

# Business Insurance

May 29, 2006

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\$5

## Late News

### Vermont enacts health care reforms

Vermont Gov. Jim Douglas has signed comprehensive health care reform legislation that will heavily subsidize health insurance premiums for lower-income residents and enable the state to achieve near-universal coverage within a few years. Aside from an increase in tobacco taxes to help finance coverage, the law relies on a new annual tax of \$365 per employee on employers not offering health insurance. Very small employers would be exempt.

### Alea selling E&S unit to Praetorian

Alea Group Holdings (Bermuda) Ltd. is selling its Delaware-based excess and surplus lines subsidiary Alea North America Specialty Insurance Co. to Insurance Corp. of Hannover, a unit of Praetorian Financial Group Inc., for between \$30 million and \$36 million. Alea, which entered runoff last year, will assume all of the liabilities of the excess and surplus lines unit written before the closure of the deal.

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## CalPERS lays out cost-shifting plan

### Members face higher copays in shakeup of huge program

By JOANNE WOJCIK

**SACRAMENTO, Calif.**—In an effort to limit rapidly rising health care costs and to address the needs of an aging population, the California Public Employees' Retirement System is considering whether the time has come for it to share more of its burden with its more than 1.2 million members.

If the changes under consideration are approved by the CalPERS board at its June 20 meeting, it would be only the second time since 1993 that the nation's third-largest health care purchasing pool has increased cost-sharing with plan members. In 2001, CalPERS increased copayments that were introduced in 1993 for its health maintenance organization members from \$5 to \$10.

Under consideration in the latest proposals are further increases to

copays, the elimination of HMO coverage in rural areas, the addition of another preferred provider option and contracting with health plans to provide Medicare Part D coverage (see box, page 26).

If all of the proposals are adopted, they would shave as much as 5% off premium increases expected for 2007, a spokesman said. However, the 2007 rates have not yet been made public.

"We have been successful in the past two years moderating premium increases without changing benefits," said Terri Westbrook, executive assistant officer, health benefits, when she addressed CalPERS Board's Health Benefits Committee on May 16. "But steps taken so far will not alone continue to produce measurable costs savings, year after year."

See **CALPERS** / page 26

## Quanta quits most lines after huge storm loss

### Lower rating cripples insurer

By RUPAL PAREKH

**HAMILTON, Bermuda**—Embattled Quanta Capital Holdings Ltd. is downsizing its operations by placing the bulk of its specialty lines insurance and reinsurance business into runoff and selling a portion of its U.S. business.

Hamilton, Bermuda-based Quanta announced the changes last week, though it had been exploring strategic alternatives since a March

ratings downgrade to B++ from A- by A.M. Best Co. Inc.

Best downgraded Quanta after the insurer and reinsurer reported hefty losses stemming from the string of hurricanes that pounded the U.S. last year. According to the company's 2005 financial statement, Quanta posted a net loss of \$106 million last year after the storms blew through its reinsurance protections. Quanta, which recorded gross premiums of \$608.9 million in 2005, reported \$87.4 million in losses stemming directly from the hurricanes.

See **QUANTA** / page 27



Prime Minister Tony Blair, left, and Secretary of State for Work and Pensions John Hutton discuss proposed reforms to the United Kingdom's pension system.

## U.K. pension reforms compel employers to pay into new plan

By JONATHAN GARDNER

**LONDON**—Sweeping U.K. pension reforms will require many employers to contribute the equivalent of 3% of workers' salaries into a new national private pension plan, raising concerns that some employers may reduce existing benefits or drop their defined benefit plans entirely.

Under the legislation, low-cost private pensions will be introduced in 2012, with employees contributing 4% of income between £5,000 and £33,000 (\$9,430 and \$62,238) and the employer contribution being phased in in 1% increments over three years. A further 1% would be contributed to participants' accounts through tax relief, bringing the total minimum contribution to 8% of employees' salaries.

Presented to Parliament last week by Secretary of State for Work and Pensions John Hutton, the proposal estimates that employers will see an additional £2.6 billion (\$4.91 billion) in retirement funding costs from the

changes, a 7.2% increase over the £36 billion (\$68.0 billion) employers were contributing to employees' pensions in 2004.

Under the reforms, an employee would automatically be enrolled into the national plan or his or her employer's plan, depending on which provides better benefits. Employees could then opt out of participating in either plan.

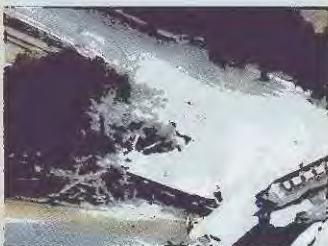
Specific proposals for the administration of the national plan, as well as how funds would be invested, are still under consideration.

Other proposed changes outlined in the legislation include raising the state pension eligibility age from 65 to 66 over two years between 2024 and 2026, from 66 to 67 between 2034 and 2036, and to 68 between 2044 and 2046.

The proposal for a national low-cost pension plan was first made by the Pensions Commission, a government-backed independent body led by Lord Adair

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## BENEFITS MANAGEMENT

### REGULATORY & LEGISLATIVE DEVELOPMENTS

States forge ahead with health care reform efforts; changes in publicly funded health care in Canada could impact employers; dependent care obligations extended.

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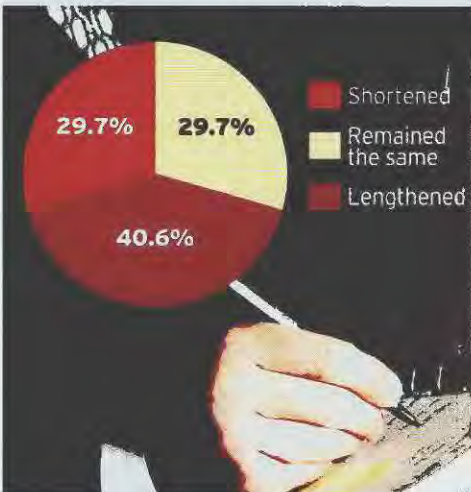
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### Online poll - [ 5/22 - 5/26 ]

Over the past three years, has the period of time between binding coverage and you receiving a policy:



Participate in BI's online polls at [www.businessinsurance.com](http://www.businessinsurance.com).

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### REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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# Complaint over single racist remark insufficient to protect worker's job

By JUDY GREENWALD

**RICHMOND, Va.**—Complaining about a single racist comment, no matter how offensive the remark, does not protect an employee from subsequent employer retaliation under civil rights law, says a federal appellate court in a recent decision.

However, a dissenting opinion in the 4th U.S. Circuit Court of Appeals case, *Robert L. Jordan vs. Alternative Resources Corp.*, says the majority opinion puts employees in the untenable position of requiring them to report racist comments, but giving them no job protection when they do so.

Defense attorneys say the case is fact-specific, and does not have implications for future decisions. However, an attorney for the U.S.

Equal Employment Opportunity Commission, which submitted an amicus brief in the case on the plaintiffs' behalf, said the decision could be influential, although other courts may rule differently.

Mr. Jordan was employed jointly by Barrington, Ill.-based Alternative Resources Corp., which has since merged with another company, and Armonk, N.Y.-based IBM Corp. in IBM's Gaithersburg, Md., office.

The incident that led to the racist comment was the October 2002 arrests of Lee Boyd Malvo and John Allen Muhammad, who have been charged with sniper attacks in Maryland, Virginia and District of Columbia, shooting 13 people and killing 10 over a period of several weeks.

According to the May 12 decision, while at

IBM's office, Mr. Jordan heard co-worker Jay Farjah, who was watching a news report of the arrests on television, exclaim, "They should put those two black monkeys in a cage with a bunch of black apes and let the apes (expletive) them."

Mr. Jordan, a black man, complained to his supervisors about the remark and was fired a month later. He was told he was "disruptive," his position "had come to an end" and that IBM's employees and officials "don't like you and you don't like them," according to the decision.

Mr. Jordan sued IBM and ARC, charging his firing was a retaliatory discharge under Title VII of the Civil Rights Act of 1964. A lower

See RULING / page 25



A 2005 freight train crash led to a \$205 million insurance payment by FM Global to textile company Avondale Mills Inc.

## FM pays \$215M crash claim

**MONROE, Ga.**—Avondale Mills Inc. will receive a total of \$215 million from Factory Mutual Insurance Co. to cover property and business interruption losses stemming from a 2005 train wreck, according to a filing with the Securities and Exchange Commission.

The settlement between the Monroe, Ga.-based textile manufacturer and its Johnston, R.I.-based insurer, which does business as FM Global, was made public last week shortly after Avondale announced that it plans to shut down or sell all of its operations within the next few months because of lingering problems associated with the train wreck in Graniteville, S.C.

The wreck occurred when a 42-car train carrying chlorine and other materials slammed into a locomotive owned by Norfolk Southern Railway Co. during the early morning hours of Jan. 6, 2005 (*BI*, Jan. 17, 2005). Leaking chlorine gas killed nine people, including six Avondale employees at a facility adjacent to the tracks. More than 200 people suffered respiratory injuries.

Under an agreement reached earlier this month but not made public until last week, FM Global agreed to pay Avondale \$215

million, including \$115 million already paid out as advance payments to settle the claim. According to the SEC filing dated May 16, the settlement does not have any impact on Avondale's claims against Norfolk Southern. The filing says that Avondale "specifically intends to preserve its rights to continue to pursue its claims against Norfolk Southern, all related parties and affiliates of Norfolk Southern, and all other persons or entities, other than Factory Mutual, who may be legally responsible for damages resulting from the Norfolk Southern derailment," with FM Global reserving the same rights.

"The settlement is not adequate to make us whole," said Stephen Felker Jr., Avondale's manager of corporate development. "But it is a settlement we agreed to with FM Global. And we intend to pursue all legal options in our lawsuit against Norfolk Southern."

Avondale, which employs about 5,000 people, plans to close or sell all of its U.S. operations, Mr. Felker said.

Neither Avondale nor FM Global immediately responded to calls for comment on the settlement.

—By Mark A. Hofmann

# Dependent care payment rules issued by IRS

By JERRY GEISEL

**WASHINGTON**—Newly proposed Internal Revenue Service regulations update and clarify expenses that employees can pay for through dependent care flexible spending accounts.

Benefit experts welcome the regulations, published in the May 24 Federal Register, for several reasons. Perhaps the most significant is the consolidation of dependent care FSA guidance, which previously had been scattered among various information letters and informal comments by IRS officials.

"They have pulled together information into one place," said Dennis Blair, a senior vp with Aon Consulting in Newburyport, Mass.

At the same time, the regulations update the last set of IRS dependent care FSA reimbursement rules, which were issued more than a quarter of century ago. Those rules had grown stale, experts said, failing to address dependent care situations that have become increasingly common.

"It brings the regulations into the 21st century," said Sharon Cohen, an attorney with Watson Wyatt Worldwide in Arlington, Va.

"A fair amount of catching up was necessary," said Andy Anderson, of counsel with the law firm Morgan, Lewis & Bockius L.L.P. in Chicago.

The regulations are vital for both employers and employees. Only dependent care expenses that the IRS recognizes as bona fide can be reimbursed through FSAs. Employers, or their FSA administrators, have to know

which expenses are reimbursable and communicate that information to plan participants.

Through the proposed rules, "greater clarification is provided on what can be reimbursed," said Scott Sims, general counsel with Hewitt Associates Inc.'s HR outsourcing group in Orlando, Fla.

## FSA contributions grow

Average percentage of employees contributing to and average contribution to a dependent care FSA \$3,541



Source: Hewitt Associates Inc.

Federal law effectively restricts dependent care FSA contribution eligibility to a relative small group of employees. For example, in the case of employees' children, expenses can be covered through an FSA for children under age 13.

Additionally, expenses for dependent care services must be necessary for the care of the individual and for "gainful employment." That latter requirement walls off dependent care expenses related to children for two-payment families in which

See FSA / page 26

# Dodgers tag Hartford with claims suit

Team says insurer's definition of 'total disability' is too narrow

By GLORIA GONZALEZ

**LOS ANGELES**—The Los Angeles Dodgers baseball team has sued the Hartford Life Insurance Co. for denying a \$1.7 million claim related to a hip injury suffered by retired relief pitcher Paul Shuey.

In a lawsuit filed in Los Angeles Superior Court earlier this month, the Dodgers allege that the Hartford, Conn.-based insurer wrongfully denied coverage from an insurance policy intended to provide coverage if Mr. Shuey became temporarily or permanently disabled.

During the 2003 baseball season, Mr. Shuey began experiencing severe pain in his right hip joint while pitching, and he had arthroscopic surgery on the hip in October 2003. While the pitcher participated in rehabilitative programs and pitched in minor league games in an attempt to return from the injury, he never fully recovered, leading to another surgery in 2004 and his retirement in 2005.

The Dodgers paid Mr. Shuey more than \$1.7 million in salary owed to him for the 2004 season and sought reimbursement from Hartford. According to the lawsuit, though, the insurer argued that Mr. Shuey's attempt to rehabilitate the hip and return to his team during spring training in 2004 suggested that he was not totally disabled as defined in the policy.

In addition, Hartford claimed that the Dodgers failed to produce adequate evidence that Mr. Shuey's disability was due to his hip injury and that a thumb injury the pitcher suffered might have contributed to his disability and was not covered under the policy, the suit states.

In its lawsuit, the Dodgers allege that Hartford's interpretation of the phrase "total disability" is so literal that a player who was unable to play baseball at the Major League level could fail to qualify for coverage if he were still capable of playing amateur or recreational baseball. The Hartford has evidence of the player's total disability, including Mr. Shuey's

own testimony and evaluations by the Dodgers and third-party observers, the team states in its lawsuit.

The Dodgers asked the court to order the insurer to arbitrate the coverage issues and to award compensatory damages for all costs related to Hartford's denial of the claim and the ensuing litigation.

Representatives of the Dodgers could not be reached for comment. A spokeswoman for Hartford, Conn.-based Hartford said it was against company policy to comment on pending litigation.

This is the second lawsuit the Dodgers have filed against Hartford in about three years. The team also sued the insurer in April 2003 for failing to pay a \$4 million claim in connection with a disability policy on injury-plagued pitcher Kevin Brown.

Earlier this year, the Houston Astros sued Philadelphia-based CIGNA Corp. for denying a \$15.6 million claim related to an injury suffered by first baseman Jeff Bagwell (BI, April 24).



Former relief pitcher Paul Shuey of the Los Angeles Dodgers is at the center of a coverage dispute between the Dodgers and Hartford Life Insurance Co.



Kentucky Derby-winning colt Barbaro suffered a career-ending fracture during the Preakness Stakes. Insurance market sources say the horse has coverage from at least two U.S.-based insurers.

## Injured Derby winner insured for millions

**WEST GROVE, Pa.**—Thoroughbred racehorse Barbaro—the 2006 Kentucky Derby champion that injured his right hind leg during the 131st annual Preakness Stakes earlier this month—is covered by at least \$15 million worth of insurance placed in the U.S. market, market sources say.

Providing bloodstock coverage for Barbaro were Manchester, N.H.-based North American Specialty Group, a division of Swiss Reinsurance Co. that wrote about \$9 million in coverage; and Great American Insurance Group, a unit of Cincinnati-based American Financial Group Inc., which had a \$6 million share of the risk, sources said.

Terms were not available, though bloodstock insurance typically covers exposures such as the death or disability of a horse, as well as loss of breeding income.

Market sources added that prior to the Preakness—the Baltimore race that is the second part of

thoroughbred racing's "Triple Crown"—brokers from Willis Holdings Group Ltd. were trying to place approximately \$10 million more worth of coverage on Barbaro, who last week underwent surgery to repair three broken bones. A spokesman for Willis declined to comment.

"Due to privacy reasons, we do not confirm coverage we place. Only the insured should control the public release of this type of information," a Swiss Re spokeswoman said in a statement.

Calls to Great American's equine property/casualty unit in Ocala, Fla., were not returned. The colt's owners, Roy and Gretchen Jackson of West Grove, Pa., meanwhile, declined to discuss insurance coverage for Barbaro but asserted that market sources' figures were "inaccurate."

The horse's injury, considered career-ending, is expected to take months to heal.

—By Rupal Parekh and Regis Coccia

## Active hurricane season predicted

NOAA says only 5% chance of below-normal season

**MIAMI**—As many as six major hurricanes will form during the Atlantic hurricane season that begins June 1, according to the National Oceanic and Atmospheric Administration.

NOAA's 2006 Atlantic hurricane outlook, released Monday at the National Hurricane Center in Miami, projects that there is an 80% chance of an above-normal hurricane season, a 15% chance of a near-normal season and only a 5% chance of a below-normal season. NOAA predicts that between 13 and 16 named tropical storms will form, between eight and 10 of which will grow into hurricanes, of which four to six will be major hurricanes. "This prediction indicates a continuation of above-normal activity that began in 1995," said NOAA in its forecast. "However, we do not currently expect a repeat of last year's record season."

Meanwhile, Newark, Calif.-based Risk Management Solutions Inc. last week released a catastrophe risk model that incorporates a five-year-forward-looking view of hurricane frequency.

In a statement, the catastrophe modeler said, "RMS believes that hurricane risk over the next five years is best represented by landfalling hurricane activity rates that are higher than the long-term historical average."

Earlier this month, cat modeler AIR Worldwide Corp. of Boston released a paper defending its long-term models based on a century of historical data—rather than five-year forward projections—as a better approach.

—By Mark A. Hofmann



The National Oceanic and Atmospheric Administration sees only a 5% chance of a below-normal hurricane season in 2006.

## Wholesale broker accused of condoning harassment

By RUPAL PAREKH

**LOS ANGELES**—BB&T Corp.'s wholesale brokerage unit violated California state employment laws by condoning a pattern of hostile behavior by a top executive, a former employee has charged in a \$50 million harassment suit against the firm and two of its current officers.

Filed by Constance D. Callan in Los Angeles County Superior Court this month, the suit names the company itself—CRC Insurance Services Inc., a subsidiary of Win-

ston-Salem, N.C.-based BB&T—along with company Chairman and Chief Executive Officer Tom Curtin and Chris Houska, a managing director.

According to the complaint, since joining CRC as a leader of its California operations in 2000, Ms. Callan ranked as the firm's top insurance producer, bringing in more than \$100 million annually in revenue. Ms. Callan is currently the top casualty wholesale producer in the country, the suit states.

Meanwhile, the book of business overseen by Mr. Houska, who

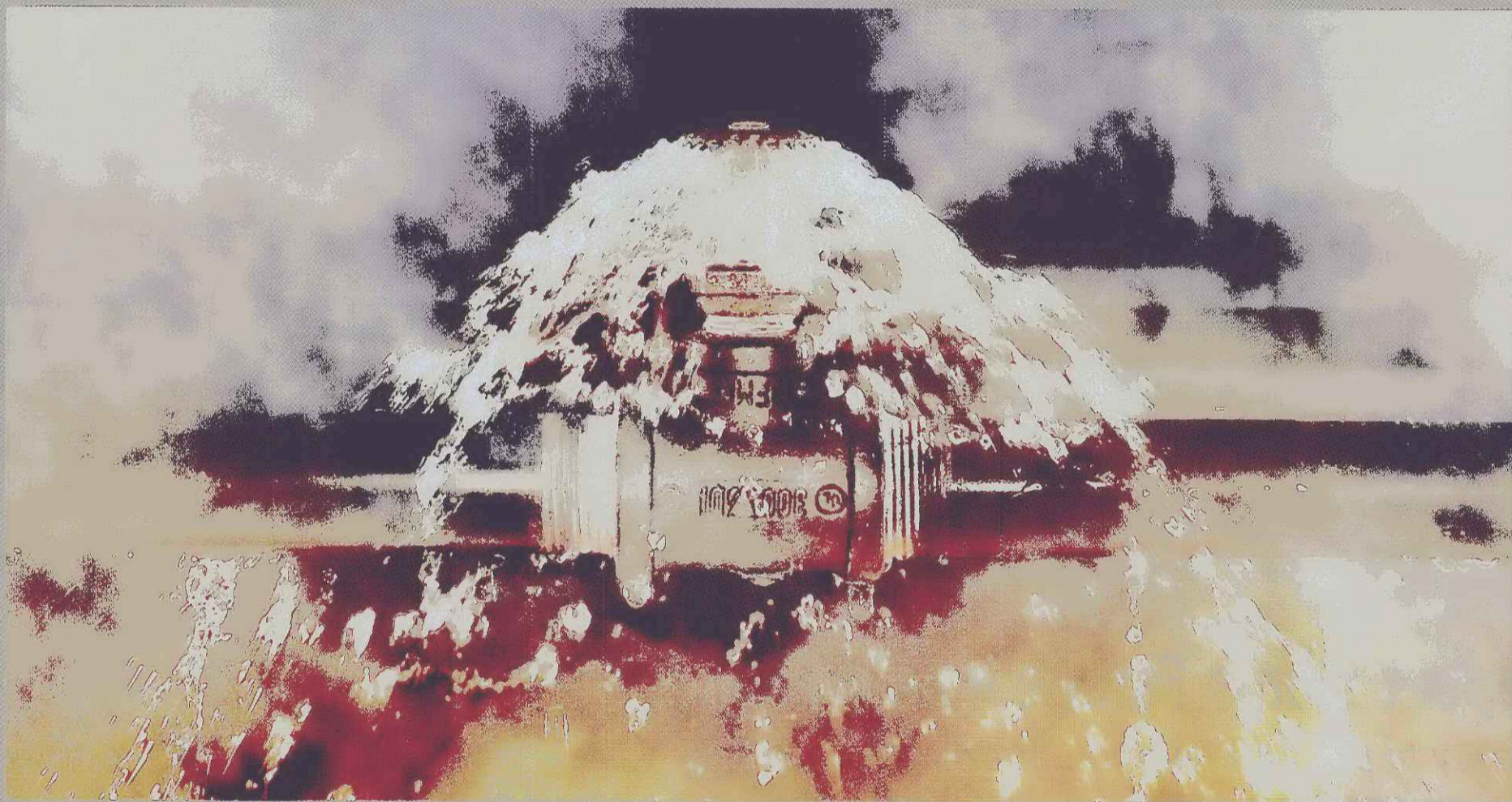
joined CRC in 2005 through the company's acquisition of Sterling West Insurance Services Inc., "paled in comparison to that of Callan," the lawsuit states. Mr. Houska consequently behaved in a hostile manner toward Ms. Callan, and "engaged in a pattern of sexually offensive and 'frat-like' behavior designed to insult, intimidate, demean, harass and humiliate" her, the suit states. In one instance cited in the suit, Mr. Houska called Ms. Callan an expletive

See CRC / page 24

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that appealed to both the company and its landlord. The existing system was replaced with one designed for high-pile storage and the building was outfitted with new heaters to prevent the pipes from freezing. In addition to protecting its inventory, the company saved almost \$30,000 a year in premiums. It's all part of Wausau TotalValue<sup>SM</sup> and our commitment to lowering our customers' total cost of risk. A commitment backed by the financial strength of the Liberty Mutual Group. To learn more, visit [www.wausau.com](http://www.wausau.com) or contact your Wausau representative.

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# Court rules on pregnancy bias

## Employers not obligated to modify duty: 6th Circuit

By DAVE LENCKUS

**CINCINNATI**—Federal pregnancy anti-discrimination law does not require employers to offer job-saving light-duty work to pregnant employees if such work is not offered to disabled employees who were not injured on the job, a federal appeals court has ruled.

Even if an employer offers light-duty work to employees injured on the job, the federal Pregnancy Discrimination Act of 1978 does not require extending the program to pregnant workers, a 6th U.S. Circuit Court of Appeals panel ruled unanimously on May 16.

The decision, which affirms a lower court's ruling, is in line with the appellate court's rulings in earlier cases and essentially concurs with rulings in two other federal appellate courts.

But the plaintiff's attorney in the case said the 6th Circuit's 3-0 decision could result in a U.S. Supreme Court review of how "narrowly" federal courts have interpreted the Pregnancy Discrimination Act.

Whether the attorney, Michael D. Cooke of Iuka, Miss., asks the Supreme Court to review the 6th Circuit's decision is uncertain, however, because of a financial dispute with his client, Amanda Reeves.

Meanwhile, labor and employment attorneys advise employers not to amend their employment

policies on pregnant workers in light of the decision.

Ms. Reeves had been a truck driver in Tennessee for Phoenix-based Swift Transportation Co. Inc. for a few months in 2002 when she became pregnant and was medically restricted from lifting more than 20 pounds. Her physician, though, permitted her to continue driving.

### Pregnancy bias law

The Pregnancy Discrimination Act provides that **pregnant employees** "shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work."

But citing an employment policy requiring drivers to push and pull up to 200 pounds of freight on a dolly, Swift terminated Ms. Reeves in November 2002. The company refused to offer her light-duty work, because her physical limitations did not result from a workplace injury.

Ms. Reeves was not eligible for unpaid leave under either the federal Family Medical Leave Act or a Tennessee maternity leave statute because she had not met their minimum length-of-employment re-

quirements.

According to court papers, Ms. Reeves argued that Swift's light-duty policy is discriminatory because it allows the company to offer light-duty work to employees with similar physical limitations to hers but not pregnant employees. Additionally, the policy violates the provision of the Pregnancy Discrimination Act that provides that pregnant employees "shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work."

Also, according to court papers, Ms. Reeves never had to load or unload her truck or lift, push or pull heavy weight during her tenure with Swift. In addition, another company employee testified in a deposition that she did not know of any drivers who have had to push or pull 200 pounds.

But in its ruling, the 6th Circuit panel called Swift's light-duty policy "indisputably pregnancy blind," because "it simply does not grant or deny light work on the basis of pregnancy, childbirth, or related medical conditions." Therefore, it complies with the Pregnancy Discrimination Act's employer requirement to "ignore" employee

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# Market softened in 2005: Survey

By SALLY ROBERTS

Corporate risk managers enjoyed another year of soft market conditions in 2005, and the market shows no signs of hardening any time soon, a recently released survey reveals.

Despite unprecedented catastrophe losses last year, the median total cost of risk was down for the first time since 2001, and the decrease was due almost entirely to lower insurance prices, according to the "2005 RIMS Benchmark Survey," produced by Advisen Ltd. for the Risk & Insurance Management Society Inc. in New York.

Following three years of skyrocketing insurance costs following the Sept. 11, 2001, terrorist attacks, prices in most lines of business began to moderate in 2004. But higher retained losses and rising workers compensation costs through the first half of 2004 kept the overall risk cost 3% higher than the year before, Advisen said.

In 2005, however, the median total cost of risk fell about 11%, according to the 2005 results, which are based on data from insurance programs of more than 1,400 U.S. and Canadian companies.

Despite an estimated \$58 billion in insured losses from hurricanes Katrina, Rita and Wilma, policyholder surplus rose last year, and the abundant underwriting capacity increased competition and lowered insurance costs, according to Advisen.

"The property/casualty industry overall produced very strong profit, and policyholder surplus increased, which increased capacity," said David Bradford, editor-in-chief of New York-based Advisen. "It's just supply and demand. There's just more insurance available this year than last

year, and that's going to continue to keep downward pressure on prices," he said.

Almost every line of business tracked showed a premium decrease in 2005.

Directors and officers liability and employment practices liability saw the biggest premiums declines—a 19% median fall for each—while fiduciary liability and umbrella and excess liability premium remained flat for the year, Mr. Bradford said.

While property premiums, viewed on a quarter-by-quarter basis, experienced an upturn in the fourth quarter of 2005, the increase was likely a short-term response to catastrophe losses, Advisen said. Overall, median property premiums fell 7% in 2005, Mr. Bradford said.

One of the more significant developments of 2005, Advisen notes, is the near 18% drop in workers compensation premiums. While the premium decline follows overall market pricing trends, workers comp is highly regulated and is therefore less susceptible to large movements in any one year, Advisen said. It attributes the decrease, in part, to workers comp reforms in major states such as California and Florida.

In California alone, reform measures are estimated to have saved employers more than \$8 billion since 2003, Advisen said.

Advisen encapsulates the previous year's quarterly benchmark results into an annual survey and releases that information as a printed report showing annual trends.

The 104-page report that includes data collected between October 2004 and October 2005 for 15 industry groups is available for online purchase at <http://www.RIMS.org/benchmark> or by calling 800-655-6590.

# Report slams Fannie Mae on finite

## Agency to pay \$400 million fine over accounting

By JUDY GREENWALD

**WASHINGTON**—A government report that is harshly critical of various practices at the Federal National Mortgage Assn. says the organization inappropriately accounted for a finite risk contract with a unit of the Radian Group and explored—but never entered into—other finite risk arrangements with Marsh & McLennan Cos. Inc and a unit of ACE Ltd.

Observers disagree on whether the report signals greater scrutiny of the use of finite contracts by entities other than insurance industry companies.

James C. Lockhart, acting director of the Office of Federal Housing Enterprise Oversight, which last week issued its 340-page report on Fannie Mae, said in a statement that "the image of Fannie Mae as one of the lowest-risk and 'best in class' institutions was a facade. Our examination found an environment where the ends justified the means. Senior management manipulated accounting; reaped maximum, undeserved bonuses; and prevented the rest of the world from knowing. They co-opted their internal auditors. They stonewalled

OFHEO."

Fannie Mae has agreed to implement corrective measures and pay a combined penalty of \$400 million to the OFHEO and the Securities and Exchange Commission, according to the OFHEO.

In a chapter on improper earnings management, the report says Fannie Mae "explored the use of finite insurance policies as a means to manage earnings and entered into one small policy" in 2001 with Radian Insurance, a unit of the Philadelphia-based Radian Group Inc. that writes nontraditional mortgage insurance for second and high-loan-to-value mortgages.

The report describes the Radian policy as a pool insurance policy covering a higher-risk loan-purchase program. According to an e-mail quoted in the report from a Radian official, Radian was paid a one-time premium of about \$40 million.

Citing e-mails between Fannie Mae officials, the report concludes: "It is clear that Fannie Mae anticipated that it would collect as much in claims from the Radian pool policy...as it would pay in premiums...In fact the Radian policy accomplished the same income-shift-

ing objectives as the scuttled (Marsh) policy. The Radian policy shifted income from 2002 to 2003 and 2004."

The report continues: "Current Fannie Mae management has determined that policy was not eligible for insurance accounting, the accounting used to achieve the income-shifting effect, and that Fannie Mae should have accounted for it as a loan. The improper accounting and its income-shifting effect will be reversed" in a restatement.

A Radian spokesman could not be reached for comment.

The report says also that Fannie Mae "actively explored but did not enter into major finite policies" with New York-based broker Marsh and a U.S. subsidiary of Hamilton, Bermuda-based ACE.

According to the report, Fannie Mae began discussions with MMC in the early spring 2001 but terminated them in the late summer or early fall of the same year, before it entered into the contract with Radian.

The report says Fannie Mae began exploring an ACE policy in mid-2003. "For reasons that are

See **FANNIE MAE** / page 24

### BI Online

## Emerging Risk Strategies

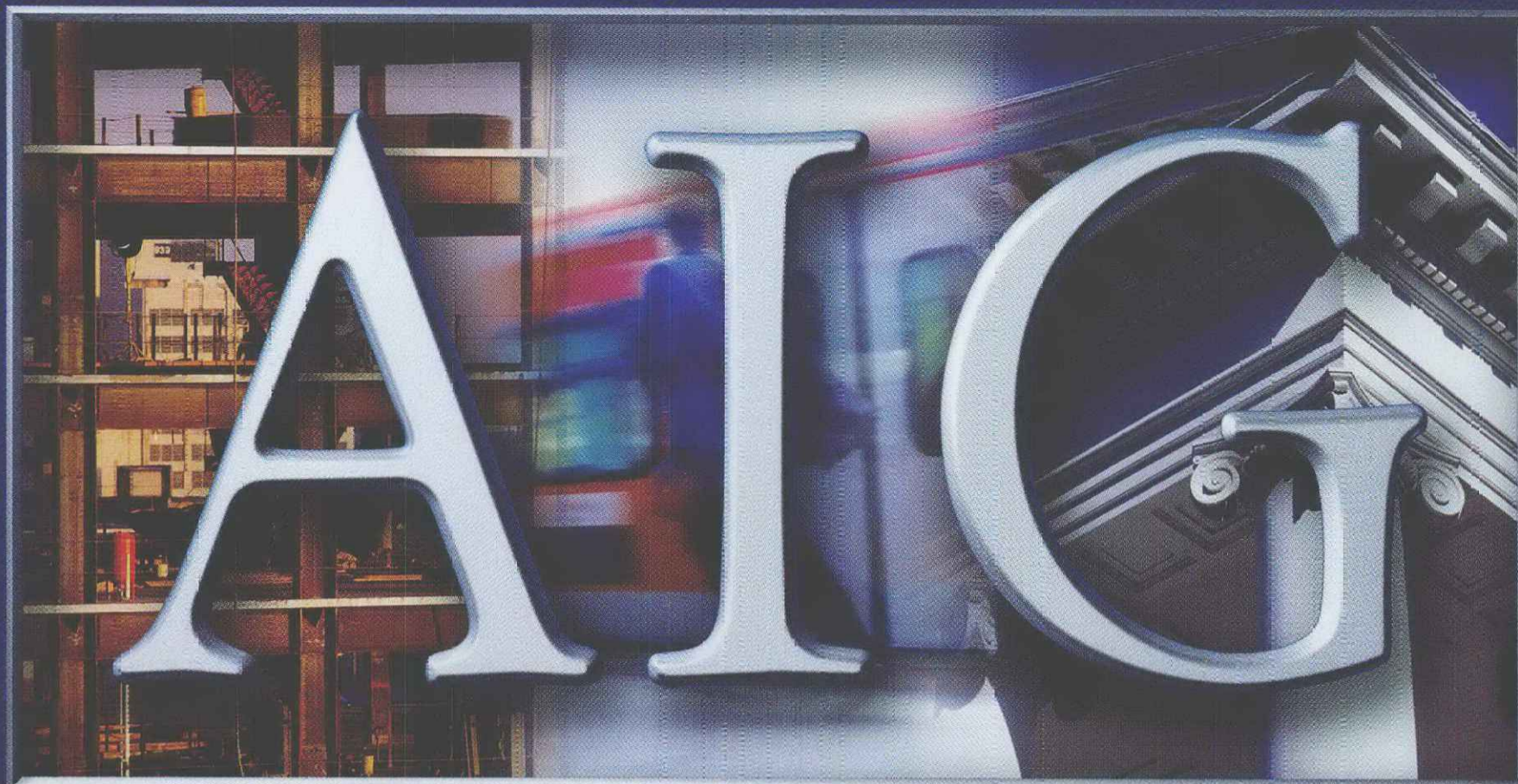
Exclusively at [www.BusinessInsurance.com](http://www.BusinessInsurance.com) is an interview on enterprise risk management that features columnist John J. Hampton and former Risk & Insurance Management Society Inc. President Christopher Mandel.

Mr. Hampton and Mr. Mandel recently discussed the ideas outlined in Mr. Hampton's May 15 column on Emerging Risk Strategies. In that column, Mr. Hampton suggested that corporations implementing ERM can benefit from appointing two executives, a chief strategy officer as well as a chief risk officer. In the interview online, Mr. Mandel, a proponent

of ERM and the 2004 Risk Manager of the Year, offers his views on the concept.

To read the interview and prior columns, please visit [www.BusinessInsurance.com/EmergingRiskStrategies](http://www.BusinessInsurance.com/EmergingRiskStrategies). To weigh in on this or other topics, please join BI's online Forums at <http://forums.BusinessInsurance.com>.

Mr. Hampton is the KPMG Professor of Business and Director of Graduate Business Programs at Saint Peter's College in Jersey City, N.J. He specializes in business ethics, legal liability and enterprise risk management. He is a former executive director of RIMS.



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## Editorial

# Crisis looms unless problems with pensions are addressed

WE WELCOME EFFORTS by the U.K. government to address that country's pension problems and hope that proposals it has offered, which are, in many ways, radical, will at least stimulate discussion in other nations facing similar issues.

As we report on page 1, the United Kingdom is proposing several changes to the state pension system, including raising the retirement age, eventually, to 68, and introducing what comes very close to a mandatory occupational pension plan for employers and employees.

Under the plan, employers will have to contribute the equivalent of 3% of employees' salaries to a national low-cost pension plan, employees will contribute 4%, and a further 1% will be contributed through tax-relief, bringing a total combined minimum contribution of 8%. That total contribution is not enough to ensure a comfortable retirement on its own, but it will go a long way to reducing the huge hole in retirement savings that is looming in the United Kingdom.

Employers that already offer pensions that are at least comparable will be exempt from

the plan and although employees will be automatically enrolled in the plan, they will be allowed to opt out.

Some fear that the introduction of a national low-cost plan will be the final nail in the coffin for traditional employer-sponsored plans in the United Kingdom, as companies may prefer to jettison their own more expensive plans in favor of a ready-made, government-endorsed alternative.

In some cases that will likely happen, but regardless of the new proposal, market forces will still be at work, we believe, to encourage companies to offer attractive benefits, including generous pensions, to attract the caliber of employees that they are seeking.

If one thing is abundantly clear regarding the pension problems of so many developed nations, it is that there is no one easy answer.

Employers, employees and governments are all going to have to contribute to any solutions if a crisis is to be averted. The introduction of a serious workable plan in one country can only help foster similar attempts at providing solutions elsewhere.

# Technology offers healthy savings

FOR THOSE OF US who thought the health care industry will forever be paper-intensive, a newly released study offers encouraging news.

The study, conducted by America's Health Insurance Plans, found that about three-quarters of all health insurance claims received by its members are now submitted electronically. That's a huge change and improvement from just four years ago, when less than half of claims were submitted electronically.

Why is that move to electronic claims processing important? Simply put, it saves a lot of money. AHIP pegs the average cost to process a clean claim submitted on paper at \$1.58. That's almost double the 85-cent average per-claim cost of claims that are filed electronically.

That may sound like pocket change, but when a health insurer is processing millions of claims each year, the savings add up quickly.

In fact, the move to electronic claims submissions is just one example of technological advances that have taken place in the health care industry.

For example, the old clumsy paper-inten-

sive way flexible spending account participants have been reimbursed is becoming history. Instead of employees filing a paper claim for reimbursement of out-of-pocket health care expenses, then waiting for an FSA administrator to process the claim and send out what often is a check for a small amount, now the entire process increasingly is electronic, often starting with the swipe of an FSA debit card.

Even doctors, who have stubbornly held on to paper, are starting to change. For example, some are using electronic devices to write prescriptions rather than scrawling prescriptions on paper, at times illegibly.

But a lot more—on the electronic side—needs to be done. All health care plan participants should have their insurance coverage and medical history embedded in a card that could fit in a wallet. We believe the savings from such a system—no scrambling, for instance, to obtain medical records, when an individual is injured away from home—would vastly exceed the system's costs.

Other countries are moving in that direction, and the United States should, too.

## Schillerstrom



## Letters

## Japanese insurers support federal charter in U.S.

To the editor: The General Insurance Assn. of Japan welcomes the initiative taken by Sen. John Sununu, R-N.H., and Sen. Tim Johnson, D-S.D., introducing federal regulation of insurance on April 5. For one decade after the Japan-U.S. insurance agreement was concluded in 1994, the Japanese nonlife insurance industry has called for regulatory uniformity among the different states on as many occasions as possible, including the Japan-U.S. Insurance Consultation and the World Trade Organization financial services negotiation.

Last year, through the dialogue of the "Regulatory Reform and Competition Policy Initiative" between the United States and Japan, the government of Japan urged both the government of the United States and the National Assn. of Insurance Commissioners "to harmonize and unify the state-based insurance supervisory systems or to shift to the federal regulatory system."

As a number of U.S. insurers have stated, regulations that vary from state to state impose on all insurers, including non-U.S. insurers who operate in the United States, significant costs and burdens and hamper the

efficiency of their operations. State regulations require insurers to obtain a license in every state in which they wish to do business and to comply with respective (and often contradictory) regulatory requirements of all of them. This has caused various inefficiencies in the market, such as preventing insurers from timely marketing of new products to consumers throughout the United States and increasing operational costs to multiple filings, applications and reporting requirements.

We applaud the current initiatives to introduce a federal regulatory structure into the U.S. insurance market. It must allow consumers to have opportunities to obtain insurance products without unnecessary delay. We sincerely hope that a forward-looking discussion on this issue will take place among the concerned parties, including the private sector, to realize truly effective federal regulation. We, the GIAJ, will maintain our support for this important initiative together with our U.S. colleagues, including the American Insurance Assn. and other concerned associations.

**Tadashi Kodama**  
Chairman  
General Insurance Assn. of Japan  
Tokyo

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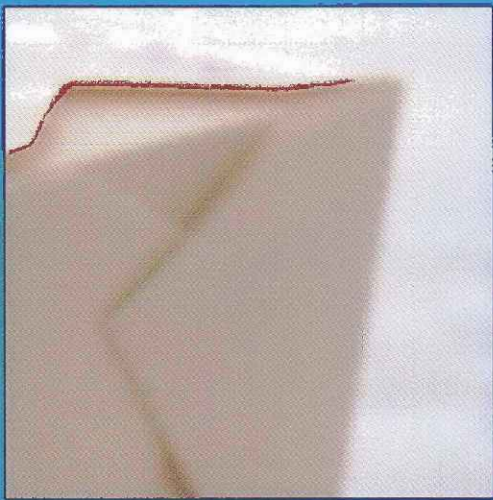
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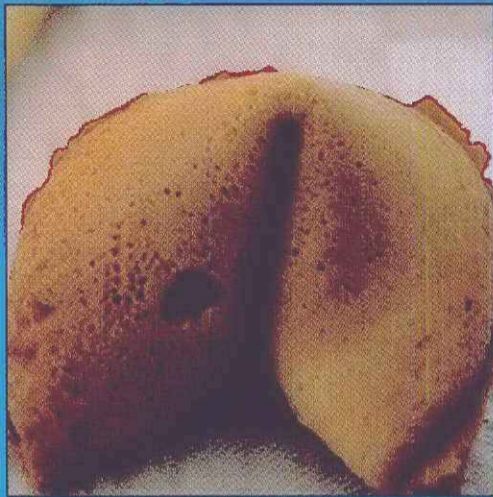
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# BENEFITS MANAGEMENT

## REGULATORY & LEGISLATIVE DEVELOPMENTS

Employers forced to extend coverage for dependents / 12

Canadian health care changes could shift some costs to employers / 16



## Drive to force health coverage gains traction

18 states consider measures

By JOANNE WOJCIK

It may seem that the labor-fueled movement to force employers to provide a minimum level of health benefits has been quieting down in recent months, but appearances are deceiving.

Although no other states so far have replicated Maryland's landmark law, the Fair Share Health Act, requiring employers to spend an amount equal to at least 8% of payroll on employee health benefits, similar measures are still alive in at least 18 state legislatures, including the harbinger states of California, New Jersey and New York.

But some of these bills, such as that under consideration in New Jersey, mandate that employers spend on employees' health benefits a set amount per hour worked, rather than a certain percentage of payroll, as does the Maryland law.

And although Massachusetts' recent approval of a measure imposing an individual mandate, which combines a state subsidy for health insurance premiums for uninsured residents with a charge on employers that don't offer coverage, may seem like a different approach toward addressing the uninsured problem, it is just a variation on the Maryland measure, observers say.

Some opponents of the mandated benefits approach had hoped a challenge to the Maryland legislation filed by the Retail Industry Leaders Assn. would stem the rising tide of legislation. That suit asserts that the law violates the federal Employee Retirement Income Security Act, which bars states from imposing benefit mandates on employers. But the ERISA suit appears to have had little, if any, impact on the movement.

If states stay the course and additional benefit mandates are enacted across the country, the result could be an administrative nightmare for large, multi-state employers.

Maryland, Massachusetts and Vermont—the three states to so far pass health reform legislation—“seem to be variations on the same theme,” said J.D. Piro, an attorney with Hewitt Associates Inc. in Norwalk, Conn.

“They all attempt to deal with the uninsured. They're

*“As long as health care costs continue to increase at the rate they've been increasing, the more states will have to do something.”*

Helen Darling  
National Business Group on Health

## State sparks blaze of reform

### Others copy Massachusetts health care changes

By JERRY GEISEL

Massachusetts lawmakers fired a shot heard around the country last month when they enacted sweeping health care reform legislation.

Intended to achieve near-universal coverage within three years, the Massachusetts law mandates that all residents be covered under health insurance plans.

To achieve this goal, Massachusetts will reallocate the hundreds of millions of dollars it now pays hospitals to offset the cost of treating the uninsured to health insurance premium subsidies for lower-income individuals.

The new law also will require all employers with at least 11 employees to offer health insurance and to make an as yet un-

defined premium contribution to it or to pay an annual \$295 per employee assessment. The revenue from that assessment also will be used to fund premium subsidies for the uninsured.

Additionally, the law will make it easier for smaller employers and individuals to purchase health insurance. The state will offer a mechanism, known as “The Connector,” in which buyers will be able to purchase policies directly from insurers approved by the state.

Within weeks of Massachusetts passing its groundbreaking measure, Vermont enacted a health care reform bill that was nearly as ambitious. While the Vermont law lacks an individual mandate, it does, like the Bay State, establish health insur-

See MODEL / next page

See FAIR SHARE / page 14

# Fair share: Legislative trend evident as more states jump on benefits bandwagon

Continued from page 11

just looking at it in different ways. At the one end, you've got the Maryland bill that targets only Wal-Mart, Mr. Piro said."

On the other end of the spectrum is the Massachusetts law, which takes a more comprehensive approach.

"The options are to provide coverage, pay a tax or put a mandate on the employee to carry insurance the same way they are required to buy auto insurance. They've taken the pay-or-play component from the Fair Share Health Care Act (and combined it with) the individual

mandate from the Cato Institute," Mr. Piro said.

Vermont is taking what Mr. Piro calls a "more traditional approach" to expanding health care coverage to the state's uninsured. That state's legislation requires employers with nine or more employees to pay a \$365 per employee fee if they do not provide health benefits.

"To that extent, there is a trend in states picking or choosing some of the mechanisms out there or all of them, as in Massachusetts' case," Mr. Piro said.

But do three states constitute a trend?

Helen Darling, president of the National Business Group on Health, a Washington-based consortium of large, national employers, thinks it does.

"In the legislative world, even a couple of things a year is a pretty big deal. I think this is part of a national trend," she said. "It is part of the relative desperation of the states to deal with problems. As long as health care costs continue to increase at the rate they've been increasing, the more states will have to do something."

Ted Nussbaum, director of health care consulting in North America for Watson Wyatt Worldwide Inc. in Stamford, Conn., said the states are rising up because "there is real concern over the uninsured population because of the effects on state Medicaid spending."

Medicaid spending now exceeds education spending in some states, said Cathy Stamm, a consultant and state law expert at Mercer Human Resource Consulting in Washington.

She suggested that lawmakers in some states may be rethinking their strategy in response to each new permutation of the Fair Share legislation.

"A lot of states are reconsidering," she said. "Instead of modeling after Maryland, they are taking into consideration what Massachusetts has done. Every time a state comes up with innovation, other states will copy."

One theme, however, remains constant.

"It might not be as extreme as Massachusetts and force individuals to buy coverage, but they're all go-

ing to find a way to charge employers that don't provide benefits, one way or another," Ms. Stamm said.

Ms. Stamm also predicted that RILA's ERISA challenge is not likely to succeed in overturning some of the measures, because lawmakers are drafting the legislation carefully.

**"Our argument is we want flexibility in how we design our benefits packages. These bills essentially tie the hand of employers."**

**Paul Kelly**  
Retail Industry Leaders Assn.

Maryland, for example, doesn't specify what benefits employees must offer. Instead, the law mandates that employers with a certain number of employees in the state simply spend a certain percentage of payroll on their employees' health care, she pointed out. The way the Maryland law is written it now would only apply to Bentonville, Ark.-based Wal-Mart Stores Inc.

Arlington, Va.-based RILA, whose members include Wal-Mart, is fighting hard at every front.

In addition to filing the ERISA challenge to the Maryland law and a Suffolk County, N.Y., statute that requires employers spend a certain dollar amount on health benefits

for each hour worked by an employee, RILA is testifying in state legislatures where similar legislation is on the table.

It also has testified before Congress because "the U.S. government has jurisdiction over ERISA, so we want to bring it to the attention of Congress," said Paul Kelly, senior vp for government affairs at RILA.

"Our argument is we want flexibility in how we design our benefits packages. These bills essentially tie the hand of employers. There's also a huge legal infirmity: They violate the federal ERISA law, which provides an incentive for big multi-state employers to offer health care coverage. It gives them uniformity. If that goes away and these states and locals further erode ERISA, what's the incentive? It would be too administratively cumbersome and complex" for many employers to continue to provide health benefits, Mr. Kelly suggested.

Indeed, having a patchwork of laws that vary by state will also be administratively complex, concurs Mr. Nussbaum.

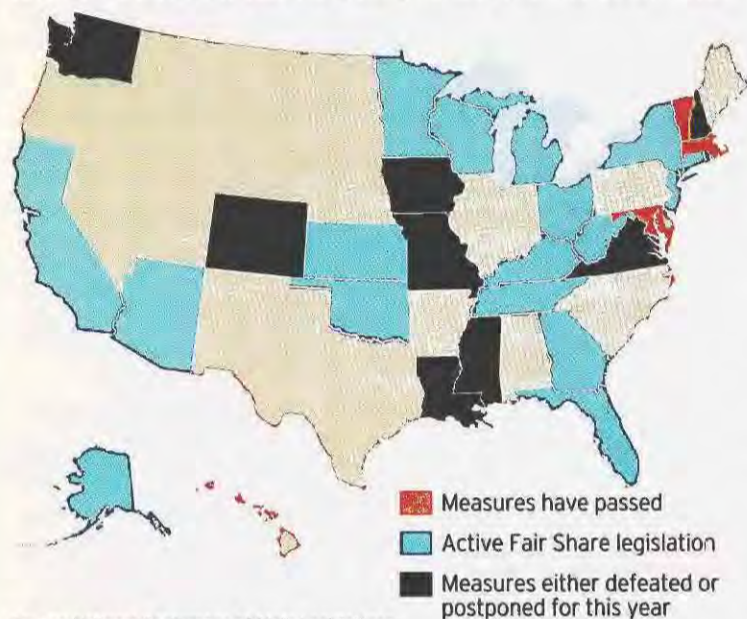
"It's potentially a nightmare for these organizations," Mr. Nussbaum said. "Most large employers are already providing health benefits that exceed the threshold set by these measures. But they will still have to meet the test."

"To the extent that ERISA nixes this, it's over. If not, you've got the possibility of 50 different versions," said Mr. Piro, who said his legal staff is divided on the ERISA pre-emption question.

"Something like this is likely to go to the U.S. Supreme Court," he concluded.

## Mandating benefits

States seek legislation requiring employers to provide health care coverage as they try to ease the growing number of uninsured individuals.



# Dependents: Extending coverage may decrease uninsured rate

Continued from page 12

the last year," said Laura Tobler, a health policy analyst with the National Conference of State Legislatures in Denver.

And publicity about current proposals is likely to stimulate more state activity in the area, said Paul Sullivan, an assistant vp with Aon Consulting in Newburyport, Mass.

The interest of states is understandable. One of the biggest—and some say fastest growing—segments of the nation's 46 million people without health insurance is young adults. For example, in 2004, of the 16.2 million people between the ages of 21 and 24, nearly 36% were uninsured, by far the highest uninsured rate of any age group of those between age 18 and 64, according to an analysis of U.S. Census Bureau data by the Employee Benefit Research Institute in Washington.

By contrast, just a little over 13% of those between ages 55 and 64 were uninsured in 2004, according to EBRI.

"States are looking for ways to increase coverage and one of the ways to do that is to make sure that those who have insurance keep it for a longer period of time" and don't age out of it, said J.D. Piro, an attorney with Hewitt Associates Inc. in

Norwalk, Conn.

"Legislators view this as a positive step towards universal coverage," said Cindy Goff, director of public policy for Blue Cross and Blue Shield of Minnesota in St. Paul.

**"It is not a very effective policy. This does not address large self-funded employers, which is where a majority of insured individuals obtain coverage."**

**Tom Billet**  
Watson Wyatt Worldwide

It isn't known how much of a dent these state initiatives will make in reducing the number of uninsured. Indeed, the state measures only apply to insured health plans, and not self-funded plans, which are shielded from state benefit rules and laws, under a 1974 federal law.

"It is not a very effective policy. This does not address large self-funded employers, which is where a majority of insured individuals ob-

tain coverage," said Tom Billet, a consultant with Watson Wyatt Worldwide in Stamford, Conn.

Still, for employees' adult children who can keep coverage through their parents' group health care plans, the cost savings can be substantial compared with buying a policy in the individual market. For example, in New Jersey, Assemblyman Neil Cohen, D-Union, the author of the law that allows employees' dependent children to keep coverage under their parents' group plans until age 30, estimates the potential cost of the premium for an adult child at between \$1,200 and \$1,800 a year, which is less than half the cost of a typical policy when purchased in the individual market, he says. That big difference, Assemblyman Cohen says, will lead more dependents and their parents to buy the coverage.

The New Jersey law is structured somewhat differently from others of its kind. That law doesn't raise the age at which employees' children are still considered dependents and thus covered in a health insurance provided through the parents' employer.

Instead, somewhat like the health care continuation provisions of the federal Consolidated Omnibus Budget Reconciliation Act,

the New Jersey law gives an employee's adult child the right to continue coverage after reaching the age at which coverage normally would be lost. Parents or the adult children can be required to pay the full cost of the extended coverage.

In other states, though, by raising the age at which employees' children are still considered dependents, employers would continue to pay the same percentage of the premium for dependent coverage but for a greater period of time since parents' children would remain covered longer, thus boosting their costs.

"This adds to costs," said Leo Tokar, vp-marketing, sales and business development at Kaiser Foundation Health Plan of Colorado.

"It is fair to say that this is a hidden tax on employers," said Andy Anderson, of counsel with Morgan, Lewis & Bockius L.L.P. in Chicago.

Paying premiums for dependents for a longer period of time isn't the only cost for employers and plan administrators. Verifying whether employees' children still are dependents, such as whether they are full-time students, is time-consuming.

"It takes a tremendous amount of time to verify," said James Crockett, manager of risk and benefits for Denver Water.

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# Canadian provinces proposing health system changes

## Partial privatization, other measures would shift costs to employers

By GLORIA GONZALEZ

Major changes being proposed in Canada's publicly funded health care system could potentially result in some shifting of health care costs to employers, but are generally expected to have a limited impact.

Quebec is conducting a public consultation on the province's proposal to pay private health care providers to perform certain medical procedures for which there is a long waiting list in the public sys-

tem and allow private insurance to cover these procedures.

Ontario, meanwhile, is proposing legislation that would revamp its prescription drug program in light of substantial increases in drug costs over the past decade. The bill would allow the provincial government to negotiate more competitive prices with drug manufacturers, allow pharmacists greater flexibility to substitute generic drugs for brand-name drugs and make the government the secondary payer of

prescription drugs for working seniors.

The Quebec proposal followed a June 8, 2005, ruling by the Supreme Court in *Chaoulli vs. Quebec (Attorney General)* that Quebec's ban on private insurance for health care services that are already provided by the province is unconstitutional (*BI*, Feb. 20).

The proposal is intended to comply with the ruling, but it would still likely stifle the development of a health insurance market in the

province because it restricts the market for insurance to three specific conditions, observers say. Tim Clarke, senior benefits consultant for Hewitt Associates in Toronto, has talked with insurers about the possibility of private insurance products and they have not shown much interest.

"The insurance companies aren't about to develop insurance products for such a narrow range of services," he said. "There's not enough volume of service to build an insur-

ance product around."

For employers, the Supreme Court decision was expected to increase the pressure from unions and employees to offer private care options, but Quebec's intention to pay for some private care may alleviate some of that pressure. Employers are carefully examining the wording of employment contracts, particularly those with unionized workforces, to ensure that they will not have to assume the cost of services being shifted out of the public sphere. "Beyond that, there isn't a lot for employers in Quebec to do right now," Mr. Clarke said.

The Canadian provinces have taken vastly different stances on private health care and private health insurance within their borders. British Columbia, for example, has openly said it is looking into the possibility of a parallel private health care system, whereas Ontario has steadfastly refused to consider the possibility.

Ontario's proposal to cap the price of generic drugs "looks like it's a positive, but you're always nervous about concluding that something the government is doing is going to save money."

Tim Clarke  
Hewitt Associates

The government of Alberta recently decided not to give its citizens the option of buying private insurance or to permit doctors to work in both the public and private health care systems. The provincial government had proposed the idea in response to escalating health care costs and a shortage of physicians that has created long waiting periods for many procedures.

"I think what it means is that everything has been put on the backburner for a while...but this issue is not going to go away," said Wade Harding, a partner with Toronto-based consulting firm Morneau Sobeco.

Alberta abandoned its proposal amid public opposition and pressure from federal government officials warning of potential violations of the Canada Health Act, which specifically bans private health care systems for services provided by the government. Any province that violates the act would face losing federal funding toward health care expenses.

Quebec, though, believes its proposal is so narrowly tailored to the requirements of the Supreme Court decision that it will enable the province to comply with the decision without violating the federal law. "That was the fine line that



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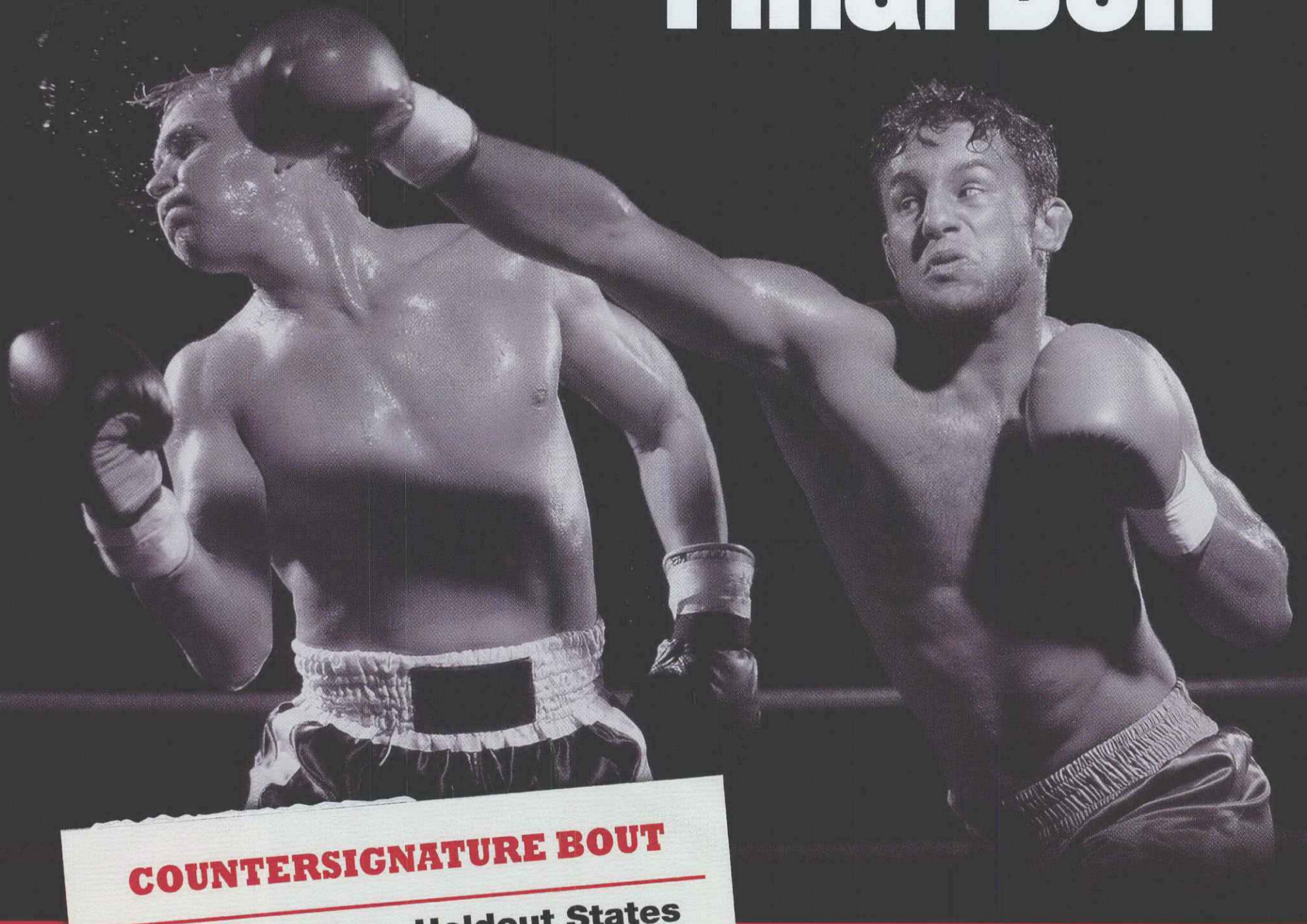
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## Canada: Provinces considering shifting health care system costs to employers

Continued from page 16

they had to walk," Mr. Harding said.

Although it is a divisive political issue, provincial governments have explored the possibility of allowing private health care systems because of the strain that providing health care services has put on their budgets. In Alberta, for example, health care expenditures comprise of 37% of the budget.

The province plans to table health legislation that will allow the government to introduce compensation models for health care providers and establish a process for determining essential services.

In response to rising health care costs, provincial governments have made changes that have resulted in a shifting of costs from the public to the private health care system. In 2004, for example, Ontario de-listed services such as chiropractic and physiotherapy visits for most residents (*BI*, July 12, 2004).

The province is now proposing comprehensive changes to its prescription drug program to address a dramatic increase in the program's cost, which has risen from \$1.03 billion Canadian (\$921.6 million) in fiscal 1995-96 to approximately \$2.77 billion Canadian (\$2.48 billion) in fiscal 2005-2006.

While changes, which are contained in Bill 102, aim to control costs for the province and improve service for its residents, several features are viewed favorably for Ontario employers. For example, a key feature is the government's intention to make more generic drugs interchangeable with brand-name drugs, which would have a positive impact on benefit plans that mandate generic substitution because there will be a decrease in costs as more generic drugs become available. This change has been estimated to provide savings of at least \$30 million Canadian (\$26.8 million) to Ontario employers, according to an

analysis by Mercer Human Resource Consulting.

Another key benefit for employers is the move to speed up the drug review process because if drugs are added to the government's program more quickly, employer-sponsored drug plans that provide retiree coverage will save money since currently they tend to pick up the costs of these drugs. "There could be some softer, more indirect advantages for employers," Mr. Harding said of these proposed changes.

The province also plans to amend its legislation to cap the price of generic drugs at a fixed percentage—50% of the price of the

equivalent brand-name product. It is unclear whether the 50% pricing guideline will apply to all existing generic products or to newly approved drugs. But in either case, the proposal should result in savings for employers because the costs of generic drugs will decline. "It looks like it's positive, but you're always nervous about concluding that something the government is doing is going to save money," Mr. Clarke said.

There are features of the bill that have the potential to increase costs for employers. For example, the government has proposed becoming the second payer for working seniors with private insurance plans, meaning that employer plans would be the first payer of drug costs for these seniors rather than the government, which typically covers most of the cost of prescription drugs listed on the government formulary for Ontario residents 65 and older. Ontario employment law, though, allows the termination of benefits at age 65 under a private health plan and employers may consider terminating these benefits in light of Ontario's proposal, according to Mercer.

Ontario is not the first province to take this step. Nova Scotia requires employers to be the first payer for all seniors, meaning that employers in the province absorb a larger percentage of prescription drug costs. "If that were to happen in Ontario, that would have an enormous impact for employers in Ontario," Mr. Clarke said.

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## Business Insurance EUROPE™



# Political risk: Countries' questionable actions restrict written coverage

Continued from page 21

favoring the oil company in a dispute over a tax refund, the company claimed in a May 17 arbitration request filed with the International Centre for Settlement of Investment Disputes in Washington.

Political pressure from the country's leftist groups also played a role, Occidental claims. A spokesman for the company said it does not have political risk coverage.

The action isn't helping soften some underwriters' ongoing refusal to write certain political risk coverages for foreign-owned natural resource extraction companies.

Keith Dunford, worldwide underwriting manager for political risk in Whitehouse Station, N.J., for the Chubb Group of Insurance Cos., said Chubb won't provide coverage for most oil and gas operations or mining entities in Ecuador.

Despite the problems in some sectors, though, it is still possible to obtain political risk coverage for many operations in Ecuador, such as manufacturing companies, said Ken Horne, managing director of the political risk practice for Marsh in New York.

Underwriters are also leery of Venezuela, where President Hugo Chavez is seen as exporting his populist policies to neighboring countries such as Bolivia.

He too has required oil and gas companies to renegotiate their concessions, Chubb's Mr. Dunford said.

## Government uncertainty

Bolivia too has seen a reduction in political risk capacity. Mr. Dunford said Chubb's appetite for political risks for all industries in Bolivia has been cool since before the election of the country's populist president, Evo

Morales, in January.

"But right now I would describe it as deep freeze," said Mr. Dunford.

Mr. Morales announced May 1, that companies working in the Bolivian natural gas fields would be nationalized. He did not expel foreign producers or shutter their operations, but the president ordered the Bolivian military to occupy gas fields and he threatened foreign oil and gas companies with expulsion.

He then gave them 180 days to renegotiate the concession treaties.

Since then, Mr. Morales has made contradictory statements regarding how foreign oil companies will be compensated for their continuing production. And he has stated that expropriations could occur in Bolivia's mining and forestry sectors, but he later retracted that statement.

Such messages create a lot of un-

certainty, said Daniel W. Riordan, executive vp and managing director of emerging market solutions for Zurich Financial Services Group in Washington.

"We are definitely cooling" and not quoting new coverage in Bolivia, Mr. Riordan said. "We as underwriters, as well as investors, need to see what the government is going to do and it's not clear."

Mr. Dunford said he is waiting to see how Bolivia compensates the oil companies ordered to renegotiate their concession agreements.

"That will tell all" and expose the extent of Bolivia's nationalization of that industry, he said.

## Limiting exposure

American International Group Inc. has let its exposure to Bolivia run down and its existing exposure is limited to outstanding global pro-

grams, said David Garlow, vp for country risk management in AIG's global trade and political risk group in New York.

With a current soft pricing for political risk coverage it is hard to justify writing the risks that Bolivia presents, Mr. Garlow said.

Yet AIG will still entertain submissions, with any deals depending on their specifics.

Several brokers say they expect that insured investors in Bolivia's oil and gas sector will generate political risk claims.

But because political risk claims can be complex and the situation remains murky, with little known about Bolivia plans to proceed with its nationalization, it will take weeks or months for insureds to determine the scope of any claims, said Bryan Squibb, managing director for Aon Trade Credit in Chicago.

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(Joint Administrators appointed)

and IN THE MATTER OF THE COMPANIES ACT 1985

NOTICE IS HEREBY GIVEN that by an Order dated 12th  
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that meetings (the 'Scheme Meetings') of the Company's  
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(the 'Company') be held together on 5th July 2006 at  
Plumtree Court, London, EC4A 4HT commencing at 2pm.  
All Scheme Creditors are requested to attend at such place  
and time either in person or by proxy.

The purpose of the Scheme Meetings will be to consider  
and, if thought fit, to approve (with or without modification)  
a scheme of arrangement proposed to be made between the  
Company and the Scheme Creditors pursuant to s425 of the  
Companies Act 1985 (the 'Scheme').

A downloadable file of the proposed Scheme, Explanatory  
Statement and Appendices are available on the Company's  
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The Scheme Creditors may vote in person at the Scheme  
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It is requested that proxy and voting forms be lodged with  
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appointed for the Scheme Meetings. A faxed copy of the  
proxy and voting form will be accepted if legible.

By the same Order the Court has appointed Paul Anthony  
Bretton Evans of Plumtree Court, London EC4A 4HT or,  
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London EC4A 4HT to act as Chairman of the Scheme  
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# CalPERS: Considers increasing copays for the second time since introduction

Continued from page 1

"Prominent drivers include hospital and doctor reimbursements, regional variances in costs and how we can incent members to choose the right care at the right time. Health care costs continue to increase and our enrollees continue to age. Without changes, rates will go up," she said.

CalPERS' moves are closely followed by employers nationwide because it has traditionally been at the forefront of innovations in health care cost-containment and because the behemoth pension fund, which spends \$4 billion annually to provide retirement and health benefits to more than 1.2 million public employees, retirees and their families, has enough clout to move the entire California health care market.

The CalPERS model served as the inspiration for a managed competition proposal espoused by former First Lady Hillary Clinton's health reform task force, which was published in 1993 but failed to muster sufficient congressional support. Under that model, CalPERS forced plans to compete, gradually reducing their ranks so that only those that provided what was deemed the most cost-effective, high quality care remained. Once it reached the point where paring health plans was no longer practical, CalPERS dug down into those health plans, eliminating from its provider network hospitals it considered to be too expensive relative to quality.

In another pioneering move, CalPERS was among the first and certainly the largest purchaser to

enter into a multiyear contract with a single health plan when it signed up with Blue Shield of California in 2003 (*BI*, May 19, 2003). That contract, which expires on Dec. 31, 2006, is also up for renewal as part of this latest proposal.

**"Private-sector employers already have much higher cost sharing than CalPERS. The public sector will soon get the shocking wake-up call that corporate America got in the mid- to late 1980s."**

**Helen Darling**  
National Business Group on Health

As a result of these efforts, CalPERS successfully reduced the rate of increase in its health care spending from a peak of 24.1% in 2003 to 9.9% in 2005 and 8.9% in 2006.

But this time, rather leading, it appears that CalPERS is following, some health benefits experts say.

In its May 16 proposal, CalPERS Office of Health Policy and Program Support itself acknowledges that all of the proposed changes are intended to bring CalPERS' benefit

package more in line with that of large private employer plans in the state, as well as to encourage participants to seek care in the most appropriate, cost-effective settings.

Helen Darling, president of the National Business Group on Health in Washington, is skeptical about whether the limited cost-sharing under consideration will go far enough in stemming the rate of increase in CalPERS' health care costs.

"Private-sector employers already have much higher cost sharing than CalPERS. The public sector will soon get the shocking wake-up call that corporate America got in the mid- to late 1980s. They will all have to get much more serious about cost control and will look a lot more like the private sector," she said.

"CalPERS has had relatively rich benefits over the years, and these changes are very much in line with, or maybe a little bit delayed, compared to what other employers are doing," said Johan DeKeyser, a principal in Hewitt Associates Inc.'s health management practice based in Newport Beach, Calif.

"They're still being more paternalistic than what other employers or large organizations are trying to do in putting more of the decision-making and related cost implications onto the participant," he said.

But Peter Lee, president of the San Francisco-based Pacific Business Group on Health, of which CalPERS is a member, disagrees.

"If CalPERS were a follower in terms of benefit design, they would have quadrupled their office visit copays and moved to only high-deductible benefit designs," he said. "That's the last thing that's on their agenda. Rather, I think they are continuing to be a leader in trying to not only make sure the CalPERS beneficiaries get the right care at the right time and at the right place."

"They realize they can't change health care trend by shifting cost. But they can encourage and foster patients to get the right care at the right time and providers to deliver high-quality, cost-efficient care," Mr. Lee added, referring to CalPERS' proposal to contract with Blue Cross's high performance provider network.

He also thinks that CalPERS will continue to lead by showing other employers the way to these high performance networks, which only recently were introduced by insurers.

"When CalPERS says 'we care about value' which is 'we care about the quality and cost of care being delivered to over 1 million Californians,' not only does it mean a lot of money flows, it raises the bar for other purchasers to say 'What am I doing in my network selection, in my benefit design, in how I provide tools to my consumers, to my enrollees?' And that's a good thing for the entire market," he concluded.

# PBGC objects to deal between Delta, union

**NEW YORK**—The Pension Benefit Guaranty Corp. has objected to an agreement between bankrupt Delta Air Lines Inc. and its pilots' union, contending that the deal could be an abuse of federal pension law.

The agreement, subject to bankruptcy court approval, calls for Delta to give the pilots' union a \$650 million note if the pilots' plan, which is massively underfunded, terminates.

In a filing in U.S. Bankruptcy Court in New York, the PBGC said such an arrangement may be an "abusive" follow-on arrangement. In essence, the

financial note is "clearly intended to bridge the gap between benefits that the pilots would have earned" under their plan and the benefits the pilots would receive from the PBGC if the plan is terminated, the PBGC said.

"Follow-on arrangements may be abusive regardless of their form, because they promote improper plan terminations and unjustifiably increase PBGC liabilities," the agency said.

If the pilots' plan is terminated, the PBGC says it will incur a "multi-billion dollar" loss.

—By Jerry Geisel

# FSA: Dependent care rules

Continued from page 3

only one parent works.

Finally, lower-income employees may find it more tax-effective to take the dependent care tax credit than make pretax contributions to a dependent care FSA.

Though only a relatively small percentage of employees contribute to dependent care FSAs, those that do reap big tax savings since they are paying for dependent care expenses with pretax contributions, often cutting the true cost of expenses by one-third.

In the proposed regulations, the IRS has provided numerous examples of expenses that can and cannot be funded through a dependent care FSA.

For example, the proposed regulations make it clear that expenses for day camps, even specialized camps, are eligible for reimbursement through a dependent care FSA.

"The IRS has received many inquiries about whether the cost of a day camp that specializes in a particular activity, such as soccer or computers, may be an employment-related expense. To provide certainty, the proposed regulations provide that the full amount paid for a day camp or similar program may be for the care of a qualifying individual, although the camp specializes in a particular activity," the agency said in the proposed regulations.

Preschool expenses can be reimbursed through an FSA, including amounts paid for food, the IRS said, noting that lunch and snacks provided to such young children "are incidental to and inseparably a part of the care."

On the other hand, expenses for kindergarten and higher grades are not eligible because those programs are primarily for education rather than for the care of a child, a rule that affirms an information letter the IRS published more than five years ago.

Fees paid to an employment agency to obtain the services of an au pair can be covered through an

FSA. On the other hand, an employee cannot be reimbursed for a pre-school deposit for a child that is forfeited because the parent later decides to send the child to a different school.

Though only a **relatively small percentage** of employees contribute to dependent care FSAs, **those that do reap big tax savings**, since they are paying for dependent care expenses with pretax contributions, often cutting the true cost of expenses by one-third.

The cost of transportation charged by a dependent care provider, such as a bus service that picks up a child and delivers the child to a daycare facility, can be covered through an FSA, but the cost an employee incurs if he or she drives the child to the facility can not.

Under the regulations proposed by the IRS, employment-related taxes, such as Social Security taxes that an individual pays on behalf of a dependent care provider such as an au pair, also are be reimbursable.

# Changes target premium increases

As part of efforts to stem health care premium increases, the California Public Employees' Retirement System is considering several changes to its health care plans that will, for the most part, shift more costs to the 1.2 million plan members.

The CalPERS board will decide June 20 whether to adopt the proposals put forward for consideration by its Office of Health Policy and Program Support. They include:

- Increase health maintenance organization copays to \$15 from \$10.
- Introduce, for all plan members, a \$250 copayment for each hospital admission and an ambulatory surgery copayment of \$25.
- Increase HMO emergency room visits copayments to \$75 from \$50, though the payments will be waived if patients are admitted as an inpa-

tient or for observation as an outpatient.

- Elimination of HMO coverage in rural areas and replacement with a lower-cost point-of-service option.

- The addition of a third preferred provider option, Blue Cross of California's Select PPO, a high-performance network that includes a subset of its regular network providers who are considered to be of equal quality but who practice medicine more cost-effectively.
- Contracting with its health plans to provide Medicare Part D coverage to its 150,000 eligible members rather than accept the subsidy from the federal government.

- Lift the lifetime maximum benefit per individual to \$5 million from \$2 million, a move that would have negligible impact on the savings the cuts are projected to make.

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# Quanta: Storm losses, ratings downgrade force insurer to shut down most business

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Following a strategic review—carried out with the help of financial advisors J.P. Morgan Securities Inc. and Friedman, Billings, Ramsey & Co.—Quanta has ceased underwriting or seeking new business and has opted to place its remaining U.S. specialty lines, Bermuda reinsurance, and European business into runoff, it said in a statement.

The company's Lloyd's of London syndicate 4000 and environmental consulting business, however, will not be affected by the runoff plan and will continue to seek new business, Quanta said. The Lloyd's business accounted for \$80.7 million of gross premiums written in 2005.

"While Quanta had made progress in its transition to a specialty lines focused carrier, the decision of A.M. Best to downgrade Quanta below the A-level in March interrupted that effort and significantly impacted our ability to write attractive business," James J. Ritchie, Quanta's chairman, said in a statement. "After consideration of alternatives, Quanta's board has made a decision that it believes enables the company to best protect the value of its capital."

Quanta additionally announced an agreement with Liberty International Underwriters, a division of Boston-based Liberty Mutual Group Inc., to acquire the renewal rights to Quanta U.S. Holdings Inc.'s environmental liability business. Terms of that deal were not disclosed. Quanta reported total environmental liability gross written premiums

of \$40 million in 2005, but it is not clear how much of that business is included in the deal with LIU.

"This approach offers us the flexibility to support our syndicate in the A-rated Lloyd's market and to protect the value of our ESC consulting operation, which provides us with fee-for-service business," said Mr. Ritchie.

"Quanta's business and people complement our existing strategy, and our acquisition of the renewal rights to Quanta's environmental business lets their brokers keep the business with an 'A' rated company. It also will give many of their existing customers an opportunity to move their business without penalty," David Cohen, LIU's chief underwriting officer of Global Casualty, said in a statement. Liberty Mutual said it is mulling the transfer of certain key staff from Quanta to LIU.

In its statement, Quanta indicated that it would consider similar transactions for other portions of its business.

## What went wrong?

"There are a lot of reasons why this company is in the position it is in," said Joyce Sharaf, assistant vp and managing senior financial analyst at Best. "The (catastrophes) clearly were a major reason... but they ran the company less than conservatively, for a startup," Ms. Sharaf said of Quanta, which opened its doors in September 2003.

"They had a very high expense

structure, including salary structure," Ms. Sharaf said. Furthermore, under the original management team, "this company was not being run conservatively in terms of its business lines, in terms of how it wrote its policies, and the biggest one—its appetite for risk—was inconsistent with its capital," she said.

"The new management team had recognized the issues and tried to reverse that, but just didn't have time to do it all," Ms. Sharaf said.

Quanta's senior management changed last year when its founding chief executive officer, Tobey Russ, resigned and Robert Lippincott III was named interim CEO.

Complicating matters at Quanta, said an analyst who did not wish to be named, "the underwriters weren't as experienced" as those at other Bermuda-based reinsurers. "They were obviously a younger company trying to come out and write business," and "they started off at a pretty inopportune time," he said.

"They did have bad luck in that the first two years of their operations were two of the worst (catastrophe) years...but had they not written the risk, they would not have suffered those losses," Ms. Sharaf noted.

In a statement, analysts from BB&T Capital Markets, a unit of Winston-Salem, N.C.-based BB&T Corp., said they were "not surprised by the decision to keep the ESC business afloat, but we question the company's plans to shut down all other underwriting businesses but

keep the Lloyd's business open."

"Lloyd's syndicates carry the rating of the entire Lloyd's group, but, with the uncertainty surrounding (Quanta), customers and brokers may be wary of placing business with an entity that may not be around in a few years."

Following Quanta's announce-

ment, Best noted Quanta's B++ financial strength rating remains under review with negative implications for the following subsidiaries of the company: Quanta Reinsurance Ltd.; Quanta Europe Ltd.; Quanta Indemnity Co.; Quanta Reinsurance U.S. Ltd.; and Quanta Specialty Lines Insurance Co.

## Late News

Continued from page 1

### Pension reform talks delayed by recess

Congressional conferees will not reach an agreement until next month at the earliest on comprehensive pension funding reform legislation. Conferees ended discussions last Thursday and left Washington as Congress recessed for a week. The talks were aimed at fashioning a compromise bill from different measures passed separately last year by the House and Senate. Legislators have yet to reach an agreement on certain contentious issues, including whether employers with subpar credit ratings should have to kick in extra money to their pension plans.

### ACE names Dowd CEO for North America

Brian Dowd, chairman and chief executive officer of ACE USA and chairman of ACE Westchester Specialty, has been appointed chief executive officer of ACE's North American insurance operating division, which comprises the operations of ACE USA, ACE Westchester Specialty and ACE Bermuda. In addition, John Lupica, president and chief operating officer of ACE USA, has been promoted to CEO of that unit, ACE said.

### U.S. reinsurers see combined ratio rise

U.S. property/casualty reinsurers reported a 98.4% combined ratio for the quarter that ended March 31, compared with a 93.9% ratio recorded by a comparable group in the same period a year ago, according to data from the Reinsurance Assn. of America. The 2006 combined ratio reflects a 70.4% loss ratio and a 28.1% expense ratio, according to the survey of 24 reinsurers by the Washington-based RAA. The

reinsurers reported \$6.56 billion in net premiums written in the quarter, down 6.5%.

### China to let AIG unit write group business

American International Group Inc. subsidiary American International Assurance Co. Ltd. has received approvals from the China Insurance Regulatory Commission to conduct group insurance business throughout its operations in China. The insurer said with the approvals, AIA is authorized to issue a single group policy contract covering a range of insurance products, including group life insurance, personal accident and health insurance, medical insurance and annuities.

### Montpelier Re attracts \$100 million investment

Private equity firm WL Ross & Co. L.L.C is set to make a \$100 million investment in Montpelier Re Holdings Ltd. Under the agreement, New York-based WL Ross will buy 6.9 million common shares of Montpelier at \$14.50 each. The first \$50 million purchase of shares will close on or about June 1, and the second \$50 million purchase will close on receipt of regulatory approvals, according to a statement by Hamilton, Bermuda-based Montpelier.

### PBGC takes over plan at Pittsburgh Brewing

The Pension Benefit Guaranty Corp. is taking over the pension plan of Pittsburgh Brewing Co. following a bankruptcy court order last month that the brewery qualified for a distress plan termination. The plan, which has been frozen since 1995, has about \$12 million in assets and \$24 million in liabilities. The PBGC expects to be liable for about \$11 million of the \$12 million funding shortfall. The plan has 532 participants.

## BI Stock Index [ 5/22 - 5/26 ]

Up-to-the-minute data for all 85 companies that comprise the BI Stock Index can be found at [www.businessinsurance.com](http://www.businessinsurance.com)

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

<b>BI Stock Index</b>	
<b>2883.23</b>	<b>0.01</b>
<b>Dow Jones</b>	
<b>11278.61</b>	<b>1.21</b>
<b>S&amp;P 500</b>	
<b>1280.16</b>	<b>1.04</b>

### Largest gains

Tower Group Inc.	9.21%
Gainsco Inc.	8.19%
Clark Inc.	6.01%
Meadowbrook Insurance	5.05%
SCOR S.A.	4.85%

### Largest losses

Alleghany Corp.	-4.68%
Aetna Inc.	-4.57%
Navigators Group	-3.90%
UnitedHealth Group	-2.93%
Everest Re Group	-1.88%

### Weekly change by market segment

Brokers	0.60%
Insurers/Reinsurers	-0.46%
Managed Care Organizations	-0.06%

Source: FinancialContent Inc. (<http://financialcontent.com>)

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### At BusinessInsurance.com

New Online Poll: Based on claim costs so far, do you expect the increase in your company's health care costs in 2006 to be: higher than in 2005; lower than in 2005; about the same.

Items in the Late News column originally appeared in BI's Daily News feature on [www.businessinsurance.com](http://www.businessinsurance.com). Visit the BI Web site to sign up to receive BI's Daily News by e-mail.



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