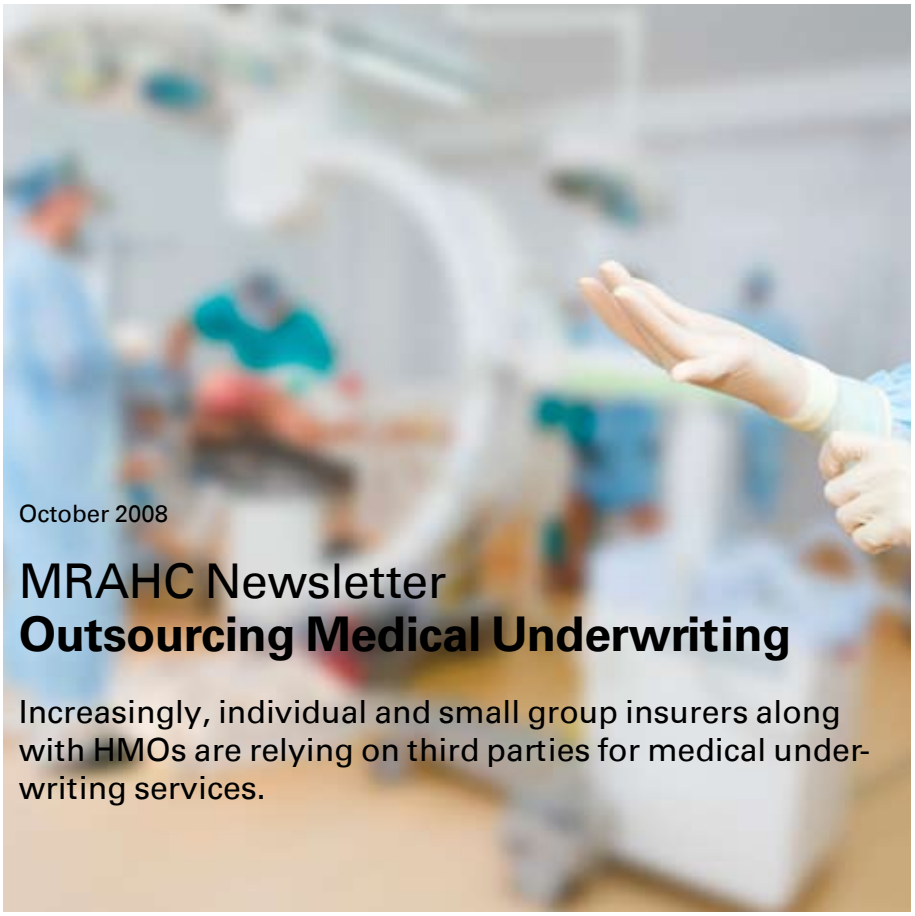
© Copyright 2008
Munich Reinsurance
America, Inc.
All rights reserved.

Munich Re America
Munich Re Group

**Joseph Sabol**
Underwriter
Munich Re America
HealthCare

**Vicki Schmelzer**
CEO
Strategic Underwriting Solutions, LLC

RATE THIS ARTICLE
★★★★★



October 2008

# MRAHC Newsletter
# Outsourcing Medical Underwriting

Increasingly, individual and small group insurers along with HMOs are relying on third parties for medical underwriting services.

**Outsourcing routine business processes is not a new idea.**

**Outsourcing a core competency like medical underwriting is relatively new.**

Table of contents

## One company's growing pains

Significa Insurance Group, Inc., a recent entry into the small employer, fully-insured PPO market in PA, OH, and AZ, was experiencing rapid growth. But as their quote activity increased, in-house underwriting resources were strained, and response turnaround times began to lag dangerously. The problem needed to be resolved quickly to avoid service issues with agents and prospective clients.

Significa contacted Strategic Underwriting Solutions (SUS) to discuss overflow underwriting options. A quote was provided within 24 hours and SUS was underwriting business for Significa (utilizing Significa's guidelines) within one week.The backlog of quotes diminished in approximately 10 days.

Significa's decision to outsource medical underwriting services is part of a new trend developing among carriers searching for new ways to remain successful in today's increasingly competitive market.

Outsourcing business processes is not a new idea. Many companies, including those in healthcare, have successfully outsourced various routine back-office business processes (data entry, billing, claims processing), citing benefits such as reduced transaction costs, improved service levels, and enhanced membership growth without adding infrastructure. The ultimate benefit, of course, is more freedom to focus on core competencies like customer service, product innovation, underwriting and building networks.

While outsourced underwriting services has existed in the MGU stop loss world for some time, a relatively new trend among individual and small employer group health insurers, as well as HMOs, is the move to outsource medical underwriting. The reasons are varied:

## Market consolidation

With many traditional small group carriers being acquired over the past 10 years, blocks of business were purchased but the necessary underwrit-

ing expertise was not always retained. As a result, when these companies experience growth in the acquired business, they don't always have the necessary underwriting expertise inhouse.

**Brain drain**

One of the last generations of underwriters to receive extensive, company-specific training and experience over years is reaching retirement age en-masse. Unlike years past, fewer companies are investing in significant training programs, and it is becoming difficult to stem the tide of attrition across the ranks of employees that possess much in the way of a company's institutional risk management knowledge.

**Fewer companies are investing in significant underwriting training programs.**

**Cost pressures**

Building an in-house underwriting department requires hiring, training, and developing staff, as well as purchasing or developing and then maintaining the necessary guidelines. Particularly in high cost-of-living areas, many organizations are finding it more cost effective to contract externally for experienced talent and tools, purchasing just the level of expertise they need for just the amount of time they need it.

**Many organizations are finding it more cost effective to contract externally for experienced talent and tools.**

**Finding the right match**

When shopping for a service provider, of course look for best practices and value-added benefits such as continuous quality improvement to achieve accurate, consistent and measurable results. Beyond that, to find the right match in a medical underwriting service provider you'll need to determine if your need is short-term (overflow) or long-term. You'll also need to identify what type(s) of expertise you need:

- Just new business or new and renewal
- Compliance services including: product development assistance, drafting policy language, filing forms/rates with government regulators to support client strategies
- Regulatory research to enhance performance
- Quoting systems
- Risk manual expertise
- Plan development
- Program development
- Consultation for block rehabilitations to improve performance
- Audit services for underwriting departments and reinsurer due diligence
- Audit consultations to provide procedures and potential audit programs
- Consultations to enhance underwriting processes and procedures for existing or new product development
- Staff training

**Evaluating a service provider**

Look for a company that offers more than a "one-size-fits all" approach to medical underwriting. Every insurer's guidelines and workflow demands are different, so requirements need to be customized to match the needs of each client. Also, look for a company run and staffed by actual underwriters – make sure you are working with people that have been in your shoes and understand the challenges and unique needs you confront every day.

When evaluating a potential medical underwriting service provider, consider the following:

- The level of expertise of their staff – is their strength in the type of underwriting that matches your need?

Table of contents

**Benefits multiply when underwriters are knowledgeable in both business operations and the medical field.**

- Are they easy to do business with – do they offer automated systems that allow swift and easy transfer of materials, applications, etc.?

- If it's a long-term need, do a cost comparison to building your own department.

- Talk through underwriting philosophies – work through several specific scenarios to see if your philosophies are aligned.

- What are their sources for underwriting guidelines – do they use commercially available guidelines or do they develop their own?

- How do they interpret their guidelines?

- How often are guidelines monitored and updated, or are they static?

- Scalable capacity – what is their ability to expand and contract service levels in concert with the volume cycles of your company?

A good medical underwriting service provider should be customer-focused and an extension of the health insurance company. When medical underwriting teams are composed of people who possess knowledge in business operations and the medical field, health plans can reap twice the benefits.

With the right outsourcing partner, a strategic alignment will exist between the health plan's requirements and the service provider's strategy. Evaluate whether the service provider is delivering cost savings only through labor savings, which might not be sustainable in the long term, or through a combination of technology, process improvements, and administrative application.

The bottom line is that insurance companies should never abdicate their responsibility to manage risk. But, insurers should always look at how they can do a better job of managing risk while maximizing all available resources – be they internal or external.

---

Vicki Schmelzer is CEO of Strategic Underwriting Solutions, LLC which provides high quality innovative medical underwriting solutions to the health insurance industry. For more information visit www.strategicunderwritingsolutions.com

Table of contents

Picture credit
Shutterstock.com

© Copyright 2008
Munich Reinsurance
America, Inc.
All rights reserved.

Munich Re America
Munich Re Group

**Rich Phillips**
Chief Underwriting Officer
**Bob Aristarco**
Business Development & Marketing
Munich Re America
HealthCare

RATE THIS ARTICLE
★★★★★

October 2008

# MRAHC Newsletter
# Emerging Market for Individual Health Insurance

The latest census report points to a continued decline in employer-sponsored health insurance. More middle-class workers and young adults, particularly students, are in need of individual health insurance products.

**Continued decline in employer-sponsored health insurance is fueling a need for more individual health products.**

Table of contents

The U.S. Census Bureau recently released its annual report "Income, Poverty, and Health Insurance Coverage in the United States." To the surprise of some, it showed that the number of people without health insurance actually declined to 45.7 million in 2007 from 47 million in 2006. This should be good news, but those familiar with the data aren't celebrating. A closer look reveals this decline is just a short-term reflection of recent growth in public insurance programs like Medicaid, which picked up 1.3 million more people, and Medicare, which added one million in 2007. (1 )

Overall, the number of uninsured remains considerably higher now than it was at the turn of the decade. In 2000 there were 38.2 million uninsured. Today that number is over seven million higher – an average of one million more uninsured each year. (2)

Between 2000-05 the share of Americans covered by employer-sponsored insurance (ESI) fell from 64% to 60%, representing 3 million people. Over that same time period, the number of employers (public and private) offering coverage also declined from 69% to 60%.(3) The latest census report confirms that this trend continues. In 2007, those receiving ESI fell to 59.3%, and this was before the economic downturn of 2008, with its much weaker economy and higher inflation. (4)

The rapid rise in healthcare costs over recent years has caused many businesses to reduce or eliminate the health insurance programs they offer. Firms do this by hiring more contract, temporary, or other kinds of nonpermanent workers who are often ineligible for benefits. Today, workers younger than 40 are especially impacted by these changes. At least 20 million workers, ranging from low-skill temporary workers to highly-skilled professionals such as software engineers, accountants, writers, and consultants, are either self-employed or in nonpermanent positions. (5)

The Heritage Foundation reports that ESI is declining among all occupations, but more so in some fields than others. In 2005, the lowest ESI rates were in construction (55%) and serv-

ice (57%) occupations, while the highest rates were in professional (87%) and management (90%) positions. Almost 78% of workers in manufacturing had ESI, while less than 52% in agriculture, construction, and mining received them. (6)

Not surprisingly, workers at small companies are more at risk. A 2004 Kaiser Foundation study of employer health benefits found only 52% of companies with less than 10 employees offer health insurance. (7)

**The really important story behind the Census bureau report is the continuing decline in employer-sponsored insurance.**

The takeaway from all this is that simply having a job no longer guarantees a worker will be offered health insurance. It is now necessary to have a job in the right industry in a certain type of company that employs a minimum number of people.

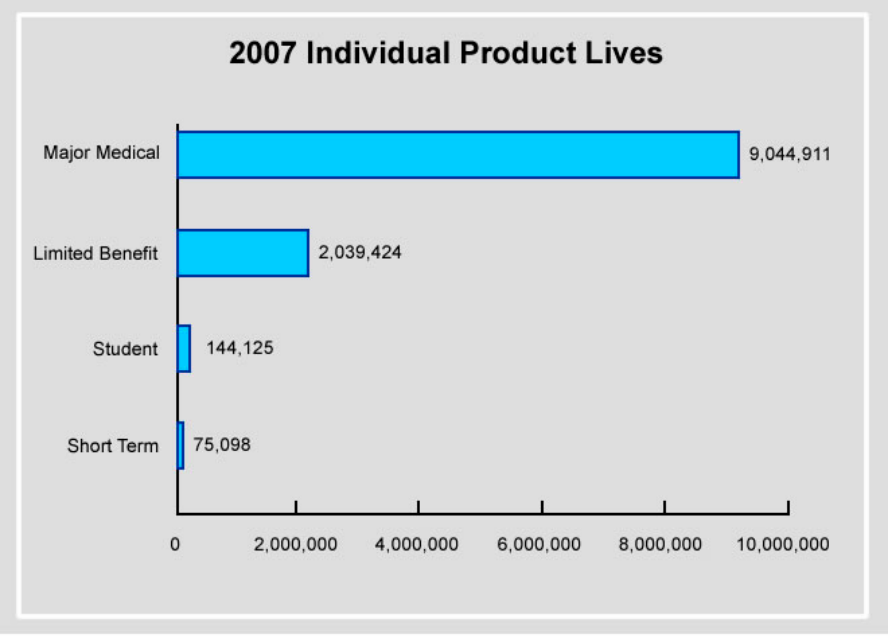
The New England Public Policy Center reports that in 2005 a third of the uninsured earned household income above the median income of $46,326. (8) And a Kaiser Family Foundation poll shows that one in four Americans considers paying for healthcare a "serious problem." (9) Separately, a study from the Commonwealth Fund found that 72 million Americans are having problems paying for medical bills or are struggling to pay medical debts. (10)

**More and more people are being priced out of the healthcare they used to take for granted.**

At the same time that the pool of workers receiving health coverage through their employers is shrinking, other groups (retiring baby boomers, those between jobs, and college students, among others) are also going without health coverage for varying periods of time, at least in part due to a lack of affordable individual insurance products.

The cumulative effect of all this is that a large and growing market for individual health products is being created.

Roughly 17 million Americans bought non-group insurance (full and limited coverage) directly from insurers in 2007, according to the research firm Mark Farrah Associates (MFA). They report that 229 companies offer major medical coverage to over 9 million individuals. Offerings range from major medical to limited benefit to student and short-term products. Wellpoint is cited as the largest player with 21% of the market. Limited benefit plans, offered by 55 companies in states where such plans are permitted, cover an additional two million individuals. Individual products for students are offered by just 12 companies, while 37 insurers offer short-term medical insurance to individuals. (11)




*Source: MFA Analysis using NAIC/CADMC Annual 2007 file data*

Table of contents

**There is no "one-size-fits-all" plan for individual coverage.**

In this environment, opportunities exist for health plans that can create new, innovative, consumer-focused products that are affordably priced. Target markets include: small business owners, the early retiree population, college students and recent grads, moderate to high-income skilled workers who are self-employed, low and moderate-income workers in construction, agriculture, and the service industries.These different market segments will require different types of products.

**Opportunities exist for innovative, affordable, customer-focused products.**

For early retirees who now have no regular income, continuing their employer plan through COBRA for 18 months is in many cases cost prohibitive. Comprehensive individual health plans, often times with higher deductibles or out-of-pocket costs, are a much less expensive option than an employer plan.

For those who cannot afford rich benefit plans, Limited Benefit Plans (Mini-Meds) provide the "dignity" of having coverage for doctor's office visits, prescription drugs, and coverage for the relatively minor but more frequent ailments.

As the name implies, coverage for more serious or chronic conditions is limited and may not fully cover these types of health conditions beyond a certain maximum benefit.

Similarly, uninsured college students or people who are between jobs need affordable coverage for sudden unexpected health or accident related conditions. Where state insurance regulations allow it,Temporary Medical is sold for individuals who fall into this category.

The bottom line is that there is no "one-size-fits-all" health plan for individuals. Instead, there will be continuing need for a wide variety of individual health insurance plans to fit many different specific circumstances, and many different stages of life. The size of this market is expanding now, and it is expected to continue to increase in the years to come.

Notes:

1. U.S. Census Bureau. *Income, Poverty, and Health Insurance Coverage in the United States: 2007*. August 2008. p.19-21. http://www.census.gov/prod/2008pubs/p60-235.pdf
2. Families USA (Public Advocacy Group) "Number of Uninsured Decreased in 2007, but Census Report Shows Growing Health Coverage Problems." Press Release August 26, 2008. http://www.familiesusa.org/resources/newsroom/statements/number-of-uninsured-decreased.html
3. New England Public Policy Center at the Federal Reserve Bank of Boston: *Policy Brief. Who are the uninsured and why are they uninsured?* March 2007, p. 2. http://www.bos.frb.org/economic/neppc/briefs/2007/briefs073.pdf
4. U.S. Census Bureau. P.20
5. New England Public Policy Center. p.2.
6.The Heritage Foundation: *Backgrounder. America's Unstable Health Insurance System: Recommendations for Increasing Stability and Coverage.* March 12, 2008. p.4 . http://www.heritage.org/Research/Healthcare/bg2115.cfm
7. PBS: Health Beat – On Line News. "The Uninsured in America." http://www.pbs.org/newshour/indepth_coverage/health/uninsured/whoaretheuninsured.html
8. New England Public Policy Center: Policy Brief March 2007 p.2.
9. Kaiser Family Foundation. Health08.0rg. "Kaiser HealthTracking Poll: Election 2008." June 2008. http://www.kff.org/kaiserpolls/h08_posr062508pkg.cfm
10.The Commonwealth Fund. *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families.* August 20, 2008. http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=700872
11. Mark Farrah Associates. Emerging Individual Market Options, July 25, 2008 http://www.markfarrah.com/healthcarebs.asp?article=45

Table of contents

Picture credit
Shutterstock.com

© Copyright 2008
Munich Reinsurance
America, Inc.
All rights reserved.

Munich Re America
Munich Re Group

**Len Dino**
President
LDI Integrated Pharmacy Services

RATE THIS ARTICLE
★★★★★

October 2008

# MRAHC Newsletter
# Rx Pipeline

This regular feature continues, as we again identify several treatments that may have significant cost impact during the next 12-18 months.

The following pharmaceuticals have been identified by LDI Integrated Pharmacy Services as treatments that may have a significant cost impact during the next 12–18 months:

**Rx:**
Elaprase™ (idursulfase)

**Condition:**
Hunter syndrome

**Cost:**
$300,000 per year

On July 24, 2006, the FDA announced the approval of Shire's Elaprase—the first treatment approved by the FDA for Hunter syndrome. Hunter syndrome is a rare disease that is inherited through the X chromosome.

It is estimated that 2,000 patients worldwide are affected by the condition.

The pathology of the disease is directly linked to the enzyme iduronate-2-sulfatase, which is not produced at all, or is produced in a defective form.The enzyme is needed in humans to facilitate the breakdown of cellular waste products which, in Hunter syndrome patients, accumulate in tissues and organs and may lead to organ dysfunction, growth delay, and in severe cases, respiratory and cardiac symptoms, neurological deficits, and death.

To encourage manufacturers to bear the high cost of the development of cures for rare disease states, the FDA has granted Elaprase an orphan drug status.

Elaprase's recommended dose is 0.5 mg/kg of body weight given as an intravenous infusion once weekly.

The annual cost for treatment is estimated to be $300,000 per year, although the exact price depends on the patient's body weight.

Table of contents

**Rx:**
Cimzia® (certolizumab pegol)

**Condition:**
Crohn's disease and/or Rheumatoid Arthritis

**Cost:**
$1,500 monthly

Cimzia®, a pegylated tumor necrosis factor (TNF) inhibitor manufactured by UCB, was approved by the FDA on April 22, 2008.

It is indicated for reducing signs and symptoms of Crohn's disease and/or Rheumatoid Arthritis (RA) and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy.

Crohn's disease is a chronic inflammatory condition of the gastrointestinal tract. Patients often experience symptoms such as diarrhea, abdominal pain, cramping, anorexia, and fever.

Conventional treatment options for Crohn's disease include aminosalicylates, corticosteroids, and immunosuppressants. When conventional therapies have failed, biologic agents are commonly recommended.

RA is a disabling autoimmune disorder that affects more than 2 million Americans and is characterized by chronic joint inflammation and fatigue.

Current treatment options include nonsteroidal anti-inflammatory drugs, corticosteroids, oral disease-modifying antirheumatic drugs (DMARDs), and injectable biologics.

The cost of this medication is approximated at $1,500 monthly and it is a lifelong therapy.

---

**Rx:**
H.P. Acthar® Gel
(repository corticotropin injection),

**Condition:**
Infantile spasm

**Cost:**
Course of treatment will be in the range of $80,000 - $100,000

H.P. Acthar Gel is natural source ACTH (adrenocorticotropic hormone). The drug stimulates the release of cortisol, aldosterone, and other hormones. Originally approved by the U.S. Food and Drug Administration (FDA) in 1952, H.P. Acthar Gel is used off-label for the treatment of infantile spasms, a condition for which no FDA approved therapy currently exists.

Infantile spasm is a type of seizure disorder occurring in infancy and early childhood. The disorder predominantly begins in the first year of life, primarily between the ages of 3-6 months. Spasms will usually last for several seconds and occur in clusters which can range from 2 to 100 spasms at a time. Infants may have dozens of clusters and several hundred spasms per day.

Although infantile spasms usually stop by the age of 5, they are often replaced by other seizure types. These spasms have been estimated to occur in about 1 per 2,000 to 4,000 live births.

The most common adverse effects associated with the use of H.P. Acthar Gel include: fluid and electrolyte disturbances, muscle weakness, peptic ulcers, hypertension, and impaired wound healing.

The current average wholesale price (AWP) for a 5 ml vial containing 80 units/ml is $29,086. Prior to August 27, 2007 the AWP for a vial containing the same amount of drug was $2,063.

It is anticipated that the cost for a course of treatment will be in the range of $80,000 - $100,000.

---

Table of contents

Picture credit
Shutterstock.com

© Copyright 2008
Munich Reinsurance
America, Inc.
All rights reserved.

This information is provided by LDI Integrated Pharmacy Services, and is for informational purposes only. For additional information visit www.ldirx.com.

## Managing Editor

Bob Aristarco
(609) 243-4343

## Staff Contacts

**Ed Griese**
President
(609) 243-877

**Rich Phillips**
Chief Underwriting Officer
(609) 951-8177

**Mike Shevlin**
Business Development
(609) 243-4893

**Donna Peterson**
PA Underwriting and Shared Services
(609) 243-8805

**Patrick Collins**
Integration, Sterling Life Insurance Co.
(609) 243-5638

**Todd Gallitz**
Underwriting
(609) 951-8184

## Questions/Comments

We welcome questions and comments on the newsletter and the topics covered.

To make comments, please contact Claudia Scott, VP Marketing.

This Newsletter is for informational purposes only and is not intended to offer medical, legal, or any other kind of professional advice. Munich Reinsurance America, Inc. and its affiliated companies ("Munich Re America") cannot provide medical or legal advice. We recommend that our clients consult their legal advisors on questions regarding the interpretation of any law or regulation that may impact their business. The articles in this Newsletter are meant to offer readers a variety of views and opinions about issues related to healthcare risk management that are culled from literature, and any views expressed herein are the views of the presenter and not the official views of Munich Re America. While the information, including the numerical data, in the articles was culled from or based upon medical literature or other industry sources, Munich Re America does not warrant the accuracy or completeness of any of the information contained in the articles.

© Copyright 2008 Munich Reinsurance America, Inc. All rights reserved. The Munich Re America and Munich Re America HealthCare names are marks owned by Munich Reinsurance America, Inc. Other names and marks used herein belong to their respective owners, and are used herein merely for identification and not for promotional purposes.

www.mrahc.com

Table of contents

© Copyright 2008
Munich Reinsurance
America, Inc.
All rights reserved.