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Reforms seek to shore up PBGC

Proposals include premium hikes, restrictions on bankrupt employers

By JERRY GEISEL

WASHINGTON—Employers would pay higher federal insurance premiums but be allowed to contribute to their pension plans after their plans were fully funded, the Bush administration proposed last week.

The pension reform package, outlined by Labor Secretary Elaine Chao during an address at the National Press Club, also would simplify pension funding rules but likely boost required contributions by employers with older workforces.

For the first time, bankrupt companies with underfunded plans would be barred from boosting plan benefits, while plan participants could not accrue new benefits or take benefits as a lump sum. Companies with junk bond credit status with severely underfunded plans would face similar restrictions.

Additionally, employers with underfunded plans would have to expand their disclosure of their plans' funding level to participants.

Finally, the package calls for the adoption of a controversial proposal released by the Treasury Department last year recognizing the legitimacy of cash balance and other hybrid pension plans, but it attaches certain conditions that employers said were objectionable in exchange for that regulatory seal of approval.

The impetus of the package is the sharp decline in the financial condition of the Pension Benefit Guaranty Corp., the federal agency that guarantees—up to certain limits—pension plan participants' benefits.

Reeling from the huge losses incurred when it took over the pension plans of several failed steel manufacturers, the PBGC has seen its deficit rise nearly 20-fold since 1994—the last time Congress revamped pension funding rules—to a record $23 billion.

And administration officials say that while the PBGC is in no imminent danger of collapse, its financial health only will get worse—increasing the likelihood that taxpayers would one day have to bail out the agency—if the PBGC's revenue stream isn't boosted and the agency better protected from losses.

See PBGC/page 18

Rx reimporters fear Canada plans to cut off U.S. drug supply

By RUPAL PAREKH

OTTAWA—Possible changes in Canadian regulations that would restrict the export of prescription drugs to the United States are prompting fears of increased health costs among U.S. cities and states that import drugs.

Some of those U.S. cities and states are already exploring alternative sources of drugs, including pharmacies in Europe, in preparation for any restrictions imposed on Canadian pharmacies.

According to estimates from the U.S. Department of Health and Human Services Task Force on Drug Importation, some 12 million prescription drug products at a cost of nearly $700 million entered the United States through Canada in 2003 alone.

Canadian Health Minister Ujjal Dosanjh in recent months has cited concerns about the ability of his country's prescription drug supply to meet U.S. demand, calling it "a matter of common sense that Canada cannot be the drug store of the United States."

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No coverage on tap?

Lawsuits over beermakers' ads spark cover fights

By DOUGLAS McLEOD

NEW YORK—A series of proposed class action suits accusing beer and liquor producers of targeting underage drinkers has triggered battles between three of the nation's largest brewers and their liability insurers over coverage of the suits.

Miller Brewing Co., Coors Brewing Co. and Samuel Adams Brewery Co. Ltd. are all suing or being sued by various insurers over defense and indemnity coverage for at least five proposed class actions filed since late 2003.

The class actions charge that liquor producers' allegedly deceptive marketing practices are responsible for widespread harm ranging from alcohol-related injuries and deaths to unwanted pregnancies and juvenile delinquency. The plaintiffs are seeking disgorgement of billions of dollars of profits from the sales and injunctions barring illegal marketing in the future.

While the lawsuits name more than two dozen

See BREWERS/page 17

Late News

Marsh, Spitzer close to settlement: Report

Representatives of Marsh & McLennan Cos. Inc. and New York Attorney General Eliot Spitzer declined to comment on a report that they are nearing a settlement of Mr. Spitzer's fraud and antitrust charges against the brokerage. Citing sources familiar with the matter, the Wall Street Journal reported Friday that Marsh had offered to settle the charges for $600 million but that Mr. Spitzer's office was seeking $750 million and a public apology. Mr. Spitzer sued Marsh in October, charging the company with steering clients to insurers paying it the highest contingent commissions and rigging bids to channel business to favored insurers.

Serio to join lobbying firm

Outgoing New York Insurance Superintendent Gregory V. Serio is joining Park Strategies L.L.C., a New York-based lobbying firm headed by former U.S. Sen. Alfonse D'Amato. Mr. Serio is expected to leave office on Jan. 18, and New York Gov. George E. Pataki has indicated that he plans to name as Mr. Serio's replacement former Assemblyman Howard D. Mills III, R-Orange County. Mr. Mills, who ran an unsuccessful campaign against Democratic U.S. Sen. Charles Schumer in the November elections, has been working as a deputy superintendent with the insurance department since Jan. 3.

Mr. Serio

Industry probes likely to expand: Survey

Investigations into the insurance industry's compensation practices will expand in 2005, and most companies will be able to settle any charges against them this year, according to the majority of industry executives recently surveyed. Ninety-two percent of the 100 executives surveyed at the Insurance Information Institute's annual Property/Casualty

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D&O coverage won't be used for McKesson Corp. settlement

SAN FRANCISO—No directors and officers liability insurance will be used to pay plaintiffs $960 million to settle a securities class action lawsuit filed against McKesson Corp., a subsidiary and current and former executives.

Most of the company's D&O coverage has been exhausted by previous settlements and defense costs, a spokesman for the San Francisco-based medical drug and supplies distributor said.

The remaining D&O coverage will be used to fund part of the $240 million of reserves that McKesson says it also has established to cover its estimated cost to resolve the remaining claims against the company, he said. Insurance would account for less than 10% of that reserve, he said.

The claims were triggered by alleged accounting fraud at a McKesson subsidiary, formerly called McKesson HBOC, said the spokesman. The subsidiary is now called McKesson Information Solutions.

The settlement by McKesson ranks behind only those in securities cases filed against Cendant Corp. and WorldCom Inc. The settlement was announced Wednesday.

The lawsuit stemmed from the drop in McKesson's stock price after McKesson HBOC began issuing financial restatements in April 1999. McKesson acquired the unit, originally named HBO & Co., in a January 1999 transaction.

On April 28, 1999, McKesson HBOC announced a restatement of $26 million of improperly recorded software revenue for the fiscal quarter that had ended less than a month earlier and of $16 million of additional improper revenue for previous quarters of that fiscal year. McKesson HBOC later restated more than $327 million of its reported revenue for previous years.

The settlement class consists of shareholders who acquired HBOC securities from Jan. 20, 1997, through Jan. 12, 1999, or acquired McKesson securities from Oct. 18, 1998, through April 27, 1999, or held McKesson common stock on Nov. 27, 1998, through Jan. 12, 1999.

—By Dave Lenckus

Asbestos reform heads on but cost still unknown

By MARK A. HOFMANN

WASHINGTON—Senate Judiciary Committee Chairman Arlen Specter, R-Pa., is sticking with his plan to send an asbestos liability reform bill to the Senate leadership within the next few weeks, even though the reform's price tag remains unknown.

PHOTO: ZUMA PRESS

Sen. Specter

During a hearing last week Sen. Specter unveiled draft discussion legislation designed to replace the current litigation-based system for compensating victims of asbestos-related illnesses with a national trust fund. The hearing was somewhat unusual in that it occurred while the Senate was not in session.

The 273-page document, while describing many of the mechanics of how a trust fund would operate, does not specify how large the trust fund should be. Defendant companies, their insurers and existing asbestos trust funds, would fund the proposed mechanism.

Sen. Specter noted that the omission was not accidental, because there is no consensus on the issue. He said that a $140 billion figure agreed to by Senate Majority Leader Bill Frist, R-Tenn., and then-Minority Leader Tom Daschle, the former Democratic senator from South Dakota, last year was "entitled to weight," but Sen. Specter did not endorse it at the Jan. 11 hearing.

The size of the fund could determine the legislation's fate, too. John Engler, president of the National Assn. of Manufacturers, noted during the hearing that the draft "does not address the central issue of funding.

"The maximum size of the fund must be no more than $140 billion, as finally agreed to last fall," he said.

A representative of the Assn. of Trial Lawyers of America, however, told the committee that $140 billion would not be enough.

"We believe the cost of compensating victims is clearly greater than $140 billion and could approach $200 billion," said Michael Forscey, a partner in the Washington law firm of Forscey and Stinson. "The central issue of financing—who pays into the fund and how much—is far from resolution. It seems unreasonable to move forward without a resolution to this issue that is grounded in sound claims estimates."

The AFL-CIO has also called for funding above the $140 billion level.

See ASBESTOS/page 19

California proposes HMO cover mandate for 'necessary' meds

By JOANNE WOJCIK

SACRAMENTO, Calif.—Draft regulations requiring health maintenance organizations in California to cover all "medically necessary" medications could drive up HMO premiums in the state by making it more difficult for the plans to enforce drug cost-containment programs, some industry observers say.

The rules, which make California the first state to mandate the broad coverage of medically necessary medications, were proposed earlier this month by the state's Department of Managed Health Care.

The department was given the power to impose guidelines for determining which drugs health plans must cover under 2002 legislation, which was passed in response to two court cases challenging this authority.

The draft regulations, which are subject to public comment, specify that "every plan that provides outpatient prescription drug benefits must ensure that enrollees have access to all medically necessary prescription drugs."

Drugs without a proven specific medical benefit, though, such as those for cosmetic, weight loss or sexual performance enhancing purposes, are excluded from coverage.

The rules also state that copayments for covered prescription drugs cannot exceed 50% of the price that an HMO pays for the drugs and can never exceed their retail prices.

"Premiums are going to increase as a result of this," predicted John D. Piro, chairman of Hewitt Inc.'s health care law consulting practice in Norwalk, Conn.

"Will it drive up costs? That's hard to say. But it's also hard to say it would not," said Linda Bergthold, a benefit consultant in the Los Angeles office of Watson Wyatt Worldwide. "Whenever a regulatory department of a state promulgates a regulation that is this broad, there are unintended consequences."

In particular, HMOs and bene-

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Inside Business Insurance

Online

- The **Datebook** calendar lists upcoming industry seminars and meetings and allows you to add info about your own event.
- Searchable **directories** provide access to all the listings of industry vendors found in *BI*'s Market Sourcebook.
- New **Opinion Poll** for readers: Should employees be required to forfeit unused flexible spending account balances at the end of the year?

Departments

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Health savings accounts see strong early growth

By JERRY GEISEL

WASHINGTON—Health savings accounts linked to high-deductible insurance plans now occupy only a small sliver of the health insurance market but are off to a fast start, according to a survey.

The survey, based on responses from 29 members of the Washington-based trade association America's Health Insurance Plans, found that, as of September 2004, 438,000 people were enrolled in HSA high-deductible plans. HSAs were authorized under legislation that Congress passed in late 2003 and that went into effect on Jan. 1, 2004.

The early growth rate of HSAs far exceeds that of medical savings accounts, a somewhat similar health care plan that hit the market in 1997.

About 40,000 MSAs—later renamed Archer Medical Savings Accounts by Congress—were sold during their first year of existence, but they failed to reach the same level of market penetration over the past 10 years that HSAs have already achieved in the last year, said AHIP President and Chief Executive Officer Karen Ignagni.

"This is an emerging market off to a fast start," Ms. Ignagni said.

That growth came even though many individuals have not heard of HSAs, another survey found. The Watson Wyatt Worldwide survey of 1,000 workers, which was conducted last October, found that just 29% of the respondents had heard of HSAs.

After receiving an explanation of how HSAs work, though, 60% said they liked the idea of controlling HSA funds and 55% said they liked the idea of lower premiums for the high-deductible-linked health plan.

Clearly, the HSA market is growing. The AHIP says it knows of at least 75 member insurers offering HSAs, compared with 29 in its September survey.

"There is demand for lower-premium products," which insurers are meeting to fulfill through HSAs, Ms. Ignagni said.

Premiums for HSA-linked products are much lower than those for traditional plans, due to the cost-sharing requirements imposed on

See HSA/page 16

PHOTO: GETTY

Chlorine gas leaking from a car following a Jan. 6 train crash in Graniteville, S.C., killed the train's engineer and eight others.

Retention to respond to rail crash losses

GRANITEVILLE, S.C.—Norfolk Southern Railway Co. will rely on a large self-insured retention to absorb property and environmental liability claims from a deadly train crash and has excess coverage that can be tapped if needed.

The National Transportation Safety Board was called to the scene of the Jan. 6 accident in Graniteville, S.C., to determine why the 42-car train carrying chlorine and other materials slammed into a locomotive parked on a rail spur. Chlorine gas leaking from one of the cars killed the train's engineer and eight others. More than 200 local residents and workers at a textile mill suffered respiratory injuries.

Norfolk Southern also owned the locomotive that was struck in the crash.

A spokeswoman for the Norfolk, Va.-based railroad said Norfolk Southern's large retention and excess insurance are in place to respond to claims from the accident, but she declined to give details of the coverage.

Industry sources said Lexington Insurance Co., a Boston-based subsidiary of American International Group Inc., is one of Norfolk Southern's insurers. AIG declined to comment.

Shortly after the crash, Norfolk Southern set up an assistance center to pay some of the losses suffered by residents of the area. Confusion as to whether those payments would preclude the filing of personal injury or property claims forced the railroad to clarify why it had quickly set up the center and began issuing checks.

Robert A. Wells, Norfolk Southern's general manager of casualty claims, issued a statement that said the railroad was providing assistance to those who suffered "incidental expenses" due to property damage or evacuation. Those payments "do not preclude submission of personal injury claims, claims for subsequently incurred incidental expenses and unforeseen property damage claims in the future," the statement said.

Six of those killed by the leaking gas were employees of Avondale Mills Inc., a textile manufacturer with a facility adjacent to the track where the wreck occurred. The crash happened around 2:30 a.m., while approximately 400 workers were at the plant, said Stephen Felker Jr., manager of corporate development for the Monroe, Ga.-based company.

—By Michael Bradford

Errors & omissions

● Due to a production error, a photograph of Dr. Stanley Biber in the Jan. 10 Between the Lines column was not credited. The photo was provided courtesy of Trinidad Chronicle-News Staff reporter Marty Hackett.

Advent of gay marriage alters Massachusetts partner benefits

By JUDY GREENWALD

Nine months after gay marriage became legal in Massachusetts, employers with operations in the state are still struggling to adjust their benefit plans.

Some companies, particularly some that had domestic partner benefit programs that applied only to same-sex couples, have now rescinded those programs.

But others, especially those that had offered domestic partner benefits to same-sex and heterosexual couples, which accounts for most employers, are staying with their existing domestic partner policies.

And amid the focus on domestic partner benefits that has grown out of the gay marriage issue, some employers are introducing heterosexual domestic partner benefits for the first time. At least one employer, the Boston-based Dana Farber Cancer Institute, ultimately decided not only to retain its existing same-sex domestic partner benefits program but to expand it to include heterosexual couples. "It didn't seem fair to keep it in place without allowing opposite-sex domestic partners to take advantage of the benefit as

well," said Peggy Malumphy, director of compensation and benefits.

"The majority of companies are trying to be inclusive, rather than exclusive, in their benefit policies, and…it has been challenging for plan sponsors to continue to stay current with the ever-changing legal landscape around marriage," said Andrew Sherman, senior vp with The Segal Cos. in Boston.

At the same time, observers note that these policies affect only a small proportion of their total employee population.

Complicating the issue for Massachusetts employers is that gay marriage in the state may be only transitory; efforts are underway to introduce a constitutional amendment that would ban gay marriage in the state. And gay marriage proponents can take little comfort from referenda in 11 states in November that approved constitutional amendments to ban gay marriage, bringing the total number of states with such amendments to 17.

The focus in Massachusetts has been primarily on health benefits, which fall under state law. Rules

See MASSACHUSETTS/page 16

California faces PEO cover flap

Comp fund sues to name firm's clients as insureds

By ROBERTO CENICEROS

SACRAMENTO, Calif.—Employee leasing firms in California are battling court challenges that could imperil one of their key attractions for employers: their ability to offer cost-effective workers compensation coverage for leased workers.

The firms, which are known as professional employment organizations, say that an attempt by California's State Compensation Insurance Fund to prevent them from buying workers compensation coverage on behalf of their clients would stymie PEOs' value as providers of risk management services and undermine existing state rules.

But SCIF, which is California's insurer of last resort, argues that issuing policies in the names of PEOs rather than in those of their clients prevents SCIF from managing its own risk portfolio effectively, because the PEOs often have employees working at a variety of companies.

PEOs typically contract to lease workers to employers. They often market themselves as a cost-effective way for employers to outsource the management of human resources, employee benefits, payroll and workers compensation coverage.

Several observers note, though, that few competitive workers compensation insurers are willing to provide coverage for PEOs. And because PEOs often cannot purchase coverage elsewhere, observers say, many depend on residual markets such as SCIF.

That coverage situation has come to a head in California, with San Francisco-based SCIF suing state Insurance Commissioner John Garamendi.

SCIF's lawsuit, filed on Dec. 22, aims to reverse a California Department of Insurance order forcing SCIF's insurance policies to recognize Staff Resources Inc., a Chico, Calif.–based PEO, as the only named insured for the employees leased to its client employers.

One month earlier, the Department of Insurance had also ordered SCIF to cooperate with California's Workers Compensation Insurance Rating Bureau to revise rating rules for PEOs.

But SCIF in its suit says it needs to issue separate policies that rate each of SRI's clients individually, instead of issuing a blanket policy covering SRI and its clients under the PEO's name. SCIF argues that it cannot properly manage its own risks because it can't determine whom it is insuring.

SRI is named as a "real party in interest" in SCIF's suit against Mr. Garamendi because SRI won an administrative appeal prohibiting SCIF from directly issuing policies to SRI's clients instead of issuing a policy to cover SRI and its clients in SRI's name.

SCIF also maintains that employee-leasing arrangements permit some employers to dodge the development of their own rating experience by relying on the rating of the PEO. Directly insuring the clients' employers, rather than issuing blanket insurance policies to PEOs, also

See PEO/page 17

HIPAA requires employers to inform workers of rights

By JERRY GEISEL

WASHINGTON—Employers soon will be required to provide workers who leave their employment with more comprehensive educational statements informing them of their rights under a 1996 federal law that curbs the ability of employers to exclude health insurance coverage for new employees' pre-existing medical conditions.

Under the Health Insurance Portability and Accountability Act of 1996, employers can deny coverage for new employees' pre-existing conditions for as long as 12 months. But that exclusionary period is offset by employees' prior continuous coverage.

For example, if an employee had been covered under a prior corporate health care plan for seven continuous months, the new employer could deny coverage for that condition for a maximum of five months. "Continuous" coverage is defined under HIPAA as that without a break exceeding 63 days.

The intent of HIPAA was to make it easier for employees to change jobs without fear of losing their health care coverage for pre-existing conditions.

Interim regulations published in 1997 by the departments of Health and Human Services, Labor and Treasury shortly before HIPAA went into effect laid down employer responsibilities under the law, including providing terminating employees with certificates detailing when coverage began and ended.

The final regulations issued last month by the three agencies expand the scope of the coverage certificates to include "educational statements" that explain to employees their HIPAA coverage rights.

"It is an explanation of what the law is all about," said Henry Saveth, an attorney with Mercer Human Resource Consulting in New York.

To aid employers in complying with the HIPAA information mandate, which applies for plan years beginning on or after July 1, 2005, the regulations provide a model notice, which employers can adopt

See HIPAA/page 17

Firm barred from seeking damages in singer's death

By JUDY GREENWALD

NEW YORK—Rhythm and blues singer Aaliyah was not a "property asset" of her record company and the company cannot not seek compensation in connection with her death as a result of a 2001 plane crash, a New York appellate court ruled.

In *Barry & Sons Inc. vs. Instinct Productions L.L.C.*, a panel of the New York Supreme Court's appellate division unanimously ruled that the record company was in effect pursuing wrongful death benefits, which only family members can receive.

PHOTO: ZUMA PRESS

A talent promotion firm representing the late R&B singer Aaliyah was barred from seeking wrongful death benefits.

The appeals court overturned a lower court ruling that Aaliyah was the record company's "property asset," not an employee, and that, therefore, the company could proceed with its suit.

Aaliyah, who was 22 when she died, was killed along with eight others when their plane crashed in the Bahamas, where she had gone to film a video produced by Northridge, Calif.-based Instinct Productions L.L.C. According to press reports, the plane was overloaded and cocaine and alcohol were later found in the pilot's body.

New York-based Barry & Sons, which did business as Blackground Records, was formed by Aaliyah's uncle, Barry Hankerson, in 1992 to develop, promote and capitalize on her musical talent, according to court papers. The singer owned a 10% stake in the company. In 2001, Blackground Records entered into a contract with Instinct to produce a music video titled "Rock the Boat." Instinct chartered the plane that crashed.

After her death, Aaliyah's parents filed suit against Instinct and several other parties and reached an undisclosed settlement in 2003, according to the Jan. 6 decision. Blackground Records filed suit three months later, charging that the singer's death was the result of Instinct's negligence in failing to arrange safe transportation.

New York law says a wrongful death action can be brought only by a "personal representative" of the deceased, not a company, according to the appeals court opinion. Blackground "is simply seeking damages for her alleged wrongful death in contravention of the statute," according to the opinion, which also said that the lower court judge who permitted the suit to proceed ignored "well-settled law."

In settling their suit, Aaliyah's parents "have been compensated for the damages resulting from her death," the opinion says. "Permitting Blackground's claim would expose Instinct to the risk of paying the same damages a second time. And, if Blackground is allowed to recover for the wrongful death of Aaliyah, what is to prevent others who anticipated profits from the talents of Aaliyah from bringing a negligence action on account of her death?" the opinion stated.

"Allowing tangentially injured parties to bring wrongful death actions would...lead to a proliferation of litigation and, to the detriment of the decedent's survivors, create unlimited liability for entities sought to be held liable for wrongful death," the court said.

Furthermore, "The concept that a person is a property asset of another is, of course, abhorrent to modern day thinking. Courts almost universally reject the antiquated proprietary view of the master/servant relationship."

Instinct's attorney, David H. Fromm, of Brown Gavalas & Fromm L.L.P. in New York, said the Blackground lawsuit was akin to suing the person responsible for the accidental death of "the guy who provides copying services" because his replacement charges more. A ruling in Blackground's favor would have permitted such lawsuits to proceed "no matter how remotely affected" the plaintiff is, and ultimately take money away from those who have the right to recover, said Mr. Fromm.

Barry & Sons Inc., doing business as Blackground Records, vs. Instinct Productions L.L.C., Brent Coert et al.; Appellate Division, First Department, 2005 NY Slip Op 000-96.

Paul Winston

Making a case for tort reform

If the cause of improving our civil justice system is ever to gain wider support, advocates need to update their tactics. The recent experience of two New York reformers may provide some inspiration.

Last week, two agitators for reforming the legal system were charged with disorderly conduct for heckling lawyers outside a Nassau County, N.Y., courthouse, according to the Associated Press. The two men, while waiting in line to enter the court, were loudly telling a lawyer joke, the AP reported.

The joke: "How do you tell when a lawyer is lying? His lips are moving!" Apparently, a thin-skinned lawyer in line began moving his lips in the ear of court officials, who cited the pair for what a court spokesman termed "being abusive and...causing a disturbance," the AP stated.

Paul Winston

The men, Harvey Kash and Carl Lanzisera, are founders of Americans for Legal Reform. Their Web site–*www.americans4legalreform.com*–contends that all lawyers are corrupt and that they have hijacked the U.S. legal system to serve their own interests, rather than those of the public. They contend the current system does not resemble the intent of the U.S. Constitution. I'm sure their recent experience will do nothing to dissuade them, especially with regard to the First Amendment.

It is not their philosophy that caught my eye, though, but instead their unorthodox tactics. Apparently, heckling lawyers is not an isolated occurrence for this group.

This made me wonder whether it's time for other tort reformers to improve their game.

For years, tort reform advocates have followed the traditional playbook for protest and persuasion. They have written books, articles and speeches. They have gathered petitions and issued declarations. They write blogs, organize conferences and create mock awards. I'll grant you, the awards get a lot of attention, but does the rest have as much impact? Reformers are preaching to the choir, while the rest of the congregation is looking at their watches or the inside of their eyelids.

These traditional tactics have consistently failed to convince not only the public of the need for reform but also a wider segment of state and federal lawmakers. Nor has the movement garnered much notice from the media conglomerates that influence public opinion.

Could heckling lawyers be the answer? No, probably not, no matter how satisfying it may seem. But other means of protest could grab the public's attention. And if the public is paying more attention, then you can bet lawmakers will take notice.

Here are a few nonviolent protest suggestions for your consideration:

● **Mooning.** The nation appears to be fixated on the recent gesture by Minnesota Viking Randy Moss pointing his derriere in the direction of hapless Green Bay Packers fans. I have seen countless articles trying to understand Mr. Moss' "motives." If tort reformers started pretend-mooning lawmakers and trial attorneys, surely the public would ask questions about their plight.

● **Skywriting.** Apart from the appearance of large UFOs and total solar eclipses, nothing makes thousands of people look up in the sky in wonder like a skywriter with a message. "Surrender, ATLA!" would certainly give the public something to ponder.

● **Hire the publicist used by Brad Pitt and Jennifer Aniston.** This person knows how to move media empires, as witnessed by getting People magazine to issue a special early edition last week on the couple's separation. Walter Olson is good, but he's not that good.

● **Form a human chain to block Gulfstream dealers.** Borrow a page from labor activists and watch the TV vans and helicopters congregate like ants at a picnic. Nonstop coverage, with close-ups of perplexed and inconvenienced trial lawyers with money burning a hole in their pockets, will move the public to their cause. If Gulfstream dealers are not in your area, a Humvee or Maybach dealership will do.

● **Get Bruce Springsteen to sing protest songs.** On second thought, he didn't bring much support to the Kerry campaign. Perhaps a new Woody Guthrie is needed. Ashlee Simpson?

● **Boycott smoking.** This could be enormously effective on two fronts. Not only will such widescale personal renunciation draw public attention and compassion to your sacrifice and cold turkey antics but also will rob tobacco companies of money to pay the trial attorneys. When the tap runs dry, they will probably have to pursue honest work, like drywall installation.

Such dramatic steps can work. Remember when ER docs started walking out in protest over malpractice litigation and liability insurance gouging a few years ago? What happened? Widespread media attention and a host of reform bills in numerous statehouses.

Editorial Director Paul Winston's commentary appears fortnightly. He can be reached at pwinston@businessinsurance.com.

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Editorial

Time to jumpstart pension reform

IS THE NEW BUSH administration pension reform package the way to go in revamping the nation's badly outdated pension laws?

Given the absence of complete detail in the package, that is a question we can't answer yet with a definitive yes or no.

But based on what has been presented, there is a lot we do find appealing. To start, we like what Labor Secretary Elaine Chao describes as a fresh start to funding rules. The proposed rules would completely replace existing rules, and not be layered on top of them.

That is a welcome and important change from the approach legislators have taken in the past when reform measures were stacked on top of others from prior years, resulting in a mind-boggling complexity of rules.

Such complexity certainly has been a disincentive for employers to continue to offer defined benefit plans.

We also welcome a long-overdue rewrite of the law that would enable employers to make additional contributions to their pension plans even if their plans were fully funded.

The logic of such flexibility is obvious. As anyone who has followed the ups and downs of pension plan funding over the past few years knows, a well-funded pension plan can quickly become an underfunded one when, for example, the equities markets slump or interest rates decline.

If employers could "overfund" their pension plans during good times, the plans would enjoy a surplus. Then, when times turned tough, the plans likely still would be at least fully funded, eliminating the need for employers to make contributions when they could least afford to do so.

Also welcome is the recommendation that employers in bankruptcy with underfunded plans be barred from boosting benefits. If a company is in trouble, the last thing it should be doing is adding to its costs. Nor is it fair to expect other employers, through the premiums they pay to the Pension Benefit Guaranty Corp., to guarantee benefit improvements made by companies in grave financial difficulty.

Other parts of the package are more problematic, most notably a provision that would require employers with older workforces and/or many retirees to value their pension plan liabilities on a different and less favorable basis than employers with younger workforces.

While we understand the logic of the concept of the use of a so-called yield curve to value pension plan liabilities, we question its application in the real world. Companies with older workforces would have to funnel a lot more money into their pension plans, and we wonder if that might give them an incentive to terminate their plans.

That quibble aside, the Bush administration package is the catalyst that Congress needs to get the pension funding reform movement going.

With the number of defined benefit plans dwindling and the federal insurance program that guarantees the benefits to participants in those plans way short of what it needs to pay the promised benefits, the time to begin that reform movement is now.

Bill won't cure state's ailment

YOU HAVE TO WONDER what most members of the Maryland General Assembly were thinking when they voted to override Gov. Robert Ehrlich's veto of a medical malpractice "reform" bill that is basically an exercise in robbing Peter to pay Paul.

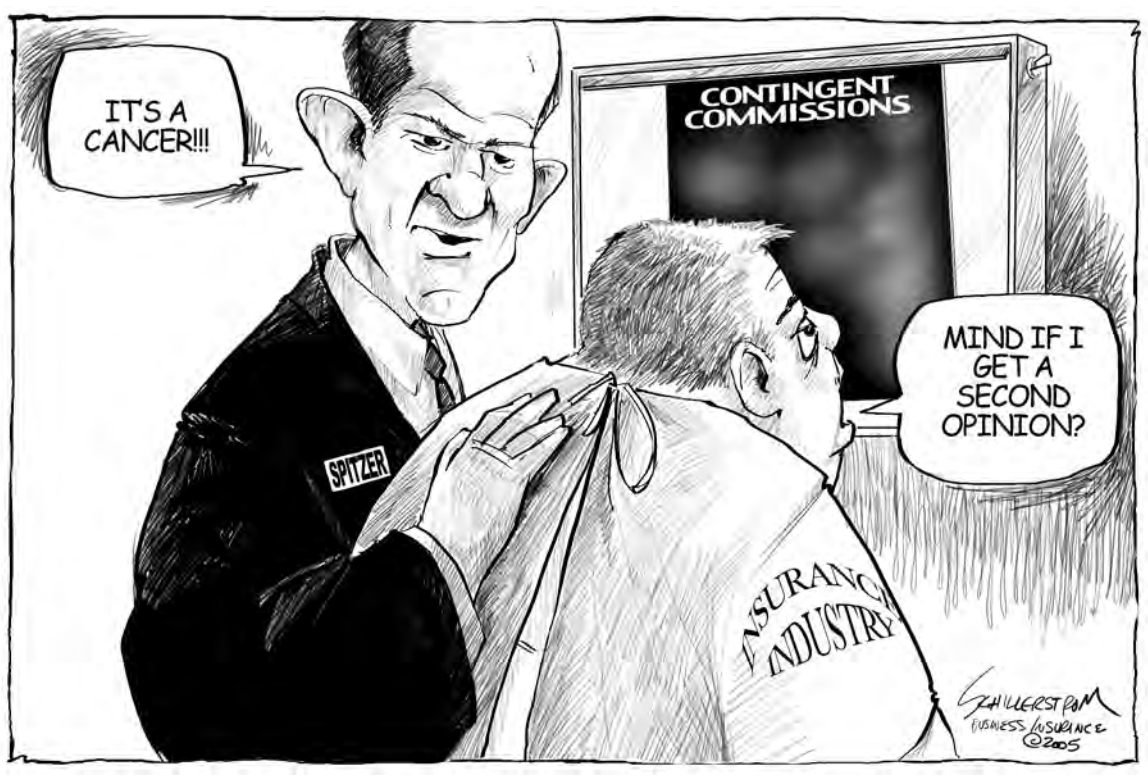
Some of the reason might have been pure pique, because lawmakers didn't like it much when the governor called them into special session during the week between Christmas and New Year's to deal with the state's skyrocketing medical malpractice insurance costs. Whatever the reason for the General Assembly's action, the result wasn't pretty. What Gov. Ehrlich proposed was in large part a tort reform bill; what the lawmakers produced was in large part a tax bill.

That's because the centerpiece of the measure is a new tax on HMOs to provide funds to help offset increases in physicians' medical malpractice insurance costs. If malpractice liability insurance costs are driving up the costs of health care, how does slapping a tax on HMOs—which are after all, part of the health care system—reduce costs?

The bill does provide some modest changes in tort law, but the measure's negative features—which aren't limited to the new taxes—outweigh its pluses.

The bill may bring some short-term relief to some physicians, but health care consumers ultimately will pay for that relief. Since the underlying structural reasons for the state's soaring malpractice insurance costs remain largely unaddressed by the measure, don't be surprised if lawmakers find themselves called into special session sooner rather than later to get right the second time what they could have done right the first.

Schillerstrom



Letters to the Editor

Real burden of TRIA borne by taxpayers

To the editor: Regarding reauthorization of the Terrorism Risk Insurance Act, it is a travesty for there to even be a TRIA. If we are at war, coverage is excluded, and the president should at least declare war. Then losses would be covered under public policy format, with no profit or earnings subsidy accruing to the insurance industry.

If we are not at war then continuing TRIA will do for terrorism coverage what the National Flood Insurance Program has done for flood insurance. What I mean is that NFIP has transferred the risk of loss onto the taxpayer. TRIA is doing the same. If no loss, the industry profits. If there is a loss, the industry is reimbursed. Gee, do you think this will cause risks to be written that would never pass muster if the industry was on the hook?

Look at the overdevelopment along the coasts for flood. No way this happens without the federal flood subsidy. I also believe this stifles any attempt at developing a private market solution.

TRIA is just another cartel payment by the government that comes out of my pocket. No way I agree with that!

Bill Ford
Birmingham, Ala.

Online Opinion Polls

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Not all health networks are created equal

By Joseph Driscoll

As national health care costs soar, businesses are straining under increasingly heavy financial burdens. One way that employers and self-funded groups are mitigating costs is by partnering with national health networks to take advantage of negotiated rates with facilities and providers. When choosing a preferred provider organization, though, it's important to look beyond the discounts that result from negotiated fees. Not all networks are equal, and neither are the savings they offer. There are several important questions to ask before partnering with a health network.

One of the first things to consider is the makeup of a PPO network. Many PPOs comprise leased networks. National access is quilted together through relationships with existing regional networks. While this can encompass a tremendous number of providers and health care facilities, it can also leave a PPO and its customers vulnerable to lower savings, a lack of quality control, administrative concerns and the disruption of coverage.

Conversely, proprietary PPOs contract directly with participating providers and facilities. This enables the PPO to have a stronger position in negotiations. Proprietary PPOs also have more control over the integrity and stability of their network.

Makeup of networks, number of providers as important as possible cost savings

It is also important to understand the true size of a PPO network—after all, cost means nothing without access. An important question to ask is whether the number of participating providers equals the number of individual physicians. Many PPOs count "bellybuttons," meaning that each provider is counted only once, regardless of multiple specialties or locations. Some networks inflate their access numbers by including a physician more than once for multiple specialties or practice sites. Another access consideration is the number of urgent care centers, skilled nursing facilities and hospices included in the facility count.

When PPOs quilt health systems together for greater access, it can be difficult to ensure the overall integrity of the network. It is important to understand a network's criteria for participating providers and facilities. PPOs that are committed to quality often implement their own credentialing policies and procedures to screen for board certification, state licensure and good standing with state medical boards. In addition, there are several independent, nationally recognized quality assurance organizations, including URAC, the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations, that review and certify the quality of PPO networks. Their endorsements are important indicators of network integrity.

Comparing savings among PPO networks can be deceptively complicated. In reality, without a clear understanding of the elements used to calculate discounted rates, discounts can be meaningless in terms of true savings. The reason is that there are many possible methodologies used to determine discounts. Some measure the difference between the provider's submitted charges and the contracted reimbursement amount for the services rendered. Others consider the difference between the amount for covered charges and the amount reimbursed by the claim payer, and still others compare the provider's submitted charges to the amount reimbursed by the claim payer.

The differences don't end there. Some methodologies include noncovered/ineligible charges and benefit limitations in the discount calculation. Others exclude member liabilities such as deductibles or coinsurance in the discount calculation. The result is that a single claim with the same charges and same end cost to the payer can be manipulated to show significantly different discounts.

Another important factor when making a cost comparison is the overall charge structure. A fixed reimbursement rate sets negotiated prices for specific procedures and hospital stays. This methodology helps both hospitals and payers control health care costs by forecasting the frequency and associated costs of medical services. In this way, all parties participate in cost management and payers are better able to anticipate and manage expenses.

Alternative reimbursement arrangements such as straight discounts can significantly drive up the cost of health care by making it impossible for payers to estimate and project expenses. In a straight discount arrangement, facilities agree to accept a set percentage of fees for medical services. While this can result in significant discounts, there are no mechanisms for controlling the costs. A facility, for example, may agree to a 50% discount on a $1,000 procedure. If, however, the hospital raises the cost to $2,000, the percent of the discount remains the same, while the cost to the payer doubles.

Finally, it is critical to take into account the data that is used in the quoting of savings. If a PPO bases its discounts on claims experience for one customer or one demographic, it gives an incomplete picture of the actual costs. Instead, a PPO should quote discounts on the average claims experience of all its customers, which represents many different demographics. In addition, the higher the volume of claims utilization, the more statistically valid the discounts information will be.

Partnering with the right PPO can be a highly efficient and successful way to manage health care costs. Armed with the right questions, payers are empowered to make educated comparisons to determine which organizations will provide the best savings and access for their needs.

Joseph Driscoll is president and chief executive officer of Private Healthcare Systems in Waltham, Mass.

Refusal of service no trigger to wrongful eviction cover

Racial discrimination by refusing to serve patrons did not fall within the coverage of a restaurant's commercial general liability insurance policy, according to the Supreme Court of Delaware.

In 2001, the Delaware Human Relations Commission found that J.P.'s Wharf Restaurant and its owner, Peter Russo, engaged in racial discrimination when the restaurant refused to serve certain patrons and ordered them to leave. The Commission ordered J.P.'s to pay damages totaling $6,000 to the complaining patrons and to pay a $5,000 civil penalty. J.P.'s was covered under a CGL policy issued by Westfield Insurance Group. The policy covered personal injury, defined as injury—other than bodily injury—arising out of one or more of several offenses such as false arrest, malicious prosecution or wrongful eviction. J.P.'s filed an insurance claim with the insurer for expenses related to the discrimination complaint. The insurer brought this suit seeking a declaration from the court that the policy did not cover these expenses. The trial court ruled for J.P.'s. The insurer appealed.

The appellate court said that the insurer's "wrongful eviction" clause plainly required that the claim involve a possessory interest in property such as that of a tenant or owner. Because the patrons who filed their racial discrimination complaints against J.P.'s had no possessory interest in the restaurant premises, the court said that the "wrongful eviction" provision in the policy did not cover expenses J.P.'s incurred in resolving those complaints. The trial court decision was reversed.

Westfield Insurance Group vs. J.P.'s Wharf Ltd., Supreme Court of Delaware, Sept. 17, 2004 (BI/03/F.-$10)

Legal briefs

ERISA pre-empts slayer statutes

The Employee Retirement Income Security Act pre-empts a state slayer statute that prevents anyone convicted of murder from benefiting in any way from the death, according to an Ohio appellate court.

Lubaina Ahmed was employed as a physician at the Ohio Valley Health Services & Education Corp. As a benefit of that employment, Dr. Ahmed was enrolled in a life insurance policy. Dr. Ahmed designated her husband, Nawaz Ahmed, as her primary and secondary beneficiary. Their son, Ibtisam, was designated as the contingent beneficiary. Subsequently, a second son, Ahsan, was born but was never designated as a secondary contingent beneficiary. Mr. Ahmed murdered Dr. Ahmed and was sentenced to death. The Ohio probate court declared that, under the state slayer statute, all property and insurance proceeds should be paid as if Mr. Ahmed predeceased his wife. The insurance company paid Ibtisam Ahmed half of the benefits as the contingent beneficiary. The remaining half was withheld because of a dispute whether Ahsan Ahmed or Ibtisam Ahmed was entitled to those benefits. Ahsan Ahmed filed this suit seeking a declaration from the court that he was entitled to the remaining life insurance benefits. The trial court ruled against Ahsan Ahmed, and he appealed.

The appellate court said that the life insurance policy here was governed by ERISA. Furthermore, the court said that state slayer statutes interfere with nationally uniform plan administration and, therefore, are pre-empted by ERISA. Because ERISA pre-empted Ohio's slayer statute, the court said, the determination of who is a beneficiary of the life insurance policy was a question of federal law and must be determined under federal common law. According to the court, the proceeds of the policy should be paid to Dr. Ahmed's estate rather than to a designated contingent beneficiary. The trial court decision was reversed and the case sent back for further proceedings.

Ahmed vs. Ahmed, Court of Appeals of Ohio, Sept. 24, 2004 (BI/05/F.-$10)

Comp benefits payable despite community corrections stay

A state law mandating the suspension of workers compensation benefits during a worker's confinement in a jail, a prison or a department of corrections did not apply to a resident of a community corrections program, according to the Colorado Court of Appeals.

At issue in this case was whether Hilario Vasquez was required to repay workers compensation benefits he received from the City and County of Denver, his employer, while he was a resident of a community corrections program. In May 2000, Mr. Vasquez suffered a lower back injury, for which he received compensation benefits over the next two months. Unbeknownst to his employer, Mr. Vasquez was convicted of a felony and received a six-year community corrections sentence. He was admitted to a privately owned community corrections program and was at liberty to leave the premises to go to work. His employer requested repayment of the benefits paid to Mr. Vasquez, alleging that he was not entitled to receive them while he was residing in the county detention facility. An administrative law judge agreed with the employer and ordered Mr. Vasquez to repay the benefits. He appealed. The Industrial Claim Appeals office agreed with Mr. Vasquez. The employer appealed.

The appellate court emphasized that the state law in question barred benefits during which an individual is confined in a "jail, prison or any department of corrections facility." Furthermore, the court said that the law defined the term "community correction program" as a "community-based or community-oriented program that provides supervision of offenders." According to the

Continued on next page

Private, government terror cover is possible

By Ronald R. Robinson

The Terrorism Risk Insurance Act of 2002 is a private financial markets/government insurance program designed specifically to cover only losses from foreign terrorist attacks on American soil, ships, aircraft and international missions. It will expire on Dec. 31. What sort of terrorism risk programs ought to, could—and will—be developed to replace TRIA? Should private financial market products or government/insurer risk transfer partnerships replace TRIA? What scope of terrorism coverage should be available in personal, property and casualty lines?

If these TRIA succession issues are to be resolved by deliberation rather than by default, TRIA will have to be continued for at least two years beyond Dec. 31, so that what follows can be created and implemented in an orderly manner, without gaps in terrorism risk coverage.

Two key issues, though, must now be resolved independent of that question, whatever happens to TRIA. How shall newly emerging and interim private terrorism insurance products be structured, and what role will that process play in the TRIA succession debate?

Before Sept. 11, 2001, all policies in place in all major lines of insurance in the United States included, or were read to include, terrorism risks. But the coverage in these lines did not provide the specificity of coverage for terrorist losses that many analysts now believe is crucial to the continued solvency of private markets. Historically validated specific-peril underwriting principles and their unique standard language provisions could easily be adapted to create stand-alone coverage sections or endorsements amending policies to create a specific-peril terrorism coverage program in each line of insurance. This approach stands the best chance of establishing solvent and easily administered coverage. The resulting product could be the core structure in any successor program to TRIA, be it private or public or a partnership of both.

A specific-peril program for terrorism risks would contractually define and limit the risks transferred from policyholders to insurers and/or to the federal government and, thus, leave no doubt as to the portion of the risk retained by each party. Using this historically proven contract approach, insurance for future terrorist losses could be quantified and prudently issued in order both to continue and expand this coverage in all lines. More importantly, this process can begin now in the private sector as a precursor to and foundation for whatever it is that follows TRIA.

A private market/government partnership successor to TRIA using a specific-peril program approach would consist of two coverage tiers, constructed much like classic tiered large-risk programs. First, the private-sector tier would consist of primary, umbrella and excess policy specific-peril terrorism endorsements or sections in: life, workers compensation, health and accidental loss policies; first-party policies for fire, property destruction and business interruption loss; and third-party liability policies.

Second, a federal government tier would attach above the limits of the private-sector tier and "follow form" to the latter's underlying policies in all lines.

In such a partnership specific-peril program, the actual coverage for both tiers would rely on contract language, not the statutory and political decision approach that defines TRIA. This language would be written specially for each separate policy section or endorsement in each line using specific-peril underwriting principles. Premiums need finance such a specific-peril terrorism program only at the private tier, with U.S. Treasury revenues and surpluses being used to fund the governmental tier. The private insurance market has the most efficient mechanism to collect premium from and then return it to all segments of our society through investments, the payment of claims, awards and defense fees and costs, and the creation of jobs. Traditional private-sector economic forces, bolstered by this premium mechanism, should, in turn, stimulate our economy, increase Treasury revenues and, thus, pay for government-tier losses.

If terrorism insurance coverage is to continue, let alone expand, the TRIA succession debate must begin in earnest now with an extended TRIA in place.

As the governmental tier would become involved in a given claim, the last private insurer directly handling the loss would continue to administer it. The money necessary to pay a loss in excess of the private tier would come from the Treasury, while the private tier would handle the claim and actually pay the loss. Insurance companies have existing, tested and comprehensive claims-handling mechanisms. They are the partner that can better pay and defend claims. Specific-peril program claim decisions would be contractually based and not, as under TRIA, be driven by statutory and political paradigms. The culture of the private financial markets, driven as it is by contract, would be unlikely to engage in the politically based claim decisions that are mandated in TRIA.

A specific-peril terrorism insurance program would require neither dramatic nor extensive changes to existing infrastructures or laws. It could be built "from the ground up" in the private sector, rather than being imposed by government "from the top down." TRIA could provide temporary stability and security while private insurance markets made the necessary specific-peril program underwriting choices, created policy provisions and fixed policy limits, tier attachment points and premium rates. TRIA's public coverage approach could, at the same time, be revised along these lines, a new government-tier approach created or the role of Treasury in this coverage ended. If insurance for this risk is to continue, let alone expand, the TRIA succession debate must begin in earnest now, with an extended TRIA in place to provide a realistic window of time within which to do this critical job.

Ronald R. Robinson is executive partner in the Los Angeles law firm of Berkes Crane Robinson & Seal L.L.P. and chair of the Chicago-based Defense Research Institute's TRIA subcommittee.

Continued from previous page

law, the court said, a private individual, partnership, corporation or association can operate such programs. Accordingly, the court said, because a community corrections program is not a jail, prison or any DOC facility, it did not fall within the suspension of benefits provision. Thus, the court said that Mr. Vasquez was not barred from receiving compensation benefits for the period he was in the community corrections program.

City and County of Denver vs. Industrial Claim Appeals Office, Colorado Court of Appeals, August 12, 2004 (BI/04/F.-$10)

ERISA administrator didn't abuse discretion

The 5th U.S. Circuit Court of Appeals ruled that an Employee Retirement Income Security Act insurer/plan administrator had not abused its discretion when it denied a beneficiary benefits under a group accidental death insurance policy.

Terry Gilmer, as an employee of Nolen Sistrunk Inc., was covered under a group accidental death insurance policy underwritten and administered by PFL Life Insurance Co. Mr. Gilmer died in 1999 following a traffic accident. The accident occurred while he was driving on an interstate highway when his truck swerved and crashed into the back of another truck. The police report stated that, at the time of the accident, road conditions were good and the weather clear. Mr. Gilmer's death certificate stated that a heart attack was a significant cause of his death. His medical records revealed he suffered from high blood pressure, which was poorly controlled, complained of shortness of breath and was a smoker. PFL denied a claim from Mr. Gilmer's daughter, Melissa Brown, for benefits under the policy, concluding Mr. Gilmer's death was not accidental. Ms. Brown sued PFL, alleging it abused its discretion in denying her benefits. The trial court ruled against her, and she appealed.

On appeal, Ms. Brown argued that PFL could deny the benefits only if the heart attack was the probable cause of Mr. Gilmer's death. The court rejected her argument, stating that under the abuse of discretion standard, PFL's decision need only evince a "rational connection between the known facts and the decision." Considering all of the evidence here, the court said, PFL could have rationally concluded that Mr. Gilmer's heart attack contributed to his death. The trial court decision was affirmed.

Brown vs. PFL Life Insurance Co., 5th U.S. Circuit Court of Appeals, Oct. 1, 2004 (BI/01/F.-$10)

Employer doesn't benefit from employees' breaks

A workers compensation claimant was denied benefits because his injury occurred at a time when the claimant was not performing employment services, according to the Court of Appeals of Arkansas.

James McKinney worked as a sheet metal fabricator for the Trane Co. In December 2001, Mr. McKinney left his work station to go on a break. He walked to the break table to get his cigarettes and turned around to go outside. However, he turned back to get a soda he had left on the break table. He took the most direct route by leaping over some buckets instead of going all the way around. He landed on the floor on a pile of aluminum parts that he had not seen before leaping. His leg slipped, and he was injured. Mr. McKinney filed for, but was denied, workers compensation benefits. He appealed.

The appellate court said that Mr. McKinney, on his way to his cigarette break, was involved in nothing generally required by his employer and was doing nothing to carry out his employer's purpose. Therefore, the court said that the employer got no benefit from Mr. McKinney's activities on break. Thus, the court concluded that the jump and landing that caused Mr. McKinney's injury did not occur at a time when Mr. McKinney was performing employment services. The court affirmed the decision to deny him workers compensation benefits.

McKinney vs. Trane Co., Court of Appeals of Arkansas, Jan. 28, 2004 (BI/02/F.-$10)

Breach of contract claim pre-empted by ERISA

Claims for breach of contract and professional negligence brought by a sponsor of an employee pension plan covered by the Employee Retirement Income and Security Act were pre-empted by ERISA, according to the 4th U.S. Circuit Court of Appeals.

Information Systems & Networks Corp. sponsors an employee pension plan covered by ERISA. The employer retained Principal Life Insurance Co. to assist in the administration of the plan, with the duties of maintaining plan records, issuing required distributions to plan beneficiaries upon ISN's approval, collecting contributions made by ISN to the plan and issuing statements regarding plan participation. ISN sued the insurer in federal court, raising claims of breach of contract and professional negligence. According to the suit, the insurer had committed claim administration errors and thus made improper distributions totaling at least $300,000 and that, but for those errors, the funds at issue would have been forfeited to the plan, where they might have been credited to or returned to ISN as the plan sponsor. The insurance company responded by asserting that ERISA pre-empted all of ISN's claims. The trial court agreed with the insurer and dismissed ISN's suit. ISN appealed.

The appellate court said that the gist of ISN's complaint was that certain distributions made by the insurer were erroneous because the beneficiaries were not entitled to those distributions under the terms of the plan. Accordingly, the court said that the trial court correctly determined that ISN's claims boiled down to allegations of improper administration of the plan. The court emphasized that those state common law tort and contract actions that are based on alleged improper processing of a claim for benefits under an employee benefit plan are pre-empted by ERISA. The trial court decision was affirmed.

Information Systems vs. Principal Life Insurance Co., 4th U.S. Circuit Court of Appeals, June 5, 2004 (BI/02/N.-$10)

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available, at $10 each, by sending a check payable to Mayo H. Stiegler, to Business Insurance 360 N. Michigan Ave. , Ill 60601-3806. Please provide the listed number for each opinion ordered.

Commentary

Buyers, beware these warnings

It's one of my favorite times of the year—awards time.

A couple of weeks ago, Michigan Lawsuit Abuse Watch announced the winners of the Wacky Warning Label Contest. For anyone who has been traveling abroad and missed the results, the top award honored a label warning consumers not to use a toilet bowl brush for personal hygiene purposes. Second place recognized a warning that alerted parents that children's scooters move when used.

Now, the tentative results of the Unfortunately Not So Wacky Risk Management and Employee Benefits Warnings Contest have been released by a panel of 10 independent and somewhat cranky risk and benefits managers.

The contest this year was open to warnings issued to and by risk and benefits managers, and the judges recognized warnings in both categories.

The fifth-place award honors the benefits managers warning on health insurance premium invoices:

Microscopically lower premium hikes that still far exceed the inflation rate, account for a record percentage of the gross domestic product and likely won't occur again in the near future absent meaningful health care reform may not be a metric that would help you impress your supervisors about your job performance.

Finishing just ahead in the voting to capture the fourth-place trophy is the warning to hospitals in health maintenance organization contracts:

Charging excessively high rates to bolster profits or cover fat expenses could be as dangerous to your longevity in this pricey health care market as 50 pounds of excess weight is to a 54-year-old coal miner who has smoked since junior high and hasn't been inside a gym since.

The Pension Benefit Guaranty Corp. earned third place for its employer warning. The judges liked the warning because of the PBGC's attempt to inject a note of optimism:

We encourage employers facing a 58% PBGC premium increase to consider that things could be worse. At least until this premium hike, you didn't have the kind of financial troubles that would force you to terminate your plans and dump their liabilities on us.

To employers planning to terminate their plans and dump their liabilities on us: The agency has recently moved and changed its contact information, all of which is now being withheld from the public.

In an unprecedented vote, the judges' selection for second place also goes to the PBGC for a warning that offers employers some advice:

Future premium increases will be tied to the rise in the national average wage, so employers should contemplate freezing or slashing employee pay.

The first-place award goes to a warning that is brand new yet is quickly becoming part of the boilerplate language included in the contracts that individuals must sign when accepting outside corporate directorships:

Fleecing corporate shareholders or showing your face around the boardroom just long enough to collect your perks without offering a scintilla of oversight may create the impression among corporate shareholders that you are corrupt or a carpetbagger. Big, angry institutional shareholders that lose a boatload of money because of your criminal or cavalier behavior and can afford nastier attorneys than you can may find that taking a chunk of your hide in the form of cold, hard cash from your personal accounts is a lot more meaningful and fun than collecting their entire recovery from D&O insurers. Innocent and hardworking outside directors who find themselves in legal trouble because of others' actions may want to consider prefunding their eventual losses.

Dave Lenckus

The judges also recognized a couple of unusual entrants with Honorable Mentions.

One went to Madison County, Ill., the favorite venue of plaintiffs attorneys nationwide, for the road and airport signs that welcome visitors to the area:

Welcome citizens of the world. You are all citizens of Madison County.

The welcome signs also offer visitors coupons to one of the most popular restaurants in the area—Mi Courthouse, Su Courthouse.

An honorable mention also went to the state of Mississippi, a former favorite venue of plaintiffs attorneys until recent tort reforms in the state, for its welcome signs:

Welcome to Mississippi. Maps to Madison County, Ill., Available Here.

The results of the contest are tentative, because the judges have not finished reviewing one more warning for risk managers. We'll get back to you with final contest results in several months. That's when the new warnings about property/casualty insurance policy issuance delays should arrive—within the policies risk managers purchased during January renewals.

Senior Editor Dave Lenckus can be reached at dlenckus@business insurance.com.

Products & Services

Companies form health service provider

MARBLEHEAD, Mass.—Two companies, HCPro Inc., a provider of health care regulatory and management information based in Marblehead, Mass., and Stevens & Lee, a professional services company based in Reading, Pa., have launched the Healthcare Risk Management Institute.

The company was created to offer services to nursing homes, hospitals, physician practices and other health care providers, including assistance in managing and reducing risk by improving communications and customer service between health care professionals and patients and their families.

The company offers risk evaluation services and loss prevention education, as well as a Five-Star Service Excellence Culture Program, which focus on the causes of financial loss, legal risk, claims and litigation. It also offers guidebooks, videos and other tools to assist health care providers.

For more information, contact Marcia Wessell, marketing manager for HCPro, at 781-639-1872, ext. 3154, or at *mwessell@hcpro.com*; or Jenna Hahn, director of marketing for Stevens & Lee, at *jmha@stevenslee.com*. More information can also be obtained by visiting the Healthcare Risk Management Institute's Web site at *www.hcriskinstitute.com*.

Best offers new options for executive reports

OLDWICK, N.J.—A.M. Best Co. Inc. has introduced two new formats of Best's Executive Summary Reports (Financial Overview), which are online reports that provide financial information for property/casualty and life/health insurance companies.

The new options include comparison reports and composite reports. These reports allow users to compare performance results among companies. The comparison report displays the side-by-side analysis of a primary company against up to five other companies. For the composite reports format, the information displayed is not broken out separately for each company; the primary company's results, though, can be compared to a selected peer group's average results. The information available in these reports includes five years of balance sheets and income statement data, Best's ratings, bond portfolio composition, capitalization analysis and ceded reinsurance analysis.

Previously, Oldwick, N.J.-based Best's Executive Summary Reports were available only as single company reports, which are still offered.

The new reports are currently available on approximately 3,300 property/casualty insurers; the life/health reports will be available in the second quarter of 2005.

To obtain more information, visit *www.ambest.com/sales/execsummary*. To order these reports, contact Best's customer service at 908-439-2200, ext. 5742, or at *customer_service@ambest.com*.

Crawford offers dependent care services

ATLANTA—Crawford & Co. is offering a dependent care program for employers and their employees.

The program, Crawford Care Management, intends to assist employers and employees by enhancing employee productivity and minimizing the stress associated with caregiving.

Services are available for employees' seriously ill or disabled children and their spouses, as well as elderly parents. The programs offers assessment and care services, which include telephone consultations, onsite assessment, placement services, caregiver training and support and monitoring services.

For more information, contact Atlanta-based Crawford Care Management at 800-352-7359 or visit *www.crawfordcaremanagement.com*.

VMC forms alliance to offer benefits program

GURNEE, Ill.—VMC Behavioral Healthcare Services has formed an alliance with San Francisco-based WellCall Inc. and Elgin, Ill.-based Hines & Associates Inc. to offer a benefit program that includes behavioral health, wellness and disease management services.

The program, Coordinated Lifestyle Management, is intended to help enhance employee health and well-being. The employee assistance program portion includes child and elder care services, legal services and financial services. The wellness program consists of personalized coaching, education, referral and screening services for weight management, stress management and smoking cessation, among other things. The disease management element includes education, the coordination of care and appropriate intervention services for those employees with chronic conditions.

For more information, contact Gurnee, Ill.-based VMC at 888-645-2842 or visit the company's Web site at *www.vmceap.com*.

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

FSA obligates brokers to disclose pay

By SARAH VEYSEY and PETA MILLER

LONDON—Risk managers are entitled to ask their brokers to provide details of the commissions they receive and brokers are obliged to respond under regulations that came into force last week.

The London-based Financial Services Authority, an independent regulator, assumed the oversight of U.K. intermediaries on Jan. 14, taking over from the General Insurance Standards Council, a self-regulating body.

Under the FSA's rules, brokers are required to give risk managers information of the commissions they receive only if the risk managers request such information, an FSA spokesman said. This is one area in which the regulation of brokers dealing with commercial buyers differs significantly from the regulation of business with personal lines customers, he added, explaining that brokers are not required to disclose information on commissions to personal lines customers even if asked.

This requirement has been part of the FSA's proposals for the regulation of insurance brokers since about January 2004, the spokesman noted, and was not prompted by New York Attorney General Eliot Spitzer's investigation into insurance broking practices.

The FSA also requires brokers to fulfill certain requirements about the information given to buyers about the insurance they are being sold, such as exclusions, and policy documentation must be more thorough.

John Tiner, chief executive officer of the FSA, has also begun work to ensure that there is greater contract certainty in the insurance market. A meeting between the FSA and interested parties—including risk manager representatives—was held last month, and Mr. Tiner said the FSA hoped a "market-driven solution to the issue of contract certainty" would be developed within two years.

Buyers of insurance will have access to an ombudsman if they have any complaints about their broker, the FSA spokesman said. He noted, though, that while commercial risk managers will have access to this service, it is unlikely that many will use it.

Risk managers more likely will register complaints with their brokers, David Gamble, executive director of the London-based Assn. of Insurance and Risk Managers, said. The threat of FSA intervention should help resolve such complaints, he said.

Brokers will be required to inform the FSA of all complaints they receive, according to the FSA spokesman.

Risk managers welcomed the added transparency that FSA regulation will bring.

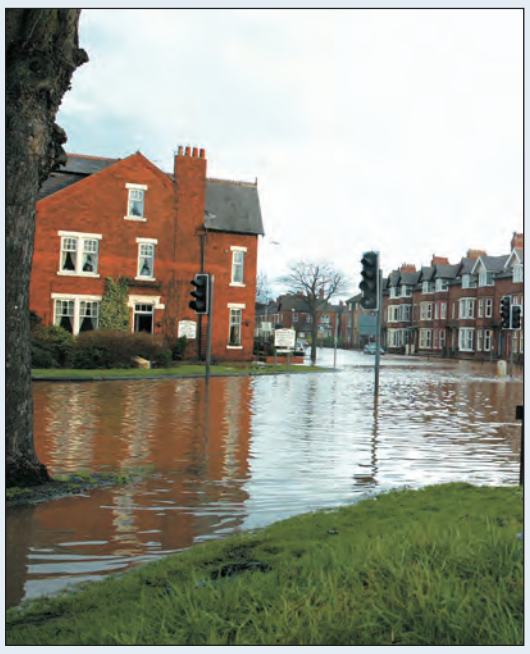
Chris Holden, insurance risk manager for London-based Tube Lines, said that he was now receiving more information from his broker than previously. For example, he said, he has received a far more detailed renewal report covering points not previously included in such communications.

Mr. Gamble said AIRMIC would

See FSA/page 15

Storms damage Northern Europe

PHOTO: AFP



Windstorms this month caused flooding and other damage in cities including Carlisle, England.

Severe storms that hit Northern Europe Jan. 8 and 9 have left several people dead and could cause sizable insurance losses.

Although many sources said it was too early to tell the full extent of the insured loss from the storms, a spokeswoman for London-based insurer Norwich Union said that losses from severe flooding in Carlisle, England, on Jan. 8, which killed three people, could cost the company "tens of millions" of pounds.

Most of the losses are expected to be from personal lines claims, but there will be some commercial claims resulting from the storms, said the Norwich Union spokeswoman and a spokesman for London-based broker Heath Lambert Group, which has issued guidance for companies affected by the storms.

Windstorms that hit Scandinavia and Baltic countries Jan. 8-9 caused significant insured losses, insurers in the region report.

A spokesman for If Skadeförsäkring Holding AB, a wholly owned subsidiary of Helsinki, Finland-based Sampo P.L.C., said the Stockholm, Sweden-based insurer will pay 22 million euros ($28.7 million), after reinsurance, for damage in seven Northern European countries.

Damage in Sweden alone accounted for between 11 million euros and 17 million euros ($14.3 million and $22.2 million) of the total, he said.

Codan A.S., an insurer based in Copenhagen, Denmark, will pay 110 million Danish kroner ($19.2 million) as a result of the storms.

Codan's reinsurers will pay losses up to a maximum of 3 billion kroner ($525.9 million) above this amount, but "we don't expect to reach that limit," a Codan spokesman said.

The storms killed 13 people from three countries and caused power outages, travel disruption and flooding.

London-based Royal & SunAlliance Insurance Group P.L.C. said its preliminary estimate for claims arising from the recent storms in the United Kingdom and Scandinavia was £30 million ($55.8 million), after reinsurance.

Meanwhile, fierce winds in Scotland last week left at least six people dead.

—By Sarah Veysey

German insurers object to unsolicited ratings by Fitch

By PETA MILLER

BERLIN—Fitch Ratings Ltd.'s plan to issue insurer financial strength ratings on European insurers has met with resistance from Germany's insurance industry.

Fitch in December published a consultative document stating that it planned to issue unsolicited ratings, known as "q ratings," on up to 200 insurers in France, Germany and the United Kingdom.

In response, the German insurance association, the Gesamtverband der Deutschen Versicherungswirtschaft e.V., earlier this month asked the rating agency to delay its plans. The GDV is concerned about, among other things, the appropriateness and transparency of Fitch's methodology, as well as the brevity of the consultation period, which ran from Dec. 16, 2004, to Jan. 7.

"Because of severe shortcomings in Fitch's methodology and procedures, we urge Fitch to, for the time being, refrain from publishing any of the q ratings for German insurers based on the defective calculations and the model as released," the Berlin-based GDV wrote in a letter to the London unit of Chicago-based Fitch.

Fitch, though, maintains that its methodology is sound and reflects internationally accepted principles. The effort to rate European insurers' financial strength was prompted by demand from insurance brokers and financial analysts that rely on Fitch's ratings.

In the consultation document, Fitch notes that it will base the "q" ratings on an examination of up to five years of the most recent public financial results of a company.

This data is analyzed in five modules: capitalization, profitability, liquidity, operating profile and cashflow. The modules each generate a rating, which are then aggregated to derive an overall financial strength rating.

Anya Theis, a senior economist for the GDV, expressed concerns about the rating agency's approach.

Fitch's reliance on publicly disclosed financial information "is not detailed enough to allow the assessment (Fitch) tries to make in this model," Ms. Theis said.

For example, Fitch relies on market assumptions to determine the share of a company's investment in equities, said Ms. Theis.

Because German law does not require companies to state the proportion of certain assets invested in bonds vs. equities, Fitch's model relies on a market average, explained Fitch Managing Director Greg Carter in London. Fitch would welcome more information from companies on their particular asset split, though, he said.

The GDV also maintains that its members were not properly informed of the opportunity to provide further confidential information to influence their ratings, Ms. Theis said.

Companies can provide additional quantitative and statistical information, as long as it fits within the parameters of Fitch's ratings model and thereafter is treated as publicly available, the consultation states.

But the GDV contends two letters received by German companies in

See FITCH/next page

World Updates

Aussie P/C industry stable: Moody's

Moody's Investors Service said the outlook for the Australian property/casualty insurance industry remains stable. In a report, Moody's in Sydney, Australia, said rate decreases are being seen in renewals, but "prices are unlikely to hit the lows of the previous soft cycle."

Willis acquires U.K. broker C.R. King

Willis Group Holdings Ltd. has acquired Northampton, England-based broker C.R. King & Partners Ltd. Terms of the deal were not disclosed. C.R. King, a commercial nonlife broker, has revenues of about £1.3 million ($2.43 million), Willis said in a statement, and it was the founding member of the Willis Commercial Network, a network of 60 regional brokers throughout the United Kingdom.

Kinnect exchange adds two customers

London-based insurer Hiscox P.L.C. has joined the Lloyd's of London-backed electronic risk data exchange Kinnect. And Liberty Syndicates, the Lloyd's managing agency of Boston-based Liberty Mutual Group, will sign contracts to join the exchange shortly, London-based Kinnect said in a statement. The two companies will bring the number of Kinnect customers to 10.

Markel boosts capital of London operation

Markel International, the London-based operation of Markel Corp., has injected an additional $50 million into its London-based insurance company, Markel International Insurance Co. Ltd. The capital boost will increase Markel International Insurance Co.'s shareholders' funds to about $300 million, the company said in a statement. Markel also operates syndicate 3000 at Lloyd's of London, which has capacity of $270 million.

Briefly noted

Gross premium written by Lloyd's of London syndicate 2001, operated and capitalized by **Amlin P.L.C.**, rose 5% from 2003 levels to £780 million ($1.49 billion) in 2004, the insurer reported. Amlin provided all of the £1 billion ($1.91 billion) capacity for the 2004 year of account, compared to its 86.2% share of the syndicate's £862 million ($1.54 billion) capacity in 2003....Zurich-based **Swiss Reinsurance Co.** will donate $1 million to various organizations involved in the tsunami relief effort in Asia and will also match employee contributions.

Fitch: German insurers bristle at proposed rating

Continued from previous page

November and December 2004 from Fitch misleadingly stated that "q" ratings would be based entirely on publicly available information, Ms. Theis said.

"We think the exposure draft makes clear companies are able to provide additional information but we have heard from some people they did not feel that was the case," Mr. Carter said.

Although Fitch has already begun its assessment, there still is time for German companies to provide additional information, Mr. Carter added.

Fitch must disclose much more information on its model and give companies more time to comment, according to Ms. Theis, who noted that the comment period included the Christmas and New Year holidays.

"We felt it was sufficient time to read the document and comment," and the agency is still willing to receive responses, given the holiday period, Mr. Carter said in response.

But regardless of the comment period, German insurers are more concerned by the Fitch approach than they are by the approach of other rating agencies that issue ratings based only on public information, said Ms. Theis.

Fitch appears to rely heavily on its analytical model and does not include the same degree of subjective analysis as other rating agencies, she said. And Fitch is targeting brokers as consumers of its ratings rather than the professional investors that use other rating agencies' analyses and who are more familiar with rating agencies' methods, Ms. Theis said.

Mr. Carter said that the Fitch rating necessarily includes subjective analysis.

"If we disclose every single aspect of the model, we are putting ourselves out of business, because some subjective thinking on how to look at insurance companies has gone into it and that is proprietary information," Mr. Carter said.

Fitch received several replies to the consultation from a broad mix of constitutents in all three countries, Mr. Carter said.

"There are some things that will come out from the feedback that we will need to amend to clarify what the process is," he added.

The company plans to publish a separate paper summarizing and addressing the points raised at the end of the month and still intends to issue "q" ratings in the first quarter of the year.

The consultation paper is available online at *www.fitchratings.com* under "Criteria Reports."

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The Institute for Defense Analyses (IDA) is a not-for-profit corporation that operates three Federally Funded Research and Development Centers serving the Office of the Secretary of Defense, the Joint Chiefs of Staff, Unified Commands and Defense Agencies in addressing important national security issues, particularly those requiring scientific and technical expertise.

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Nautilus International Holding Corporation, an equal opportunity employer, is accepting resumes for the position of Chief Financial Officer. Responsibilities include directing the financial affairs of companies and the preparation of financial analyses of operations; establishing economic and technology objectives and policies; and managing financial position with respect to income, expenses, and earnings; ensure compliance with all federal, state, and local corporate, payroll, and other applicable taxes, as well as compliance with generally accepted accounting policies; help to establish and maintain relationships with lending institutions and the financial community. Risk Management responsibilities include identifying, controlling and funding risks and losses; and ensure compliance with regulatory requirements. Provide direct leadership and authority over the daily operations of the Financial Reporting, Human Resources, and Risk Management departments.

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Requires at least 7 years of experience in professional risk management activities, including experience in administrative and supervisory capacity preferably in a government environment; a BA in business/public administration, risk management, insurance, finance, or a related field. A.R.M. Certification is highly desirable.

A review of applications will be January 31, 2005.

Mail application to: Human Resources 55 N. Arizona Pl, Suite 204 Chandler, AZ 85225 or e-mail to **jobs@chandleraz.gov**. Applications may be downloaded at **www.chandleraz.gov**. EEO/ADA

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INVITATION TO NEGOTIATE

State Board of Administration of Florida

The State Board of Administration of Florida (SBA) is soliciting competitive responses from parties interested in offering loss reimbursement examination services to the Florida Hurricane Catastrophe Fund (FHCF). The Invitation to Negotiate (ITN) will be available on February 4, 2005, and may be obtained from the FHCF web site at **http://www.sbafla.com/fhcf/** (under "What's New"). The deadline for submitting an intent to bid is 1:00 p.m. EST on February 22, 2005. The submission deadline is 4:00 p.m. EST on March 9, 2005. A meeting will be held on March 23, 2005 to discuss and evaluate the responses received. Oral presentations, if conducted, will be held March 31-April 1, 2005. The SBA reserves the right to reject any or all competitive proposals, and to cancel any ITNs.

LEGAL NOTICE

In the High Court of Ireland
Commercial
Commercial List - Record Number 2005/11 COS
in the matter of Colonia Insurance (Ireland) Limited
and in the matter of the Companies Acts 1963 to 2003

NOTICE IS HEREBY GIVEN that by an order dated 14 January 2005 made in the above matter, the High Court of Ireland has directed that meetings (the **"Creditors' Meetings"**) be convened of the Scheme Creditors (being the AXA Scheme Creditors and the Non-AXA Scheme Creditors, all terms as defined in the solvent scheme of arrangement hereinafter mentioned) of Colonia Insurance (Ireland) Limited (formerly AXA Colonia Insurance (Ireland) Limited, AXA Colonia Insurance (Ireland) public limited company and Colonia Insurance (Ireland) public limited company) (**"the Company"**) and that such meetings will be held on 11 February 2005 at 12.30 pm, in respect of the AXA Scheme Creditors, and 12.45 pm, in respect of the Non-AXA Scheme Creditors, at the offices of Ernst & Young LLP, 1 More London Place, London SE1 2AF, England. All Scheme Creditors are requested to attend at such place and time either in person or by proxy.

The purpose of the Creditors' Meetings is to consider and, if thought fit, approve (with or without modification) a solvent scheme of arrangement (the **"Scheme"**) proposed to be made between the Company and its Scheme Creditors pursuant to s201 of the Companies Act, 1963.

Copies of the proposed Scheme Document, Explanatory Statement and Appendices have been sent by post to the last known address of potential Scheme Creditors. A downloadable file of these documents is available on the Company's website at **www.coloniascheme.com.**

Scheme Creditors may vote in person at the relevant Creditor's Meeting or they may appoint another person, whether a Scheme Creditor or not, as their proxy to attend and vote in their place. Voting forms and forms of proxy for use at the Creditors' Meeting have been sent to potential Scheme Creditors.

It is requested that forms of proxy and voting forms, together with any documents referred to on or accompanying the voting form, be completed and sent by post to the Company, c/o Niall Coveney at Ernst & Young, Harcourt Centre, Harcourt Street, Dublin 2, Ireland, as soon as possible to arrive no later than noon on 9 February 2005. Faxed copies (to fax no: +353 [0] 1 475 0590) will be accepted if legible.

By the same order the Court has appointed Gareth Hughes of Ernst & Young LLP, 1 More London Place, London SE1 2AF, England or, failing him, David Hughes of Ernst & Young, Harcourt Centre, Harcourt Street, Dublin 2, Ireland, or, failing him, Sean McDermott of Ernst & Young LLP, 1 More London Place, London SE1 2AF, England; to act as Chairman of the Creditors' Meetings and has directed the Chairman to report the result of the Creditors' Meetings to the Court.

In the event that the Scheme Creditors vote in favour of the Scheme it will be subject to the approval of the Irish High Court.

Please note that the Company succeeded to the entire business of Concordia Limited, of PO Box HM 666, Clarendon House, Church Street, Hamilton HM CX, Bermuda, as of 1 January 1990 pursuant to an assumption agreement dated September 1990 and the Company succeeded to the entire business of Nordstern Reinsurance (Dublin) plc, of International House, 3 Harbourmaster Place, IFSC, Dublin 1, Ireland, as of 9 September 1998 pursuant to a merger approved by an Order of the Irish High Court dated the same day.

Dated: 17 January 2005

Colonia Insurance (Ireland) Limited, 39 Wolfe Tone Street, Dublin 2, Ireland (Registered No. 154160). Requests for assistance and/or further copies of the printed documents should be directed to the Company, c/o Niall Coveney at Ernst & Young, Harcourt Centre, Harcourt Street, Dublin 2, Ireland, (tel no: +353 [0] 1 475 0555) in the first instance.

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FSA: U.K. brokers must reveal payments

Continued from page 13

prefer it to be mandatory for brokers to disclose commission arrangements without risk managers having to ask for such information. "At the moment, it is 'Ask and be told,'" he said. "We'd like it to be 'Be told.'"

But if risk managers are not given the information they require, Mr. Gamble said, it might be an impetus for them to change brokers. And if such occurrences are regular, he said, it might prompt the FSA to require brokers to automatically disclose such information.

AIRMIC last week published a list of questions that it hopes buyers will use as a checklist with their brokers, including asking for details of commission payments and any facultative reinsurance commissions connected with the original insurance placement.

"Overall, it is a good thing that organizations such as insurance brokers and other providers of financial services are regulated, because at least there is a basic compliance standard to work" with, said Chris Brett, group risk manager for media group Daily Mail & General Trust P.L.C.

But Mr. Brett said although he believes the regulation of brokers will be beneficial to insurance buyers in the medium to long term, he fears that increased compliance costs—coupled with the loss for many brokers of contingent commissions—will mean that brokers may have to change their business models.

"I think, if brokers are incurring greater costs and losing contingent commissions, that will be significant for some of them and their business models will have to change," he said. "Trying to get agreement (on change) is probably going to be very difficult in the short term."

"I want complete transparency in all the transactions undertaken on our behalf, even if that means doing things differently," Mr. Brett added.

Christian Wells, a partner in the insurance and reinsurance group and law firm Lovells in London, said that some of the increased cost of compliance with FSA regulations may ultimately be passed on to the policyholder.

Jason Goodwin, risk and insurance manager for the City of Westminster, said that it is too early to know whether the FSA's regulation of brokers will have a great impact on commercial buyers of insurance.

"It is difficult to tell whether the FSA has any teeth or whether it adds another layer of bureaucracy," he said.

Mr. Goodwin said that there needs to be greater transparency about brokers' activities, but he said recent moves by some brokers to make commissions more transparent have been driven largely by Mr. Spitzer's investigation into insurance broking practices rather than the onset of FSA regulation.

The British Insurance Brokers' Assn. welcomed the move to FSA regulation. Steve White, regulation and compliance manager at the London-based BIBA, said that member organizations had done a lot of work to ensure that they are compliant with the FSA's rules, in particular in the area of formalizing trading agreements. This, he said, is "very positive" and a great change from the days when many insurance contracts were "back-of-cigarette-packet-type arrangements."

The FSA's rules on broker conduct are the U.K. Treasury's implementation of a European Union directive on insurance mediation.

In addition to brokers, the new rules also apply to secondary-market insurance providers—such as auto retailers, removal companies and travel agents—that may sell insurance as an add-on to their core product, and to insurers who sell insurance directly to consumers, among others.

There were fears that the rules might apply to group risk managers who purchase insurance on behalf of subsidiary companies and are remunerated for doing so, and that some risk managers would, therefore, need to apply to be authorized by the FSA.

After a lobbying effort by AIRMIC, those fears were partly allayed in July, when the FSA wrote to the association to say it had "identified a possible legal basis for deciding that authorization may not be necessary for group risk managers." In the same month, the FSA's Mr. Tiner said that he did not believe that risk managers should be regarded as being remunerated for their activities when they are paid solely by other members of the same group and do not receive any additional remuneration from, for example, insurance companies.

Some risk managers, though, have nonetheless decided that they do likely fall under the FSA's scope and have applied for authorization as intermediaries. "Quite a number" of risk managers, particularly those in the construction and property industries, have applied to be authorized by the FSA, noted AIRMIC's Mr. Gamble.

The full list of the approximately 36,000 companies and appointed agents companies authorized by the FSA under the insurance mediation directive is available at *www.fsa.gov.uk*.

QUESTIONS TO ASK YOUR BROKER

The Assn. of Insurance & Risk Managers has prepared a set of questions that buyers should ask their brokers. Key questions include:

- **Can you please advise the full revenue (income) that you receive from my premium?**
- **Do any agreements or working practices require your company to perform any administrative or other services for any insurer that supplies our organization? If yes, please advise what these services are.**
- **Are there any financial ties between your company and any of the insurers involved in our organization's insurance (other than those arising from the placement of insurance)?**
- **Is any aspect of your company's business (including the purchase and development of premises and the training of staff) financed by any insurer?**

The full checklist can be viewed at *www.airmic.co.uk.*

Source: AIRMIC

Massachusetts: Advent of gay marriage affects benefits

Continued from page 4

governing many other benefits, such as 401(k) plans, fall under federal law, which does not recognize gay marriage. Meanwhile, self-insured health plans, which are exempt from state regulation under the federal Employee Retirement Income Security Act, need not comply.

Companies that have rescinded their domestic partner benefit plans in Massachusetts include The New York Times Co.; Armonk, N.Y.-based IBM Corp.; Waltham, Mass.-based Raytheon Corp.; and the National Fire Protection Assn., Boston Medical Center and Emerson College, all in Boston.

When IBM introduced same-sex domestic partner benefits in 1996, it did so with the provision that the policy would end once the state in which the employees reside recognized their marriages, said Ted Childs, vp of global workforce diversity.

When Vermont began to recognize civil unions in 2000, the policy was amended to say domestic partner benefits would end when the state recognizes their marriage "or creates a comparable status," in order to reflect the situation in that state as well, Mr. Childs said. The policy affects less than a dozen Massachusetts employees, who have until January 2006 to marry in order to retain their domestic partner benefits, he said.

"Now that gay couples can marry, they're on the same footing as heterosexuals," said a spokesman for Emerson College, whose new policy took effect Oct. 1. Out of several hundred employees, six were affected by the change, the spokesman said. Three got married, two lost coverage and the sixth switched to his partner's primary coverage. "As a practical matter, it didn't have much effect," he said.

A Raytheon spokesman said fewer than 10 Raytheon employees were affected by the change, which took effect the first of the year.

Companies that have rescinded their domestic partner benefit plans in Massachusetts include The New York Times Co., IBM Corp., Raytheon Corp., the National Fire Protection Assn., Boston Medical Center and Emerson College.

Other companies continue to retain their domestic partner benefits. Boston-based State Street Financial Corp., for instance, will maintain its domestic partner policy for both same-sex and heterosexual couples, said Boon Ooi, senior vp, compensation and U.S. benefits. Same-sex couples have the same option as heterosexual couples to stay unmarried and remain under the firm's domestic partner coverage, he said.

Maintaining consistency is "probably the biggest reason" why companies that offer domestic partner benefits to both heterosexual and gay couples are retaining their polices, said Ilse de Veer, a principal with Mercer Human Resource Consulting in Norwalk, Conn.

"I think these employers have installed domestic partner benefits years ago because they've identified employee benefit needs," said Paul Sullivan, Newburyport, Mass.-based assistant vp with Aon Consulting. "I don't think that need goes away because a certain segment of that population can now marry."

Furthermore, voters may eventually vote against gay marriage, and employers "wouldn't want to take away a benefit only to have the need arise to reinstall it in a couple of years," said Mr. Sullivan.

That possibility was the reason why Israel Deaconess Medical Center decided against its original plan to rescind its same-sex domestic partner policy, said a spokesman. "After listening to the concerns of employees about the uncertainty, we just decided to wait and see what was going to happen," he said.

Dana Farber's Ms. Malumphy said the institute originally planned to end its same-sex domestic partner benefit Dec. 31. But employees in the gay community told her, " 'It's not as black and white as you might think.' Some folks brought some compelling reasons why we should rethink our decision."

Some employees "just didn't want to jump on the marriage bandwagon," Ms. Malumphy said. "Just because they chose not to marry, why should they lose their benefits?" she asked.

Others who were in the middle of an international adoption pointed out that certain countries do not let gay couples adopt, "so if they got married, they would lose their adoption right after several years of trying to adopt a child." The institute's decision to expand its same-sex policy to heterosexual mixed couples reflects its support of work and family options and its diverse work force, said Ms. Malumphy.

Meanwhile, other employers—including Westborough, Mass.-based National Grid USA, a utility, and Boston-based Liberty Mutual Insurance Co.—are introducing domestic partner benefits covering both same-sex and heterosexual couples for the first time.

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National Grid, a subsidiary of London-based National Grid Transco, had been exploring how to encourage a more-diverse organization when gay marriage became legal in Massachusetts, so both factors motivated its introduction of a domestic partner benefits program for both same-sex and heterosexual couples, said Bill Dowd, vp of human resources. The program, which was introduced nationally, became effective Jan. 1.

Liberty Mutual also introduced its policy nationally Jan. 1, said a spokesman. It is not directly related to the Massachusetts situation, he said. "Our goal is to make sure we offer competitive plans that meet the needs of our employees, and adding domestic partner benefits to our program helps our plan more closely reflect what's happening in the world today."

Some national employers, including Falls Church, Va.-based General Dynamics Corp. and Memphis, Tenn.-based Federal Express Corp., say, though, they do not plan to recognize gay marriage in Massachusetts. The definition General Dynamic uses to define marriage on its self-insured plans is the one the federal government determined in the 1986 Defense of Marriage Act, which says marriage is a relationship between two people of the opposite sex, said a company spokesman.

A FedEx spokeswoman said at least two of its companies that operate in Massachusetts do offer domestic partner benefits, and they plan to continue them.

National employers are "really looking to have a uniform benefit package nationwide, and providing the benefit here at one location could be viewed as inconsistent with providing a uniform benefit package to other people across the country," said Aon's Mr. Sullivan. Employers also do not like state mandates, he said. They "really want the freedom to have their own plan design in their own hands," he said.

The future on this issue is unclear, say observers.

"My fairly strong guess is that this will go all the way up to the U.S. Supreme Court," said J.D. Piro, Norwalk, Conn.-based chair of Hewitt Associates Inc.'s health law consulting practice.

Meanwhile, "there hasn't been a big employer lobby" for trying to change the law in Massachusetts, said Cameron Congdon, a principal with Towers Perrin in Boston. "It's more of a wait-and-see attitude," he said.

California: Rx mandate proposed

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fit consultants are concerned that the regulations could make it more difficult for health plans to continue cost-containment efforts such as tiered formularies, which require higher co-payments for more-expensive drugs, or step therapy, under which physicians are required to prescribe either over-the-counter or less-expensive generic medications before resorting to more-costly drugs.

"We do want to make sure patients get the drugs they need but that we don't lose access to the tools that have successfully held down the cost of utilization," said a spokesman for America's Health Insurance Plans in Washington. "Plans have a responsibility to provide the best-quality care at an affordable price. We'll be following this to make sure these regulations don't prevent that."

"You don't want to extend a regulation that puts constraints on HMOs keeping costs down," Watson Wyatt's Ms. Bergthold agreed.

A spokesman for the Sacramento-based California Assn. of Health Plans, which represents 33 HMOs covering approximately 21 million members, questioned how the department will determine which drugs should be deemed "medically necessary."

Under the regulations, qualified medical and pharmacy professionals must be involved in designing prescription drug benefits, and any drugs that are excluded must be supported by medical evidence and be approved by the director of the Department of Managed Health Care.

'Whenever a regulatory department of a state promulgates a regulation that is this broad, there are unintended consequences.'

Linda Bergthold
Watson Wyatt Worldwide

"We're not opposed to having drugs by class. What we're opposed to is, if a doctor asks for a certain drug that may not be on a formulary, regardless of cost, that we'll have to cover it," the CAHP spokesman said.

"We believe that, once you've established quality and efficacy are similar or the same, then we believe part of our responsibility is to advocate for our members price and affordability," the spokesman said. "We still believe that co-pays and a tiered formulary process have been good tools to maintain affordability and choice for members."

The Pacific Business Group on Health has not yet taken a position on the draft regulations, according to Emma Hoo, director of value-based purchasing for the San Francisco-based employer coalition.

"We are looking at them and also talking to some of the California carriers," she said. "I think there is an interest in having consistency in application of medical necessity guidelines across plans, but, at same time, we recognize that there's a value add to the work that the individual plans do in developing formularies and guidelines and want to understand how that fits in, as well as better understand the implications of the cost and pricing criteria that are laid out in the rules."

The DMHC is accepting written comments on the proposed regulations until 5 p.m. on Jan. 31. The documents can be accessed at *www.hmohelp.ca.gov/library/regulations* under the heading "Proposed Regulations."

HSA: New program is off to a fast start

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enrollees. For example, the average premium for high-deductible health insurance plans sold to employers with fewer than 50 employees was just $2,224 for single coverage and $5,496 for family coverage. That cost, though, does not include any contributions made by employers to the HSAs.

Of the 438,000 people covered by HSAs in September 2004, just 13,000 received coverage through employers with at least 50 employees, while 346,000 purchased coverage in the individual market and 79,000 received coverage through the small-group market.

The timing of the law and regulations explains why HSA-based plans have been, so far, purchased largely by individuals, Ms. Ignagni said.

With HSAs becoming legal on Jan. 1, 2004, and the bulk of needed government guidance not published until mid-2004, larger employers lacked the lead time they typically need to implement major new health care plan changes and communicate them to employees.

But with the regulatory guidance now in place and more insurers entering the HSA market, experts expect significant growth over the next year in the number of employers offering HSA-based plans.

Other AHIP survey findings include:

- Thirty percent of HSA-based policies sold in the individual market were purchased by persons who were previously uninsured, and 16% of small-group HSA policies were purchased by employers who previously did not offer a health care plan.
- The average annual deductible in HSA-based policies sold to larger employers was $1,607 for individual coverage and $3,000 for family coverage.

Copies of the survey by America's Health Insurance Plans are available at www.ahip.org. A research brief summarizing the survey by Watson Wyatt Worldwide is available at www.watsonwyatt.com.

Joanne Wojcik contributed to this story.

Brewers: Insurers deny beermakers' coverage

Continued from page 1

brewers and distillers, only Miller, Coors and Samuel Adams have landed in litigation with insurers so far, according to court records and lawyers involved in the cases. Liability insurers have denied coverage to the three brewers on numerous grounds, including that the damages claimed in the class actions do not arise from "bodily injury" as defined in the policies, court filings show.

Both the proposed class actions and the coverage litigation are in early stages, and motions to dismiss the underlying actions have been filed by various defendant companies. The extent of brewers' and distillers' potential liability is hard to judge, lawyers involved in the case say. If courts dismiss the suits or refuse to certify the requested classes, defendant companies' costs could be relatively low; if the cases proceed to trial, though, the suits could prove expensive for both the defendants and their insurers, lawyers say.

"It's too early to say.... These things could be dismissed or they could be another tobacco," said one lawyer familiar with the cases, referring to tobacco liability litigation that ultimately led to multi-billion settlements between cigarette makers and state attorneys general across the country.

The liquor class actions are reminiscent of the tobacco liability suits in their targeting of a large segment of an industry and their charges of widespread injury and economic damage resulting from the defendants' alleged conduct.

Between late 2003 and the middle of 2004, six such suits were filed in federal courts in California, Colorado, the District of Columbia, North Carolina and Ohio, court records show.

Two suits consolidated in U.S. District Court in Cleveland, for example, name not only Miller, Coors and Samuel Adams but also brewers Anheuser-Busch Inc., Heineken USA Inc. and Labatt Brewing Co. Ltd.; and distillers Allied Domecq P.L.C., Bacardi & Co. Ltd., Brown-Forman Corp., Diageo P.L.C., Fortune Brands Inc. and Kobrand Corp.

The consolidated complaint argues that alcohol use by minors has reached "epidemic proportions" and that the defendant companies are contributing to the problem by marketing their products directly to people too young to buy them legally.

Citing a report in the Journal of the American Medical Assn., the suit says that minors drank 19.7% of the alcohol consumed in the United States in 1999, accounting for $22.5 billion in sales.

The suit also cites numerous examples of allegedly improper marketing, including advertising in magazines and television shows aimed largely at teens; creation of Web sites featuring cartoon characters and arcade games; and the development of "alcopops," or drinks that the plaintiffs say are sweetened to mask the taste of alcohol and appeal to underage drinkers.

A Samuel Adams Web site, for one, links to another site offering pictures and computer desktop wallpaper of "Beer Girls" intended to appeal to adolescent boys, the complaint says.

The suit argues that alcohol use by minors has reached 'epidemic proportions' and that the brewers are contributing to the problem by marketing their products directly to people too young to buy them

The brewer's parent, Boston Beer Co., has also sponsored promotions "involving extreme, sophomoric and antisocial behavior," including a "Sex for Sam" contest in which contestants scored points for having sex in public places. The promotion ended after two people were arrested for public lewdness in the vestibule of St. Patrick's Cathedral in New York, the suit notes.

The brewers and distillers have also conspired to cover up their illegal marketing with "sham" codes of marketing conduct developed by trade associations such as the Washington-based Beer Institute, the complaint charges.

Representatives of Samuel Adams and the Beer Institute declined to comment.

The successful marketing campaigns have led to injuries and deaths, damaging behavior by underage drinkers and billions of dollars in economic costs to the plaintiff class and to "society as a whole," according to the suit. The complaint seeks certification of a class of Ohio parents and legal guardians whose money was used by minors to buy beer or liquor between 1982 and the present.

The defendants have denied the allegations, citing their own efforts and those of trade groups to discourage underage drinking. They are now pursuing a motion to dismiss the complaint.

As the class actions move forward, Miller, Coors and Samuel Adams are fighting with their insurers over coverage of defense costs and any eventual damage awards. The coverage actions include suits filed by:

- Several units of Hartford Financial Services Group Inc. against Miller and the brewer's other insurers in New York. Miller, meanwhile, filed its own declaratory judgment action against Hartford and units of ACE Ltd. and American International Group Inc. in Milwaukee. Both suits were removed to federal courts from state courts, and the two sides are now sparring over which court should hear the dispute.
- Coors against Los Angeles-based Truck Insurance Exchange in a District of Columbia court. Truck removed the suit to federal from state court, but Coors is now seeking to have it remanded to state court.
- Two units of Royal & SunAlliance P.L.C. against Boston Beer and Samuel Adams in U.S. District Court in Cleveland. Boston Beer was due to answer the complaint last Friday.

Insurers in the various cases have raised several defenses against coverage. The Royal units, for example, contend that the underlying lawsuits don't claim damages arising from a "bodily injury"; that there has been no "occurrence" under the terms of the policies; and that the intentional misconduct alleged in the suits falls under the policies' "expected or intended" loss exclusion.

"The Hartford is committed to fulfilling its obligations to its policyholders," the insurer said in a statement. "However, the policies do not provide coverage for these underage drinking claims."

The question of whether there is any insured bodily injury will be a key issue in the coverage cases, though, lawyers involved in the case say.

Coors' position will be bolstered by coverage rulings stemming from claims against cell phone companies for damages allegedly caused by radio frequency radiation, said Karen L. Bush, a lawyer with Dickstein, Shapiro, Morin & Oshinsky in Washington, representing the brewer.

The 4th U.S. Circuit Court of Appeals ruled in 2003 that an insurer had to defend a Baltimore cell phone company in a class action despite the insurer's claim that the underlying suit alleged no insured bodily injury, she noted.

PEO: Workers comp cover suit

Continued from page 4

helps, in some instances, "to combat fraud and abuse," SCIF argues in its lawsuit.

A California Superior Court in Sacramento will hear the case early in March, according to the California Department of Insurance.

The lawsuit's outcome will affect how SCIF sells its policies to other PEOs, observed Nicholas P. Roxborough, an insurance attorney at Roxborough Pomerance & Nye L.L.P. Mr. Roxborough also represents the California Professional Employers Assn. and individual PEOs in the matter.

Several PEOs have filed amicus briefs in the case, arguing its outcome will affect their industry. They contend that SCIF aims to undermine an existing state rating rule that requires certain policies covering employee leasing arrangements to be issued in the name of the PEOs.

Observers say that PEOs also are concerned because SCIF's action could diminish the role of PEOs as the employer of record for employees at clients' work sites.

PEOs often tout their ability to apply risk management practices to workers comp claims. That can help the PEOs obtain insurance coverage in an otherwise-difficult market, said a spokeswoman for the Alexandria, Va.-based National Assn. of Professional Employer Organizations.

"It behooves the PEO to manage the risk and claims," the spokeswoman said. "They are not really selling insurance, but they are arranging for a policy and saying to the insurer, 'We do risk management, we do mange the claims, and we will do that under our arrangement with you for these particular clients.' "

But many insurers are loath to write PEO business because of administrative burdens and a history of industry problems, several observers say. In some instances, PEOs have closed down without paying premiums owed to workers comp insurers, they say.

"There are big, national reputable PEOs, and then there have been lots of PEOs that start and close, start and close, and change names, leaving insurance companies in the lurch," said a broker who asked not to be identified because he has several PEO clients.

Mr. Roxborough acknowledged that some PEOs have tainted the industry by leaving insurers holding the bag on claims. "The truth is, there are PEOs that did exactly that, and they did it to State Fund and other carriers," he said.

"But also, that is a small percentage of the PEO business," Mr. Roxborough noted. "There is a difference between PEOs that have been in business for years—who have a tremendous straightforward track record and pay their premiums for a long time—and those that are fly by night."

Still, there exist extremely few markets for PEOs, said John "Bev" West, regional marketing executive in Atlanta for Hilb Rogal & Hobbs. Large multistate PEOs that can afford huge deductibles backed with collateral have a few more options than do their smaller counterparts, Mr. West added.

But Scottsdale, Ariz.-based Cedar Hill Insurance Agency, a program administrator for Zurich North America, underwrites small, midsize and large PEOs that meet its criteria, said Andy Atsaves, a Cedar Hill partner and vp.

Following three years of consolidation and shakeouts in the PEO industry, coupled with arrests for fraudulent workers comp scams perpetuated by some PEO operators, the industry has improved markedly, Mr. Atsaves said.

NAPEO, in an effort to assure employers and insurers that PEOs are implementing sound risk management practices, helped develop in 2002 a workers compensation risk management certification program.

HIPAA: Rules clarify law's application

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and distribute to terminating employees and their dependents.

The model notice, among other things, explains that a pre-existing medical condition exclusion cannot exceed 12 months, with that period of time directly offset by the length of an employee's creditable coverage.

The notice also provides examples of creditable coverage, including group health coverage, COBRA coverage, and coverage under individual health plan policies, Medicare and Medicaid.

The final regulations resolve a variety of other concerns. For example, the regulations make clear that coverage under a foreign country's national health insurance plan is considered creditable coverage, said Paul Sullivan, an assistant vp with Aon Consulting in Newburyport, Mass.

Additionally, the final rules address a situation in which, for example, an employee has coverage through his employer's plan while his spouse has coverage through her employer's plan.

According to the final rules, if the spouse were to lose coverage because she had reached her plan's lifetime limit on paying for claims, the employee's health plan would have to offer her coverage, even if the period for enrolling in the plan would not begin until later in the year.

The three agencies are also asking for comments on a proposed regulation involving the interaction of the Family and Medical Leave Act and HIPAA.

Under the FMLA, employees can take up to 12 weeks of job-protected leave because of illness or to take care of a variety of family-related situations. During the leave, employers must continue employees' health care coverage on the same basis as prior to leave.

Employees, though, sometimes voluntarily drop health coverage while on FMLA.

In cases where employees do voluntarily drop their health care coverage, the agencies have proposed, employees still would be considered to have coverage for the purposes of determining if the 63-day continuous coverage requirement had been met.

"The clock would not start to tick," said John Piro, an attorney in the Norwalk, Conn., office of Hewitt Associates Inc.

PBGC: Reforms proposed

Continued from page 1

"If nothing is done, the financial integrity of the PBGC will be compromised and more importantly the pension security of 34 million people will be put at risk," Ms. Chao said, referring to the number of people in employer-sponsored pension plans insured through the PBGC.

"The hole is going to get deeper. Eventually, the PBGC runs out of cash" if nothing is done, said James Keightley, a partner with Keightley & Ashner in Washington, and a former PBGC general counsel.

Additionally, Ms. Chao said, pension funding rules have gotten so complex that virtually no one understands them, which is a disincentive, many say, for employers to offer defined benefit plans.

While by no means endorsing the administration package, pension experts welcomed the proposal as a catalyst for needed reforms that will shore up the PBGC as well as encourage employers to hang on to their defined benefit plans.

"This starts the debate, and that is important," said Chris Bone, chief actuary with Aon Consulting in Somerset, N.J.

"We are in a lot more precarious position than we were a decade ago," said Syl Schieber, director of Watson Wyatt Worldwide's Research and Information Center in Washington.

Still, as serious as the problems are, Congress has time to act.

"The system may be hanging by a thread, but it is not too late to save it," said James Klein, president of the American Benefits Council in Washington.

Increased premiums

One element of the administration package—PBGC premiums—would affect all employers with defined benefit plans. Under the package, the base premium, now $19 a year per plan participant would rise to $30, with future increases linked to the national growth in workers' wages.

Above that base, employers with underfunded plans now pay an additional premium of $9 for each $1,000 of plan underfunding. Under the new proposal, the PBGC board—comprised of the secretaries of Commerce, Labor and Treasury—could adjust this risk-based premium to reflect changes in the agency's financial condition.

Administration officials say the premium hike is a modest one, noting that the increase to $30 would put the premium at the level it would be if the premium had been indexed to wage inflation since it was last increased in 1991.

But some employers say a premium hike could encourage companies to move to defined contribution plans, which the PBGC does not cover.

"At some point, employers, especially those with well-funded plans, may say, 'Do we want to pay premiums for a program we never intend to use?'" said Michael Pikelny, benefit consultant and corporate actuary at Hartmarx Corp. in Chicago.

Experts concur, though, that pension funding rules are too complex and welcome simplification.

"What we have now is a Rube Goldberg contraption, except it does not work. It has been almost impossible to explain modification upon modification. They are starting fresh, and that is the right idea," said Ethan Kra, chief actuary with Mercer Human Resource Consulting in New York.

Under current rules, for example, there are several ways to measure liabilities, with the amount of contributions required based on numerous factors.

By contrast, under the administration proposal, plan liabilities would be 100% of benefits accrued to date. If plans were less than 100% funded, sponsors would be given a "reasonable" amount of time to fund them. Administration officials last week said seven years might be considered reasonable but indicated they would like to work more with Congress on this point.

Valuation changes

The administration package also would radically change, in several ways, the way employers value plan liabilities. Under current law, set to expire at the end of the year, employers value plan liabilities with an interest rate equal to a four-year weighted average of a long-term corporate bond index.

Under the administration package, the interest rate would be tied to the yields of corporate bonds of varying maturities and to plan demographics. Plans with many older workers and retirees would use an interest rate tied to shorter-term bonds, whose yields are lower than longer-term bonds, a methodology that would boost the value of plan liabilities.

Administration officials say the use of such a "yield curve" is appropriate, noting that companies with older workforces face paying benefits sooner than do companies with younger workforces, while contributions to their pension plans will have less time to earn interest.

Some worry, though, that the financial impact of such a change could discourage employers with older workforces from continuing to offer defined benefit plans.

"Your costs are going to increase significantly, and that is not going to provide an incentive for an employer to offer a plan," said Mark Ugoretz, president of The ERISA Industry Committee in Washington.

For the first time, the financial creditworthiness of an employer would shape the assumptions organizations would have to use in valuing plan liabilities. For example, an employer with a junk bond status of five years or more would have to assume that employees would retire as soon as they are eligible and that those retiring would take their benefits as a lump sum.

Making such assumptions would drive up liabilities and force sponsoring employers to contribute more to the plans. The administration says such assumptions are reasonable, because past experience has shown that the length of time a company is in junk bond status is a strong indicator of the likelihood of plan termination.

In addition, pension plans sponsored by employers in bankruptcy would essentially be frozen, with participants not accruing new benefits and future benefit improvements barred. Participants also would not be allowed to take their benefits as a lump sum.

Companies with underfunded plans would be required to disclose the level of plan underfunding and how that compares with the two prior years. That disclosure requirement, administration officials say, could boost plan funding as employees, better aware of the financial condition of their pension plans, put pressure on their employers to step up funding.

"I like enhanced disclosure; it is a step long overdue," said Ari Jacobs, a consultant with Hewitt Associates Inc. in Norwalk, Conn.

Another change proposed by the administration would be to allow employers to fund up to 130% of plan liabilities, to build what Ms. Chao describes as a "rainy day" cushion to buffer plans against economic downturns.

Imports: Possible restriction of U.S. supply

Continued from page 1

Additionally, the health minister—a former attorney general for the Canadian province of British Columbia—has expressed his disapproval of physicians in Canada who sign off on prescriptions for consumers in the United States.

"The practice by some doctors of countersigning prescriptions without actually having a relationship with the patient and properly assessing the patient is absolutely unethical and unprofessional," said Mr. Dosanjh in a December statement.

While no legislation has yet been drafted to regulate Canadian pharmacies that send prescriptions abroad, officials from Canada's department of Health are considering changes, a spokeswoman for Mr. Dosanjh said.

"The Minister is waiting to get recommendations from Health Canada officials," on whether a change in the regulations should be made, and those recommendations are expected to be delivered no later than next month, the spokeswoman said.

Some options, outlined by Mr. Dosanjh in an interview on CPAC, Canada's political television channel, include: the elimination of countersigning on foreign prescriptions; requiring that Canadian doctors sign prescriptions only for individuals who travel to, or are residents of Canada; and the creation of a list of short-supply drugs not permitted for exportation.

"It is not my intention to shut down Internet pharmacies," Mr. Dosanjh said in the interview. But "if the ultimate result is that the Internet pharmacies are shut down, so be it," he said.

David MacKay, executive director of the Winnipeg, Manitoba-based Canadian International Pharmacy Assn.—which represents 35 Canadian mail-order pharmacies that serve approximately two million U.S. patients and produce annual total sales estimated at $1 billion Canadian ($811.7 million)—charged that President Bush pressured Canadian Prime Minister Paul Martin in recent discussions to curtail the export of drugs into the United States.

"The timing and tactics seem more than coincidental," Mr. MacKay said in statement earlier this month. "CIPA's been openly communicating with Health Canada for two years; now they won't even take our calls."

Andy Troszok, a pharmacist and president of CIPA, asked, "Why would our government willingly kill a billion-dollar sector they once supported and the 4,000 jobs associated with it?"

White House Press Secretary Scott McClellan, in response to the allegations, said that "any such assertion is just nonsense." He acknowledged, though, that the leaders recently "did talk about the importation of drugs," and he added, "I think the President's views are very clear and well known when it comes to drug importation."

President Bush has voiced safety concerns related to drug importation, as have the American Medical Assn. and pharmaceutical companies such as New York-based Pfizer Inc.

The U.S. Food and Drug Administration has steadfastly opposed prescription drug importation, and a federal report released in late December recommended against allowing the reimportation of prescription drugs, citing safety risks and little savings for consumers.

Under current law, it is illegal for anyone other than the original manufacturer to reimport prescription drugs into the United States.

But several states and cities continue to challenge the government ban by facilitating the importation of prescription medicines for employees and residents.

"In the last fiscal year, we saved about $3 million because of the Canadian drug program," said Marilyn Montagna, personnel director for the city of Springfield, Mass. Under its health plan, all of Springfield's 20,000 employees, retirees and dependents have the option of buying their prescription drugs through a Canadian pharmacy. Of that number, about 3,000 currently import their medicines from Canada, Ms. Montagna said, and on average, they save between 40% and 50% over the cost of drugs purchased in the United States.

Cities and states violating the federal ban on drug importation to date have not been impeded by U.S. authorities. But now, amid the possible changes to Canadian drug export laws, they are being forced to consider different methods of securing prescription drugs at reduced cost.

"At this point, it's fair to say that we are trying to identify what, if any, alternatives are available to us," Ms. Montagna said.

"The Canadian government should not slam the door on American consumers seeking more-affordable prescription medicines from safe Canadian pharmacies," Minnesota Gov. Tim Pawlenty said in a statement.

He and other U.S. officials around the country in recent weeks have written letters urging the Canadian government not to alter Canada's prescription drug policy to the detriment of U.S. consumers.

If new regulations are imposed, though, Minnesota pledged to explore outlets across the Atlantic.

"In the unfortunate event that Canada changes its policy, we will seek a way to keep our MinnesotaRxConnect.com Web site operating by facilitating purchases from European countries with safe pharmacy systems," Gov. Pawlenty said.

The state governments of Illinois, Kansas, Missouri and Wisconsin all currently use the I-Save-Rx program, which makes prescription drugs from pharmacies in both Europe and Canada available to residents.

"Even if Canada moves forward with its plans to shut its borders to American consumers, I-Save-Rx will continue to provide access to safe and affordable medicine from other countries, like the United Kingdom and Ireland," Illinois Gov. Blagojevich asserted in a statement.

This week, Rhode Island will join the list of states that facilitate drug importation from abroad. In addition, it will offer licenses to Canadian pharmacies to sell prescriptions to Rhode Island residents.

What happens with regard to Canada's regulation of the prescription drug trade between it and the United States remains to be seen.

"If no Canadian pharmacies apply, then we won't license any," said Robert Marshall, assistant director of health for the Rhode Island state health department. But in the meantime, he said, they have received several calls from pharmacies in Canada in recent weeks showing an interest in applying for a license.

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Late News

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Insurance Joint Industry Forum, which was held in New York last week, said they are convinced that investigations into certain industry practices by several state attorneys general and insurance departments will expand in 2005. And 67% said they thought that most companies would be able to settle charges against them this year.

Maryland Legislature overrides HMO tax veto

The Maryland General Assembly voted last week to override Gov. Robert Ehrlich's veto of a medical malpractice reform bill that would tax health maintenance organizations to help offset increased medical malpractice insurance rate hikes. Gov. Ehrlich had called a special legislative session in late December to deal solely with medical malpractice. But the Republican governor said in his veto letter that he objected to the bill—H.B. 2—passed by the Democratically controlled legislature because of, among other things, the HMO tax and because it "fails to contain adequate legal reforms."

Vermont licenses 43 captives in 2004

Vermont licensed 43 new captives in 2004, bringing the total to 524 captives in the nation's largest domicile at year end. Captives of every type allowed in the state were formed last year. Of the new licensees, 29 were pure captives, which insure the risks of their parents and affiliates. Eight were risk retention groups, while association captives and other types were among the remaining new formations.

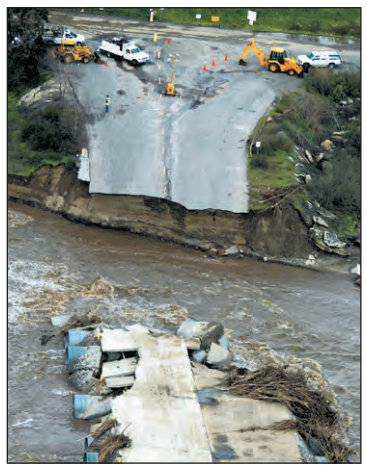

PHOTO: KRT

Flood waters destroyed a road just east of San Juan Capistrano, Calif.

PCS declares catastrophe in storms in Western U.S.

The Insurance Services Office Inc.'s Property Claim Services unit has issued a catastrophe number for damage stemming from recent flooding, freezing, and snow damage in California and Nevada. The assignment of a catastrophe number means PCS expects insured losses from the storms to exceed $25 million.

Texas regulator to leave after current term

Texas Insurance Commissioner Jose Montemayor notified insurance department employees last week that he is not seeking reappointment to his post, though he will stay through the state's current legislative session, which is expected to end in May. Mr. Montemayor gave no specific reason for his decision, which comes at the end of his third two-year term. Meanwhile, Utah Gov. Jon M. Huntsman Jr. appointed Kent Michie to replace Merwin Stewart as state insurance commissioner. Mr. Michie, who has worked for 35 years in business and investment banking, is currently serving as executive vp of the Wasatch Front Economic Forum, a Salt Lake City-area business advisory group.

EEOC charges law firm with age discrimination

The U.S. Equal Employment Opportunity Commission has sued Sidley Austin Brown & Wood, charging the law firm with age discrimination in its employment practices. The EEOC charges that the Chicago-based firm violated the Age Discrimination in Employment Act when Sidley & Austin, the predecessor firm, either involuntarily downgraded or expelled 31 former partners from the firm because of their age in October 1999. The suit, filed in federal court in Chicago, also applies to partners who were involuntarily retired from the firm since 1978 because of a mandatory retirement policy. The firm plans to defend the action.

Comp reform bill introduced in Texas

A bill introduced last week in the Texas Senate calls for boosting workers compensation benefits and allowing health insurers to develop physician networks to treat injured workers. Senate Bill 5, introduced by Sen. Todd Staples, R-Palestine, also calls for the use of "evidence-based" guidelines in treating injuries. Employers and insurers in Texas have sought legislation that would allow them to direct injured employees to receive care from networks of doctors who would follow nationally recognized treatment guidelines.

Briefly noted

The U.S. Labor Department has given final approval for **Alcoa Inc.** to use its Vermont-based captive to fund U.S. employee benefit risks. The aluminum producer will use its captive to reinsure group term life insurance policies written by Metropolitan Life Insurance Co. for employees who work for Alcoa and two of its affiliates. MetLife will retain 50% of the risk....Brokerage **USI Holdings Corp.** said that it has reached a definitive agreement to acquire Summit Global Partners Inc. of Dallas for an undisclosed sum. The deal, announced in September and set to close next month, is expected to contribute about $66 million in revenues annually to Briarcliff Manor, N.Y.-based USI.

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Asbestos: Price tag of fund still unknown

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The allocation of liabilities among those paying into the fund has also not been determined. Insurers have been adamant that their share cannot exceed $46 billion, regardless of how big the fund ultimately proves to be.

There is also an unresolved question of whether a new fund could constitutionally acquire the assets of the existing trust funds that compensate victims of asbestos-related disease. Under the Frist-Daschle agreement, those trust funds would provide about $4 billion to a new fund, with insurers responsible for $46 billion and defendant companies the rest.

Sen. Specter said that he "would like to see a bill presented to the majority leader by early February." He acknowledged that some observers would consider that an unrealistic timetable, but he said that sometimes the establishment of unrealistic timetables is the only way to achieve goals.

The size of the fund is one of several issues upon which no consensus has been reached among stakeholders—including business, labor, insurers and trial lawyers—as they've met with Sen. Specter and 3rd U.S. Circuit Court of Appeals Judge Edward Becker, who has been working with Sen. Specter on the issue for years and who outlined the bill during last week's hearing.

Other problem issues include how much compensation smokers with asbestos-related disease should receive, how cases pending in the courts when a trust fund comes into being would be treated and whether insurers could seek the subrogation of workers compensation payments that were duplicated by the trust fund.

Craig A. Berrington, general counsel of the American Insurance Assn., told the committee on behalf of AIA and several other insurance industry trade groups that there was no point in having a trust fund that is "designed to fail" eventually by allowing asbestos liability cases to return to the court system.

"Our view on the trust fund is that it shouldn't be designed to fail," said Julie Rochman, an AIA senior vp, in an interview after the hearing. "The whole benefit of a trust fund is that you get certainty and finality, and, unfortunately, the proposal that is before us today contains a lot of leakage, a lot of holes to be filled in with respect to some very important provisions. So we don't get certainty, and we don't get finality."

The issue of when claims would revert to the tort system is particularly critical to businesses, noted Lisa Rickard, president of the U.S. Chamber Institute for Legal Reform, at a Washington news conference late last week. "We really believe reversion should be moved out as far as possible," Ms. Rickard said.

Online Poll

[1/10-1/14]

Do you think average property/casualty insurance premiums will fall over the next six months?

Yes 65%

No 30%

Do not know 5%

BI Stock Index

[1/10-1/14]

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

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

***BI* Stock Index**	2,362.42	-0.65
Dow Jones	10,558.00	-0.43
S&P 500	1,186.19	-0.14

Largest gains

Humana Inc.	13.05%
Meadowbrook Ins. Group	9.38%
PacifiCare Health Sys.	8.56%
Baldwin & Lyons Inc.	7.49%
Vesta Insurance Co.	6.33%

Largest losses

Unico American Corp.	-4.58%
Unitrin	-3.60%
RenaissanceRe Holdings Ltd.	-3.47%
Allmerica Financial Corp.	-3.23%
Torchmark Corp.	-3.20%

Weekly change by market segment

Brokers	16.03%
Insurers/Reinsurers	12.98%
Managed Care Organizations	16.78%

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