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Court gives Legion policyholders direct access to reinsurance / 3

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ACE uncovers finite problems

Insurer to restate earnings since 2000 after accounts review

By RUPAL PAREKH

HAMILTON, Bermuda—ACE Ltd. last week became the latest major insurer to say it will restate several years of earnings to correct improper accounting for finite risk deals, and such moves are expected to continue as more companies scrutinize their books.

ACE announced last week that during its own investigation of its finite risk contracts it had identified eight deals that were accounted for improperly. As a result, the Hamilton, Bermuda-based insurer said that it would restate full-year earnings for 2000 through 2004, as well as its results for each of the quarters in 2003 and 2004 and the first quarter of 2005 (see chart, page 19).

The financial impact of the restatement is relatively small, lifting shareholders equity by approximately $1.0 million overall, reflecting adjustments made for improper accounting for finite contracts along with other unrelated adjustments prompted by its accounting review, the company said in a statement.

ACE, like many of its insurance industry peers, in recent months has received various subpoenas related to its use of finite risk products. Authorities, including New York Attorney General Eliot Spitzer and the Securities and Exchange Commission, are investigating whether companies have used the tools improperly to manipulate their results.

Of the more than 100 finite risk contracts analyzed as part of ACE's review—conducted by independent lawyers and accountants, as well as internal auditors—eight transactions were found to be accounted for incorrectly, the insurer said.

All eight were incepted between 1997 and 2001, the company reported. In three of the deals, ACE was the purchaser; in three others, it was the seller. The remaining two were struck between ACE units.

ACE chief Evan G. Greenberg said he doesn't expect the insurer to uncover more problems related to finite risk products.

See ACE / page 17

Senate panel to vote on pension funding reforms

By JERRY GEISEL

WASHINGTON—Legislation stiffening pension funding rules is headed for a Senate tax committee vote this week.

The Finance Committee on Tuesday will take up, and almost certainly pass, a bipartisan measure introduced late last week by the panel's chairman, Sen. Charles Grassley, R-Iowa, and ranking minority member Sen. Max Baucus, D-Mont.

The measure is a response to the massive failure of United Airlines' pension plans and the prospect of more multi-billion dollar plan collapses swamping the Pension Benefit Guaranty Corp., which already has a $23 billion deficit.

"The PBGC can't sustain many more hits to its bottom line, and the potential for a taxpayer-funded bailout is growing every day we do nothing," Sen. Grassley said.

The Finance Committee measure, like one passed last month by the House Education & the Workforce Committee, would: tighten funding rules so that companies would have to fund liabilities faster; prevent employers with underfunded plans from boosting benefits; tie valuing liabilities to plan demographics; and raise the base PBGC premium rate.

But the bills differ in other ways. For example, the House bill would prospectively protect cash balance plans from age discrimination suits. The Senate measure doesn't have any cash balance provisions, though the issue remains under discussion, committee staffers say.

Additionally, the two measures differ in how employers can claim credit—as an offset to be applied to future contributions—for prior contributions that exceed minimum requirements, as well as the methodology employers would have to use to value plan liabilities.

The Senate bill also is far broader than the House bill. It includes, for

See PENSION / page 19

Some employers linking employee premiums to health screen programs

By JOANNE WOJCIK

As more employers require employees to take greater financial responsibility for their own health care as part of the consumerism movement, some employers are going even further, tying employees' premium contributions to their participation in health risk appraisals and, in some cases, to improvements in health status.

But while most health benefits experts embrace the concept, some are concerned that employers that place such demands on their employees may be encroaching on employee's rights.

At a time when most employers are still seeing double-digit increases in employee health care costs, Westell Technologies Inc., an 800-employee telecommunications and teleconferencing company in Aurora, Ill., slashed the cost of its self-insured health plan by 27% using a comprehensive health screening program that included premium surcharges.

"It's voluntary. However, we do offer an incentive for anyone who does participate," said Gary Hansen, vp of human resources at Westell. "The cost of their employee insurance does not go up. Then we freeze the cost for a year. If a person chooses not to take the test, then their cost is $10 more a paycheck."

The program was developed and patented by Darren Hodgdon, founder and chief executive officer of Chicago-based Health IQ Diagnostics (see related story).

"We baseline people; we give them education tools, help counsel them to improve their health, we establish accountability and the ex-

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Late News

U.K. court blocks runoff arrangement

A U.K. court has blocked a solvent scheme of arrangement after a group of mainly U.S. policyholders argued that an aviation insurer's long-tail liabilities could not be estimated fairly. The ruling, which the judge in the case said is likely the first time a solvent scheme has been blocked, will prevent British Aviation Insurance Co. Ltd. from rapidly running off the business it sought to have covered by the scheme. Schemes of arrangement for several years have been used by U.K. insurers as a means of running off business without placing a company in liquidation. Advocates of the process say that the approach avoids delays and costs associated with lengthy liquidations.

ELIC estate awarded $700 million in punitives

A federal jury in Los Angeles last week awarded $700 million in punitive damages but no compensatory damages in a lawsuit accusing French billionaire Francois Pinault's holding company, Artemis SA, of fraud in the 1991 sale of the now-defunct Executive Life Insurance Co. However, it is unclear whether the award will stand, as, under federal and California case law, punitive damages cannot be assessed in the absence of compensatory damages, lawyers say. The jury in May found Artemis S.A. liable on three counts–conspiracy to commit fraud, intentional misrepresentation and concealment–but only the conspiracy count was accompanied by a finding of harm to the ELIC estate.

Bias can extend to names: Court

An employer who insisted on calling an employee "Manny" instead of his actual name is

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NEWSPAPER

INTERNATIONAL
U.K. regulator changing enforcement process
Australia issues code of insurer conduct
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Pension: Proposal would tighten funding rules

Continued from page 1

example, several provisions Sen. Grassley first introduced several years ago following the failure of one-time energy giant Enron Corp., which wiped out about $1 billion in 401(k) plan assets held by Enron employees.

The Senate bill would, for example, require employers to allow employees, after three years of service, to sell company stock their companies contributed as a 401(k) plan match. That requirement is a response to an Enron design in which employees could not sell company shares contributed as a 401(k) match until they were age 50. The lock-in resulted in employees watching helplessly as the value of Enron shares they held through the 401(k) plan plummeted in value as the corporation was engulfed in an accounting scandal.

There also are differences beyond the two bill's provisions. In the House, Ways and Means Committee Chairman Bill Thomas, R-Calif., earlier said he wanted to meld the pension funding bill to a broader bill that would restructure the Social Security program. A Republican Finance Committee aide said Sen. Grassley has no interest in linking the pension bill to one revamping Social Security.

In addition, Finance Committee staffers expect an effort to be made this week when the bill is voted on to amend the measure to give commercial airlines extra time to fund plan liabilities. The staffers, acknowledge, though, that an agreement on how such relief should be provided has not yet emerged.

Despite the differences, a congressional consensus is beginning to emerge on what should be the core elements of a pension funding reform measure, Washington observers say (see box).

"They are trying very hard to get something passed and the chances are reasonably good they will succeed," said Janice Gregory, vp-retirement policy at the ERISA Industry Committee in Washington.

Those core elements include:

- Higher PBGC premiums. Both measures would raise to $30 per plan participant the annual premium employers pay the PBGC. The Senate bill would put this increase in effect immediately, while the House bill would phase the increase in over five years for employers whose plans are at least 80% funded and three years for plans less than 80% funded.
- Faster amortization of plan liabilities. Both bills would require employers to fund liabilities over seven years. Employers now, in some cases, can amortize liabilities over 30 years.
- Curbs on benefit increases. The two bills would bar employers whose plans are less than 80% funded from increasing benefits.
- Overfunding. The Senate bill would allow employers to make tax-deductible contributions until their plans were 180% funded. The House bill would allow such contributions until the plans were 150% funded. Both measures are a significant change from current law that generally bars new contributions after a plan is 100% funded.

But the bills differ in several significant ways. For example, while both bills would base valuation of plan liabilities on rates of corporate bond rates of varying maturities and plan demographics, under the House bill the actual rate to be used would be a three-year average of bond rates. The Senate bill would not allow such smoothing, making it much more difficult for employers to predict how much they would have to contribute to their plans.

Comparing pension bills*

Issue	House bill	Senate bill
Liability amortization	Seven years	Same
Base PBGC premium	$30 with phase-in	$30 but with no phase-in
Benefit increases	Not allowed for employers with underfunded plans	Similar to House bill
Interest rate assumptions	Based on plan demographics and corporate bond yields	More complex than House bill
Overfunding	Contributions allowed up to 150% of liabilities	Contributions allowed up to 180% of liabilities
Cash balance plans	Protection from age discrimination suits	No provision but under discussion
Company stock in 401(k)	No provision	Requires employers to allow diversification after three years

*As passed by the House Education & the Workforce Committee and proposed by Senate Finance Committee leaders

BI Stock Index [7/18 - 7/22]

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

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

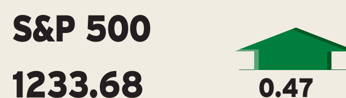
***BI* Stock Index**
2598.29

-0.32

Dow Jones
10651.18

0.10

S&P 500
1233.68



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Largest gains

Company	Change
Gainsco Inc.	10.67%
PMA Capital Corp.	8.00%
Baldwin & Lyons Inc.	5.99%
SCPIE Holdings Inc.	5.07%
United Fire & Casualty	4.36%

Largest losses

Company	Change
Aetna Inc.	-6.06%
Hilb Rogal & Hobbs Co.	-5.87%
CIGNA Corp.	-5.49%
USI Holdings Corp.	-5.41%
Humana Inc.	-4.36%

Weekly change by market segment

Segment	Change
Brokers	-2.07%
Insurers/Reinsurers	0.61%
Managed Care Organizations	-2.97%

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

Late News

Continued from page 1

liable for employment discrimination, said the 9th U.S. Circuit Court of Appeals in San Francisco. A three-judge panel on Thursday unanimously affirmed a district court's ruling upholding a jury verdict that found Greg Young, chief executive officer of Austin, Texas-based BJY Inc., liable for employment discrimination when he continued to insist on calling Mamdouh El-Hakem "Manny" over Mr. El-Hakem's strenuous objections. Mr. Young had said that a "Western" name would increase Mr. El-Hakem's chances for success at the engineering firm and would be more acceptable to the company's clientele, court papers show.

Illinois enacts comp reforms

Illinois Gov. Rod Blagojevich last week signed compromise workers compensation reform legislation that calls for implementing a medical fee schedule indexed to the Consumer Price Index. The measure also increases some benefits, establishes a state workers comp fraud unit, strengthens fines for fraud and creates a work-stop order for employers that fail to obtain insurance.

Delaware cuts captive taxes

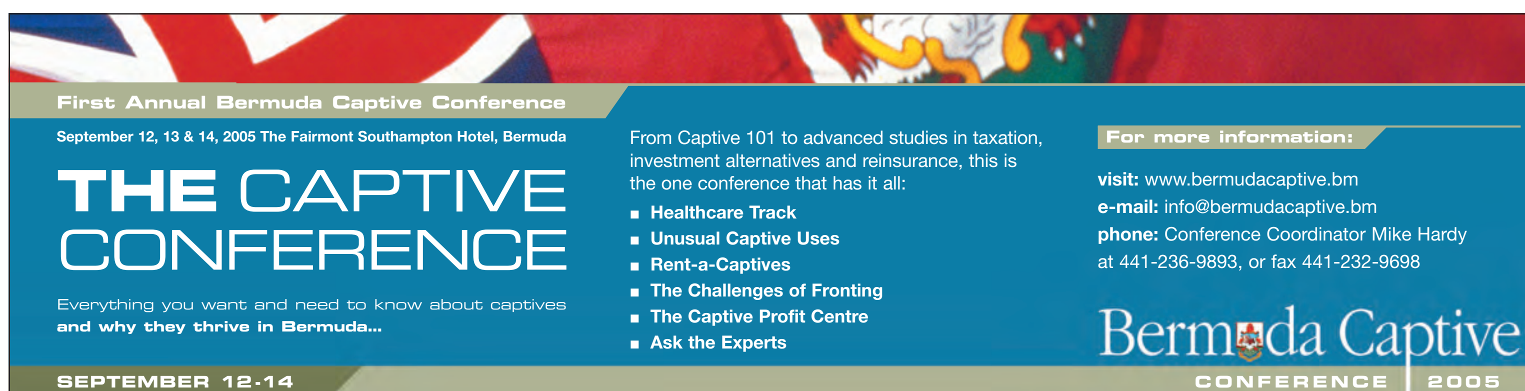
Under a measure signed by Delaware Gov. Ruth Ann Minner, captives' direct written premiums will be assessed a flat 0.2% tax, while a flat 0.1% tax will be assessed on reinsurance premiums. That is a significant reduction from prior law, in which the tax rate started at 0.7% for the first $20 million of premiums, then gradually declined. H.B. 218 also imposes new tax caps and allows sponsored or cell arrangements and so-called special purpose captives.

Ex-McKinsey partner to head Aon Consulting

Aon Corp. has named Andrew M. Appel as chief executive officer of Aon Consulting Worldwide. He succeeds Donald C. Ingram, who had "longstanding" plans to retire as Aon Consulting's CEO but will remain chairman, Aon said. Mr. Appel previously was a senior partner in the financial services and technology practices of consultant McKinsey & Co. Aon CEO Gregory C. Case, who replaced longtime chief Patrick G. Ryan in April, also joined the brokerage from McKinsey.

Ontario comp premiums up by 3% for 2006

Ontario employers will face the first increase in their workers compensation premiums in three years in 2006. The board of directors of Ontario's Workplace Safety and Insurance Board has raised the average premium rate for 2006 by 3% to $2.26 for every $100 of insurable earnings. The board blamed an increase in the unfunded liability—the difference between the total cost of the claims in the system and the funds in the system to pay for them—for the increase.



At BusinessInsurance.com

New **Online Poll**: Do you think employees are taking time off under the Family and Medical Leave Act for reasons beyond what the law intended?

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

Inside

Employers still waiting for more FMLA guidance

Companies are having problems with the Family and Medical Leave Act
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Another defined benefit plan is being phased out

New hires at Hewlett Packard will be covered by a 401(k) plan.
Page 4

Finite risk deals legitimate, useful tool for business

Finite risk deals serve a useful purpose and should not be discarded, an editorial says.
Page 8

U.K. companies face new age discrimination rules

Proposed changes will create new duties for employers in the United Kingdom.
Page 13

Online poll - [7/18-7/22]

Do you agree with the proposition that commercial insurance brokers should never accept contingent commissions, regardless of the level of disclosure?

Yes 29.3%

No 62.3%

Not sure 8.4%

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

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Court gives policyholders direct reinsurance access

PITTSBURGH—Pennsylvania's Supreme Court on Tuesday upheld a 2003 lower court finding that four policyholders of defunct insurer Legion Insurance Co. can obtain direct payment of their claims from Legion's reinsurers.

In the 2003 ruling, a Commonwealth Court of Pennsylvania judge agreed with policyholders that reinsurance contracts had been negotiated between the policyholders and the reinsurers and that Legion and its sister company, Villanova Insurance Co., acted as fronting insurers. Therefore, the judge said, the policyholders have third-party beneficiary rights and should be able to access the reinsurance directly.

Pennsylvania Insurance Commissioner Diane Koken, however, appealed the trial court ruling, claiming that there is nothing in Pennsylvania law to support the policyholders' position. She said policyholders do not have a right to directly access reinsurance proceeds that are intended to reimburse a direct insurer for claims payments made on behalf of its policyholders.

Pennsylvania Insurance Commissioner Diane Koken failed to have the lower court decision overturned.

Pennsylvania's high court last week, however, allowed the lower court's decision to stand without hearing arguments.

The high court's action clarifies Pennsylvania law that says courts must look at requests for direct access on a case-by-case basis and rule depending on the relationship between the policyholder, the insurance company and the reinsurer, said Rick McMenamin, a partner at Morgan, Lewis & Bockius L.L.P. in Philadelphia.

Mr. McMenamin represented Fort Worth, Texas-based American Airlines Inc. in the trial proceedings. The other policyholders in the case are: Psychiatrists' Purchasing Group Inc., a Delaware-domiciled medical malpractice purchasing group; Rural/Metro Corp., a Scottsdale, Ariz.-based emergency and medical transportation company; and Pulte Homes Inc., a Bloomfield Hills, Mich.-based homebuilder.

The policyholders had various reinsurance arrangements.

—By Roberto Ceniceros

California Supreme Court decision opens new avenue for sexual harassment lawsuits

By ROBERTO CENICEROS

SAN FRANCISCO—Employers in California face new employment practices liabilities arising from sexual affair-linked favoritism by managers, following a ruling by the state's Supreme Court last week.

In a unanimous decision, California's high court ruled that employees can sue for sexual harassment when their supervisor favors other workers with whom the manager has engaged in consensual sexual activities.

The ruling, which dramatically expands plaintiffs' ability to sue for sexual harassment under California's anti-discrimination law, is the first by a state supreme court to address workplace sexual favoritism and has implications for other states, according to several defense and plaintiffs attorneys. The U.S. Supreme Court has not addressed the matter, the attorneys note.

Because of the decision in *Edna Miller vs. Department of Corrections,* employers now

have increased responsibility for monitoring workplace relationships, defense and plaintiffs attorneys and the state's attorney general agree.

"California employers can no longer just rely on an anti-nepotism policy," said a spokesman for California Attorney General Bill Lockyer. "They need to take extra steps to ensure there is not a hostile work environment created by virtue of consensual sexual relations between employees."

Yet employers are in an difficult bind, because in monitoring or investigating workplace relationships, they risk violating a state labor code prohibiting discrimination for lawful activity workers engage in during their off time, said Shannon B. Nakabayashi, an attorney who filed an amicus brief on behalf of employers.

Indeed, the two laws could cause a conflict for employers in cases where relationships span the workplace and workers' homes, said Michael Evans, senior vp and chief risk officer for Sutter Health in Sacramento, Calif.

Plaintiffs attorneys in states outside of California, meanwhile, are now likely to cite the decision in attempts to create a new cause of

See **HARASSMENT** / page 17

Many Canadian employers still working to comply with high court pension ruling

By GLORIA GONZALEZ

A year after a controversial Supreme Court of Canada decision required the distribution of surpluses in partially wound-up pension plans, Canadian employers are still struggling to comply with the ruling and determine its ultimate impact on their pension programs.

The full ramifications of the court's July 29, 2004, ruling will not be apparent for several years because many issues remain unresolved, but it has already had an impact on how Canadian employers manage their pension plans, pension experts say.

While some employers have changed their funding or investment policies as a result of the ruling, there has not been an exodus from defined benefit plans, as some pension experts predicted.

In *Monsanto Canada Inc. vs. Ontario (Superintendent of Financial Services),* Canada's high court upheld a regulatory determination that the Ontario Pension Benefits Act requires the distribution of a proportional share of actuarial surplus when a defined benefit pension plan is partially wound up (*BI*, Aug. 9, 2004). A partial wind-up refers to the termination of part of a pension plan and the distribution of the assets of the pension fund related to that part of the plan.

> **The *Monsanto* decision**
>
> In *Monsanto Canada Inc. vs. Ontario (Superintendent of Financial Services)*, the Supreme Court of Canada upheld a regulatory determination that the Ontario Pension Benefits Act requires the distribution of a proportional share of actuarial surplus when a defined benefit pension plan is partially wound up. The July 29, 2004, decision already has had an impact on how Canadian employers manage their pension plans.

After the ruling was released, the Financial Services Commission of Ontario, which has responsibility for regulating pensions in the province, ordered the sponsors of the 281 plans directly impacted by the decision to file updated reports on the plans' funding positions.

Most of the sponsors have not yet filed the reports due to the complexity of the issues involved and the difficulty in collecting the historical data necessary to determine the funding position of the plans, observers say. "It's been a much more complex undertaking than plan sponsors originally thought it would be," said Stephen Pibworth, legal consultant for Hewitt Associates Canada in Toronto.

Even the employers directly involved with the litigation have unresolved issues. Pfizer Canada, which became a party in the case after purchasing the pharmaceutical unit at the heart of the partial wind-up, has not yet determined the amount of surplus that needs to

See **MONSANTO** / page 16

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Employers wait for Labor Department guidance on FMLA

Intermittent leave, vague medical requirements causing problems

By JUDY GREENWALD

Employee abuse of the Family and Medical Leave Act is causing employers some significant problems with no apparent relief in sight, observers say.

Although the federal Department of Labor, which administers the 1993 law, has been expected to issue new FMLA regulations at least since a 2002 U.S. Supreme Court decision that relates to it, no date has been set for their release.

Employers and other observers say in general, the FMLA works well, and provides a valuable benefit to employees. But certain provisions of the law, most notably those related to taking intermittent leave, as well as vagueness as to the medical conditions that entitle employees to take the leave, are causing problems.

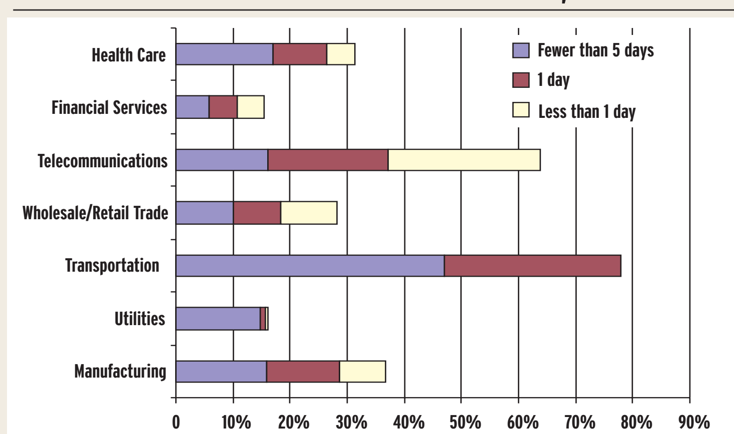
"We've had the law in place since 1993, and I think it's time to take a look at it and see if it's doing what we really intended to have it do," said Jamie Marsden, human resources director for the City of Gillette, Wyo.

However, numerous organizations, as well as some U.S. senators and representatives, including Sen. Edward Kennedy D-Mass. and Sen. Hillary Clinton D-N.Y., say they oppose any effort to make it more difficult for employees to take advantage of the benefit.

Under the FMLA, employees at organizations with at least 50 workers can take up to 12 weeks of unpaid job-protected leave annually to care for a newborn, a newly adopted child or a seriously ill family member; or to recover from his or

See FMLA / page 16

Prevalence of Intermittent FMLA leave, 2004



Source: Employment Policy Foundation

Big employers leaving defined benefit plans

Employer	Action	Effective date
Hewlett Packard Co.	DB plan limited to older, longer service employees; enriched 401(k) for others	1-1-06
Sears Holdings Corp.*	Enriched 401(k) for all future benefits	1-1-06
Motorola Inc.	DB plan limited to current employees; enriched 401(k) for new employees	1-1-05
IBM Corp.	DB plan limited to current employees; enriched 401(k) for new employees	1-1-05
NCR Corp.	Enriched 401(k) for new and younger employees; others given choice between an enriched 401(k) or staying in DB plan	9-1-04
Aon Corp.	DB plan limited to current employees; second DC plan added for new employees	1-1-04

*for Sears, Roebuck & Co. unit

HP to phase out defined benefit plan

By JERRY GEISEL

PALO ALTO, Calif.—Hewlett Packard Co. is phasing out its defined benefit pension plan, as the exodus of big employers from the plans continues.

Effective Jan. 1, 2006, newly hired employees and employees whose combined age and service are less than 62 will be covered only under a 401(k) plan, which Hewlett Packard is enhancing. Hewlett Packard will match 100% of those employees' 401(k) plan contributions, up to 6% of pay.

Employees whose combined age and service are at least 62 will remain in the defined benefit plan and a 401(k) plan in which Hewlett Packard matches 100% of employees' salary deferrals up to the first 3% of pay, and 50% of employees' pretax contributions on the next 2% of pay.

The phasing out of the $3.2 billion defined benefit plan is the second major change the Palo Alto, Calif.-based technology giant has made to the plan in the past several years. Just over 2½ years ago, Hewlett Packard amended the plan so those employees hired as of Jan. 1, 2003, were covered under a cash balance design.

Hewlett Packard—which last year generated more than $79 billion in revenues, making it the nation's 11th-largest corporation—said in a statement that the latest changes to its retirement savings program are being made "to better match industry benchmarks."

The phasing out of Hewlett Packard's defined benefit plan came as part of a corporate restructuring announced last week. Hewlett Packard intends to reduce its workforce of around 150,000 employees by about 10% as it tries to reduce annual operating expenses by $1.9 billion.

Other big employers that in the past year announced they are phasing out their defined benefit plans include IBM Corp. of Armonk, N.Y.; Sears Holding Corp. of Hoffman Estates, Ill.; NCR Corp. of Dayton, Ohio; and Motorola Inc. of Schaumburg, Ill.

Supreme Court nominee praised by business, tort reform advocates

WASHINGTON—Business and tort reform advocates are hailing President Bush's choice of Judge John G. Roberts Jr. of the U.S. Court of Appeals for the District of Columbia Circuit to replace Associate Justice Sandra Day O'Connor on the U.S. Supreme Court, despite Judge Roberts' short tenure as a federal judge.

PHOTO: NY TIMES

Supreme Court nominee John G. Roberts Jr. currently serves as a judge for the U.S. Court of Appeals for the District of Columbia.

They point out that Judge Roberts, who was confirmed as an appellate judge just over two years ago, spent much of his career representing corporate clients in private practice.

"It may be an important indication of where Judge Roberts would stand on legal reform issues that he had a long career as a top appellate lawyer for business interests," said Glenn Lammi, chief counsel of the Washington Legal Foundation.

In a statement released shortly after President Bush revealed Judge Roberts as his high court choice, U.S. Chamber of Commerce President Tom Donohue called the nominee "highly regarded and well-respected by the legal and business communities." He said the Chamber would "participate in the process as appropriate."

Before being appointed to the appeals court, Judge Roberts had been head of the Appellate Practice Group of Washington-based Hogan & Hartson L.L.P. He also had served in the Justice Department under Presidents Reagan and George H.W. Bush.

—By Mark A. Hofmann

Insured damages slight from Hurricane Emily

Powerful Hurricane Emily spared insurers from major property losses, leaving mainly cosmetic commercial damages in the parts of the Caribbean and Mexico where it hit last week, experts say.

At its strongest, Emily—which began churning in the Atlantic while Hurricane Dennis lashed the United States' Gulf Coast—became a Category 4 hurricane and reached maximum sustained wind speeds of 155 mph, the National Hurricane Center in Miami reported.

The storm made landfall twice in Mexico, hitting the Yucatan Peninsula on July 17, and striking again in the northeastern part of the country, about 75 miles south of the U.S.-Mexico border on July 20.

Overall, "the extent of damage is not major from what we're seeing," said Jeffrey T. Bowman, president of the international operations for Atlanta-based claims adjuster Crawford & Co.

In Mexico, Crawford's adjusters reported ripped roofs, broken windows, and other wind-related cosmetic losses to hotels and properties along the resort-laden stretch of the Yucatan known as the "Mayan Riviera." In Monterrey, the company had received a couple of relatively large flood claims, Mr. Bowman said, but it was too early to judge the full scope such damage.

EQECAT Inc. last week estimated that insured losses were likely to be between $100 million and $600 million in the Yucatan and between $50 million and $350 million elsewhere in Mexico.

AIR Worldwide Corp. did not issue a loss estimate for Emily, but Atul Khandari, manager of wind risk modeling for the Boston-based cat modeler, said that initial indications are that losses from the storm will be minimal, as "most of the damage is cosmetic" and "not real structural damage."

—By Rupal Parekh

PHOTO: ZUMA PRESS

Hurricane Emily, while powerful, caused on 'cosmetic' damage in Mexico and the United States.

Errors & Omissions

• A chart on page 24 of the July 18 issue contained incorrect information. Arthur J. Gallagher & Co. reported $29.3 million in contingent commissions associated with its retail business in 2003, which represented 2.2% of its gross revenues for that year. Also, Brown & Brown Inc.'s net income in 2003 was $110.3 million

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COMINGS & GOINGS - INDUSTRY

Mr. Bates

Mr. Meyer

Mr. Blecher

Mr. Pollock

Brokers:

David P. Trezies is the new executive chairman of London-based UIB Holdings (UK) Ltd., succeeding Mounir Kabban, who has been named president. Previously, Mr. Trezies was chairman of Marsh Ltd.

Atlanta-based Beecher Carlson has named **Mike LaRocca** executive managing director in its Los Angeles office. Before joining Beecher Carlson, he was regional executive officer at Willis North America.

Also at Beecher Carlson, **Mike Blecher** was named managing director of the company's Los Angeles office. Previously, he was a senior vp and partner at Lockton Cos.

Willis Group Holdings has named **Anthony Russo** as senior vp and global chief information officer. Before joining Willis, he was senior vp and CIO for American International Underwriters, a unit of American International Group Inc.

Also at Willis, **Jay Chappell** has been named CEO of the Dallas office. Previously, he was a senior vp, practice leader-FINPRO south central zone, for Marsh & McLennan Cos. Inc.

Aon Risk Services has promoted **Michael Heffernan** to managing director of the San Jose, Calif. office. Previously, he was co-national director of Aon's wrap-up group.

London-based Heath Lambert Group has appointed **Michael Haynes** managing director of its Hong Kong operations. Before joining Heath Lambert, he was managing director of Euler Hermes Credit Underwriters.

Also at Heath Lambert, **Chris Wright** has been appointed to head the sports and leisure practice. He previously was client services director of sports, leisure and entertainment at Marsh.

And **Matthew Bates** has been named sales and development director of Heath Lambert National. He will remain managing director of Heath Lambert Risk Management.

Scott G. Meyer has joined Chicago-based brokerage Thilman Filippini as managing director. Previously, he was an executive vp and managing director with Aon Corp.

Benfield Inc. in Westport, Conn., has named **Stuart M. Tilghman** as senior vp, origination. He most recently was a senior vp in the property/casualty treaty division at Guy Carpenter & Co. Inc.

Marsh USA Inc. has made several promotions in its Pittsburgh office.

Linda George has been named mid-Atlantic FINPRO practice leader. She formerly was a department manager.

William Jasper, previously a client executive, is the new mid-Atlantic international practice leader.

Five former client advisors were promoted to senior vp: **Brian Andrews** and **Mary Beth Dougherty** in property; **Janet Egger** in health care; **Kimberly Hays** in casualty; and **Kelly Mazur** in insurance services.

Insurers:

American International Group Inc. has made two senior-level appointments.

- **David L. Herzog**, former chief financial officer for AIG's Worldwide Life Insurance, is now comptroller and senior vp.
- **Robert A. Gender** is now treasurer of AIG. He previously was assistant treasurer.

Boston-based OneBeacon Insurance Group has named **Kevin Rehnberg** senior vp. Previously, he was senior vp at St. Paul Travelers Cos.

David J. Witzgall has been named treasurer and vp of American Financial Group Inc. in Cincinnati. Previously, he was senior vp and chief financial officer for AFG-unit Great American Insurance Co.

Liberty International Underwriters in London has appointed **Graeme Brydon** European casualty manager. Before joining the company, he was a senior vp at Alea London Ltd.

ACE USA has named **Alfred E. Bergbauer** senior vp of ACE USA International Advantage. Before joining ACE, Mr. Bergbauer was south region international practice leader at Marsh USA Inc.

New York-based Assurant Inc. has made several senior-level appointments.

- **Robert B. Pollock**, formerly executive vp and chief financial officer, has been appointed president and chief operating officer.
- **P. Bruce Camacho** is the new executive vp and CFO. Formerly, he was president and CEO of Assurant Solutions.
- **Jerome A. Atkinson**, former executive vp, general counsel of Assurant Solutions, is now executive vp and chief compliance officer.

Assurant Solutions has been split into two businesses, Assurant Specialty Property and Assurant Solutions, the division now known as Consumer Protection Solutions.

- **S. Craig Lemasters** is the new president and CEO of Assurant Solutions. Formerly, he was executive vp and chief marketing officer.
- **John B. Owen**, formerly chief information officer, is the new president and CEO of Assurant Specialty Property.

Reinsurance:

New York-based Holborn Corp. has named **Frank T. Harrison** chief executive officer. He will remain president and director. Mr. Harrison succeeds John N. Gilbert, who will remain chairman and director of the brokerage.

New York-based Guy Carpenter & Co. Inc. appointed **Michael Lazarus** as senior vp of facultative operations in the Australian, New Zealand and Pacific region, a newly created position. Mr. Lazarus, who will be based in Sydney, Australia, previously was head of clients and markets for Aon Risk Services.

Brian Kensil has been promoted to chief operating officer of New York-based Folksamerica Reinsurance Co. Previously, he was senior vp and chief administrative officer.

Hamilton, Bermuda-based ACE Tempest Reinsurance Ltd. has named **Guy Swayne** chief underwriting officer, international. He previously was executive vp of ACE Financial Solutions International.

Managed care:

CIGNA HealthCare has named **G. David Shafer** president of CIGNA Pharmacy Management in Bloomfield, Conn. Most recently, he was executive vp of national operations for AmeriChoice.

Dr. Robert Grossman is the new chief medical officer for Health Net of the Northeast Inc. Before joining Health Net, Dr. Grossman was medical director for HealthGuard of Lancaster in Lancaster, Pa.

Other providers:

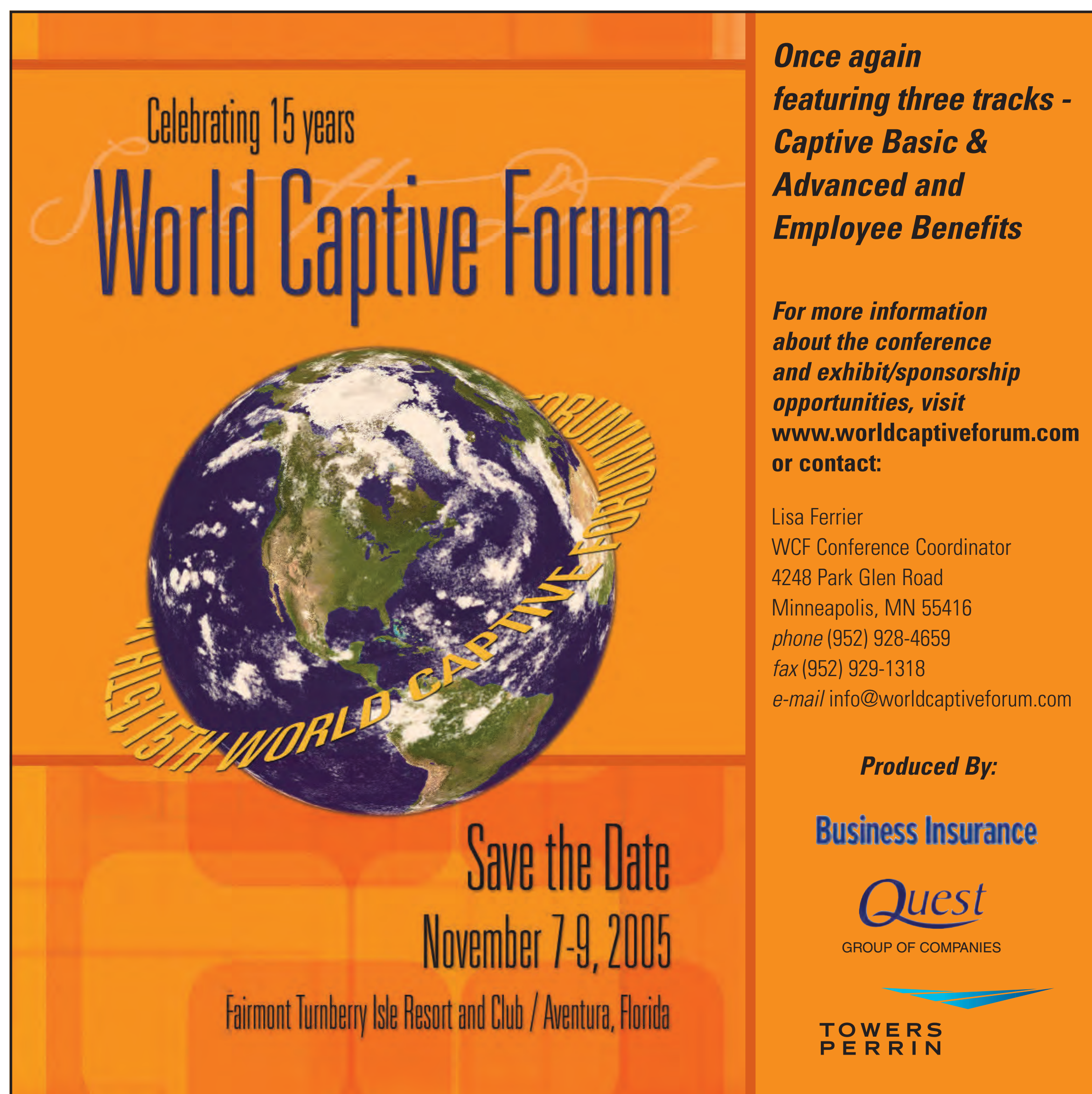
Mound Cotton Wollan & Greengrass, a New York-based law firm concentrating on commercial insurance and reinsurance, has named **Albert A. Skwiertz Jr.** as special counsel. Previously, Mr. Skwiertz was managing director and counsel at Swiss Re Financial Services Business Group.

Schmid & Voiles, the in-house law firm of the Cooperative of American Physicians Inc.-Mutual Protection Trust in Los Angeles has named **Bruce Bailey** to head the firm's new operation in San Diego. Previously, Mr. Bailey was a partner with Bacalski, Bailey, Koska & Ottson L.L.P.

John Darden has been named chief financial officer of Specialty Risk Services in Hartford, Conn. Previously, he was senior vp and CFO of Acordia Inc.

New York-based Chadbourne & Parke L.L.P. has expanded its insurance and reinsurance practice with the addition of five new partners, all of whom previously were partners at Denton, Wilde Sapte. The five are: **Adrian Mecz, Christopher Cardona, Michelle George, John Barlow** and **Mark Pring**.

Michael J. Warfield is the new president of the Mattei Cos. L.L.C. Most recently, he was president of U.S. Risk Underwriters in Dallas.



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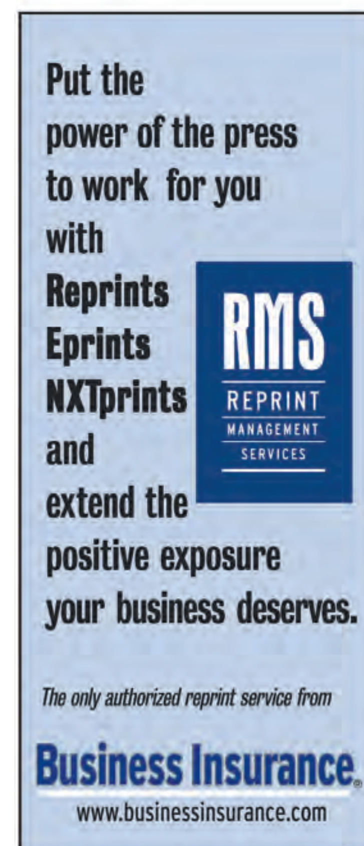

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Pennsylvania eliminates conflict between HSAs, state law

HARRISBURG, Pa.—Pennsylvania Gov. Ed Rendell has signed legislation that clears the way for commercial insurers in the state to offer health savings accounts linked to high-deductible plans.

The bill, H.B. 107, eliminates a conflict between the 2003 federal law that created HSAs and a Pennsylvania law that mandates first-dollar coverage for metabolic disorders.

Under federal law, the high-deductible plan linked to the HSA generally cannot provide coverage until a deductible of $1,000 for single coverage and $2,000 for family coverage is satisfied. The only exceptions to that requirement are preventive services and prescription drugs considered preventive in nature.

That federal requirement conflicted with Pennsylvania law mandating first-dollar coverage for metabolic disorders. The bill signed by Gov. Rendell eliminates that conflict by exempting high-deductible health insurance plans linked to HSAs from any state benefit mandate that would prevent insurers from offering the arrangement.

The measure also makes clear

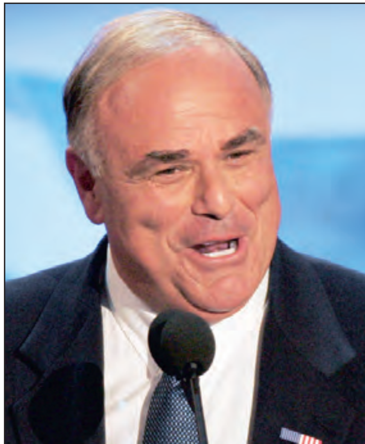
PHOTO: KRT

Gov. Rendell

that funds taken out of an HSA to pay for qualified medical expenses are exempt from Pennsylvania state income taxes. However, a provision that would have excluded HSA contributions made by employees or employers from employees' taxable income was stripped from the bill prior to its passage.

Meanwhile, Minnesota Gov. Tim Pawlenty has signed legislation that amends Minnesota law to conform with legislation Congress passed in late 2003 that gives federal tax breaks to health savings accounts linked to high-deductible insurance plans.

Under the measure, H.F. 138, contributions employees make to HSAs will be tax-deductible, while employer contributions will not be added to employees' Minnesota taxable income. Additionally, distributions made from the accounts to pay for medical-related expenses will not be taxed.

The change in tax law, retroactive to Jan. 1, 2004, should help the HSA adoption rate in Minnesota, said a spokesman for Blue Cross and Blue Shield of Minnesota, a major HSA provider in the state.

—By Jerry Geisel

Employers seek to shift cost of health care to employees

WASHINGTON—More than 75% of large U.S. employers may ask their employees to pay a greater share of the increasing cost of health insurance, according to a new survey.

Health care costs per employee have risen by an average of 12% over the past year, and survey respondents project another increase of 11.1% over the next 12 months without any changes to plans, according to a PricewaterhouseCoopers Management Barometer survey of 150 top executives at large, U.S.-based multinational companies, released by the Washington-based PricewaterhouseCoopers Health Research Institute.

While making employees pay a higher share of health care costs appears to be the solution for the majority of employers surveyed, one in five employers said that doing so would have very little impact on reducing their company's overall health care costs. The most promising option for reducing corporate health care cost increases was to provide financial incentives for employees to live healthier lifestyles, according to more than 80% of surveyed executives.

Seven in 10 respondents to the survey said requiring employees to pay higher deductibles would lead to an employee reduction of spending on discretionary health care, while one in five said that it probably would not. Six in 10 companies said requiring employees to pay higher deductibles would cause employees to defer needed care and risk long-term problems.

—By Gloria Gonzalez

Do you have asbestos or environmental claims with these insurers?

- The Home Insurance Company
- Highlands Insurance Company
- Integrity Insurance Company
- Kemper (American Motorists and Lumbermens Mutual)
- Legion/Villanova
- Midland Insurance Company
- Reliance Insurance Company
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Editorial

Finite risk has a place when deals are legit

IT MIGHT BE TEMPTING to deal with investigations into finite risk coverage in the same way that several large brokerages have reacted to the contingent commissions investigations: do away with the cause of the problem.

We hope, however, that such a radical approach is not applied in this case, regardless of what is quickly becoming a chain of financial restatements by insurers that have used or sold finite risk products.

While we welcomed brokers' decisions to eliminate contingent commissions, the finite risk probes have highlighted a different problem that requires a different solution. Contingent commissions present a fundamental conflict of interest, whereas finite risk coverage, when structured properly, presents a useful and legitimate tool for managing significant losses.

Since its introduction in the late 1970s, finite risk coverage, in its various forms, has provided a sophisticated and relatively low-cost means of transferring risk and smoothing out the effect of past losses over several years.

Policyholders, insurers and reinsurers have all benefited from the coverage, even though the products account for only a small portion of the insurance market.

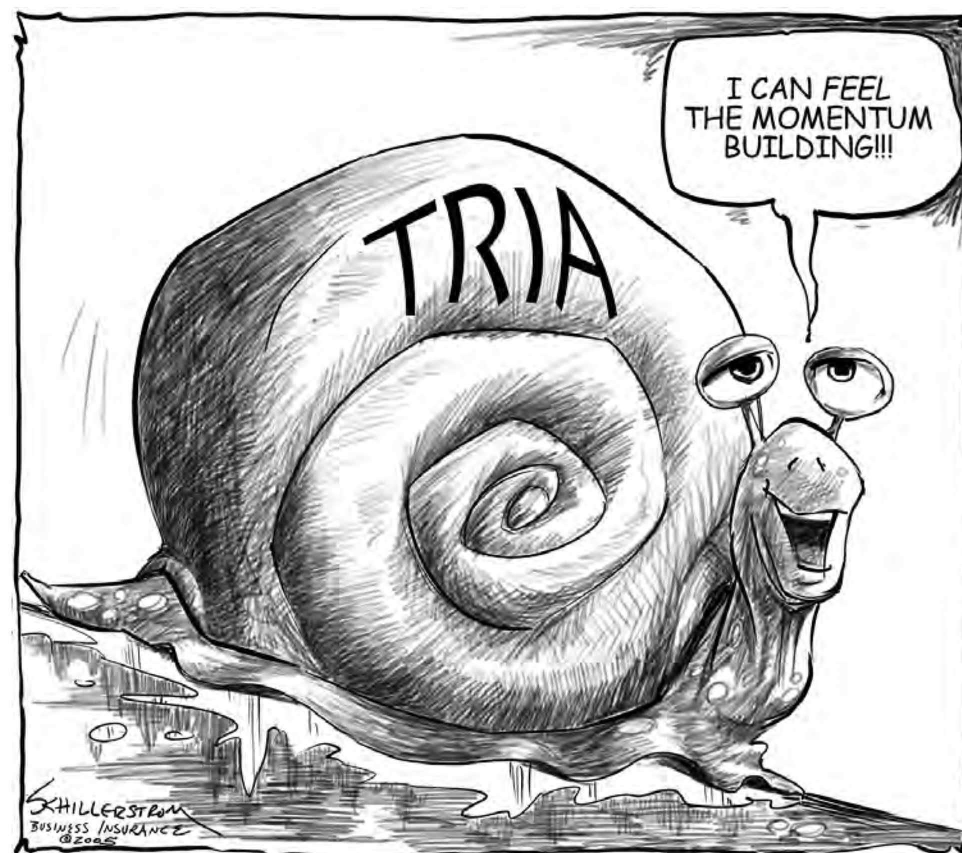
However, in reaction to the probes by the New York Attorney General's office, the Securities and Exchange Commission and others, the sale and use of finite risk coverage is slowing and could reach a complete halt.

While the initial reaction is understandable, we hope all parties with an interest in finite risk coverage will keep working with regulators to ensure that these products survive.

One of the often-cited criticisms of finite risk products is that they are used to mask financial problems. Improved disclosure will help counter that criticism, and the National Assn. of Insurance Commissioners' proposed enhanced disclosure requirements could help in that regard.

But there still needs to be more work done with regulators to provide clearer guidance on just how much risk needs to be transferred for the products to pass muster as insurance. Such guidance may impose stricter limits on finite coverage that would doom some products. But it would be better to have a set of products that clearly meet regulatory approval than no products at all.

Schillerstrom



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Greenspan remarks underscore need for backstop

WHEN FEDERAL RESERVE CHAIRMAN Alan Greenspan speaks, people generally listen closely. We certainly hope that's the case regarding his brief comments last week regarding the federal government's role in the provision of terrorism insurance coverage.

During an appearance before the House Financial Services Committee, Mr. Greenspan made two points regarding terrorism insurance in response to questions from the committee. The first was that the private insurance system can't be expected to handle "a very substantial scope of damage" caused by an act of terrorism by itself.

His second point was that he didn't see how "we can avoid the issue of a significant segment of government-backed reinsurance" in the terrorism insurance arena.

Mr. Greenspan's comments come at a most welcome time. Less than a month ago, the Bush administration announced its opposition to an extension of the current federal terrorism insurance financial backstop, which was created by the Terrorism Risk Insurance Act of 2002.

That backstop expires at the end of the year, and risk managers already report that some insurers are insisting on terrorism exclusions in policies that run into 2006.

The administration, however, left open the door for a scaled-back TRIA program in which the private insurance industry would accept an increasing portion of the risk.

While we'd prefer an outright extension of the current program, we continue to believe that even a scaled-back program is better than no program at all.

Mr. Greenspan's comments, brief as they were, underscore that position.

With the Senate about to become occupied with debate over the nomination of Judge John G. Roberts Jr. to the U.S. Supreme Court, and the already crowded legislative calendar shrinking each day, we hope lawmakers heed Mr. Greenspan's words and move swiftly to ensure that a backstop is in place when TRIA expires on Dec. 31.

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Industry needs fundamental reform

Put aside traditions and adapt business model to meet customer needs

By Joe Plumeri

There's no question that the investigations of the insurance broking industry by New York Attorney General Eliot Spitzer—as well as by other state attorneys general and regulators—has focused critical attention on the inner workings of a business to which few outsiders had previously paid much attention.

The investigations tested many aspects of the industry—the value brokers deliver to clients, how brokers are compensated for their services, how brokers manage conflicts and, most important, whether brokers are serving their clients' best interests. The real test, though, is whether we are content to simply respond to regulators' concerns or whether we use this as a catalyst for fundamental reform.

There is not and never will be a timeless business model for any industry—models are always subject to change—and our industry needs to adapt its culture, technology and business practices to address the powerful forces of change transforming the global economy.

Because of the role insurance plays in our economy, this should be of interest not just to those in the industry but to anyone involved in commerce. Insurance is essentially the "DNA of capitalism." Without the ability to limit and distribute risk, investment would be cramped, startups would be nonstarters and even the greatest enterprises would struggle to take the smallest steps forward. No loan would ever be made, no building built, no product manufactured, no growth generated.

How this industry operates is important to every participant in the global economy, and the industry needs to accept the accountability and responsibility that comes with being central to the flow of commerce.

> Our industry needs to adapt its culture, technology and business practices to address the powerful forces of change transforming the global economy.

Fundamental principles

A new model for this industry should be based on three fundamental principles:

- Client advocacy means having a passion for the client's best interests every day, not just when it's time for the sale or renewal. It's about understanding clients' unique needs and developing innovative solutions. And the principle of client advocacy requires that a broker be paid by only one party in any transaction. It's time that the entire industry steps up to a higher standard and abolishes contingent commissions. Insurers shouldn't pay them. And brokers, regardless of whether they are global, local or regional, shouldn't accept them.
- Transparency must extend beyond compensation. Certainly, brokers need to disclose how much they make. But true transparency means brokers laying out for clients, clearly and upfront, how the brokers help them—how they model and forecast risk, market their risk to insurers and what the insurer's participation is and will be. Of course, when brokers take on other roles, such as managing general agent, agent or program manager, and when those roles are clearly articulated, receiving compensation from an insurer is acceptable, as long as such compensation is transparent to all parties. The black-box approach—put money in one side and get a policy out the other—just doesn't work anymore.
- Innovation is an area in which our industry has to invest heavily. While we are making progress, the technology still sometimes looks like two cans strung together rather than the sophisticated systems found in other financial services industries. We have the collective brain power to solve complex problems, but the industry loses efficiency, value and service with outdated systems.

Delivering value

To make good on those principles, the industry needs a model built around three equally important components: manufacturing, distribution and service.

For too long, all of the emphasis in this business has been on the "manufacturing" side—getting the insurance policy placed at the right price with the right coverage. But this approach leads to commoditization, which, in turn, invites the payment of contingent commissions and the unacceptable perception of conflict that comes with them.

Manufacturing, or placement, should focus on delivering value through creative solutions; ensuring price transparency—you have to know what you are getting and how much it will cost, whether hard goods or insurance—and the security that comes from having rigorous internal controls that protect client interests.

Distribution is about delivering solutions, finding what the client needs rather than selling what the broker has in the storeroom. In some cases, that entails placing an insurance policy. In others, it involves sending an engineer to a construction site to assess risks, delivering an environmental assessment or conducting the necessary due diligence during an acquisition to make sure the client isn't surprised by hidden problems. Distribution is about human beings relating to and helping other human beings—what used to be called relationships.

Service, the final element of the model, has too often been treated as an afterthought in the insurance industry. Clients buying insurance have two questions. They first want to know, "What's the deal?" A chief financial officer would never restructure a company's debt and not know every last detail. But when it comes to insurance, the still-accepted practice is "deal now, detail later." Insurance buyers wait an average of nine months before they get their policy. In no other industry with so many complexities and so much at stake do the parties shake hands one day and figure out in the days, weeks and months ahead what exactly they shook hands about. Changing this will require investments in technology along with changes in behavior.

The second question clients ask is: "God forbid, I have a claim, how and when am I going to get paid?" Claims advocacy should be the thing brokers do best, because nothing else matters if clients' claims aren't paid. But, for some reason, the industry has pushed this fundamental reason for insurance to the backroom. That is not acceptable in a client-focused business.

Addressing the concerns of regulators is not the end, as something we put behind us. Rather, it must be about putting our traditions behind us and beginning a transformation of how we operate that elevates our clients' interests, advances openness, spurs innovation, improves service and, most important, delivers value based on true relationships.

Joe Plumeri is chairman and chief executive officer of Willis Group Holdings Ltd. This article is adapted from Mr. Plumeri's recent address to the Risk & Insurance Management Society Inc.

BI searching for top companies in industry

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

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

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

The categories are for best overall:

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- Commercial property/casualty insurer.
- Property/casualty reinsurer.
- Employee assistance program provider.
- Employee benefits consulting firm.
- Insurance wholesaler.
- Managed health care organization.
- Reinsurance intermediary.
- Risk management consulting firm.
- Surplus lines insurance company.
- Third-party claims administrator.

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

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Visit *www.businessinsurance.com/readerawards* today to cast your vote.

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

To submit an article for the Perspective section:

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- You will receive from us an acceptance or declination of your article idea.
- If accepted, we will respond with comments and request the full article, which generally should be 700 to 800 words in length.
- All articles are to be accompanied by a photograph of the author and a brief biography.
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Between the Lines

Compiled by Joanne Wojcik

Spam can be good for you

Spam! Spam! Spam! Spam! Lovely Spam! Wonderful Spam!

New research has found that spam may actually be good for you.

But not the kind of spam you eat. Rather, the kind of spam you read.

People who received a steady stream of those pesky e-mails nagging them to practice healthy habits tend to exercise more and lose weight, according to researchers at the University of Alberta, Canada.

The researchers drew their conclusions after they sent the reminders to volunteers at five large Canadian workplaces who were participating in a larger study about exercise and health.

Those who received the e-mails exercised more and knew more about the benefits than those who did not. They also reduced their body mass index, a measure of body fat based on height and weight. By contrast, those who did not get the e-mails actually gained weight over the three-month study.

Louisiana turns profit on commissioner's truck

It turns out Louisiana Insurance Commissioner Robert Wooley's gaffe may actually have been good for his department. The taxpayer-purchased 2005 Harley Davidson-edition Ford F250 Super Duty pickup that Mr. Wooley was forced to forfeit several months ago fetched $42,378 at auction—$2,578 more than the insurance department paid for it earlier this year.

Unfortunately, a second vehicle that taxpayers bought for Mr. Wooley—a 2004 Eddie Bauer-edition Ford Expedition purchased in December 2003 for $40,000—did not fare as well. Although nine people submitted bids, none met the $31,000 minimum the state had sought. The Expedition will now either be sold at public auction or over an Internet auction site such as eBay.

PPOs: Pig people or preferred providers?

Are health insurers greedy pigs? They are, according to the California consumer group that crafted landmark Patient Bill of Rights legislation.

The Foundation for Taxpayer and Consumer Rights has launched an animated Internet campaign, "Pig People from Outer Space," attacking health insurers. The video specifically targets former WellPoint Inc. CEO Leonard Schaeffer, whose wallet got significantly fatter as a result of the Woodland Hills, Calif.-based insurer's merger with Indianapolis-based Anthem Inc.

The objective is to communicate to the masses as simply as possible what is really happening with their health care dollars, said Jerry Flanagan, a spokesman for the Los Angeles-based consumer watchdog group.

The Foundation for Taxpayer and Consumer Rights has launched an Internet campaign targeting health insurers.

"And what better example of health insurance greed than the recent Wellpoint-Blue Cross-Anthem merger," he said. Mr. Schaeffer and other Wellpoint executives have been criticized for the amount of compensation that they were awarded in the merger. "It's emblematic of a problem across the board in insurance companies," Mr. Flanagan said.

Mr. Schaeffer declined to comment.

Those who visit the Web site, *www.consumerwatchdog.org/healthcare/PigPeople/*, can sign a petition urging state lawmakers to enact legislation making health insurance subject to the same pre-approval requirements as other lines of insurance under Proposition 103.

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

Paint manufacturers can be sued

MADISON, Wis.—The Wisconsin Supreme Court has ruled that a boy who claims he suffers from cognitive and other medical problems because he ingested lead paint as toddler can sue paint manufacturers, even though he does not know which manufacturers produced the paint that caused his problems.

The court held in its July 15 decision in *Steven Thomas vs. Clinton L. Mallett et al.* that even though the pigment manufacturers are faced with possible liability for paint they may not have produced or marketed, Mr. Thomas could still proceed with his suit under the theory of risk contribution.

"Many of the individual defendants or their predecessors-in-interest did more than simply contribute to a risk; they knew of the harm white lead carbonate pigments caused and continued production and promotion of the pigment notwithstanding that knowledge," the opinion states.

Quoting an earlier decision by the same court, the ruling states "that between the plaintiff, who probably is not at fault, and the defendants, who may have provided product which caused the injury, the interests of justice and fundamental fairness demand that the latter should bear the cost of injury."

The court said also in its 4-2 decision that Mr. Thomas was still entitled to sue the manufacturers even though he had already reached a settlement with landlords of the homes where he had ingested the paint. The homes were built in 1900 and 1905, when the use of lead paint was common, and contained up to 50% lead pigment, according to the decision, which partially overturns a state appellate court opinion.

—*By Judy Greenwald*

9/11 rescue workers must keep claims in New York federal court

NEW YORK—A New York federal court will retain exclusive jurisdiction over all lawsuits by firefighters, police officers and rescue workers alleging respiratory injuries from their participation in the cleanup and handling of debris following the Sept. 11, 2001 terrorist attacks, a federal appeals court ruled last week.

The decision, reached by a three-judge panel in the United States Court of Appeals for the Second Circuit, overrides a June 2003 lower court ruling that found court jurisdiction of such claims to be dependent upon whether workers' exposure occurred at the World Trade Center site or elsewhere, and if exposure occurred before or after Sept 29, 2001—the day that the rescue operation for victims ended and the recovery effort began.

The earlier decision provided for inconsistencies in plaintiffs' potential damage awards.

In cases remanded to state court, plaintiffs' suits could be tried without a ceiling on damages, while litigation retained in federal court would be subject to a cap under the Air Transportation Safety and System Stabilization Act of 2001. Passed by Congress within days of the terrorist attacks, ATSSSA restricts the city of New York's liability relating to Sept. 11 claims to the greater of the city's insurance coverage or $350 million.

"We cannot conclude that Congress intended such differences," wrote Judge Amalya Kearse in her 46-page decision.

The ruling last week upholds that all medical claims stemming from the terrorist attacks should not be tried in state court, but rather funneled through a single federal court.

—*By Rupal Parekh*

PHOTO: KRT

Rescue personnel injured in New York after the Sept. 11, 2001, terrorist attacks can only seek damages in New York federal court.

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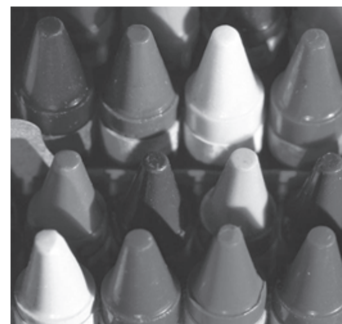

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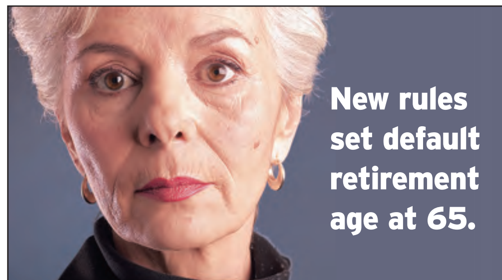
Employers review retirement policies in light of E.U. age discrimination rules

By BARBARA COCKBURN

LONDON—U.K. employers need to take steps to avoid potential age discrimination claims when proposed rules take effect next year, attorneys say.

But although the rules would create additional employment-related exposures and duties for employers, they are not likely to necessitate major changes to age-related aspects of occupational pension arrangements.

The rules, proposed earlier this month by the government's Department of Trade and Industry, stem from a European Union directive on age discrimination, which formed part of a broad E.U. effort to end various types of discrimination.



The regulations, which are slated for implementation in October 2006, would bar age discrimination in employment practices and would set at 65 the default retirement age for U.K. workers.

Currently, employers are allowed to retire an employee below age 65 without justification. Under the change, employers could retire workers at or above age 65 as long as the move constituted a genuine retirement, while retirement ages below 65 would not be permitted without justification.

Under the rules, employers still could treat workers differently based on age under certain circumstances, but they would have to meet a new "objective justification" standard. That standard generally requires an employer to demonstrate that the disparate treatment "fulfills a legitimate aim" and that the circumstances make it necessary, according to the Department of Trade and Industry.

Also, the rules would grant workers over the age of 65 the right to bring claims of unfair dismissal.

See DISCRIMINATION / next page

FSA review recommends greater autonomy for its regulatory committee

By SARAH VEYSEY

LONDON—The U.K.'s financial services regulator plans to introduce more independence for its regulatory decisions committee, the body that makes enforcement rulings and can levy fines.

The London-based Financial Services Authority regulates the U.K.'s insurance industry and in January took over regulation of insurance brokers.

The FSA in February launched a review of its enforcement process after an independent tribunal criticized its investigation into endowment policy mis-selling by life insurer Legal & General Assurance Society Ltd. The tribunal said the FSA's enforcement procedures were opaque, among other things.

The review was conducted by David Strachan, director of retail firms at the FSA, and David Pritchard, former deputy chairman of London-based banking group Lloyds TSB Group P.L.C. They were advised by Queen's Counsel Michael Brindle, a member of the London-based Fountain Court barristers' chambers.

The FSA review's findings were published last week and have been accepted by the FSA board.

The review recommended that the regulatory decisions committee should have its own, dedicated legal function, and that before a case is referred to the committee it should be reviewed by lawyers who have not been part of the team investigating an alleged breach of FSA rules.

This latter recommendation likely will be welcomed by companies regulated by the FSA, according to Neil Mirchandani, a partner at Lovells law firm in London, because "there is clear delineation," which will help enhance the perception of independence in the enforcement process.

But Mr. Mirchandani noted that having two different legal teams involved in the enforcement process will likely slow it down, causing delays in rulings.

In a statement, Legal & General also welcomed this separation between the regulatory decisions committee and the FSA's enforcement division, which it said "properly recognizes the importance of the regulatory decisions committee in ensuring fair treatment for firms."

The review also recommended that communication between the FSA's enforcement division and the regulatory decisions committee should no longer be confidential. The FSA said such communication would now be disclosed to interested parties.

The regulatory decisions committee should no longer be involved in cases that are settled and should only become involved where no settlement can be reached, the review recommended.

More cases likely will now be settled before they reach the regulatory decisions committee stage, noted Mr. Mirchandani.

The review recommended that a discount system be introduced for companies that settle their cases early. The maximum discount in fines levied should be 30%, according to the review, depending on the seriousness of the rule breach and other factors.

This change will make explicit reductions in fines levied on companies settling early. This was already happening in practice, noted Mr. Mirchandani.

Early settlement of cases means consumers are compensated more swiftly. It also can save FSA resources that otherwise would be devoted to investigating cases, the FSA noted in the publication of the review's findings.

The review findings can be found at *www.fsa.gov.uk*.

Code of conduct for insurers

The Insurance Council of Australia's new General Insurance Code of Practice requires insurers to:

- Handle claims promptly. Once all the relevant information for a claim is received and no further assessment is required, a decision should be made within 10 working days.
- Inform policyholders at least once every 20 business days of the progress of claims under investigation.
- Fast-track claims or make advance payments when customers show they are in financial hardship as a result of the damage or loss leading to their claim.
- Enable claims arising from a natural disaster to be reviewed after they have been settled if customers think that the initial loss assessment was incomplete.
- Disclose reasons for declining coverage and refer customers to another insurer, the Insurance Ombudsman Service or the National Insurance Brokers Assn.
- Handle disputes and rectify mistakes in a transparent and efficient manner and within a specified timeframe. For example, respond to complaints within 15 days once all relevant information is received.

Code of conduct to promote good relations, practices

By ELIZABETH FRY

SYDNEY, Australia—Insurers in Australia will be obligated to deal with claims and claims disputes promptly under an updated code of practice released last week.

The code, which applies to commercial and personal general insurers, is designed "to promote good relations between insurers, agents and consumers," according to the code's introduction.

General laws governing business practices already cover some provisions required under the latest code, one lawyer said.

And although the code will apply to commercial policies, risk managers at large companies will normally negotiate their own terms and service agreements with insurers rather than rely on the code.

The General Insurance Code of Practice, which becomes effective in June 2006, outlines requirements for insurers to abide by in handling claims and communicating with policyholders, among other things (see box). It was drawn up by the Insurance Council of Australia in Sydney and was adopted by ICA members, which represents about 90% of the Australian insurance market.

Policyholders can report breaches of the code to the Insurance Ombudsman Service and a Code Compliance Committee, which comprises the ombudsman, and industry and consumer representatives.

The code does not cover workers compensation, compulsory third party, health or marine insurance or reinsurance.

"As an industry, we are conscious that consumers have higher expectations about service delivery and

See CODE / page 15

Updates

Equitable drops part of negligence suit

Equitable Life Assurance Society has dropped part of its negligence claim against its former auditors, Ernst & Young. The failed life insurer has withdrawn its "lost sale" claim against the auditor, but it is still claiming £700 million ($1.22 billion) in damages for alleged negligence. Equitable Life had argued that if its directors had been aware of the dire financial situation facing the company in the late 1990s, it would have tried to sell the insurer. But that claim was dropped after former directors of Equitable Life said in court that they would not have considered a sale. Equitable Life closed to new business in 2000 after the House of Lords forced it to pay out generous annuity rates to certain customers.

'Proportionate liability' for auditors proposed

The U.K. government's Department of Trade and Industry has proposed changes to company law that would introduce "proportionate liability" for auditors involved in lawsuits. Currently, audit firms are subject to unlimited liability. Last year, the government ruled out a cap on auditor liability. The proposed revisions to company law will go before Parliament in the fall.

Munich Re profits fall due to reserve boost

Munich Reinsurance Co. said its profits for the second quarter of 2005 will be reduced by 400 million euros ($483.92 million) because of a $1.6 billion reserve boost at its U.S. subsidiary, American Re Corp. The Munich, Germany-based reinsurer said it was boosting reserves at American Re after a review "aimed at drawing a line under the additions to reserves required several times during recent years." Munich Re in a statement said the reserve boost was needed to cover losses from liability and workers compensation business incurred between 1997 and mid-2002, as well as for longtail asbestos and environmental claims.

Survey: Rates down in Australian market

Commercial insurance rates in Australia are decreasing across most lines of business, according to a survey by the National Insurance Brokers Assn. of Australia. Sydney-based NIBA surveyed its 500 member companies about rates for a six-month market conditions study. Brokers responding to the survey said 53% of their clients experienced reductions in premiums at the June 30 renewal.

Discrimination: Proposed E.U. retirement rules would impact employers

Continued from previous page

Under the change, requiring employees to stop working "merely because they have reached a particular age will potentially be unlawful age discrimination," Richard Lister an employment lawyer at London-based law firm Lewis Silkin, said in a statement.

He explained that "termination of employment at retirement age will only be fair and justified under the age laws if it is by reason of retirement."

He believes employees may well bring claims alleging that the true reason for dismissal was something else other than retirement, such as a performance issue or a layoff, particularly where colleagues have been allowed to work beyond retirement.

He recommended that employers should be consistent in dismissing people when they reach retirement age and "be specific about retirement being the reason."

Rachel Dineley, head of the national discrimination unit at law firm Beachcroft Wansbroughs in London, said that it will be for the employment tribunal, where unfair dismissal cases are heard, to determine, depending on the circumstances of the case, whether an employer has shown that it has adopted "a proportionate means to a legitimate aim."

Paul Mander, a partner in the employment, pensions and incentives group at London law firm Berwin Leighton Paisner, said that employers should now start reviewing employment practices and procedures to ensure that any contractual retirement age below 65 can be objectively justified. He noted that under the proposed rules, employers would have to provide written notice to employees of their intended retirement date at least six months in advance, as well as consider requests to work beyond that date.

"There needs to be a total change of assumptions, because under the new rules, you can no longer assume a person is fit or unfit to work because of their age," Mr. Mander said.

Mark Hunt, head of employment law at international law firm Reed Smith in London, said that the regulations will mean employers will need to implement procedures for dealing with applications to continue work beyond age 65.

"With an aging population, these will become more common as people realize they will have to work for longer because we are living longer and therefore will need to fund our retirement."

Impact on pensions

The proposed rules make certain exemptions for occupational pension plans, which will enable employers to continue to link benefit provisions to age-related criteria. Under the draft rules, employers will continue to be able to set minimum or maximum ages for admission to an occupational pension plan, and use age in actuarial calculations of benefits, among other things.

Employers also would be allowed to close defined benefit pension plans to new members without violating the proposed new rules.

Mark Dowsey, a Reigate, England-based consultant in Watson Wyatt Worldwide's employee benefits practice, said that the exemptions for occupational pension plans "remove a significant element of perceived risk of litigation."

Mr. Lister said that many employers will say they need to set their retirement age at 65 because of the cost of pension provisions.

"Many employers might say that they could not survive without forcing someone to retire at age 65 because it cannot afford to contribute to the occupational pension arrangement for longer."

The London-based Confederation of British Industry broadly welcomed the government's approach with respect to pensions.

Sumantra Prasad, policy adviser in the CBI's employment and pensions group, said that many employers cannot afford to keep their plans open to new members, so they will be relieved that the exemptions will mean they can legitimately close defined benefit plans to new members.

But Mr. Dowsey questioned whether the government is overreaching in setting the regulations in terms of the breadth and number of exemptions for occupational pension schemes.

"At the back of my mind, there's a question whether the government has interpreted the European Commission's directive correctly, because E.U. laws are not usually prescriptive, but a set of statements and principles."

The DTI will accept comments on the proposed rules through Oct. 17; responses can be submitted online at *www.dti.gov.uk/er/equality/age.htm.*

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UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

IN RE PETITION OF JOHN C. GIBBONS, AS LIQUIDATOR OF **NEW CAP REINSURANCE CORPORATION LIMITED**, DEBTOR IN FOREIGN PROCEEDINGS
CASE NO. 99-B-42752 (SMB)

NOTICE IS HEREBY GIVEN THAT ON JULY 14, 2005, THE BANKRUPTCY COURT ENTERED AN ORDER (THE "ORDER") PURSUANT TO 11 U.S.C. § 304. THE ORDER SHALL REMAIN IN EFFECT UNTIL JANUARY 23, 2006. A HEARING TO CONSIDER WHETHER THE ORDER SHALL BE CONTINUED BEYOND JANUARY 23, 2006 IS SCHEDULED TO BE HELD ON JANUARY 19, 2006 AT 10:00 A.M. (THE "RETURN DATE") BEFORE THE HONORABLE STUART M. BERNSTEIN, IN ROOM 723 OF THE ALEXANDER HAMILTON CUSTOM HOUSE, ONE BOWLING GREEN, NEW YORK, NEW YORK. ALL PAPERS SUBMITTED FOR THE PURPOSE OF OPPOSING CONTINUATION OF THE ORDER BEYOND JANUARY 23, 2006 SHALL BE FILED WITH THE COURT, WITH A COPY TO THE CHAMBERS OF THE HONORABLE STUART M. BERNSTEIN AND SERVED ON COUNSEL FOR THE PETITIONER LISTED BELOW, SO AS TO BE RECEIVED AT LEAST FOURTEEN (14) DAYS PRIOR TO THE RETURN DATE. ANY PERSON WISHING TO OBTAIN A COPY OF THE ORDER SHOULD CONTACT COUNSEL TO THE PETITIONER.

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IN THE HIGH COURT OF JUSTICE CHANCERY DIVISION
COMPANIES COURT No. 4436 of 2005
IN THE MATTER OF LA MUTUELLE DU MANS ASSURANCES IARD
AND IN THE MATTER OF THE COMPANIES ACT 1985

NOTICE IS HEREBY GIVEN that, by an order dated 12 July 2005 made in the above matter, the Court has directed that a meeting (the "**Creditors' Meeting**") of the Scheme Creditors (as defined in the scheme of arrangement mentioned below) of the above-named company (the "**Company**") be held on Monday 5 September 2005 at the offices of PricewaterhouseCoopers LLP, 1 Embankment Place, London WC2N 6RH, United Kingdom commencing at 12:00pm (United Kingdom time). All Scheme Creditors are requested to attend at such place and time either in person or by proxy.

The purpose of the Creditors' Meeting is to consider, and if thought fit, to approve (with or without modification) a solvent scheme of arrangement proposed to be made between the Company and the Scheme Creditors (in respect of marine insurance contracts written by the Company through its branch in the United Kingdom **only**) pursuant to section 425 of the Companies Act 1985 (the "**Scheme**"). Scheme Creditors may vote in person at the Creditors' Meeting or may appoint another person, whether a Scheme Creditor or not, as their proxy to attend and vote in their place. Corporations can attend the Creditors' Meeting only by proxy or by duly authorised representative.

Scheme Creditors are requested to lodge Voting Forms with The Scottish Lion Underwriting Agencies Limited at 5th Floor, Cutlers Exchange, 123 Houndsditch, London EC3A 7PQ, United Kingdom (marked for the attention of Steve Crawley) on or before 2 September 2005. Voting Forms may also be handed in at the registration desk at the Creditors' Meeting at any time prior to the taking of the poll at the Creditors' Meeting. A copy of the Voting Form, if sent by fax to The Scottish Lion Underwriting Agencies Limited (+44 (0)20 7626 6331, marked for the attention of Steve Crawley), or sent by email in ".pdf" format (or any other readily accessible form to **solventscheme@scottishlion.co.uk**), will be accepted if legible. However, the use of email is entirely at each Scheme Creditor's own risk and Scheme Creditors sending copy Voting Forms by email are advised to lodge or hand in the originals as set out above.

Copies of the Scheme and the statement required to be provided to Scheme Creditors pursuant to section 426 of the Companies Act 1985, as well as blank Voting Forms, may be obtained from the website (**www.mmaukbranchsolventscheme.co.uk**) or by contacting Steve Crawley of The Scottish Lion Underwriting Agencies Limited at the above address.

The chairman of the Creditors' Meeting will be Jeff Lloyd or, failing him, Steve Crawley, both of The Scottish Lion Underwriting Agencies Limited (or, failing them, another from The Scottish Lion Underwriting Agencies Limited).

The requisite majority for approving the Scheme is a majority in number representing three-fourths in value of the Scheme Creditors present and voting either in person or by proxy at the Creditors' Meeting. If approved by the requisite majority of Scheme Creditors, the Scheme will not become effective until the Court pronounces an order sanctioning the Scheme and an office copy of the Court's order is presented to the Registrar of Companies for registration.

Further information may be obtained by contacting Steve Crawley or Vanessa Robinson of The Scottish Lion Underwriting Agencies Limited, 5th Floor, Cutlers Exchange, 123 Houndsditch, London EC3A 7PQ, United Kingdom (Tel: +44 (0)20 7626 4266, Email: **solventscheme@scottishlion.co.uk**).

BI 07-25-05 A 13,14,15 7/22/05 5:49 PM Page 3

Code: Provisions to improve customer relations, practices

Continued from page 13

we have addressed these expectations," said ICA President Michael Hawker.

However, apart from the turnaround time provisions, the requirement to update policyholders on the progress of claims, and the requirement to make financial hardship payments, insurers are assuming hardly any substantive obligations that they do not already have under the law, according to Fred Hawke, a Melbourne-based insurance partner at law firm Clayton Utz.

"Between privacy law, financial services reform requirements, the Insurance Contracts Act and the Insurance Act, there is not much real change," he said.

"For example, access to information and the opportunity to correct mistakes is an obligation under the Privacy Act and having complaints addressed within 15 days is generally in accordance with Australian complaints standards," he said.

Syd Levett, general manager group insurance and risk for Melbourne-based packaging company AMCOR Ltd., said that although he welcomed the code because it provided the insurance industry with a focus, it would not have a significant affect on large policyholders. Those companies negotiate their own service agreements with insurance carriers and brokers, he said.

Chris Spraggon, group risk manager of Sydney-based energy provider AGL Ltd., said the code improved the insurance industry's image and but he agreed it did not do much for large corporations. "As a consumer of domestic insurance, the Code is positive, but as a risk manager of a major corporation it doesn't do much because you are big enough to negotiate your own terms," Mr. Spraggon said.

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- Established an effective system for communicating benefit programs to employees.
- Skillfully administers benefit programs through the application of technology.
- Develops in his or her career and promotes the advancement of the benefits management profession.

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

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LEGAL NOTICE

IN THE HIGH COURT OF JUSTICE CHANCERY DIVISION
COMPANIES COURT No. 4433 of 2005
IN THE MATTER OF THE SCOTTISH EAGLE INSURANCE COMPANY LIMITED
AND IN THE MATTER OF THE COMPANIES ACT 1985

NOTICE IS HEREBY GIVEN that, by an order dated 12 July 2005 made in the above matter, the Court has directed that a meeting (the "**Creditors' Meeting**") of the Scheme Creditors (as defined in the scheme of arrangement mentioned below) of the above-named company (the "**Company**") be held on Monday 5 September 2005 at the offices of PricewaterhouseCoopers LLP, 1 Embankment Place, London WC2N 6RH, United Kingdom commencing at 11:00am (United Kingdom time). All Scheme Creditors are requested to attend at such place and time either in person or by proxy.

The purpose of the Creditors' Meeting is to consider, and if thought fit, to approve (with or without modification) a solvent scheme of arrangement proposed to be made between the Company and the Scheme Creditors pursuant to section 425 of the Companies Act 1985 (the "**Scheme**"). Scheme Creditors may vote in person at the Creditors' Meeting or may appoint another person, whether a Scheme Creditor or not, as their proxy to attend and vote in their place. Corporations can attend the Creditors' Meeting only by proxy or by duly authorised representative.

Scheme Creditors are requested to lodge Voting Forms with PricewaterhouseCoopers LLP at Plumtree Court, London EC4A 4HT, United Kingdom (marked for the attention of James Allison) on or before 2 September 2005. Voting Forms may also be handed in at the registration desk at the Creditors' Meeting at any time prior to the taking of the poll at the Creditors' Meeting. A copy of the Voting Form, if sent by fax to PricewaterhouseCoopers LLP (+44 (0)20 7804 4349, marked for the attention of James Allison), or sent by email in ".pdf" format (or any other format readily accessible by email to **scottisheaglesolventscheme@uk.pwc.com**), will be accepted if legible. However, the use of email is entirely at each Scheme Creditor's own risk and Scheme Creditors sending copy Voting Forms by email are advised to lodge or hand in the originals as set out above.

Copies of the Scheme and the statement required to be provided to Scheme Creditors pursuant to section 426 of the Companies Act 1985, as well as blank Voting Forms, may be obtained from the website (**www.scottisheaglesolventscheme.co.uk**) or by contacting James Allison of PricewaterhouseCoopers LLP at the Plumtree Court address.

The chairman of the Creditors' Meeting will be Dan Schwarzmann or, failing him, Clare Whitcombe, both of PricewaterhouseCoopers LLP (or, failing them, a partner of PricewaterhouseCoopers LLP).

The requisite majority for approving the Scheme is a majority in number representing three-fourths in value of the Scheme Creditors present and voting either in person or by proxy at the Creditors' Meeting. If approved by the requisite majority of Scheme Creditors, the Scheme will not become effective until the Court pronounces an order sanctioning the Scheme and an office copy of the Court's order is presented to the Registrar of Companies for registration.

Further information may be obtained by contacting:

Steve Crawley or Vanessa Robinson of The Scottish Eagle Insurance Company Limited, 5th Floor, Cutlers Exchange, 123 Houndsditch, London EC3A 7PQ, United Kingdom (Tel: +44 (0)20 7626 4266, Email: **solventscheme@scottishlion.co.uk**), or

Bill Vince or James Allison of PricewaterhouseCoopers LLP, Plumtree Court, London EC4A 4HT, United Kingdom (Tel: +44 (0)20 7583 5000, Email: **scottisheaglesolventscheme@uk.pwc.com**).

LEGAL NOTICE

THE SCOTTISH LION INSURANCE COMPANY LIMITED
NOTICE OF THE CREDITORS' MEETING

NOTICE IS HEREBY GIVEN that a meeting (the "**Creditors' Meeting**") of the Scheme Creditors (as defined in the scheme of arrangement mentioned below) of the above-named company (the "**Company**") will be held on Monday 5 September 2005 at the offices of PricewaterhouseCoopers LLP, 1 Embankment Place, London WC2N 6RH, United Kingdom commencing at 10:00am (United Kingdom time). All Scheme Creditors are requested to attend at such place and time either in person or by proxy.

The purpose of the Creditors' Meeting is to consider, and if thought fit, to approve (with or without modification) a solvent scheme of arrangement proposed to be made between the Company and the Scheme Creditors pursuant to section 425 of the Companies Act 1985 (the "**Scheme**").

Scheme Creditors may vote in person at the Creditors' Meeting or may appoint another person, whether a Scheme Creditor or not, as their proxy to attend and vote in their place. Corporations can attend the Creditors' Meeting only by proxy or by duly authorised representative.

Scheme Creditors are requested to lodge Voting Forms with PricewaterhouseCoopers LLP at Plumtree Court, London EC4A 4HT, United Kingdom (marked for the attention of James Allison) on or before 2 September 2005. Voting Forms may also be handed in at the registration desk at the Creditors' Meeting at any time prior to the taking of the poll at the Creditors' Meeting.

A copy of the Voting Form, if sent by fax to PricewaterhouseCoopers LLP (+44 (0)20 7804 4349, marked for the attention of James Allison), or sent by email in ".pdf" format (or any other readily accessible form to **scottishlionsolventscheme@uk.pwc.com**), will be accepted if legible. However, the use of email is entirely at each Scheme Creditor's own risk and Scheme Creditors sending copy Voting Forms by email are advised to lodge or hand in the originals as set out above.

Copies of the Scheme and the statement required to be provided to Scheme Creditors pursuant to section 426 of the Companies Act 1985, as well as blank Voting Forms, may be obtained from the website (**www.scottishlionsolventscheme.co.uk**) or by contacting James Allison of PricewaterhouseCoopers LLP at the Plumtree Court address.

The chairman of the Creditors' Meeting will be Dan Schwarzmann or, failing him, Clare Whitcombe, both of PricewaterhouseCoopers LLP (or, failing them, a partner of PricewaterhouseCoopers LLP).

The requisite majority for approving the Scheme is a majority in number representing three-fourths in value of the Scheme Creditors present and voting either in person or by proxy at the Creditors' Meeting. If approved by the requisite majority of Scheme Creditors, the Scheme will not become effective until the Court of Session in Scotland pronounces an order sanctioning the Scheme and a certified copy of the Court's order is presented to the Registrar of Companies in Scotland for registration.

Further information may be obtained by contacting:

Steve Crawley or Vanessa Robinson of The Scottish Lion Insurance Company Limited, 5th Floor, Cutlers Exchange, 123 Houndsditch, London EC3A 7PQ, United Kingdom (Tel: +44 (0)20 7626 4266, Email: **solventscheme@scottishlion.co.uk**), or

Bill Vince or James Allison of PricewaterhouseCoopers LLP, Plumtree Court, London EC4A 4HT, United Kingdom (Tel: +44 (0)20 7583 5000, Email: **scottishlionsolventscheme@uk.pwc.com**).

FMLA: No release date set for DOL rulings on employee abuse of program

Continued from page 4

her own serious medical condition. Employers are required to maintain group health benefits during the leave, and once the leave is over to restore the employee to the same or an equivalent job.

According to a survey by the Washington-based Employment Policy Foundation released in April, an average of 14.5% of employees took FMLA leave in 2004, with employees in the health care, manufacturing, utilities and telecommunications industries its most frequent beneficiaries.

Employers and others say in general, the law is a good one. "It provides the opportunity to hire talented people that otherwise couldn't go to work for you," said Herb Greenberg, president and CEO of Princeton, N.J.-based Caliper Corp., a human resources consulting firm with about 190 U.S. employees.

The FMLA is used appropriately 95-97% of the time, said Susan O'Flaherty, vp of disability management services for J.P. Morgan Chase in Chicago. It is that remaining small percentage that "causes so many problems," she said.

One problem facing employers is the expanding definition of serious medical conditions. Observers say the law was intended to cover serious illnesses, such as heart disease, but has been interpreted to cover a host of minor conditions as well. "It's kind of over the years mushroomed out, and grown to incorporate a lot of other things, and was that the intent?" asked Ms. Marsden, who said employees have requested leave for ingrown toenails and colds. "At what point can we make a dividing line?"

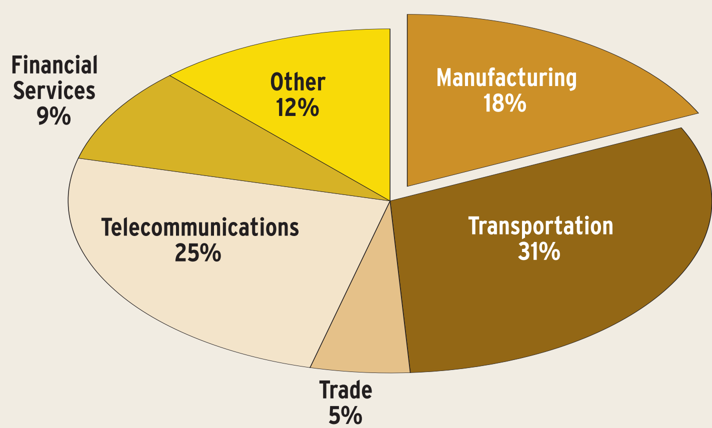
"I don't think anybody thought this was going to be a sick leave policy," said Chris Tampico, director of employment policy with the National Assn. of Manufacturers in Washington.

Observers say clearer guidelines are needed. "They obviously can't list every condition" and relatively minor conditions can become more serious, such as a cold developing into pneumonia, said Michael Eastman, director of labor law policy for the U.S. Chamber of Commerce in Washington. "But there at least needs to be more guidance about minor conditions, and when they don't qualify as serious health conditions," he said.

While determining the seriousness of medical conditions is subjective, employers would like to see the DOL "trying to narrow the scope a little bit," said Christine Walters, an independent consultant with the Glyndon, Md.-based FiveL Co.

> "I don't think anybody thought this was going to be a sick leave policy."
>
> **Chris Tampico**
> **National Assn. of Manufacturers**

Rich Gisonny, a principal with Towers Perrin in Valhalla, N.Y., said one suggestion has been to increase the time of incapacity required for a medical condition to be deemed serious to 10 days from three, which is the standard under the current FMLA regulation.



Source: Employment Policy Foundation analysis of EPF FMLA survey

Intermittent leave

Another problem is use of intermittent leave, where employees take their leave in increments rather than all at once. Under current regulations, in some cases employees can technically take as little as six minutes in FMLA leave at a time, which is not only a major administrative headache for employers, but can cause significant productivity issues as well.

According to the EPL, there has been an increase in the use of intermittent leave, which was intended to help employees who must undergo recurring procedures such as physical therapy, chemotherapy or kidney dialysis. A 2000 DOL survey found that only 25% of those employees who used the FMLA did so more than once annually. But by 2004, this had increased to 35%, according to the EPL.

Dr. Presley Reed, chairman and chief medical officer of Westminster, Colo.-based Reed Group LLC, a disability case management services firm, said that for some of his clients, 90% of employees who take FMLA leave do so on an intermittent basis. "It becomes a way of getting time off," he said.

There are employees who use FMLA leave to come in late every Monday, leave early on Fridays, or take time off around vacations or holidays, said Mr. Eastman. Coming in 15 minutes late to an office may not be an issue, but it can pose a problem in a manufacturing plant, where the employer may need everybody there on the assembly line to start it up, said Mr. Eastman.

Intermittent leave "provides a very convenient door for employees to more or less come and go without the kind of accountability and productivity an employer would like," said David Zaretzke, Friday Harbor, Wash.-based administrative services director for San Juan County, Wash.

One employee's use of intermittent leave for dental problems has been "going on for almost six years," said Sharon Scibek, director of human resources, at Rockville, Md.-based National Electrical Benefit Fund, a pension plan.

To address this issue, observers have proposed anywhere from one-hour to four-hour minimums. Ms. Marsden said requiring minimum one-hour increments would be "easier administratively to handle" than having to trace back shorter time periods.

It is not known when, or even necessarily if, the Bush administration will propose new regulations. The DOL has been expected to issue regulations in light of the 1992 U.S. Supreme Court decision in *Ragsdale et al. vs. Wolverine World Wide Inc.*

That opinion held that employers are not required to provide more than 12 weeks of leave under the Family and Medical Leave Act, even if they failed to notify employees that any leave they took would be counted against their FMLA entitlement.

Plans, but no policies yet

The DOL has said that it plans to issue regulations in response to this as well as other judicial decisions, and many expect it to more broadly address other employer FMLA concerns as well. However, a DOL spokeswoman said, "There hasn't been any decisions on polices or timing as of yet."

"They keep promising, and we keep hearing they're waiting for just the right time to make this technical correction," said Shelly Wolff, a national practice leader for health and productivity in the Stamford, Conn., office of Watson Wyatt Worldwide. Ms. Wolff said she had expected the proposed regulation to be released earlier this month.

Towers Perrin's Mr. Gisonny said the DOL may have delayed its proposal's release because of the controversy generated by the Fair Labor Standards Act regulations it issued last year. That experience could be causing the DOL "to think seriously and make sure they've sort of crossed their T's and dotted their I's before they try issuing these," he said.

Some are against the changes proposed by business groups. In April, more than 200 organizations, as well as federal legislators, wrote to the DOL on the issue. "We very strongly oppose changes that would make it more difficult for workers to take leave," said Kelly Ross, legislative representative for the AFL-CIO in Washington.

Monsanto: Court decision outlines principle, but not guidelines for plans' surpluses

Continued from page 3

be distributed, a spokeswoman for the Toronto-based company said. "We're still working out all the details," she said.

All employers affected by the decision are still struggling to determine the impact of the decision because the question of ownership of the surpluses remains unanswered. "The Supreme Court handed down a principle, but didn't hand down any implementation guidelines," said Paul Purcell, retirement leader for Mercer Human Resource Consulting in Toronto.

If a plan's documentation shows members own the surplus, employers simply have to determine the amount of the surplus and the method for distributing it, pension experts say.

The issue becomes more complicated if an employer is deemed to own the surplus, they say. Due to statutory requirements in Ontario, plan sponsors must gain the consent of members to distribute any surplus, even if the sponsor owns the surplus. This effectively forces employers to reach a surplus sharing agreement with members to gain their consent for the distribution, pension experts say.

"No employer can expect to get 100% of the surplus," said Barry Gros, a partner at Toronto-based consulting firm Morneau Sobeco.

Pension plan member groups are expecting an equal share of any surpluses and employers appear to be giving in to that demand, said Douglas Rienzo, a partner in the pensions and benefits department at Osler, Hoskin & Harcourt L.L.P.

"For many plans, we're seeing it cluster around this 50-50," he said. "That has the advantage of intuitively seeming fair to people."

Another issue arising out of the *Monsanto* decision involves the funding position of the plan. The plans directly impacted by the ruling all had surpluses at the time of the partial wind-ups, but many may now be in deficit positions, consultants say.

Regulators have indicated that they will not force a distribution if the plan sponsor can prove that the reason for a diminished surplus is valid, such as the downturn of the financial markets that has forced many Canadian defined benefit plans into deficit positions, lawyers say.

> "No employer can expect to get 100% of the surplus."
>
> **Barry Gros**
> **Morneau Sobeco**

"There could be a legitimate reason why the surplus is not there," Mr. Rienzo said. "If the reason for the disappearance of the surplus is legitimate, it's our understanding that will be the end of the story."

If an employer, though, used the surplus to take a contribution holiday or to provide benefits to members who are not part of the partial wind-up group, authorities could consider that an invalid use of the surplus and order funds be put back into the pension plan. "I think it's a very real possibility," Mr. Gros said.

The *Monsanto* decision has already had an impact on the way employers manage their pension plans. Several plan sponsors have decided to minimize the risk of creating future surpluses that they cannot control and are funding pension deficits at minimum required levels, Mr. Purcell said.

But speculation that the decision would lead to an exodus from defined benefit pension plans has not been borne out. A January study by Morneau Sobeco showed that only 9% of plan sponsors indicated they were considering converting to a defined contribution plan or terminating their defined benefit plan in response to the ruling.

The decision, though, provides an additional incentive for defined benefit plan sponsors to consider converting to defined contribution plans, consultants say. "*Monsanto* is part of the discussion, not the main issue," Mr. Gros said.

The full impact of the ruling will not be felt for many years with pension experts believing that the ruling will lead to future litigation. For example, member groups who believe they own the surplus will likely file lawsuits challenging any determination that the surplus is owned by employers.

In addition, member groups may also file lawsuits related to plans previously in surplus that are now in deficit positions, asking the courts to force the employers to divert more funds into the pension plans.

Another potential area of litigation comes from current members of the pension plan who feel the distribution of plan assets to former members adversely impacts their own pensions. "This is fertile ground for pension lawyers," Mr. Purcell said.

ACE: Improper accounting for finite risk deals causes insurer to restate results

Continued from page 1

Seven of the problematic finite contracts had an insufficient level of risk transfer to constitute insurance under rules established by the Financial Accounting Standards Board, ACE acknowledged, noting that the contracts should have been recorded as deposits. Another contract was struck between two ACE units, and certain reserves were not properly eliminated as part of the company's consolidation, the insurer said.

Six of the contracts have either expired or have been commuted, while two that were inherited through acquisitions remain in effect but will be treated as deposits going forward, ACE said.

During a conference call with analysts, ACE executives declined to identify the counterparties to the contracts and provided few details about individual contracts. They did say, however, that not all counterparties were insurance or reinsurance companies.

The executives also noted that of the eight contracts, three were accompanied by either written or oral side agreements that "reduced or eliminated the anticipated" risk transfer under the deals.

Those contracts with side agreements consisted of: one "buy side" transaction entered into by a company that ACE acquired when it bought the property/casualty operations of CIGNA Corp. in 1999; one "sell-side" transaction with a nonpublic company; and one inter-company transaction, Philip Bancroft, ACE's chief financial officer, said during the conference call.

In addition, two other contracts involved subsequent amendments made to the contracts that altered their degree of risk transfer, Mr. Bancroft said.

ACE said its investigation found no evidence of misconduct by current senior management or by members of the company's board. ACE did not elaborate on the issue of possible misconduct by others, and during the conference call, President and Chief Executive Officer Evan G. Greenberg said only that "we're neutral about anything beyond current management."

Mr. Greenberg also noted that "we don't expect anything additional" in terms of problems related to finite risk products, though the insurer "can't speak with certainty yet."

ACE noted in its statement that it has established certain internal controls whereby "buy side" finite risk contracts must be authorized by its CEO and "sell side" contracts will be subject to new guidelines and restrictions.

ACE will continue cooperating with ongoing state and federal regulatory probes, Mr. Greenberg said. The insurer plans to file an amended 10-K annual report for 2004 early next month and will release its second-quarter earnings next week.

Other insurers

ACE's restatement follows similar moves by other insurers that placed their books under scrutiny amid the growing investigations into the use of finite risk products.

At the center of finite risk investigations has been a $500 million retrocessional loss-portfolio deal struck between New York-based American International Group Inc. and Stamford, Conn.-based General Reinsurance Corp. AIG acknowledged it accounted for the transaction improperly, and in May restated more than four years worth of its results, reducing its shareholders' equity by $2.7 billion (*BI,* May 9).

Also in May, Chicago-based CNA Financial Corp. restated its results to correct for several reinsurance contracts with a Bermuda-based affiliate, causing a cut of $29 million to shareholders' equity; and two units of Zurich Financial Services Group in Australia admitted to misrepresenting financial reinsurance transactions over a five-year period.

ACE's move was expected, analysts say, and given the scope and profile of state and federal probes of finite risk practices, more such restatements are likely.

Mark Lane, a principal and research analyst with William Blair & Co. in Chicago, said that ACE's restatement "was not a big surprise."

"The entire industry has been the subject of a review of the accounting for nontraditional insurance products, or what's known as finite risk insurance," Mr. Lane said. "ACE is, or was, a relatively big player in the finite market."

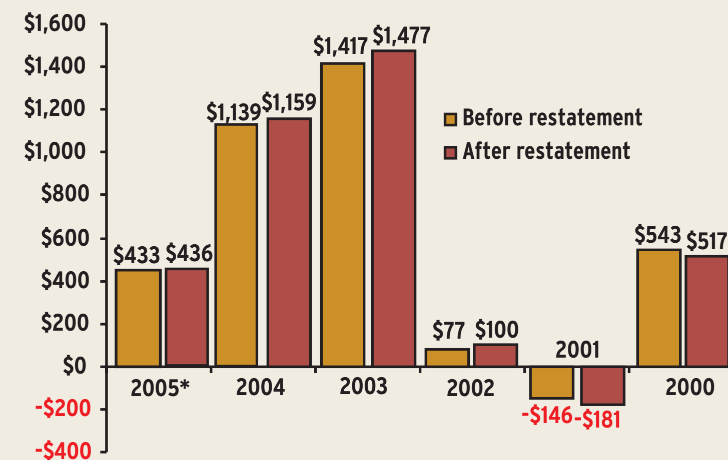
"It was a bit earlier than I had expected, but I'm not surprised that they had to do some sort of restatement," said J. Paul Newsome, vp and senior equity analyst with A.G. Edwards & Sons Inc. in St. Louis.

Mr. Newsome added that the fact that there was "a very modest affect on earnings suggests that they weren't playing around with the numbers."

Both Messrs. Lane and Newsome agreed that similar announcements should be expected from companies going forward.

But while such restatements bring companies one step closer to resolving regulator concerns, formal settlement agreements with regulators may not be reached in the short-term.

"The finite risk probes are quite broad, and are still going to continue for some time," said Mr. Lane. "It helps that (ACE) completed their internal review," he said, "but this is a broader industry issue."



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Harassment: Court decision opens new avenue for claims

Continued from page 3

action in other jurisdictions, said Gerald L. Maatman Jr., a partner in the Chicago law firm of Seyfarth Shaw L.L.P. Plaintiffs in other states will now argue that the California decision makes it reasonable for their courts to allow them to engage in discovery that could unveil similar practices, he said.

Court records show that in reaching last week's ruling, California's Supreme Court relied on a 1990 Equal Employment Opportunity Commission policy statement on employer liability. The EEOC said sexual favoritism could rise to the level of creating a hostile workplace in violation of the federal Title VII of the Civil Rights Act of 1964.

Courts nationwide have not given weight to the EEOC's policy statement, Mr. Maatman said. California's ruling, though, could change that, he added.

Hostile favoritism

The *Edna Miller* case involved a California prison warden who was accused of having sexual relationships with three employees while favoring them in job promotions, court records show. The warden retired following an internal affairs investigation that found widespread belief among prison staff that workers involved with the warden received favorable benefits.

Two plaintiffs in the case sued California's Department of Corrections for sexual harassment under California's Fair Employment and Housing Act, an anti-discrimination law. The women said they were unfairly impeded in seeking merit-based promotions, while better jobs went to candidates involved with the warden, even when those candidates were less qualified. The plaintiffs also sued for retaliation that occurred when they complained.

> "If I had a client who said they heard gossip that people were being affectionate in the workplace, I would follow up on that. You have to protect yourself."
>
> **Shannon B. Nakabayashi**
> **Morgan, Lewis & Bockius L.L.P.**

A trial court and an appeals court both found that the plaintiffs did not have standing to sue for sexual harassment. In particular, the appeals court said the plaintiffs did not meet the standard for such claims as they did not present evidence they had been sexually propositioned or that any sexual affairs were "nonconsensual."

The Supreme Court agreed that an isolated instance of favoritism on the part of a supervisor engaged with an employee may not constitute sexual harassment. But pervasive "sexual favoritism" can create a hostile work environment, the court found.

"It may create an actionable hostile work environment in which the demeaning message is conveyed to female employees that they are viewed by management as sexual playthings or that the way required for a woman to get ahead in the workplace is by engaging in sexual conduct with their supervisors or management," Justice Ronald George wrote for the court.

Before last week's decision, California plaintiffs could only sue for sexual discrimination under the FEHA if they were unfairly treated because of their gender, said Ms. Nakabayashi, a partner at Morgan, Lewis & Bockius L.L.P. in San Francisco.

By allowing lawsuits by men or women who claim they are merely exposed to sexual activity involving coworkers—rather than subjected to direct harassing conduct—the court dramatically increased plaintiffs' ability to sue for sexual harassment under the FEHA, she added.

Morgan, Lewis & Bockius filed an amicus brief in the *Edna Miller* case on behalf of the Employers Group, a Los Angeles-based employers association that focuses on human resource issues.

While the *Edna Miller* case is unusual because of the pervasiveness of sexual relations among the prison's staff, and even though the Supreme Court said an isolated incident or workplace gossip about an affair may not present a cause of action, employers must now investigate even rumors about workplace affairs, Ms. Nakabayashi said.

"If I had a client who came to me and said they heard gossip that people were being affectionate in the workplace, I would follow up on that," Ms. Nakabayashi said. "You have to protect yourself."

A plaintiffs attorney agreed. Employers now need to expand their examination of sexual harassment complaints and act when they hear even rumors of affairs involving a supervisor and preferential treatment, said Phil Horowitz, a San Francisco attorney and chairman of the California Employment Lawyers Assn. CELA also filed an amicus brief in the case.

The high court remanded the case to the appeals court for further proceedings consistent with its ruling.

Edna Miller vs. Department of Corrections, California Supreme Court; S114097.

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Screen: Employers offer financial incentives to workers for wellness efforts

Continued from page 1

pectation is that their health score improves the next year. And their score is solely based on medically derived biomarkers or metrics. It's all in the blood," Mr. Hodgdon said.

Perception vs. reality

While employees do answer a questionnaire, the responses are compared against the blood test findings to separate perception from reality.

For example, based on a study of 12,000 randomly selected questionnaires and screenings, 42% of people who said they didn't smoke tested positive for nicotine. In addition, 33% of those who perceived their health to be good had three or more clinical risk factors, according to Mr. Hodgdon.

All employees who take both the health risk assessment and the biometric test receive a confidential report that contains at least 25 pages of findings, as well as a score that is similar to an academic grade, with 100 points considered a perfect score and 70 an average score. Once employees have their score, they are expected to improve it by at least 5% each year to qualify for additional financial incentives.

"The recipe that's getting the most substantial outcomes is where the first year is the freebie, but the next year there has to be verified improvement in your health score," Mr. Hodgdon said. "The way it's promoted is that you're going to get a discount if you do it. That translates into a penalty if you don't."

Employers usually achieve about 80% participation by charging between $30 and $50 per month for individuals, and somewhere between $75 and $100 for family coverage.

"You've got to make it meaningful," he said.

"From what it appears Health IQ is doing, (it) is a step in a right direction," said Ryan Kennedy, chief executive officer of San Jose, Calif.-based Liberty Benefit Insurance Services. "If you do just the health risk questionnaire or assessments, a lot of people know what the right answers are, so very often that is not going to give you the total picture. If you couple some form of blood work with it, you get a more accurate picture."

But he questioned the fairness of penalizing individuals who did not make significant improvements in their health status.

"Most good programs have a financial incentive for participation, not 'did you actually change your health,' because several things could come up. One is the privacy issue. How are you going to report back that John Doe has a condition?" Mr. Kennedy said. There also could be allegations of age discrimination because people who are 55 are going to have lower scores than those who are 25, he added.

"No doubt, there's a massive correlation...incentive—however you go about doing it—and outcome. You do need to provide the carrot and stick approach. The question is, which carrots and which sticks?" he asked.

> "Part of the consumerism movement is employees and dependents knowing what their health risks are."
>
> **Paul Prickett**
> **Snap-on Inc.**

To prevent the possibility that its employees might find the blood testing component of the program an invasion of their privacy, Kenosha, Wis.-based Snap-on Inc. gave employees the option of taking the health risk assessment program alone, or in conjunction with the blood test, according to Paul Prickett, director of corporate benefits.

Health IQ usually doesn't unbundle the two components of the program, Mr. Prickett said.

"We had battled back and forth with the issue of confidentiality. We're going to know who took the tests, because we need to know that because of the way we (encouraged) employees to participate. We gave them a credit in their payroll contributions," Mr. Prickett said. "But we made it clear that we are not going to see individual results. We are only going to get aggregate results."

But arming employees with information is just the first step in a comprehensive wellness program, Mr. Kennedy said.

"It's important that you know there's a problem. Now what are you going to do to fix the problem is a much bigger issue," he said.

There should also be health coaching after an employee receives his or her test results, Mr. Kennedy said.

But Mr. Hodgdon insists that it takes the jolt of receiving results from a health screening to get some people into wellness programs, regardless of what the programs may have to offer.

"There's a lot of really good programs out there, but what we've found is everybody is challenged to get people to use them," he said. "We're able to drive people. We see ourselves as kind of a fuel additive. We're not gasoline that's going to make the engine run. But we're going to make everything in the provider mix for that participant run better."

As an example, Mr. Hodgdon pointed to the redistribution of risk that occurred within Westell's employee population when its employees started taking better care of their health.

"Its extreme risk population fell by 52%, and its high risk population fell 47%," he said. "All those decreases were gains in the minimal and the moderate (risk) population."

"It's like everything else. You could have the best tool set, (but) it's what you do with it. Westell has done a tremendous job of communicating the program to their employees. They presented this as a fiscal strategy," Mr. Hodgdon said.

Plexus Groupe Inc., a 40-employee benefits broker in Chicago, is using Health IQ's program to encourage healthy employees to join a high-deductible consumer-driven health plan that costs 15% less than its preferred provider organization plan. After two years, in addition to driving most of the healthy workers into the lower-cost plan, the company kept premium increases in its PPO flat.

"Our employees understood it because of the business that we're in. But we absolutely saw a change in people's lifestyles when they got their scores," said Mitchell Andrews, a partner at Plexus Groupe.

As an insurance broker, Plexus Groupe also is promoting the program to its employer clients.

"Employers need to take action. When employers cringe and say, 'I don't know if I can do it,' I say 'that's OK. But let's remember we've had this conversation when you see another premium increase next year.' This is an option they have available that isn't as onerous as cost-shifting. It also enhances productivity. Healthy people feel better and are more productive," Mr. Andrews said.

Snap-on considered productivity gains when it implemented the program last year.

"If employees are not able to be at work, they're not productive, and we've got to backfill them. And there's a huge cost to backfill them, especially if it's an unplanned-for absence. That gets expensive," said Mr. Prickett. "It's a health cost component" as well as the costs of absenteeism and presenteeism

Snap-On also invited employees' spouses to participate in the program, providing additional financial incentives if they took one or both tests, he said.

"We didn't really approach it as being a 'wellness' program. We approached it as part of our health plan. The idea was, we want employees to be aware of their health situations. And because they can enroll dependent spouses, we wanted to open it up to the dependent spouses as well," Mr. Prickett said.

The incentive ranged from $10 to $40 a month based on how many people participated and whether they took both the health risk assessment and the biometric test.

When the testing was conducted last fall, "we had forecasted we'd get 25% of participants to do it, but we ended up with more like 35% or 40%," he said. Moreover, "very few people did just the health risk assessment." As a result, "we had a huge walk up that we had not planned for," Mr. Prickett said.

Because fewer than half of its 5,400 eligible employees participated in the program, Snap-on probably won't provide an additional incentive for employees who improve their health scores, according to Mr. Prickett.

However, the company does plan to offer the incentive to participate again this year.

"We're going to most likely see more participation this year, and those people wouldn't have a baseline to start with," he said. But, "it's important for those people who took the test the first year to take it the second year, if they took action, to see the benefit of that."

"Part of the consumerism movement is employees and dependents knowing what their health risks are," Mr. Prickett said.

HIPAA provision lets employers offer discounts for wellness participation

Financial incentive programs tied to participation in wellness programs and improvements in health status became possible under a little-known provision in the Health Insurance Portability and Accountability Act of 1996.

Under HIPAA, group health in-

surance plans generally may not charge similarly situated individuals different premiums or contributions, based on a health factor. For example, people whose body mass index is low may not be charged a different premium or contribution to those having a high body mass index.

However, group health insurance plans are not prohibited from establishing premium discounts or rebates, or modifying otherwise applicable copayments or deductibles in return for "adherence to programs of health promotion and disease prevention." Such programs are often referred to as "bona fide wellness programs."

The following criteria, established by the Department of Health and Human Services, apply to "bona fide wellness programs":

- The rewards that are offered to an individual must be limited.
- The program must be reasonably designed to promote good health or prevent disease for the individuals in the program, and must give eligible individuals the opportunity to qualify for the reward at least once a year.
- The reward must be available to all similarly situated individuals, and a reasonable alternative standard must be made available for any individual for whom, due to a health factor, it would be unreasonably difficult to meet the initial standard (or for whom it is medically inadvisable to attempt to satisfy that standard).
- All plan materials that describe the terms of the wellness program must disclose the availability of a reasonable alternative standard.

"To the extent that employers make additional investments in programs that promote good health and employees participate in them, those employees who choose to participate in them should be rewarded financially," said Darren Hodgdon, founder and chief executive officer of Health IQ Diagnostics in Chicago. "This is what we encapsulated into our intellectual property, the business model of that."

Mr. Hodgdon's other company, LifeStart Wellness Network, has been designing and building corporate fitness centers since 1984. He created Health IQ while earning his MBA at Notre Dame University.

Health IQ was acquired by American Healthways, a Nashville, Tenn.-based disease management company, in June.

"Intuitively, people may misread into it that it's discriminatory," he said. "The model is really designed to reward people who take action regardless of their health status. It's those people who choose to do nothing that you have the ability to shift some more costs to."

"Essentially, anybody, regardless of their condition, should be able to manage those biomarkers. That can either happen through lifestyle changes or drug therapy. For example, individuals with genetically high cholesterol can take statins," he said, drugs which lower cholesterol levels.

Health IQ's program costs from $75 to $125 per participant.

For more information, visit *www.myhealthiq.com.*

—By Joanne Wojcik

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Pension: Proposal would tighten funding rules

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example, several provisions Sen. Grassley first introduced several years ago following the failure of one-time energy giant Enron Corp., which wiped out about $1 billion in 401(k) plan assets held by Enron employees.

The Senate bill would, for example, require employers to allow employees, after three years of service, to sell company stock their companies contributed as a 401(k) plan match. That requirement is a response to an Enron design in which employees could not sell company shares contributed as a 401(k) match until they were age 50. The lock-in resulted in employees watching helplessly as the value of Enron shares they held through the 401(k) plan plummeted in value as the corporation was engulfed in an accounting scandal.

There also are differences beyond the two bill's provisions. In the House, Ways and Means Committee Chairman Bill Thomas, R-Calif., earlier said he wanted to meld the pension funding bill to a broader bill that would restructure the Social Security program. A Republican Finance Committee aide said Sen. Grassley has no interest in linking the pension bill to one revamping Social Security.

In addition, Finance Committee staffers expect an effort to be made this week when the bill is voted on to amend the measure to give commercial airlines extra time to fund plan liabilities. The staffers, acknowledge, though, that an agreement on how such relief should be provided has not yet emerged.

Despite the differences, a congressional consensus is beginning to emerge on what should be the core elements of a pension funding reform measure, Washington observers say (see box).

"They are trying very hard to get something passed and the chances are reasonably good they will succeed," said Janice Gregory, vp-retirement policy at the ERISA Industry Committee in Washington.

Those core elements include:

- Higher PBGC premiums. Both measures would raise to $30 per plan participant the annual premium employers pay the PBGC. The Senate bill would put this increase in effect immediately, while the House bill would phase the increase in over five years for employers whose plans are at least 80% funded and three years for plans less than 80% funded.
- Faster amortization of plan liabilities. Both bills would require employers to fund liabilities over seven years. Employers now, in some cases, can amortize liabilities over 30 years.
- Curbs on benefit increases. The two bills would bar employers whose plans are less than 80% funded from increasing benefits.
- Overfunding. The Senate bill would allow employers to make tax-deductible contributions until their plans were 180% funded. The House bill would allow such contributions until the plans were 150% funded. Both measures are a significant change from current law that generally bars new contributions after a plan is 100% funded.

But the bills differ in several significant ways. For example, while both bills would base valuation of plan liabilities on rates of corporate bond rates of varying maturities and plan demographics, under the House bill the actual rate to be used would be a three-year average of bond rates. The Senate bill would not allow such smoothing, making it much more difficult for employers to predict how much they would have to contribute to their plans.

Comparing pension bills*

Issue	House bill	Senate bill
Liability amortization	Seven years	Same
Base PBGC premium	$30 with phase-in	$30 but with no phase-in
Benefit increases	Not allowed for employers with underfunded plans	Similar to House bill
Interest rate assumptions	Based on plan demographics and corporate bond yields	More complex than House bill
Overfunding	Contributions allowed up to 150% of liabilities	Contributions allowed up to 180% of liabilities
Cash balance plans	Protection from age discrimination suits	No provision but under discussion
Company stock in 401(k)	No provision	Requires employers to allow diversification after three years

*As passed by the House Education & the Workforce Committee and proposed by Senate Finance Committee leaders

BI Stock Index [7/18 - 7/22]

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

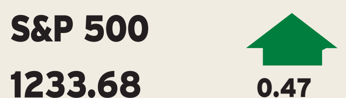
BI Stock Index 2598.29

-0.32

Dow Jones 10651.18

0.10

S&P 500 1233.68



0.47

Largest gains

Company	Change
Gainsco Inc.	10.67%
PMA Capital Corp.	8.00%
Baldwin & Lyons Inc.	5.99%
SCPIE Holdings Inc.	5.07%
United Fire & Casualty	4.36%

Largest losses

Company	Change
Aetna Inc.	-6.06%
Hilb Rogal & Hobbs Co.	-5.87%
CIGNA Corp.	-5.49%
USI Holdings Corp.	-5.41%
Humana Inc.	-4.36%

Weekly change by market segment

Segment	Change
Brokers	-2.07%
Insurers/Reinsurers	0.61%
Managed Care Organizations	-2.97%

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

Late News

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liable for employment discrimination, said the 9th U.S. Circuit Court of Appeals in San Francisco. A three-judge panel on Thursday unanimously affirmed a district court's ruling upholding a jury verdict that found Greg Young, chief executive officer of Austin, Texas-based BJY Inc., liable for employment discrimination when he continued to insist on calling Mamdouh El-Hakem "Manny" over Mr. El-Hakem's strenuous objections. Mr. Young had said that a "Western" name would increase Mr. El-Hakem's chances for success at the engineering firm and would be more acceptable to the company's clientele, court papers show.

Illinois enacts comp reforms

Illinois Gov. Rod Blagojevich last week signed compromise workers compensation reform legislation that calls for implementing a medical fee schedule indexed to the Consumer Price Index. The measure also increases some benefits, establishes a state workers comp fraud unit, strengthens fines for fraud and creates a work-stop order for employers that fail to obtain insurance.

Delaware cuts captive taxes

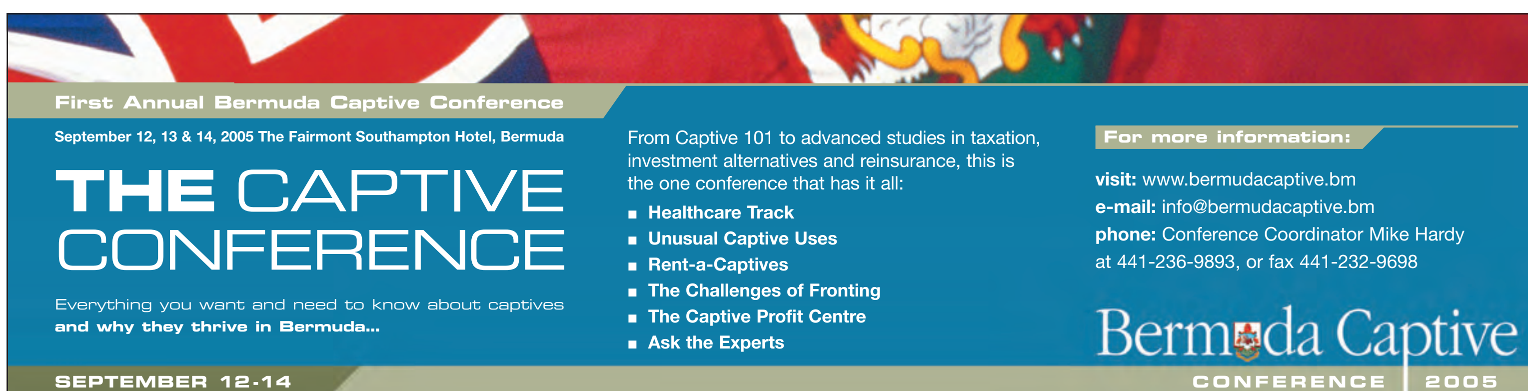
Under a measure signed by Delaware Gov. Ruth Ann Minner, captives' direct written premiums will be assessed a flat 0.2% tax, while a flat 0.1% tax will be assessed on reinsurance premiums. That is a significant reduction from prior law, in which the tax rate started at 0.7% for the first $20 million of premiums, then gradually declined. H.B. 218 also imposes new tax caps and allows sponsored or cell arrangements and so-called special purpose captives.

Ex-McKinsey partner to head Aon Consulting

Aon Corp. has named Andrew M. Appel as chief executive officer of Aon Consulting Worldwide. He succeeds Donald C. Ingram, who had "longstanding" plans to retire as Aon Consulting's CEO but will remain chairman, Aon said. Mr. Appel previously was a senior partner in the financial services and technology practices of consultant McKinsey & Co. Aon CEO Gregory C. Case, who replaced longtime chief Patrick G. Ryan in April, also joined the brokerage from McKinsey.

Ontario comp premiums up by 3% for 2006

Ontario employers will face the first increase in their workers compensation premiums in three years in 2006. The board of directors of Ontario's Workplace Safety and Insurance Board has raised the average premium rate for 2006 by 3% to $2.26 for every $100 of insurable earnings. The board blamed an increase in the unfunded liability—the difference between the total cost of the claims in the system and the funds in the system to pay for them—for the increase.



At *BusinessInsurance.com*

New **Online Poll**: Do you think employees are taking time off under the Family and Medical Leave Act for reasons beyond what the law intended?

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