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Aon revamps London fees

Broker says it will make its compensation clear

By SARAH VEYSEY and PETA MILLER

LONDON—Aon Ltd.'s plan to impose upfront charges on certain London market placements as payment for services provided to the market has been cautiously welcomed by risk managers and insurers.

Under the plan, the London-based unit of Aon Corp. will, for specialty business attaching on or after Jan. 14, 2005, charge a fixed percentage of premiums for services such as policy issuance and claims handling.

The announcement comes in the wake of New York Attorney General Eliot Spitzer's investigation into contingent commissions, which brokers have previously said were paid to compensate them for, among other things, services that they provided to the market.

Shortly after Mr. Spitzer sued Aon rival Marsh & McLennan Cos. Inc. alleging that it sought to maximize contingent commission payments through bid rigging and client steering, Aon announced that it would stop accepting contingent commission payments from underwriters. Such payments represented 1.6% of the company's revenues as of September 2004.

At the time of the announcement, Aon Chairman and Chief Executive Officer Patrick G. Ryan said: "We cannot permit even the slightest impression of a conflict between acceptance of these commissions and our paramount obligations to our clients."

Mr. Ryan added: "We will work closely with insurance carriers, regulators and other constituencies to establish a new business model that ensures appropriate linkage of compensation to specific, measurable services in a way that is transparent, accepted and understood by our

See **COMMISSIONS**/page 32

Beneficial side effects overlooked

Dental, vision plans aid in spotting illness

By JOANNE WOJCIK

The recent passage of legislation giving federal employees the opportunity to purchase dental and vision benefits on a voluntary basis demonstrates the often-overlooked value such benefits can play in the early detection of some serious diseases, such as diabetes, hypertension, cancer and osteoporosis, benefit experts say.

Because of surging medical benefit costs, though, many employers are cutting back on these other benefits, either reducing their contribution to the premiums or turning them into voluntary programs.

But when employees are required to pay 100% of the tab for dental and vision programs, participation rates fall, causing adverse selection. Only those employees most likely to use the benefits sign up for them, benefit consultants say.

In fact, adverse selection is occurring in some plans, which is leading to higher percentage-rate increases for dental and vision plans than for medical coverage, they say.

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PHOTO: GETTY

Benefit experts say the first proposed regulations for the Uniformed Services Employment and Reemployment Rights Act of 1994 will help employers reintegrate workers in the military reserves who are called to active duty.

Regulations expected to help as troops return

Guidelines welcomed on reservists' benefits

By JUDY GREENWALD

WASHINGTON—Proposed Department of Labor regulations to guide employers with workers who are returning after being called up for active military duty from the reserves may need some modification, but, once finalized, the rules will prove useful as companies strive to reintegrate these employees into their workforce, observers say.

The Uniformed Services Employment and Reemployment Rights Act of 1994 grants re-employment and reinstatement benefits to employees who leave their jobs for a period of military service. It was enacted in 1994, but no regulations for it have been proposed until now.

The issue has taken on some urgency because of events in Iraq and elsewhere. According to the Labor Department, more than 420,000 "citizen-soldiers" have been mobilized since Sept. 11,

See **RESERVISTS**/page 30

Late News

Drug reimportation often unsafe: Task force

Importing prescription drugs from abroad poses significant health risks, but a safer, government-regulated importation program would be costly and pass on

minimal savings to consumers, a report by a federally appointed task force says. "Some means of drug importation may be relatively safe in specific instances," the report says. But "there are significant risks associated with the way individuals are currently importing drugs." A large number of drug importation transactions are taking place through poorly regulated and sometimes bogus Internet-based operations that provide consumers with products that are inferior to U.S.-approved drugs, the task force said.

SEC probes Marsh's insurance investments

The Securities and Exchange Commission has launched a formal investigation into insurance investment funds managed by Marsh & McLennan Cos. Inc. The embattled brokerage said that it was releasing to the SEC information concerning related-party transactions in which directors and officers of the brokerage had an interest. The transactions on which the SEC requested information include those related to Trident Funds, which are private-equity investment funds managed by MMC Capital, a unit of New York-based MMC. The funds invest in insurance-related businesses.

Court blocks PBM accountability measure

The U.S. District Court for the District of Columbia granted the Pharmaceutical Care Management Assn. a preliminary injunction blocking the enforcement of a section of the district's Access Rx Act that would have required

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Spotlight

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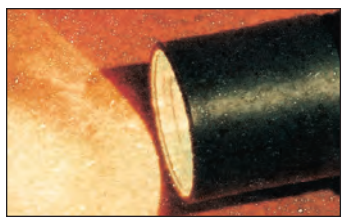

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FIRM BOOSTS ITS ASBESTOS FUND

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PNC to settle class action investor suit for $30 million

By RUPAL PAREKH

PITTSBURGH—PNC Financial Services Group Inc. has agreed to pay $30 million to settle a class action lawsuit brought by investors claiming that the banking company used fraudulent insurance contracts to improve earnings statements.

Pittsburgh-based PNC announced the settlement in a U.S. Securities and Exchange Commission filing last week.

The suit evolved out of a federal probe examining transactions between PNC and AIG Financial Products Corp., a unit of New York-based American International Group Inc., that in 2001 allegedly helped PNC hide losses through the transfer of $762 million worth of volatile, underperforming loans to three special-purpose entities.

Under the terms of the settlement, which is subject to court approval, "neither PNC or any of our current or former officers, directors or employees will be required to contribute any funds to this settlement," according to the regulatory filing.

PNC's four insurance companies will be responsible for paying the $30 million sum, which will be placed into a settlement fund for the plaintiffs.

Anchorage, Alaska-based American International Surplus Lines Insurance Co.—an affiliate of AIG's financial products unit—is one of the insurers; the remaining three were not disclosed.

AIG will submit an additional $4 million into the fund to resolve potential claims brought against it by plaintiffs.

A PNC representative did not return calls seeking comment on the settlement.

In addition to the PNC deal, AIG previously was charged with entering into a fraudulent contract with the Plainfield, Ind.-based telecommunications company Brightpoint Inc.

Last month, the insurer paid $126 million to the Department of Justice and the Securities and Exchange Commission to settle claims relating to both the PNC and Brightpoint deals, though AIG did not admit to any wrongdoing as part of the settlement (*BI*, Nov. 29). Of that sum, $46 million was allotted for an SEC restitution fund related to the PNC transactions.

PHOTO: AP/WIDEWORLD

A United Airlines proposal would create new defined contribution plans for its pilots, then terminate its existing pension plans.

Wary PBGC finds fault with United Airlines' pension plan changes

By JERRY GEISEL

WASHINGTON—United Airlines' plan to terminate its existing pension plans and replace them with lower-cost plans could face opposition from the Pension Benefit Guaranty Corp.

The agreement, which still has to be ratified by the financially distressed airlines' pilots, calls for United to create new defined contribution plans for the pilots and to give the pilots $550 million in notes that could be sold in the capital markets. Elk Grove Village, Ill.-based United then would terminate its pension plans, shifting the plan's $6.4 billion in guaranteed benefits to the PBGC.

But PBGC Executive Director Bradley Belt said the agency is concerned that the agreement could set what he describes as a "dangerous" precedent.

"The company is making generous new pension promises even as it is refusing to honor its old pension promises," he said in a statement.

"We will be scrutinizing this agreement very closely and will take all appropriate steps to protect the financial interests of the pension insurance program," Mr. Belt said.

The battle—verbal so far—between United and the PBGC is reminiscent of one that occurred in the mid-1980s when bankrupt steel manufacturer LTV Corp. said it could no longer afford to contribute to its pension plans. The PBGC then took over the plans. After LTV set up new, lower-cost defined benefit plans, the PBGC returned the original plans to LTV, an action ultimately affirmed by the Supreme Court.

In 2002, though, the PBGC ended up once again taking over the LTV plans, which had more than $2 billion in unfunded benefits, after LTV went out of business.

CGL coverage not forfeited in M&A, Ohio court rules

By DAVE LENCKUS

CLEVELAND—A company at the center of any kind of merger or acquisition does not lose its insurance protection for prior years of coverage, even if its policies do not contractually convey with it during a change in ownership, an Ohio appellate court has ruled.

The Dec. 17 decision, which reverses a lower court's ruling, is a victory for policyholders in an area in which there is only a smattering of conflicting case law.

In the case, The Glidden Co. is asking its comprehensive general liability insurers to cover its cost to defend against the lead paint liability claims it faces.

Many of its insurers, though, have rejected Glidden's claim, arguing that the company lost its cover-

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PHOTO: GETTY

The Glidden Co. is seeking coverage from underwriters that wrote the company's comprehensive general liability insurance from 1959 through October 1986 to defend against lead paint liability claims.

Inside Business Insurance

Halliburton must maintain Dresser's retiree coverage

Halliburton Co. must continue the more favorable retirement plans for ex-employees of its Dresser Industries Inc. unit, a court rules. **Page 4**

USI institutes cost-cutting measures

USI Holdings is cutting staff, ending leases and selling off some operations to reduce overhead. **Page 4**

Policyholders deserve a place at the table

While the transparency of compensation practices is important, the real key is inclusion of clients in the process, an editorial says. **Page 8**

Tenet settles charges of unnecessary surgery

Tenet Healthcare Corp. will pay $395 million to settle charges alleging unnecessary heart surgeries. **Page 26**

Unfair firing found, but no sex discrimination

A U.K. employment tribunal has ruled that a former Merrill Lynch employee was not the victim of sex bias but had been dismissed unfairly. **Page 25**

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- The **Datebook** calendar lists upcoming industry seminars and meetings and allows you to add info about your own event.
- Searchable **directories** provide access to all the listings of industry vendors found in *BI*'s Market Sourcebook.
- New **Opinion Poll** for readers: Do you think Social Security should be amended to allow participants to invest their contributions?

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Halliburton must keep Dresser's retiree coverage: Court

By JUDY GREENWALD

HOUSTON—Halliburton Co. cannot cut medical coverage for retirees at a company with which it had merged and must retain the more favorable retiree medical plans of the unit, a federal court has ruled.

Houston-based Halliburton, which merged with Dallas-based Dresser Industries Inc. in 1998, last year began to make changes to achieve parity in its medical plans for all retired employees, including retirees in Dresser's richer plans.

Halliburton's amendments would have eliminated health insurance coverage for 3,200 retirees over the age of 65 who were eligible for Medicare, effective Jan. 1, 2005.

The amendments also revised the prescription drug benefit for those retirees, although they would still have been given access to a prescription drug program toward which Halliburton would contribute $22 a month.

In January 2004, Halliburton filed suit against several retirees who challenged the change, stating that it was seeking a prompt resolution of the issue.

Judge Lynn Hughes, of the Southern District of Texas in Houston ruled that the merger contract between Halliburton and Dresser created a contract to continue the more favorable retirement plans for former Dresser employees, according to Halliburton.

Halliburton will report a fourth-quarter pretax charge of up to $13 million as a result of the judge's ruling.

In addition to reporting the charge, the company said it is considering its options, which include an appeal to the 5th U.S. Circuit Court of Appeals in New Orleans.

PHOTO: REUTERS

The merger agreement between Houston-based Halliburton Co. and Dallas-based Dresser Industries Inc. created a contract to continue benefit plans that were more favorable for former Dresser employees, a federal judge has ruled.

PHOTO: GETTY

Fort Worth, Texas-based American Airlines finds that its medical component cost per workers compensation claim is higher in Texas than in any other state.

Texas employers seek comp reforms

By ROBERTO CENICEROS

When Texas legislators convene in January, they will face employers seeking fundamental changes to the state's costly workers compensation system.

A state audit commission has already recommended that lawmakers scrap the Texas Workers Compensation Commission, the agency responsible for administering much of the system—a plan some employers endorse.

Employers and insurers also plan to push legislation that would allow them to direct injured employees to receive care from networks of medical doctors who would follow nationally recognized treatment guidelines. Currently, an injured employee in Texas can see any doctor of his or her choosing.

That has led to overutilization, fraud and employees not returning to work as soon as possible, employers say. It has also led to making Texas' workers comp system one of the most expensive for medical treatment delivery, they add.

For example, American Airlines' medical component cost per claim in Texas is 133% greater than it is in Oklahoma, 122% greater than in New York, 109% greater than in Florida and 30% greater than in Illinois, said Dan Hagan, managing director corporate affairs for the Fort Worth, Texas-based airline.

The cost comparisons are for the same jobs. Only in California, with its notoriously expensive system, do costs comes close, with expenses in Texas exceeding medical costs in California by 6%, Mr. Hagan said.

"It's really the fact that we have injured workers that are not getting good care or, in some cases, getting excessive treatment by certain providers," Mr. Hagan said. "That means they don't have good outcomes. They don't get back to work as soon as it might be good for them or good for us.

"That translates into higher costs," Mr. Hagan said. "The way to get costs in line is to get (employees) good care and back to work."

That does not appear to be happening.

A study released in November by the Cambridge, Mass.-based Workers Compensation Re-

See COMP/page 6

States ratify UnumProvident disability claims handling deal

By ROBERTO CENICEROS

CHATTANOOGA, Tenn.—Regulators in at least 40 states have ratified a national settlement agreement reached last month with UnumProvident Corp. over the disability insurer's claims handling practices.

Final adoption of the agreement required insurance regulators in two-thirds of participating states to sign off on the deal.

UnumProvident's life insurance units have 15 days from the ratification date to notify more than 200,000 qualified claimants of their right to seek the reassessment of claims closed or denied since Jan. 1, 2000, for reasons other than settlement, death or reaching benefit maximums, according to the Tennessee Department of Commerce and Insurance.

The reassessment of claims is also available for claimants requesting it for claims similarly closed or denied between Jan. 1, 1997, and Dec. 31, 1999.

Under the terms of the settlement, UnumProvident said it expected to pay $127 million in claims adjustments and other payments.

The payments include a $15 million fine.

In addition, the Chattanooga, Tenn.-based disability insurer agreed to change its claims handling practices.

The settlement stems from market conduct examination that allegedly uncovered several problems, including an inappropriate burden placed on claimants to justify benefit eligibility.

Although the agreement will settle regulators concerns, UnumProvident still faces individual and class action lawsuits alleging the company improperly denied or terminated disability claims (*BI*, Dec. 6).

USI cuts staff, operations in cost-reduction move

By JOANNE WOJCIK

BRIARCLIFF MANOR, N.Y.—USI Holdings is cutting staff, terminating leases and selling off some of its noncore insurance brokerage operations to reduce its overhead, the company said Tuesday.

The move is expected to save $5 million before taxes but will result in an $11 million charge to cover employee severance, lease termination costs and service contract terminations.

Among the operations that will be sold are specialized benefits services segments that either exhibit significant earnings volatility or do not fit with the company's core business strategy, according to a USI statement. The disposal costs are expected to produce a loss between $10 million and $13 million before taxes, according to company estimates.

USI also lowered its adjusted cash earnings per share guidance for 2004 to a range of from 96 cents to 98 cents, down from a range of from $1.03 to $1.18, reflecting lower-than-expected new business during December, the continuing softening of the property/casualty market and expenses related to ongoing insurance industry investigations by state attorneys general and other insurance regulators.

Despite its lower earnings projections, these cost-cutting moves should put the Briarcliff, N.Y.-based insurance broker in a stronger financial position than most of its peers, particularly since a large portion of USI's business is derived from employee benefits business, analysts say.

"Due to the steady increases in employee benefit costs associated with the rising health care delivery costs, the employee benefits segment revenue should help reduce the future pressures of a P/C cycle pricing decline in the future, creating a smoother earnings stream than its peers, in our view," said David Lewis, an analyst at SunTrust Robinson Humphrey in Atlanta, in an advisory issued following Tuesday's announcement.

Mr. Lewis said he also anticipates that USI will benefit from its 2004 acquisitions, including the previously announced acquisition of Summit Global Partners, which is expected to close early in the first quarter of 2005.

"We think management is making the right hard decisions," he said in his advisory.

M&A: CGL coverage not forfeited in sale

Continued from page 3

age when ownership of the company changed hands several times during the 1970s and 1980s in various merger and asset purchase transactions. The insurers argue that Glidden and its former owners did not obtain permission to transfer Glidden's coverage to its new owners and that anti-assignment provisions in Glidden's policies barred the company's former owners from unilaterally transferring that coverage during sale transactions.

Insurers in the case hoped the court would follow a 2003 California Supreme Court decision that precluded automatic coverage transfers in asset purchases. That court, though, allowed coverage transfers in certain kinds of mergers.

But the Ohio appellate court refused to follow that decision. Instead, it turned to a 1992 9th U.S. Circuit Court of Appeals decision and some dissenting opinions in pro-insurer rulings for guidance in ruling that insurance benefits follow liability in all successor liability situations.

The California Supreme Court decision is contrary to a longstanding principle that allows policyholders acquired in mergers or asset purchase transactions to retain their prior coverage without having to obtain the consent of their insurers, said policyholder attorney William Passannante, a partner with Anderson Kill & Olick P.C. of New York.

Before that decision, "no one went off to get the consent of their insurers, because everyone knew the rule had been that you can freely assign policy rights at the end of the policy period," said Mr. Passannante, who represented Glidden in the Ohio case.

While insurance policies contain anti-assignment provisions, those provisions are designed to prevent a company from assigning only an open policy to a different organization, according to Mr. Passannante. The provisions do not apply to policies covering a completed policy period, he said.

Insurer attorneys in the case did not return phone calls.

But Laura A. Foggan, counsel for the Complex Insurance Claim Litigation Assn., which filed an amicus brief in the case, disagreed with Mr. Passannante.

Ms. Foggan said the California ruling was in line with some of the limited case law on this issue and that there is no longstanding principle under which acquired companies automatically retain their coverage. She said that anti-assignment provisions apply to both closed and open policies.

Courts that have allowed automatic coverage transfers have done so in merger transactions in which only one entity could make a claim against the insurers that wrote coverage for the acquired entity before the transaction, Ms. Foggan said.

But the California court and others have recognized that allowing coverage to transfer in a partial asset acquisition of a company's division or unit unfairly changes the responsibilities of the acquisition target's insurers, Ms. Foggan said.

In such asset acquisitions, the seller might retain ownership of its former unit's policies but agree to allow its former unit to tap it to cover claims stemming from periods before the unit's sale. Glidden had such an arrangement with one of its former parent companies.

But following such transactions, third-party claimants likely would sue both the unit and its former parent, which likely would prompt both to seek defense coverage and indemnification from the unit's insurers, Ms. Foggan said.

An asset acquisition also could trigger disputes between the entities involved in the transaction, again prompting both to seek a defense and indemnification from the same insurers, Ms. Foggan said.

In the Glidden case, the company is seeking coverage from the U.S., Lloyd's of London and London market underwriters that wrote the company's CGL insurance from 1959 through October 1986. Glidden manufactured lead-based paint until 1974.

Between 1967 and 1986, though, Glidden's ownership and its position in its corporate parents' organizational structures changed several times through mergers and asset acquisitions. Glidden, originally an independent company and later a division of SCM Corp., ultimately was acquired by a subsidiary of London-based Imperial Chemical Industries P.L.C. after another company acquired SCM and sold off its operations in piecemeal fashion.

After its own series of corporate ownership changes, SCM survives today as Millennium Holdings L.L.C., which is a co-plaintiff in the litigation along with two of its subsidiaries.

The Ohio Court of Appeals ruled that while Glidden's coverage does not move with the company through its ownership changes under contract law, coverage for preacquisition liabilities does follow Glidden under the "operation of law" theory.

The court said its ruling does not create any additional risk for Glidden's insurers, because they were aware of the risk of mergers, acquisitions, asset sales and other corporate restructurings when they wrote Glidden's coverage.

"To find an insurance company is not obligated to provide coverage to a party that is liable for a risk the insurance company promised to insure against and for which they were paid an agreed premium would result in an unfair windfall to the insurance company," the court ruled.

The Glidden Co. et al. vs. Lumbermens Mutual Casualty Co. et al., Ohio Court of Appeals, Eighth District, Dec. 17; No. 81782.

Comp: Employers seek changes

Continued from page 4

search Institute found that injured workers in Texas received temporary disability benefits 50% longer than injured employees in the 11 other large states examined.

General Motors in 2001 spent $3,548 per employee for workers comp coverage at its Arlington, Texas, assembly plant, said Don Rich, GM personnel director for the facility.

In contrast, GM during the same period spent $1,437 and $1,182 per employee at manufacturing facilities in Oklahoma City, Okla., and Shreveport, La., respectively. At a Janesville, Wis., facility, meanwhile, GM spent $931 per employee for coverage, Mr. Rich said.

GM and American Airlines are members of Texans for Workers Compensation Reform, an employer workers comp advocacy group launched in October.

Winning the ability to contract with medical networks that employers could steer their employees to would help ensure that workers get the best care, GM's Mr. Rich said.

Additionally, Mr. Rich said, he could invite network doctors to visit his workplace. A firsthand look at the modified duty and ergonomics programs in place could make the doctors more comfortable in releasing injured employees to return to work, knowing they were not likely to reinjure themselves, he said.

Insurers also favor directing employees into networks, said a spokeswoman in Austin, Texas, for the American Insurance Assn.

"Costs need to be brought back into check, and networks are seen as the vehicle for doing that," she said.

How much control employers and insurers might gain over employee care is among factors lawmakers would have to determine.

One possibility calls for requiring an employee whose employer contracts for network services to receive treatment only from a doctor he or she chooses within the medical group. But that employee could change doctors within the network a certain number of times.

Or, perhaps, he or she could be allowed to obtain care outside the network after a certain amount of time, observers say.

Allowing an employee to change physicians once within a network if he or she is not happy with the treatment received would be reasonable, GM's Mr. Rich said.

Workers compensation treatment costs 'need to be brought back into check, and networks are seen as the vehicle for doing that.'

American Insurance Assn.

While organized labor wants workers comp system improvements, it may not be in sync with employers' desire for networks, the AIA spokeswoman acknowledged. A labor representative of the Dallas office for the United Auto Workers did not return telephone calls.

Making networks successful would require providing doctors with incentives to participate, said David Henkes, a San Antonio doctor and the chair of a Texas Medical Assn. ad hoc task force on workers comp.

Networks can't just aim to slash medical fees, Dr. Henkes said. Many Texas physicians already decline to treat workers comp injuries because of burdensome administrative requirements and payments that are too low.

The push for networks, though, has numerous supporters, including the Texas Workers' Compensation Commission. Having employees select among doctors within an insurer's network could address overutilization, return-to-work failures and high costs, the TWC said in a recommendation for the upcoming legislature, which convenes Jan. 11.

But the TWC—which administers key system functions such as benefits delivery, employer compliance and self-insured employer certification—is itself under fire and faces possible dismantling in the next legislative session.

A state sunset commission recently recommended that lawmakers transfer the TWC's regulatory authority to the Texas Department of Insurance. Other TWC functions also should be transferred because, among other problems, it has missed key opportunities to demonstrate direction and improve the system, the sunset commission found.

Under Texas law, all state agencies must undergo a sunset assessment, typically every 12 years, to determine whether they should continue to exist. The TWC recently underwent such a review in preparation for action by legislators, who meet every other year in Texas.

The Austin-based Texas Assn. of Business, the equivalent of a state chamber of commerce, supports the call to replace the TWC with a single commissioner, such as the state's insurance commissioner.

In a statement issued last August, the TAB called for the sunset commission to recommend dismantling the TWC. Noting that the TWC board is composed of an even number of commissioners who often philosophically split on issues, the TAB said that it is impossible to expect any major changes to surface from the organization.

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Editorial

Invite clients to the table

ONE ANSWER to the question of how brokerage firms will make up for the loss of contingent compensation has been provided by Aon Corp.'s London-based unit: upfront charges for services rendered to underwriters.

As we report on page 1, Aon Ltd. is planning to impose the new, transparent payment system in January for specialty business placed in the London market, and other brokers are expected to unveil new business models soon. This move is not surprising, but only time will tell whether Aon will or can adapt its London business model for use in other markets.

Aon "will work closely with insurance carriers, regulators and other constituencies" to develop a compensation system that is "transparent, accepted and understood by our clients," according to Aon Chairman and Chief Executive Officer Patrick G. Ryan.

While we agree that transparency is important, the real key is the inclusion of clients in the process. Brokerage clients need a place at the table, and insurance buyers need to voice their concerns to ensure that their interests are protected.

There are many constituencies involved in the purchase of insurance coverage, but it is the policyholders that pay for the coverage and they have the right to know and approve exactly how their money is spent.

In the past, while insurers and brokers justified between themselves the payment of contingent commissions, their clients were largely left out of the discussion.

As we've stated before, volume-based contingent compensation—disclosed or not—is a slippery slope and should be abolished. And many brokers, including Marsh Inc., Aon Corp. and Willis Group Holdings Ltd., have done so. No one can deny that brokers have a valuable role in placing insurance coverage and should be compensated for their services. But let's not lose sight of the problem that triggered New York Attorney General Eliot Spitzer's lawsuit and the ongoing investigation.

Informing clients of compensation practices and gaining their approval of those practices is key.

Let's shorten 'hellhole' list

THERE'S BAD NEWS and good news in the American Tort Reform Assn.'s recently released 2004 tally of "judicial hellholes."

As we reported last week, ATRA's third annual listing of jurisdictions—sometimes encompassing whole states—where defendants can't get a fair hearing in civil cases makes for some disturbing reading. Perhaps most disturbing is the fact that some of the same suspects keep popping up year after year. That's particularly true of Madison County, Ill., which earned the dubious distinction of first place in this judicial hall of shame for the second year running.

That's the bad news. And it's not only bad news for corporate defendants that find themselves the target of class actions filed in the hellholes. It's bad news for the citizens of the hellholes themselves. Imagine a multidefendant class action that could reap tens of millions of dollars for an aggressive attorney competing for docket space with your garden-variety personal injury case. Two words: good luck.

But there's good news in the ATRA report as well, news that would have seemed unimaginable even two years ago. First, the number of jurisdictions meriting the designation of judicial hellhole is getting smaller. Only nine were deemed bad enough for that appellation this year, compared with 13 in last year's report. That's still nine too many, but the shrinking list may indicate that the legal climate is improving.

And perhaps most significantly, Mississippi—home to some of the worst hellholes in previous years—is cited as an example of how conditions can change for the better, with the right combination of political leadership and public awareness of the impact of out-of-control litigation. Mississippi's transformation may not be complete, but it holds out hope for progress elsewhere.

ATRA provides a real service by spotlighting problem jurisdictions in its annual list of judicial hellholes. Shining a light on such places is the first step toward correcting abuses. We hope that continued attention will mean an even shorter list of hellholes next year.

Schillerstrom

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Letters to the Editor

Unum settlement fails disabled policyholders

To the editor: The multistate settlement between insurance regulators of Maine, Massachusetts, New York and Tennessee and UnumProvident Corp. regarding Unum's disability insurance claims practices is a crushing defeat for disabled policyholders. The other state insurance regulators should refuse to ratify it.

The agreement fails the more than 200,000 Unum policyholders whose claims have been denied or abbreviated in several ways:

- The multistate examination failed to achieve its stated purpose of determining whether Unum engaged in systemic "unfair claim settlement practices" in violation of state laws. Unum spokespeople have repeatedly emphasized that the report made no finding of violations of law or market conduct regulations. Unum is under no obligation to change its claims practices, which the settlement failed to repudiate.
- The agreement excludes policyholders whose claims were denied or terminated before 1997, as well as holders of policies sold by insurance companies that got out of the disability business and transferred their existing policies to Unum. This despite the fact that the claims practices prompting the investigation began in 1993 and were extended to policies assumed from other companies. The settlement may exclude more wrongfully denied policyholders than it includes.
- Disabled policyholders whose claims were denied or terminated from 1997-1999 will receive no personal notification of the settlement. Those whose claims were denied or terminated after 2000 will receive a turgid, confusing three-page letter informing them of their right to apply to have their claims reconsidered. The burden of reassessment is placed on disabled policyholders, many of whom have already fought long, confusing and exhausting battles against the company. In short, those who do qualify for relief under the settlement are not going to get paid. They are going to be sent back to run the claims maze once again.
- The settlement offers possible redress only to those whose claims were denied or terminated. Unum is known to pay many claimants for a short period, then arbitrarily end coverage and wrap the claimant in red tape. The settlement contains no provision to reopen settlements that may have been forced unfairly on claimants.
- Unum's claims processing practices were examined not by insurance regulators but, rather, by attorneys employed by insurance companies. The settlement fails to require Unum to change its claims practices in any specific way.

In this case, not even New York's attorney general stood up for the chiseled and cheated private consumer against powerful business interests. As is so often the case in insurance matters, the regulators proved themselves ruled by the regulated.

Eugene R. Anderson
Anderson Kill & Olick P.C.
New York

Year in Review – Employee Benefits

Top employee benefits stories in 2004

1. Interest in consumer-driven health care plans mushrooms
2. Group health care cost increases start to cool
3. PBGC's financial woes worsen dramatically
4. The drive to reimport lower-cost prescription drugs from Canada grows
5. IBM partially settles cash balance plan litigation and later phases out its plan
6. The Anthem-WellPoint merger gets a green light, creating the nation's largest health insurer
7. Employer interest in captive benefit funding arrangements grows
8. California voters overturn the play-or-pay health care law
9. Big employers start to move away from defined benefit plans
10. UnitedHealth Care continues its growth-through-acquisition strategy

Ongoing cost pressures increase challenge to maintain benefits within budget limits

Coping strategies include cost sharing, consumer-driven plans, patient education, drug imports

By RUPAL PAREKH

In 2004, health care cost inflation remained the foremost issue on benefits managers' minds. They wrestled not only with how to contain health-related costs for their employers but also with how to communicate benefits information effectively to workers.

The rising price tag on group health care plans continued to be the top concern, despite single-digit rate increases this year, the lowest uptick since 1999, according to a survey released last month by New York-based Mercer Human Resource Consulting.

"The biggest challenge we face is maintaining affordable health benefits for our employees," said Kip Wall, chief executive officer of the Office of Group Benefits for the state of Louisiana in Baton Rouge. "Trying to design health plans that will meet their needs and are within their budget is difficult," he said.

In order to lower premiums, the four health plans Louisiana state employees were offered in 2004 carried more restrictions, more cost-shifting to plan participants and a closed formulary prescription plan with mandatory generic drug coverage, said Mr. Wall.

Lea Gerber, director of risk and benefits management for Elixir Industries, a Gardena, Calif.-based manufacturing company, noted that "trying to keep our costs down but having to ask the employees to pay more out of their pockets" was especially tough for her this year.

"We did not raise the employee premium contribution," Ms. Gerber said, though the company raised employee cost-sharing for certain services. Copayments for Elixir employees went up from to $25 this year from $15 last year for routine doctor visits, while emergency room deductibles were raised to $150 from $50. "That's a significant increase," Ms. Gerber acknowledged.

Putting more cost pressures on employees, Ms. Gerber said, is that "some of the HMOs that were more reasonably priced have now gone out of business." Of Elixir's 1,300 workers, for whom the company subsidizes at least 75% of their health plan premiums, half are enrolled in the company's self-insured plan and the remainder are split between HMOs and preferred provider organizations. With fewer HMOs in the marketplace, Ms. Gerber said, she expects more employees in the future to move into the company's self-insured plan.

"Everybody's looking for answers on what to do. That's why consumer-driven health plans are the hot topic," said Michael Pikelny, employee benefits manager for Hartmarx Corp., a Chicago-based clothing manufacturer.

Indeed, "consumerism" and consumer-driven health care plans were embraced by some em-

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Recaps of top stories pages 14-18

Timeline of 2004 events page 19

Key newsmakers page 20

Benefits: Cost pressures call for coping strategies

Continued from page 10

ployers and employees in 2004, but not by others.

"Our philosophy is to try to provide different types of plans that are best suited to our employees and let them pick," said John Reschke, vp of employee benefits for Chicago-based Aon Corp.

Since Aon implemented a pilot CDHP in 2001, plan membership has grown from about 200 to nearly 3,000 in 2004, Mr. Reschke said. He added that the "dramatic increase in participation in that plan" that took place this year is encouraging. Mr. Reschke said he believes "there will be continued growth" among Aon employees participating in the consumerist model.

Mr. Pikelny, however, said that although the company has not altogether ruled out CDHPs as an alternative cost-control strategy, he personally is "not convinced that's the answer."

"We somehow need to provide our employees with better tools for negotiating health care," he said.

As workers are again and again forced to pay more for their health care, it is becoming harder for employees to understand and value their plan benefits, experts and managers say.

'It's very complicated and hard to communicate how plan members should make a choice that's in their best interest.'

Kip Wall
Louisiana Office of Group Benefits

According to Helen Darling, president of the Washington-based National Business Group on Health, not only is the cost issue not improving, "it's just gotten much worse." As a result, the employers she works with—including Johnson & Johnson, Ford Motor Co. and Microsoft Corp.—are grappling with major changes in benefits and the employee education process.

"It's very complicated and hard to communicate how plan members should make a choice that's in their best interest," Louisiana's Mr. Wall said. "After a while, it all sounds like alphabet soup."

When it comes to health care, "a lot of employers are spending a lot of money to communicate effectively to their employees," said Ed Kaplan, health practice leader for The Segal Co. in New York.

The goal is to "arm employees with decision-making tools," to foster smarter health care spending, Mr. Kaplan said. There is a trend right now of organizations turning to technology to convey health benefits information to workers, he said.

The Louisiana Office of Group Benefits, for example, no longer relies solely on group meetings to explain health care options to employees. "We're using more Web-based applications and have added additional information to our Web site, including video presentations," said Mr. Wall.

In addition, "we've provided all of our work sites with a DVD of our annual enrollment presentation that employees can take home or watch at work," he said. There is merit in the use of visual support tools to convey health plan designs and benefits, Mr. Wall said, especially among employee populations of "varying levels of education and sophistication."

"Next year, we want a Web-conferencing capability," he said, to "really drive home the point."

Some benefits managers took even more extreme measures to reduce health costs and explain their actions to workers.

"Affordable health care, specifically prescription medications," presented the biggest challenge this year, said David Hill, director of human resources for Caldwell County, N.C., in Lenoir.

While considering several cost-cutting strategies in 2004, Mr. Hill traveled to Canada to meet with a group of physicians and visit several pharmacies to explore a Canadian prescription drug option for the county's 525 employees. The county established a relationship with a pharmacy in Windsor, Ontario, and subsequently launched a prescription reimportation program that is billed each month for prescriptions filled for Caldwell county employees. The pharmacy is paid out of the county's health fund. Employees' copayments for Canadian drugs are half what they pay otherwise, he said.

Employees were notified that the Canadian prescription drug program, which covers only maintenance medications, is strictly voluntary, Mr. Hill said, but they were also informed about the potential savings. On the Canadian prescriptions, "we realize a 43% savings (over) what those prescriptions would have cost (if) purchased locally," Mr. Hill said. The combined county and employee savings average $7,000 per month, he said, and already, "10% of the workforce utilizes this option."

"Health insurance costs are going to rise. We can either sit back and let it happen or do something about it," Mr. Hill said.

Consumer-driven plans led benefit trends in 2004

1 Consumer-driven plans

While it was obscure just a few years ago, the term "consumer-driven health" definitively entered the vernacular of most benefit managers during 2004.

December's announcement that UnitedHealth Group was acquiring Definity Health Corp.—the Minneapolis-based startup that started it all—put an almost fitting cap on a year exploding with activity involving consumer-driven health care.

Just as the managed care movement got its jump start from federal health maintenance organization legislation in the 1970s, the passage of federal legislation authorizing health savings accounts, coupled with large-deductible insurance plans, has given the consumer-driven health movement a boost, benefits experts say.

Further growth is also expected following the issuance in July of the Treasury Department guidance resolving several key issues that employers had about HSAs and the re-election of President George Bush, a staunch proponent of this approach to financing health care (see story, page 24).

The release of several studies showing that consumer-driven plans may help curb runaway health care costs also served to remove a major roadblock stopping employers from offering consumer-driven health plans: lack of experience.

Further fueling interest in the consumer-driven concept among employers was the introduction of various permutations of such plans by veteran players in the health insurance market.

Today, more than 40% of health insurers either offer a consumer-driven product or have one in development. Even the Blue Cross & Blue Shield Assn. is getting in on the act, saying that, by the end of 2005, its member plans will be offering HSA-type consumer-driven health plans in 49 states and the District of Columbia.

Continued merger and joint-venture activity—such as Definity Health's sale to UnitedHealth, the partnership of Guardian Life Insurance Co. of New York and Oak Brook, Ill.-based Destiny Health; and North Richland Hills, Texas-based MEGA Life & Health Insurance Co.'s acquisition of Norwalk, Conn.-based HealthMarket Inc.—are also expected to create more options for employers.

While just 4% of large employers offered a consumer-driven health plan for 2004, 14% say they are likely to offer one beginning in 2005, and 26% say they may offer such an option in 2006. A recent employer poll conducted by *Business Insurance* found that 38.5% respondents plan to offer a consumer-driven health plan in 2005.

And enrollment in consumer-driven health plans—generally starting at about 10% of eligible employees in a given group—is expected to take off as more employees are exposed to the concept, attracted by innovative support tools made possible by technological advances and by the use of convenient debit cards.

While the Minneapolis-based managed care research firm InterStudy estimates enrollment in consumer-driven plans at somewhere between 1 million and 1.5 million in 2004, a recent report by Forrester Research Inc. of Cambridge, Mass., predicts that consumer-driven health plans will have 2.7 million members by the end of 2005 and will constitute as much as 24% of the health insurance market by 2010.

These new-fangled plans have even gotten the attention of the National Committee for Quality Assurance, the Washington-based organization that develops standards for measuring the quality of managed care plans. This year, NCQA announced that it was changing its accreditation program to reflect the evolution occurring in the health plan market.

Now, if only computer spell-check programs would stop turning the acronym "HSA" into "HAS," perhaps then consumer-driven health will truly become part of the American vocabulary.

—By Joanne Wojcik

2 Group health costs cool

When it comes to the question of where group health care plan costs have been heading, for the past few years the answer has been the same: up, by a lot.

This year was no exception. Several major surveys confirmed that continuing trend, with costs climbing at a rate several times higher than the overall increase in the cost of living.

Still, the news was far from all bad. In 2004, cost increases, while still hefty, slowed down dramatically. A Mercer Human Resource Consulting survey of more than 3,000 employers—the largest of its kind—found that group health care plan costs climbed by an average of 7.5% this year.

That was the smallest increase since 1999—when costs grew an average of 7.1%—and broke a three-year run of double-digit cost increases. Cost increases peaked in 2002, when they climbed by an average of 14.7%, and in 2003 they rose 10.1%.

The easing of health care plan cost increases, which was much greater than employers had predicted, was the result of several factors.

One major factor, experts say, was plan design changes implemented by employers that shifted more health care costs onto employees through higher deductibles and copayments. But employee cost-shifting, they say, also helped to control costs through employees' reduced use of services.

Additionally, smaller, fully insured employers benefited from a point in the underwriting cycle that saw both nonprofit and for-profit health insurance companies cut back premium increases from prior years.

At the same time, insurers and employers have been taking a variety of steps—big and small—to try to reduce the rate of cost increases. For example, Blue Cross & Blue Shield of Michigan has mailed out thousands of coupons to enrollees waiving copayments when they switch for the first time from certain brand name drugs to far-less-costly generics. That and other generic drug inducements has resulted in prescription drug savings of more than $125 million over the past three years, the plan says.

Health plans have reduced costs in other ways as well. This year, for example, the California Public Employees' Retirement System, that state's largest purchaser of health care services, excluded 38 high-cost hospitals from its largest health maintenance organization—a move that it expects will cut its health care costs by tens of millions of dollars annually.

Employers have been active as well.

Hundreds, if not thousands of them, especially smaller firms, have adopted various types of consumer-driven health care plans. Those plans feature high-deductible health insurance plans coupled to some type of savings accounts, which employees tap to pay for a portion of their uncovered expenses. Unused account balances can be rolled over to pay for succeeding years' expenses and, in the case of one type of account—health savings accounts—unused balances can be tapped to pay for retiree health care expenses.

It is too soon to know how significant a dent consumer-driven plans will make in health care cost increases, but many are hopeful that the increased adoption of the plans, along with other plan design changes, will make double-digit annual plan cost increases permanently disappear.

—By Jerry Geisel

3 PBGC's financial woes

Already ailing when the year began, the financial condition of the federal agency that guarantees pension plan participants' basic benefits dramatically worsened in 2004, with perhaps the worst financial news yet to come.

In November, the PBGC reported a $23.3 billion deficit, the result of assuming more than $14 billion in losses from the actual or probable terminations of underfunded pension plans. That helped to more than double its 2003 deficit and to produce the largest deficit in the agency's 30-year history.

And more big losses appear likely. As of Sept. 30, the close of the PBGC's fiscal year, the agency said it faced a "reasonably possible" exposure of $96 billion, which represents benefits in plans sponsored by employers with a below-investment grade rating.

Financially distressed companies have made no secret of their desire to jettison their costly pension plans and shift the liabilities to the PBGC.

Continued on next page

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United Airlines, for example, has said on several occasions that it intends to terminate its massively underfunded pension plans early next year. The folding of United's plans would cost the PBGC more than $6.4 billion, which would be the agency's largest single loss by far (see story, page 3). Another financially distressed airline—US Airways Group Inc.—intends to terminate pension plans covering machinists and flight attendants. Termination of those plans would cost the PBGC just over $2 billion, the agency estimates.

While the PBGC is bleeding badly, it is in no imminent danger of defaulting on its legal commitment—established by the Employee Retirement Income Security Act—to guarantee the benefits of participants in plans it takes over. The agency has more than $39 billion in assets.

But with more than $62 billion in benefit obligations, the time will come that the PBGC will default on its commitments. To prevent that from occurring, some benefit experts say the federal government will have to step in and guarantee benefits through a taxpayer-funded bailout, a move akin to its rescue of the savings and loan industry in the mid-1980s.

Alternatively, Congress could raise premiums employers with defined benefit plans pay the PBGC, which are used to help fund its termination insurance program. The risk of that approach, though, is that it could convince employers with well-funded plans to terminate them—which already is happening in some instances—depriving the PBGC of the income it so badly needs.

The huge problems facing the PBGC have not gone unnoticed by the Bush administration. The administration intends to submit to Congress a comprehensive proposal that would, among other things, strengthen pension funding rules, reducing the PBGC's exposure to future losses.

But whether Congress can agree on a comprehensive and effective PBGC reform package remains to be seen. Its last major reform package—enacted in 1994—proved ineffective in protecting the agency from big losses, as the PBGC's deteriorating financial condition illustrates.

—By Jerry Geisel

4 Push for Rx across borders

If brand-name prescription drugs cost 20% to 50% less in Canada, compared with the United States, why not have prescriptions filled with drugs from abroad?

That is a question many employers, especially state governments, have been asking for some time, and this year some of them went beyond the asking stage to implementation.

For example, Burlington, Vt., and Caldwell County, N.C., this year set up programs through which employees have the option of purchasing prescription drugs from Canada.

Other public entities are trying additional approaches. The states of Illinois and Wisconsin last month set up a program to enable their residents to purchase prescription drugs from Canada and Europe.

The program, called I-Save-Rx, operates through a Canadian drug clearinghouse in Tecumseh, Ontario, that obtains medications from a network of 45 pharmacies in Canada, Ireland and the United Kingdom. Illinois and Wisconsin residents can order medications using a Web site or a toll-free telephone number.

The savings, compared with retail prices in the United States, can be substantial, for one simple reason: other countries impose price controls on drugs, while the United States does not. Organizers of the I-Save-Rx program cite the example of Lipitor, a cholesterol-controlling drug. A three-month supply of Lipitor is available through I-Save-Rx for $180 from Ireland, compared with an average cost of $282 in the United States.

Minnesota and New Hampshire have also set up Web sites that enable residents to purchase drugs

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from Canadian suppliers, and other states and municipalities have been examining reimportation programs as a way to cut drug costs.

Such programs, though, are operating in a gray area. Under current federal law, the reimportation of prescription drugs by any entity other than the original manufacturer is illegal. The 2003 Medicare prescription drug law, though, allows the secretary of the U.S. Department of Health and Human Services to give waivers to individuals for reimportation if safety standards can be met. Thus far, no waivers have been issued.

The federal government, though, has taken no action yet against state governments that have worked to develop reimportation programs. Still, the potential for legal action has discouraged all but public entities to set up such programs.

Those uncertainties could ease in the coming year. A task force established by the federal Centers for Medicare & Medicaid Services is looking into the reimportation issue and could make recommendations soon.

In addition, federal legislators next year are expected to make a push to enact legislation to allow reimportation—so long as, among other things, safety concerns are satisfied.

But even if that were to occur, it isn't known whether manufacturers would be willing to boost production for other countries—a move that could eat into their profit margins—to satisfy the demand from U.S. consumers.

—By Jerry Geisel

5 Cash balance pensions

In 2004, IBM Corp. continued its battle to prove that its cash balance pension plan is legal, but it also decided to phase out the disputed plan.

The IBM plan triggered controversy from almost the first day the gigantic Armonk, N.Y.-based company put the plan in place in 1999, succeeding another defined benefit plan. Older IBM employees complained that the change in plan design would mean a huge loss in benefits compared with the benefits they projected they would have received under the prior plan.

Feeling the heat, IBM significantly broadened a transition rule, essentially doubling the number of employees who could choose to stay in the old plan or opt into the new cash balance plan.

But that didn't end the controversy. A group of employees filed suit, charging that the plan's design discriminated against older employees.

Last year, a federal judge in Illinois agreed. U.S. District Court Judge G. Patrick Murphy for the Southern District of Illinois said the plan was age-discriminatory, because the identical benefit credits and interest provided to an older employee and a younger employee would purchase a smaller benefit—expressed as an annuity payable at retirement—for the older employee compared with the younger employee.

Judge Murphy's decision was a bombshell. It captured national attention not just because of IBM's widespread name recognition but also because the ruling was so sweeping that, if affirmed, it would essentially invalidate all cash balance plans.

Congressional cash balance plan critics wanted to be sure that the Bush administration would take no action to ameliorate Judge Murphy's ruling. Rep. Bernie Sanders, I-Vt., in September successfully attached on the House floor an amendment to an appropriations bill barring the Treasury Department from taking any action, such as preparing court briefs, to assist in overturning Judge Murphy's ruling.

In the wake of that development, IBM reached an agreement with the plaintiffs to partially settle the cash balance plan litigation. Among other things, IBM said it would pay $320 million in the form of enhanced benefits to settle issues relating to a 1995 plan redesign.

Additionally, IBM said it would appeal Judge Murphy's ruling that the cash balance plan was age-discriminatory. If IBM prevailed, it would have no further liability. If it lost, its liability would be capped at $1.4 billion.

But while the litigation will proceed, IBM decided to phase out the cash balance plan. Citing, among other things, an uncertain regulatory climate, IBM this month said it would close the plan to employees hired on or after Jan. 1, 2005, and instead offer those new employees an enriched 401(k) plan.

That decision made IBM the largest U.S. employer to close out its defined benefit plan. Its action, some pension experts say, could finally prompt Congress next year to make clear that cash balance plans are legal, in order to forestall other employers, also tired of the legal uncertainty, from closing out their plans too.

—By Jerry Geisel

Timeline of notable developments in employee benefits during 2004

JANUARY

■ Alcatel Inc., the Plano, Texas-based operation of the French telecommunications company, announces it is phasing out its health care coverage for current and future retirees. The action is unusual, as few companies have eliminated coverage for current retirees. Alcatel, will still make coverage available, but, starting in 2006, will not pay any of the premium.

■ A California appeals court paves the way for voters to decide whether to repeal the state's "play or pay" law, which, when it goes into effect, would require larger employers to pay 80% of employees' health insurance premiums or contribute to a state fund. Later, voters narrowly approve the repeal referendum.

FEBRUARY

■ Sears Roebuck & Co., once a symbol of corporate benefits generosity, announces it is phasing out its defined benefit pension plan and will instead beef up its 401(k) plan. New employees and employees under age 40 will be enrolled in the enhanced 401(k) plan, while employees over 40 will have a choice between the two arrangements.

■ A legislative proposal by the Treasury Department would make clear that cash balance pension plans are a legitimate plan design, but employers converting existing traditional plans to cash balance would face new, potentially expensive requirements. For the first five years after a conversion, benefits earned by cash balance plan participants would have to be at least equal to what they would have earned under the old plan. Alternatively, employees would have to be given the right to choose between the two plans.

■ Legislation introduced in the British Parliament would create a government pension insurance program to guarantee benefits when companies terminate pension plans with insufficient assets to pay promised benefits. The program, to be funded by levies on employers with defined benefit plans, is loosely modeled on the pension insurance program in the United States that is administered by the Pension Benefit Guaranty Corp.

MARCH

■ Employers can provide less generous benefits to younger workers than to older ones without violating federal age discrimination law, the Supreme Court says. In its first ruling on so-called "reverse age discrimination," the justices rule that the Age Discrimination in Employment Act permits benefit plans to favor older employees over younger ones. The case involves a General Dynamics Corp. collective bargaining agreement that eliminated retiree health care coverage to all future retirees except current employees who were at least 50 years old.

APRIL

■ New Treasury Department guidance on health savings accounts says a broad array of benefits are preventive and therefore are not subject to the cost-sharing requirements of the high-deductible health insurance plan. Services considered preventive include annual physicals, routine prenatal and well child care and child and adult immunizations. Employers welcome the guidance, saying that it is highly cost-effective to impose no or low-cost sharing requirements on preventive services to encourage employee use, which can lead to the early detection of medical conditions that would be much more expensive to treat later on. Subsequent guidance lays down rules on the interaction of HSAs with health reimbursement accounts and flexible spending accounts and makes clear that HSA enrollees—not employers—have control of funds in the HSAs.

■ Ending a one-year legislative effort, Congress gives final approval to legislation that will allow employers to value pension liabilities using an interest rate based on a long-term corporate bond index. In 2004 and 2005, the new methodology replaces the current formula, which is based on the yield on the 30-year Treasury bond. The change, which will produce higher interest rate assumptions, will save employers tens of billions of dollars in contributions that otherwise would be required.

■ The Equal Employment Opportunity Commission approves a new rule that will allow employers to reduce or even eliminate health care coverage when retirees become eligible for Medicare, without facing age-bias claims from the agency. The rule, which still must be reviewed by several federal agencies before it becomes final, removes a threat to the plans that was ignited by a federal appeals court ruling in 2000 that effectively makes it illegal for employers to provide richer health care benefits to younger retirees than to Medicare-eligible retirees.

MAY

■ In an unusual move, the California Public Employees' Retirement System eliminates 38 hospitals it

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2004 newsmakers

When **Bradley Belt** joined the Pension Benefit Guaranty Corp. in April as its executive director, he surely knew how serious the agency's financial problems were. Only a few months before, the PBGC had reported an $11 billion deficit, the worst in its history.


Mr. Belt

But the news was to get a lot worse. In November, the PBGC reported its deficit had more than doubled, the result of an unprecedented $14.7 billion in losses from the actual or probable terminations of underfunded pension plans.

In the wake of the grim news, Mr. Belt said the important thing is for Congress to act on the PBGC and pension funding reform legislation the administration has been drafting. "The last thing we want to do is allow the situation to fester," he said.

"The hole will only get bigger," said Mr. Belt, a former senior congressional staffer and one-time executive director of the National Commission on Retirement Policy.

In its attempt to stop that "festering," the Bush administration reform package will include provisions to strengthen pension funding rules, revamp the PBGC's premium structure and give the agency new tools to better protect its insurance fund, Mr. Belt said.

***

As employers considered purchasing less-expensive prescription drugs from outside the United States as a way to control rising health care costs in 2004, one of the most outspoken supporters of the tactic was Illinois **Gov. Rod Blagojevich**.

Despite federal law prohibiting the reimportation of prescription drugs, the Illinois Democrat publicly encouraged a Chicago couple's lawsuit early in the year challenging that ban. But Gov. Blagojevich went even further.


Gov. Blagojevich

After announcing that he and Wisconsin's governor, fellow Democrat Jim Doyle, were trying to organize a group of states to reimport prescription drugs, Gov. Blagojevich ultimately unveiled a plan under which Illinois residents could purchase drugs from pharmacies in Canada and Europe.

Even as the U.S. Food and Drug Administration warned employers not to flout the law, citing concerns about the safety of non-FDA-approved drugs, Gov. Blagojevich was among the most vocal proponents of drug reimportation, vowing to move ahead with plans that he said would save hundreds of millions of dollars.

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With one pension legislative victory under his belt this year, **Rep. John Boehner**, R-Ohio, now has a much more ambitious goal in mind.

Rep. Boehner, who chairs the House Education and the Workforce Committee, played a key role in forging a compromise that led to passage this spring of stop-gap legislation that will allow employers this year and in 2005 to value pension plan liabilities using interest rates from a long-term corporate bond index. That temporary change from using interest rates based on the yield of the 30-year Treasury bond—which is no longer being issued—will save employers with defined benefit plans tens of billions of dollars in contributions that otherwise would have been required.


Rep. Boehner

But far more comprehensive reforms are needed to bring stability to the defined benefit plan system, which is troubled by a shrinking employer base and a financially shaky federal pension insurance program.

To that end, Rep. Boehner has begun working on a comprehensive reform package for introduction next year that is expected to strengthen pension funding rules as well as make clear that pension hybrid plans, like cash balance, are bona-fide plans.

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For **Cari Dominguez** and the Equal Employment Opportunity Commission—the federal agency she chairs, a long-running controversy involving retiree health care plans is nearing an end.

In April, the EEOC proposed adopting a final rule to exempt retiree health care plans from the Age Discrimination in Employment Act. The practical effect of the EEOC's action, which Ms. Dominguez has championed for three years, is to allow employers to provide lower health care benefits to Medicare-eligible retirees than to younger retirees, a practice that a federal appeals court in August 2000 said violated the ADEA.


Ms. Dominguez

If employers with retiree health care plans were forced to provide the same level of benefits to all retirees, the result would be a loss of benefits, because employers likely would cut back on their coverage for younger retirees or completely eliminate coverage for all retirees, Ms. Dominguez warned.

By exempting retiree health care plans from ADEA, the EEOC "is acting to preserve these valuable benefits for retirees," she said.

Adoption of the final rule is expected early next year, an EEOC spokesman said.

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Money, lots of it, can have an amazing away of changing people's minds, and that certainly was the case with California Insurance Commissioner **John Garamendi** on the merger of managed care giants Anthem Inc. and WellPoint Health Networks Inc.

For months, Mr. Garamendi had opposed the merger of Indianapolis-based Anthem and Thousand Oaks, Calif.-based WellPoint, saying that it did not represent the best interests of California health care consumers. But in November, Mr. Garamendi dropped his opposition in exchange for numerous financial concessions. Anthem alone agreed to contribute $200 million to medically underserved communities in California.


Mr. Garamendi

With those concessions in place, Mr. Garamendi, while noting that he still had "misgivings" about the ongoing consolidation of health insurers, dropped his opposition, setting the stage for what was the largest merger of health insurers ever and the creation of the largest health insurer—outside of Medicare—in the United States. The merged companies, which now operate under the name of WellPoint Inc., serve more than 28 million medical members.

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An attempt by a U.S. senator to create more legal certainty for cash balance pension plans has yet to bear fruit, but the effort is continuing.

Earlier this year, **Sen. Tom Harkin**, D-Iowa, launched what became a series of meetings to try to develop a consensus among employer and employee groups on rules for the plans. The failure to develop such a consensus would increase the likelihood that employers would freeze or terminate such plans and offer only defined contribution plans, Sen. Harkin said.

Sen. Harkin's observation was prescient. IBM Corp., the sponsor of what probably is the best-known corporate cash balance plan, announced this month that it is phasing out its plan because, in part, of legal uncertainties.


Sen. Harkin

While many meetings under Sen. Harkin's auspices were held, a consensus has yet to develop. Indeed, one major employer group—the American Benefits Council—has pulled out, saying congressional committees were the appropriate places to try to work out a deal.

Still, some say the give and take that has occurred at the meetings has created an increased awareness of differing positions, which could lead to the development of common ground.

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When Mountlake Terrace, Wash.-based Premera Blue Cross decided it wanted to convert to a for-profit company, it was Washington State Insurance Commissioner **Mike Kreidler** who said, in effect, "Just a minute, there."

In his opposition to the conversion, Mr. Kreidler joined a growing list of regulators who have queried the need for nonprofit health plans to change their status to for-profit insurers. He cited several reasons for his opposition to the Premera conversion, including the possibility that Premera would increase premium rates for small groups and individuals in eastern Washington, where the company has a large market share.


Mr. Kreidler

"I have concluded that investor-driven profit margins and goals would put subscribers and the insurance-buying public at an unacceptable risk for excessive rate increases," he said in a statement.

Premera denies this, and is appealing the decision. Meanwhile, the plan can hold no hope Mr. Kreidler will simply go away. The Democrat won re-election to a second term in November.

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Tony Miller, co-founder of Definity Health, is considered by many to be the inspiration behind the consumer-driven health care movement.

He is also a successful entrepreneur, having shaped his small, Minneapolis-based startup into an attractive acquisition target in less than five years.

And when UnitedHealth Group forked over $300 million to close the deal on Dec. 13, it enabled Mr. Miller to also be a promise keeper to the investors who provided the financial backing to turn his vision of a new type of health plan into reality.

"We've raised a lot of money, and part of my job is to return value to those who took a chance on us," he said during an interview earlier this year when *Business Insurance* named Mr. Miller, 37, to its 40 Under 40 (*BI*, Oct. 4).


Mr. Miller

Mr. Miller said he is particularly proud of the fact that he was able to convince investors to take a chance on his novel concept even after the "Internet bubble crash" of 2000 that negatively affected many young, fledgling firms not unlike his own.

"He's a visionary," described Scott Keyes, a consultant at Watson Wyatt in Minneapolis, reacting to the announcement in early December that Mr. Miller would be staying on at UnitedHealth post-acquisition. "When you're trying to do something like this and move a market, you need enthusiasm to fire people up, and Definity always fired people up."

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Treasury Secretary **John Snow** wasn't kidding when he said last year—shortly after Congress passed legislation creating tax-favored health savings accounts—that his agency would quickly issue guidance to aid employers interested in adopting the innovative accounts.

Within half a year—a pace that many say is unprecedented in the employee benefits regulatory arena—Treasury had issued comprehensive guidance addressing a slew of what had been unanswered questions about how HSAs can operate.


Mr. Snow

It is no surprise that Treasury acted as fast as it did. When a Treasury secretary says he wants action, regulators respond. As for Mr. Snow, his enthusiasm for HSAs is obvious. HSAs, he said, "are a terrific option that I think every American ought to consider."

That fast action by Treasury, many health care experts say, has been a key reason why health insurers have so quickly entered the HSA market and why employers now are beginning to adopt the plans.

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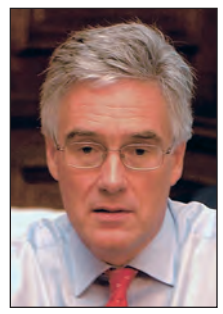
The first report of the U.K. Pension Commission—a 300-page document detailing the challenges faced by the United Kingdom's pension system—is commonly referred to as The Turner Report, after **Adair Turner**, the chairman of the independent, government-established commission and one of the report's authors.

The report, which has been widely hailed by experts as the most comprehensive look ever into the state of the pension system in the United Kingdom, found that about 9 million people are "failing to make provision that they will consider adequate when they retire."


Mr. Turner

Mr. Turner, a vice chairman of Merrill Lynch Europe and formerly director general of the Confederation of British Industry, warned in the October report, that companies and individuals must consider alternatives to the current system to avoid a huge problem of retiree poverty. And he urged employers to find ways to boost the take-up of occupational plans, such as automatic enrollment.

A further report, which will make specific recommendations, is slated for completion in the fall of 2005.

Timeline

Continued from page 19
says are charging excessively high rates from its Blue Shield health maintenance organization. The removal of the hospitals by CalPERS, one of the nation's largest purchasers of health care services, could save it $50 million a year. Critics of the move, though, say it will deprive plan enrollees from judging whether expensive hospitals are worth the cost.

JUNE

■ The design of cash balance pension plans does not discriminate against older employees, a federal judge rules. Judge Catherine Blake of the U.S. District Court for the District of Maryland, says the plans should not be considered age discriminatory as long as contributions are not reduced by age. Judge Blake's ruling, which involves a lawsuit against an Annapolis, Md.-based provider of transportation equipment, is the first since a federal judge in Illinois ruled that IBM Corp.'s cash balance plan violated age discrimination law.

■ Group health care plan participants cannot sue plans or employers in state court in coverage disputes, the U.S. Supreme Court says. The unanimous decision, written by Associate Justice Clarence Thomas, makes clear that coverage claims would have to filed under the Employee Retirement Income Security Act rather than under state laws, which, unlike ERISA, permits awards for noneconomic damages, including punitive damages.

JULY

■ Washington State Insurance Commissioner Mike Kreidler denies the effort of the state's largest health insurer—Premera Blue Cross—to convert to for-profit status. Mr. Kreidler says he was taking the action because of concerns that an investor-driven insurer would be more likely to raise rates excessively, as well as be a potential takeover candidate.

AUGUST

■ The state of Illinois launches a massive new plan in which state residents are able to purchase lower-cost prescription drugs reimported from other countries. Under the program, the state will contract with a prescription benefit manager to establish a clearinghouse of state-inspected and approved pharmacies and wholesalers in Canada, Ireland and the United Kingdom. The state says first year savings could be as much as $1.9 billion.

SEPTEMBER

■ IBM Corp. and thousands of participants in its cash balance pension plan agree to a partial settlement of a lawsuit charging that the plan is age discriminatory. Under the proposed settlement, IBM will appeal a 2003 federal court decision that the plan discriminates against older employees. If IBM loses, its liability will be capped at $1.4 billion, but if it prevails, IBM will have no additional liability. IBM later decides to phase out the controversial plan and instead offer new employees an enriched 401(k) plan.

OCTOBER

■ The Pension Benefit Guaranty Corp. has the authority to set plan termination dates, a federal appeals court rules. The decision by the 6th U.S. Circuit Court of Appeals—involving defunct steel bar manufacturer Republic Technologies International—says the agency can set plan termination dates to prevent it from being liable for so-called plant shutdown benefits.

NOVEMBER

■ After making key 11th hour concessions to satisfy state insurance regulators, Anthem Inc. and WellPoint Health Networks Inc. merge, creating the nation's largest health insurer. The combined company, which operates under the WellPoint name, will serve more than 28 million members. Some say the combination will help to keep health care costs in check because of the greater clout WellPoint will have with medical providers.

■ Group health care cost increases are slowing dramatically, according to a survey by Mercer Human Resource Consulting. The survey found that costs rose by an average of 7.5% in 2004, the lowest increase in five years and a break from a three-year run of double-digit cost increases.

■ The Pension Benefit Guaranty Corp.'s deficit more than doubles in fiscal 2004 to a record $23.3 billion as the agency incurs more than $14 billion in losses from completed or probable terminations of underfunded plans. Massive losses from the financially reeling airline industry are imminent, as United Airlines says it will terminate its plans next year and US Airways Group Inc is trying to do the same. Combined, the two airlines' pension plans are underfunded by more than $8 billion.

DECEMBER

■ Major appliance manufacturer Whirlpool Corp. withdraws from Labor Department consideration an innovative retiree health care benefits funding arrangement that would have used its captive insurance company, a tax-free trust and commercial life insurance. Under the plan, Whirlpool would have contributed at least $100 million to a voluntary employees' beneficiary association, which in turn would have purchased a group life insurance policy from Prudential Life Insurance Co. of America to insure retirees. The policy would have been reinsured by the Vermont branch of Whirlpool's captive. Experts said the arrangement could have generated several tax advantages for Whirlpool.

Between the Lines

Compiled by Joanne Wojcik

A star is hatched

The career of that lovable AFLAC duck appears to be taking off, as he waddles from television onto the silver screen.

Not long after being hailed as America's favorite advertising icon, the quacking thespian is making a cameo appearance alongside Jim Carrey in this year's holiday feature "Lemony Snicket's A Series of Unfortunate Events."

The placement in the Paramount Pictures-DreamWorks production is part of the Columbus, Ga.-based insurer's new branding campaign, which also includes a redesigned lowercase logo that incorporates the duck.

Perhaps the next step in the AFLAC duck's career is just around the corner on Hollywood's Walk of Fame.

Avoiding LiveStrong errors

A Florida hospital chain is removing or taping over patients' yellow LiveStrong wristbands because they are the same color as the "Do Not Resuscitate" bands it puts on patients who do not wish to be brought back to life if their hearts stop.

Fans of champion bicycle racer Lance Armstrong have been buying and wearing the bracelets to show their support for the foundation he created to raise money for cancer awareness and research.

"It could be confusing, particularly in the situation of a code or a cardiac arrest, where people have to think very quickly," explains Lisa Johnson, vp of patient services at Morton Plant Mease Health Care, a member of the hospital chain based in Tampa.

Fortunately, no fatal errors have been reported, Ms. Johnson said.

Most hospitals use color-coded bracelets to indicate patients' special needs to doctors, nurses or other staff. For example, purple bands may designate a patient at risk of falling, or red bands may warn of allergies. Not all hospitals use the same color-coded system, though.

Insurer backs blind musher

Nineteen-year-old Rachael Scdoris, the youngest musher to ever complete a 500-mile sled dog race and a woman twice honored as one of the 100 Most Outstanding Female Athletes in the nation, now aims to be first blind athlete to compete in the Alaska Iditarod Trail Sled Dog Race.

Rachael Scdoris and her sled dog team.

To help her achieve that goal, Portland, Ore.-based Standard Insurance Co. has awarded Ms. Scdoris a three-year sponsorship and has set up a Web site to track her progress while she trains for the world's premier long-distance sled dog race. The site will also give progress reports during the race in March.

"Rachael's story of triumph over many obstacles complements…Standard's core purpose as well as our supportive return-to-work philosophy that strives to help people with disabilities focus on their abilities and return to a productive and rewarding lifestyle," said Amber Lindsey, a public relations analyst for the insurer.

Standard, a unit of StanCorp Financial Group Inc., underwrites life and disability insurance on both a group and individual basis. For more information about the insurer and its sponsorship of Rachael Scdoris, visit *www.standard.com*.

President Bush opens HSA

It appears that President George W. Bush is, indeed, practicing what he's been preaching.

During closing remarks at a recent two-day White House conference on the economy, the president announced that he had opened a health savings account.

"I'm pleased to report that…health savings accounts are beginning to work their way through our markets," he said. "After all, I just signed up for one two days ago. When it makes it to my level, you know it's going to be widespread these days. But HSAs are making a difference."

Though the federal government provides health care services to U.S. presidents, the coverage does not extend to their dependents after they leave office.

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

Products & Services

St. Paul Travelers launches imported products lines

HARTFORD, Conn.—St. Paul Travelers Cos. Inc. has introduced a coverage program to protect U.S. companies from exposures they face when importing foreign products.

The Imported Products Program offers all lines of commercial coverage, subject to individual account underwriting. It is available to wholesalers, manufacturers, retailers and other businesses that are involved in foreign trade through the direct importation of items that are sold in the United States. The program guards against importing exposures such as inadequate safety standards, poor product quality or the inability to gain a foreign manufacturer's cooperation in the event of a claim.

The available primary limits are $1 million per occurrence, $2 million aggregate and $2 million products aggregate for general liability and $1 million combined single limit for auto.

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

Risk Sciences Group enhances RMIS program

SCHAUMBURG, Ill.—Risk Sciences Group, a subsidiary of Crawford & Co., has released an enhanced version of its risk management information system, Sigma Encore.

The Schaumburg, Ill.-based Risk Sciences Group's Sigma Encore 4.0 has been redesigned using Oracle, which provides greater speed and flexibility. Oracle is a relational database management system that stores data in the form of related tables, allowing users to access complex analytical reports that cover many different pieces of information.

The system also has been enhanced with new features, including an expanded data model, which includes reporting on nonfinancial fields such as providing summaries by location based on the location structure. Previously, queries could be performed only on financial values. Other enhancements include the addition of the My Reports portal, which contains search, save and management utilities; and enhanced template reports, which now include multilevel sorts, the e-mail distribution of report pages and report formatting.

Some of the standard features of Sigma Encore are OSHA reporting, policy management, certificate issuance and exposure management.

For more information, visit the company's Web site at *www.risksciencesgroup.com*.

EQECAT releases winter storm cat model

OAKLAND, Calif.—EQECAT Inc. has introduced a probabilistic catastrophe winter storm model, which quantifies and manages insurance exposures from snow and ice damage in the continental United States.

The winter storm model analyzes industrial, commercial and residential risk types and covers various storm occurrences, including ice storms and blizzards. It also features analyses of ice damage, roof damage and content damage and frozen pipes.

The model is based on historical storm data from 1961 to 2002 and uses more than 12,000 stochastic events. Winter storm parameters including wind speed, snow depth and snow and ice thickness are taken into account to calculate damage and insured losses.

Oakland, Calif.-based EQECAT collaborated on this model with John P. Woods Co. Inc., a Jersey City, N.J.-based reinsurance broker and subsidiary of Arthur J. Gallagher & Co. JPW provided EQECAT with claims data.

To obtain more information, visit EQECAT's Web site, at *www.eqecat.com*.

ConnectedCare introduces CDHP platform

BALTIMORE—ConnectedCare, a provider of outsourced benefit administration services, is offering a consumer-driven health plan Internet platform for employers.

The platform integrates health savings accounts, health reimbursement arrangements and flexible spending accounts. It allows employers to offer the accounts they choose, and it works in conjunction with any health plan.

The program provides online employee benefit enrollment; debit card accounts for health care-related payments; an employee communications program, consisting of group presentations, brochures and online health education tools; an advocacy services call center; online access to account balances, transactions and previous claims filed; and the ability to submit claims.

For more information, contact Baltimore-based ConnectedCare at 877-495-3341 or visit the company's Web site, at *www.connectedcare.com*.

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

James Hardie to boost asbestos fund

Plan to meet shortfall would cap payments at 35% of cash flow

By ELIZABETH FRY

SYDNEY, Australia—James Hardie Industries N.V. has agreed make up an estimated $1.5 billion Australian ($1.14 billion) funding shortfall to compensate victims of asbestos-related injuries making claims against the company.

The preliminary agreement with unions, asbestos victims groups and the New South Wales government will provide "long-term funding for asbestos-related personal injury claims," according to a statement from the building products manufacturer, which relocated from Australia to Amsterdam, Netherlands, in 2001.

The agreement, which still has to be approved by James Hardie shareholders, comes after months of criticism of the company, stemming from determinations that the $293 million Australian ($213.3 million) in funding for asbestos liabilities that the company established before its relocation would cover only a fraction of future claims.

James Hardie had maintained that the funds, held in the Medical Research & Compensation Foundation, were established following sound

See ASBESTOS/next page

PHOTO: NEWSPIX/MARC McCORMACK

James Hardie Chairwoman Meredith Hellicar at a press conference last week outlined her company's new proposed compensation package for victims of asbestos-related injuries.

Insurers not bending on U.S. knee implant settlements

By SARAH VEYSEY

LONDON—Medical manufacturer Smith & Nephew P.L.C. may take an exceptional charge of about £80 million ($155.1 million) in its fourth-quarter results to cover disputed excess product liability insurance.

London-based Smith & Nephew said the charge relates to current and potential future coverage denials for claims related to its knee implant products. The charge will cover all disputed and future claims related to the implants.

A spokeswoman for Smith & Nephew said that the claims arise from patients in the United States who received ceramic knee replacement implants manufactured by the company and later required corrective surgery after problems developed with a cement used around the implant.

The company said in a statement that, as of Nov. 30, of 2,971 patients who received the implants, 676 had undergone revision surgery. Settlements with 447 of those, amounting to £37 million ($71.8 million), had been reached.

Smith & Newphew added that it was too early to predict how many patients would need revision surgery.

The company said two of its excess insurers, whom it declined to identify, were disputing about £12 million ($23.3 million) in insurance claims related to the settlements. Smith & Nephew said the dispute centered on the level of initial disclosure made by the company to its insurers. The company noted that its primary insurer, which also participates in the excess coverage layers, was continuing to provide coverage.

"It is very concerning that two insurers have now declined coverage at this late stage," Sir Christopher O'Donnell, chief executive of the company, said in a statement. "We will take all steps available to us to enforce this coverage and to bring this matter to a satisfactory conclusion."

U.K. tribunal throws out gender bias claim but rules Merrill unfairly dismissed worker

By PETA MILLER

LONDON—A former U.K. employee of Merrill Lynch & Co. Inc. who filed a bias claim for £7 million ($13.6 million) against the financial services firm was unfairly dismissed from her job, but she was not the victim of sexual discrimination, an employment tribunal ruled.

The case filed by Stephanie Villalba, who ran Merrill Lynch's private client business in Europe in 2002, was one of the largest employment practices-related claims to be made in the United Kingdom.

Ms. Villalba had claimed that she was treated less favorably than her male colleagues doing comparable work. In addition, Ms. Villalba alleged that she was undermined and bullied by her line manager and that her dismissal in July 2003 was unfair.

Merrill Lynch contended that Ms. Villalba was removed from her position for poor performance and dismissed when no alternative position was found.

The tribunal ruled Wednesday that the dismissal was unfair and that Ms. Villalba was "shabbily and unreasonable treated."

"Employers have a responsibility for setting realistic and measurable standards of performance and for explaining these standards carefully to employees," the judgment said.

Employers must investigate when employees are found to be failing and provide them with training and allow them reasonable time to reach the standard of skill required, if that is what is lacking, according to the judgment.

"In the circumstances of the case, weighing all the factors and the lack of any procedures, we conclude that the dismissal was unfair," the judgment said.

According to the judgment, Ms. Villalba's "dismissal was not within the band of responses available to a reasonable employer in light of the circumstances and facts known."

Merrill Lynch, in a statement, welcomed parts of the decision. "We said from the start that this case was about performance, not gender," the statement said.

The level of compensation will be determined at a later hearing. No date for the hearing has been set.

PHOTO: EAP

In a closely watched case, a tribunal acquitted Merrill Lynch of bias but found the firm had unfairly fired executive Stephanie Villalba.

World Updates

Startup Glacier Re gets A- rating

Swiss startup reinsurance company Glacier Reinsurance A.G. has received an A- financial strength rating from A.M. Best Co. and a license to write reinsurance from the Swiss insurance authorities. Pfäffikon-based Glacier Re was launched earlier this month and plans to underwrite global specialty reinsurance business, including aerospace, catastrophe reinsurance, European property/casualty, marine and energy and war and terrorism. The company will write between $400 million and $500 million in gross premiums by the end of 2007, according to CEO Robbie Klaus.

Willis buys Mexican broker

London-based Willis Group Holdings Ltd. has bought Mexican insurance broker Maisterrena Asesores, Agente de Seguros y de Fianzas S.A. de C.V. Terms of the deal were not disclosed. Monterrey, Mexico-based Maisterrena has annual revenues of about $900,000, Willis said in a statement, and it serves mainly middle-market corporate clients.

JLT appoints two to board

Dominic Burke and Mike Hammond have been appointed to the board of Jardine Lloyd Thompson Group P.L.C. in London. Mr. Burke also has been appointed group chief operating officer for the London-based broker and will continue to be responsible for the company's U.K. insurance broking and employee benefits business, and for JLT Services in the United States. Mr. Hammond is the chief executive of JLT Risk Solutions Ltd.

E.U. amends pension accounting standards

An E.U. accounting standard for pensions that will be introduced next year has been amended to allow companies to immediately recognize actuarial gains and losses in their plans either in their profit and loss accounts or in separate reports. International Accounting Standard 19, with which all publicly listed companies in the European Union must comply beginning in January 2005, will allow companies to recognize gains and losses in their pension plans immediately or spread out over a longer period. Before the amendment, companies only had the option to account for such losses in their profit and loss statements. Under the amended IAS 19, when companies spread their gains or losses, they must immediately recognize those changes in a note to their accounts.

Asbestos: James Hardie to make up fund shortfall

Continued from previous page
actuarial analysis and that it was not obliged to provide any additional funding, despite mounting political pressure to do so (*BI,* March 8).

But later actuarial estimates found the MRCF would meet only a fraction of the asbestos-related claims that are likely to be made against the company.

As part of the agreement announced last week, James Hardie will:

- Make annual payments to a special-purpose fund on the basis of a November report by KPMG Actuaries, which estimated that the net value of present and future claims totaled $1.5 billion on June 30.
- Ensure that the special fund has a two-year rolling cash "buffer" and one year's contribution based on an annual actuarial assessment of expected claims for the next three years.
- Not impose a cap on individual payments to "proven claimants."

The company cautioned though, that payments to the special fund would be capped at 35% of the company's annual free cash flow, with provision for that percentage to decline over time depending on its financial performance and the claims outlook.

"The 35% level is designed to ensure that all proven claimants can be paid (while) preserving the financial health and growth prospects of James Hardie. All parties recognize that James Hardie's continuing success is crucial to the long-term security of the future payments," Meredith Hellicar, James Hardie's chairwoman, said in a statement.

'All parties recognize that James Hardie's continuing success is crucial to the long-term security of the future payments.'

Meredith Hellicar
James Hardie Industries N.V.

The agreement in principle will not become binding until James Hardie's bankers and shareholders approve a more detailed proposal. Ms. Hellicar said shareholders will consider the proposal at a general meeting in mid-2005.

James Hardie announced that it increased funding for asbestos claims in July, shortly before a special commission of inquiry—set up by the New South Wales government earlier this year to investigate the company's 2001 restructuring and relocation to the Netherlands—was supposed to make all inquiry submissions public. The commission—which was to assess whether James Hardie knew it had set aside insufficient funds to compensate asbestos victims—was due to report its findings the New South Wales state government on June 30 but was granted an extension to Sept. 21. The special inquiry found in September that James Hardie misled investors when it said in February 2001 that funding was sufficient to compensate asbestos victims.

Dennis Cooper, the managing director of the MRCF, said he looked forward to the next step, which would require the foundation to become involved in more-detailed discussions about the finer details of the proposed settlement and the mechanisms that will be required to ensure that the promises contained in the agreement can be delivered.

"We see this as a landmark day. It's also a vindication of the process we began in early 2001, when we first drew James Hardie's attention to the looming funding shortfall," Mr. Cooper said in a statement.

Tenet to pay $395M to settle charges of unnecessary surgery

SANTA BARBARA, Calif.—Tenet Healthcare Corp. will pay $395 million to settle charges brought by hundreds of patients alleging unnecessary heart surgeries were performed at a former facility of the hospital chain.

According to the company, more than 750 civil lawsuits were filed against Santa Barbara, Calif.-based Tenet by former patients who claim certain physicians practicing prior to November 2002 at Redding Medical Center in Redding, Calif., a former Tenet subsidiary, had unnecessarily performed cardiac catheterizations and heart bypass surgeries.

Lawsuits filed against those doctors are not included as part of this settlement. In July, Tenet sold Redding Medical Center to Shasta Regional Medical Center L.L.C., an affiliate of Charlotte, N.C.-based Hospital Partners of America Inc.

Under the terms of the proposed settlement agreement—pending approval in California state court—Tenet, by the end of December, will establish a $395 million settlement fund to be dispersed among the plaintiffs.

How the settlement will be funded remains to be seen. Tenet's general liability insurance companies have thus far denied coverage for the settlement, a spokesman for the health care company said. He declined to name the insurers but said that Tenet plans to "vigorously pursue" its coverage rights.

In 2003, Tenet paid a total of $54 million to the federal government and the California state government to end criminal and civil investigations of practices at the Redding center.

—By Rupal Parekh

Taking Stock

Santa agrees industry needs transparency

By Myron M. Picoult

I found the following letter in my stocking on Christmas morning and I thought our readers might be interested in seeing it:

Hi, Picoult.

I have heard about you and your relentless pummeling of Almost Donothing, the former pitiful CEO of the Nearly Defunct Fire & Casualty Insurance Co. There were times that I thought you were a bit rough on the old boy, but I have now seen for myself that your criticisms were not too far off the mark.

You may remember that last Christmas, I decided to retire and move to the Cayman Islands, and I turned over the reins of the sleigh and the North Pole to Almost Donothing. Indeed, the red suit fit like a glove! After all, I was busting my buns all year long, while Almost was, in essence, retired, but didn't know it.

Anyway, things went smoothly for a several months and I was really enjoying my beachfront condo on Seven Mile Beach. However, I must admit there were times that

I missed the frenzy and hustle bustle of preparing for Christmas. In early June, I received a panicked call in the morning from Sly DeVil, the lead director of Nearly Defunct Fire & Casualty, and later that day, a call from Mr. Useless himself, Almost Donothing, who was completely tangled in his shorts about preparations for Christmas 2004, including the projected inventory of some newly minted toys. I decided to fly up North to visit DeVil and then go on to Almost Donothing at the North Pole.

Sly DeVil was ghostly when I entered his Munchburg law office. He begged me to come on board as a consultant to Nearly Defunct Fire & Casualty. It seems that the board's search for a new CEO was not bearing any fruit. There were only a handful of candidates around and those who came in for a sniff took off real quick after they surveyed the state of Nearly Defunct. The company was basically rudderless. There was no marketing direction, Sarbanes-Oxley internal control regulations were proving to be a killer and industry pricing was rolling over. The board was clearly in a pickle and needed help. I thought to myself as he was talking, "Couldn't happen to a nicer group of guys!" Well, I kind of felt bad for DeVil, so I agreed to do some consulting for a pretty penny plus expenses.

I choked up some as I approached the North Pole. It really hit me when I went into the toy factory and was literally mobbed by many of the elves who worked so hard for me over the years. It quickly became clear that Almost Donothing was in a panic as he came to realize that all the folks at the toy factory required some direction and he didn't have a clue where to start. The state of Nearly Defunct Fire & Casualty attested to this. Almost Donothing pleaded with me to take back my old job. Since I was going to be in the States for a while, I figured I'd help him out with some free consulting. I was doing this for the ever-industrious elves and all the kids who were going to miss out on toys at Christmas, because of Almost Donothing's ineptness.

I flew back to the Caymans for a few weeks to work on strategy for both clients and to enjoy the beach again. Little did I know that my involvement with DeVil and Almost would prove to be more time consuming than I initially expected. Furthermore, I did not know that Hurricane Ivan would basically total my condo, swamp my boat and wash my car into the ocean. In reality, staying in the States during the cleanup and rebuilding in the Caymans was to be a blessing in disguise.

When I sat down with Sly DeVil a week later, he readily acknowledged that, at best, the management team of Nearly Defunct was lackluster. He admitted that there was a lack of leadership and that employees did not feel empowered, and they didn't want to make decisions. To this day, I remain amazed that the board was not canned by shareholders. The directors were as much to blame for what has happened to the company as the old chairman. Nearly Defunct Fire & Casualty basically floated along in 2004 from the benefits of the industrywide rise in prices and tightened underwriting standards of the past few years. However, it was unclear if all of the landmines had been found and whether the balance sheet could absorb any unforeseen hits. Furthermore, cash was flowing out to the accountants as they tried to get the company compliant with the Sarbanes-Oxley legislation. With respect to Almost Donothing's predicament, it was clearly related to dire lack of leadership skills again. You know, when a fish rots, it rots from the head down.

Let me get to the points I wanted to share with you. I really thought the consulting gig with Nearly Defunct would be tied to guiding them through the inevitable decline in the pricing cycle and helping to instill some underwriting discipline. From my perspective, that is critical to the industry if it wants to change the perception that it basically bounces from one crisis precipice to another and can develop some consistent ROEs. I never thought I would be dealing with the likes of Sarbanes-Oxley, the broad-based investigation by New York Attorney General Eliot Spitzer dealing with allegations of fraud and bid rigging, the political opportunism of other officials and the horrendous state of the industry's technological capabilities.

I'm sorry, Picoult, but I have to get this off of my chest before I take Rudolph and the crew up to deliver the toys. You got it! Almost Donothing can't do squat, so at the last minute, I have to fill in. He's useless. He is just one of the elves—somewhat fatter than the others—filling up the sleigh with presents.

Let's get this out of the way. Pricing in the market stinks. All the surveys show prices declining across most lines. Does it make sense? No. But when does anything in this business make sense? It is going to be interesting to see if the recent announcement from Lloyd's of London that its capacity to underwrite business in 2005 will shrink by 9% is going to be a bellwether for the industry. I guess only time will tell.

The Sarbanes-Oxley legislation is a real pain. I understand why it was passed in July 2002 and that it is essential to maintaining investor confidence. That said, the cost is off the wall in terms of both money and management time. By the way, has anyone addressed what creates so much corporate

greed?

Clearly, there has to be a more balanced approach about enforcement of the statute. I have seen the difficulties to become compliant on SOX 404, which is the internal controls segment. Nearly Defunct Fire & Casualty is a relatively small company in terms of both premium writings and capital. It is costing us an additional $1 million to get SOX 404 off the ground. Yeah, I know we have to do it, but the required time frame is unrealistic. Furthermore, our people resources have been stretched to such a point that perfunctory business decisions go begging! I know we are not alone on the cost side or the manpower squeeze, as I have heard similar comments at industry gatherings.

You know what else bugs me? I saw the estimate for our 2005 audit fees. They're up significantly again. If we have put all of these controls into place and they have all been approved by our accountants, then how come the audit fees are still skyrocketing? I still can't get a straight answer from our lead audit partner on this. In any event, if Nearly Defunct Fire & Casualty survives, the board will have to address whether it still makes sense to remain operational and if it should be done as a public entity. Let the politicos chew on that one for a while!

Now for the Spitzer probes. Boy, did that guy hit the mother lode! Contingent commissions have been around for a long time. In hindsight, they probably were not disclosed and explained as succinctly as needed. But that does not make them illegal. Bid rigging is clearly a no-no. With respect to finite and nontraditional covers, they too have been sold by a whole bunch of purveyors for some time. It just wasn't a one-company phenomenon. By the way, isn't it interesting how a whole bunch of political opportunists, insurance commissioners, attorneys general and consumer advocates come out of the woodwork on things like this? How come they missed this stuff? Any way you slice it, the NAIC does not come up looking good. There clearly has to be reform applied to the entire insurance regulatory package. State regulation alone is not the answer from both an efficiency and regulatory perspective.

Picoult, I know you have been groaning about the sorry state of the industry's technological capabilities for some time. You're right! Being on the inside now, I will acknowledge there is much to be done. In general, this is not an industry that can survive and prosper at current expense ratios. Yeah, I know you just can't look at the ratios in a vacuum. But we all know that, as a general rule of thumb, a lot of bucks are thrown at the technology side of the equation and the returns, in most instances, are not commensurate.

Although Nearly Defunct is not one of them, generally, smaller insurers do wonders on shoestring budgets compared to the sums spent by the gorillas. Nearly Defunct's new management (ho ho ho) has to make some very tough decisions real soon on where to go and how to get there on the tech side if it is to remain a viable purveyor. The task is daunting. Again, from what I have picked up at some informal gatherings, this appears to be an industry of haves and don't wants! The latter is a reflection of some insurers that acknowledge they have goofed and there is a better way to execute at least some of their technology needs, but for various reasons can't or won't come to grips with the situation. With few exceptions, within the financial services business, the property/casualty companies are at the bottom of the barrel.

It has become quite evident to me in a short period of time that the managements of most insurance companies are very focused on staying alive and keeping the business afloat. Hence, it is not surprising that the focus of the industry, for the most part, is tactical. Nonetheless, somebody has to stop and take a look at the future. As silly as it sounds, wouldn't it be interesting for money to flow into a new carrier that utilizes new technology and speaks to measured growth? It could be the beginning of a whole new breed of empire builder. I bet that would catch the eyes of a couple of fund managers!

Clearly, this industry needs a strong dose of candor and transparency!

OK, Picoult, I've got to get this show on the road. There's this chubby little elf that has a remarkable resemblance to Almost Donothing, tugging at my sleeve telling me that the sleigh is all toyed up. By the way, did I tell you that I did this note on my new Wi-Fi laptop? I'm going to print it in the office and get one of the elves to fetch it. Hopefully, you'll find it in your stocking. By the way, it looks like it is going to take a long time for the Caymans to recover. I like island living, though, and I hear Alcatraz might be up for sale. You got any connections?

Happy Holidays,

Santa

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Reservists: Proposed rules would ease reintegration

Continued from page 1

2001, including more than 260,000 who already have been demobilized after generally serving longer tours of duty than those that occurred during Operation Desert Storm, the last comparable conflict. And given the current situation in Iraq, the issue of returning reservists is likely to confront employers for some time.

"This statute, over the next few years, is going to be of incredible importance to employers, and it shocks me that employers have not been told more about it," said Evan Fray-Witzer, a Boston-based employer attorney in private practice. "There are a lot of folks who really are just surprised when they learn about the extent of the protections, and what their responsibilities are."

Observers note that although the regulation will be helpful, more USERRA-related litigation can be expected because of the sheer number of reservists who are now in active service (see related story).

The Labor Department received about 80 responses to the USERRA proposal during the comment period, which ended in November, said a spokesman. No date has been set for the release of the final regulations.

USERRA is intended to provide veterans and reservists re-employment rights and protect them from discrimination by their employer. It also requires that returning reservists be given all the benefits they would have received had they been continuously employed.

Topics covered within the proposed USERRA regulations, which were initially issued in September, include protection from employer discrimination and retaliation; eligibility for re-employment; the rights, benefits and obligations of workers absent from their jobs because of military service; re-employment rights and benefits; and compliance enforcement. Health coverage, pensions and both seniority- and nonseniority-related benefits are discussed.

Observers say that, unlike the case with some other laws, employers are generally eager to at least meet or even exceed their requirements under USERRA and welcome guidance on how to proceed.

This is one area "where employers are usually willing to do more for employees than the law requires. They understand the sacrifices (reservists are) making" and will try to do anything they can to help, even if it poses a hardship to them, said Mike Fischer, an employer attorney with Quarles & Brady in Milwaukee.

The eventual regulation will be useful, say observers, who point out there have never been regulations promulgated for either USERRA or its predecessors, which include the Vietnam Era Veterans' Readjustment Assistance Act of 1974.

"Overall, I think (the guidance) will be helpful, truly, because it provides more information and it also offers employers an opportunity to look at their policies, look at the way they handle employees who are taking military leave, and be sure they are following the law as best they can," said Amy Kohn, an employment law consultant with Hewitt Associates Inc. in Lincolnshire, Ill.

"Any guidance is definitely something that's definitely appreciated and can be an asset to both employees and employers who are trying to understand the protections of the statute," said Richard Greenberg, an employer attorney with Jackson Lewis in New York. The proposed regulation is also in an easy to understand question-and-answer format, he noted.

Ann Elizabeth Reesman, general counsel for the Washington-based Equal Employment Advisory Council, an employer group that sent the Labor Department a 21-page commentary on the proposal, said that, despite the numerous suggestions for revisions, "overall, we commend the agency for proposing regulations that are consistent with what employers understand their obligations are under USERRA. They actually offer some helpful guidance in some places." Ms. Reesman also is an attorney with McGuiness Norris & Williams in Washington.

There are no major surprises in the proposed regulations, say observers. "The regulations very closely track what I think a lot of us thought the statute was going to mean anyway, but there are definitely some areas in which the regulations make clear or clarify what might have been some judgment calls when you were just reading the statute itself," said Mr. Fray-Witzer.

For instance, the proposal makes clear that an employer is not obligated to re-employ a worker if his or her post would have been eliminated regardless of whether he or she was in military service, said Mr. Fray-Witzer. "That is not swept up in the re-employment provisions," he said. The proposal also clarifies that USERRA does not apply to independent contractors, he said.

But the regulation confirms people's general understanding of the law, said Mr. Greenberg. "It's not as if any of us read the regulation and said, 'Oh my God, where did this come from?'"

While it is not known how many, if any, of the suggestions observers make about the proposal will emerge in the final regulations, observers note that the DOL invites comments on specific issues several times within a proposal period.

Among the areas of concern are after-tax contributions to savings plans, making up benefit plan contributions, the advance notice reservists should provide of their leaving, the benefits returning reservists are entitled to and the positions they assume.

Observers say one problem they have with the proposal relates to after-tax contributions to employer-sponsored savings plans. The proposed regulations provide that if an individual who is initially re-employed subsequently leaves and cannot make up missed contributions through salary deferral, the plan must give him the opportunity to make after-tax contributions.

"It would be unprecedented to allow somebody who's no longer an employee to contribute to the plan and would cause quite a few complications for the plan," said Jan Jacobson, director of retirement policy at the American Benefits Council in Washington.

Furthermore, "a lot of time would be needed to implement the changes needed" in the computer system, plan documents and summary plan documents, she said. The council recommends eliminating the after-tax contribution requirement by limiting the repayment period to the lesser of three times the length of the military leave, five years or the entire re-employment period, said Ms. Jacobson.

This situation may arise only once or twice a year, said Kyle Brown, retirement counsel with Watson Wyatt Worldwide in Washington. "It's amazing how the H.R. department will just not know what to do with that. HR departments are very systematized right now, especially for large employers, and establishing a system for something like that that will happen as infrequently as this" can be an issue.

Another issue is that the proposed regulations generally require employers to make up benefit plan contributions for the period when the employee was serving in the military to within 30 days of his or her return, or as soon as practicable.

See RESERVISTS/next page

With many on active duty, much litigation likely ahead

By JUDY GREENWALD

Employers can expect increased litigation in coming years over the federal statute that is intended to safeguard the employment rights and benefits of military reserve members upon their return to civilian life, say observers.

They note that while proposed regulations under the Uniformed Services Employment and Reemployment Rights Act of 1994 should be valuable in avoiding litigation in many cases, the sheer number of reservists now on active duty means there will be more litigation in coming years.

To date, there has been relatively little USERRA-related litigation. A survey of decisions in 2002-03 found 11 cases, including six that were won either predominately or entirely by the employee, according to Samuel F. Wright, senior ombudsman with the Arlington, Va.-based National Committee for Employer Support of the Guard and Reserve, a Department of Defense volunteer organization.

Private employers were defendants in six of the cases, and political subdivisions of states were the defendants in the remaining five. Mr. Wright, who helped draft USERRA, said the survey has not been updated to include 2004.

There have been at least two recent appellate court decisions. *Rogers vs. City of Antonio* was filed by members of the San Antonio fire department who were either in the U.S. military reserve or the National Guard. They contended that the city violated USERRA by deeming them absent from work while they were on military leave rather than "constructively present" and depriving them of straight and overtime pay and other benefits.

In ruling in favor of the city on several of the benefits, the 5th U.S. Circuit Court of Appeals in New Orleans on Dec. 2 held that Congress intended that, with respect to rights and benefits that are not determined by seniority, under USERRA, employers must treat employees taking military leave "equally, but not preferentially in relation to peer employees taking comparable nonmilitary leaves generally provided" by the employer.

'As more and more people are being called to military leave...I think it does lead to a lot more litigation as employers really struggle' with what their benefit obligations are.

Shannon Farmer
Ballard Spahr Andrews & Ingersoll

The Oct. 28 decision in *Wanda Gordon vs. Wawa Inc.* concerned a reservist whose employer insisted he work immediately after weekend reserve duty. The reservist had an automobile accident after he lost consciousness at the wheel on his way home and died of his injuries. The 3rd U.S. Circuit Court of Appeals in Philadelphia ruled in favor of the employer, holding that a USERRA requirement that an employee coming back from military leave notify his or her employer of an intent to return to work within a required time period cannot be interpreted to mean that the employee is entitled to a rest period after military duty.

The decisions, with an appellate court ruling on these issues for the first time, are important as cases of first impression, said Maureen Q. Dwyer, an attorney with Pepper Hamilton in Philadelphia.

More litigation can be expected, observers agree.

"There's going to be some increase in USERRA litigation, whether viable claims or nonviable claims," just because there is a larger pool of potential plaintiffs, said Richard Greenberg, an employer attorney with Jackson Lewis in New York.

This is the case with the current situation, in which many of those who have been called up are 45 or older, are established in their companies and may have complicated compensation plans that could give rise to both seniority- and nonseniority-based issues, said Mr. Greenberg.

More litigation is likely, agreed Shannon Farmer, an employer attorney with Ballard Spahr Andrews & Ingersoll in Philadelphia. "Hopefully, the new regulations are going to help address some of that and cut down on some of the litigation," Ms. Farmer said. "But as more and more people are being called to military leave, and particularly when we get more into National Guard troops and reserves ... I think it does lead to a lot more litigation as employers really struggle" with what their obligations are, while employees are given the opportunity to blame their bad evaluations on their military service.

"It just creates another protected class for saying, 'Whatever happens is not because of anything I did,'" said Ms. Farmer. It will also take time for USERRA to come to the forefront of employers' minds "and become part of their everyday thinking," she said.

Anthony Rogers et al. vs. City of San Antonio, 5th U.S. Circuit Court of Appeals, No. 03-50588; Wanda Gordon vs. Wawa Inc., 3rd U.S. Circuit Court of Appeals, No. 03-3089.

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greater accountability from prescription benefit managers and the pharmaceutical industry by requiring transparent business practices and the disclosure of marketing costs. The court allowed to stand other portions of the act, which was passed in March 2004 and institutes a program providing financial assistance to seniors in obtaining prescription medication.

Carvill to sell West Coast operations

Reinsurance intermediary Carvill America Inc. has signed an agreement in principle to sell its West Coast operations to an investment group headed by the operations' president, Brendan Roche, for an undisclosed amount. The new firm, REcentis Intermediaries L.L.C., will be based in Westlake, Calif., and will continue to use the services of R.K. Carvill & Co. Ltd. in London, according to the company. REcentis will focus on reinsurance for finance and credit insurance, in addition to more traditional reinsurance lines, according to Carvill.

RLI launches specialty commercial auto unit

RLI Transportation, a division of RLI Insurance Co., has launched a commercial automobile insurance unit targeting accounts with strong safety programs and few losses. The unit will write coverage for contractors, public entities, communications firms, utilities, financial institutions, wholesalers, manufacturers, health care operations, service organizations and other entities. An account must generate at least $75,000 in premium to qualify for the insurance and show that its fleet safety program and loss record are exceptional.

20% of medication errors tied to computers: Report

Computers designed to prevent medication errors may actually be contributing to mistakes, a report has found. Nearly 20% of hospital and health system medication errors reported to the U.S. Pharmacopeia MEDMARX program in 2003 involved computerization or automation. However, facilities that have implemented computerized prescription order entry systems reported fewer harmful errors, according to a report by USP, a Rockville, Md.-based organization that sets standards for the use of medication and dietary supplements.

WTC employee's injuries not compensable: Court

A World Trade Center worker who stayed home on Sept. 11, 2001, then rushed to help rescuers is not eligible for workers compensation benefits, a New York appeals court ruled. Christopher Duff stayed home on Sept. 11, waiting for workers to finish repairing his home, even though he was scheduled to work at his job on the 86th floor of One World Trade Center. Mr. Duff was a property manager for the Port Authority of New York & New Jersey. He was present when the second World Trade Center tower collapsed and then volunteered to assist rescue efforts each day during the following week. It remains undisputed that he suffered psychological injuries, court documents indicate. The New York Supreme Court Appellate Division ruled that Mr. Duff did not qualify for benefits because he was at home and went to the site of his own volition and not at his employer's request.

GM contributes stock to retiree health fund

General Motors Corp. has contributed about 11 million shares of XM Satellite Holdings Inc. it held to a tax-free trust GM uses to prefund the health care costs of its hourly U.S. retirees. The stock was valued at $419 million by an independent appraiser when GM made the contribution to the voluntary employees' beneficiary association on Dec. 15. Total assets in the VEBA as of Sept. 30 were about $16 billion. GM's liability for accumulated retiree health care obligations was $67.5 billion as of Dec. 31, 2003, according to GM filings with the U.S. Securities and Exchange Commission.

Briefly noted

New York-based Standard & Poor's Ratings Services has placed the A+ counterparty credit and financial strength ratings of Overland Park, Kan.-based **Employers Reinsurance Corp.** under review with negative implications. The rating agency also placed the A- counterparty credit rating of GE Insurance Solutions Inc., the intermediate holding company that is ERC's immediate parent, and various ratings of both companies' affiliates under review with negative implications. S&P said the moves stem from ongoing concerns about the group's continuing reserve strengthening for past accident years....**Navigators Management Co.** is forming an excess casualty unit. The company, a subsidiary of New York-based Navigators Group Inc., said that the unit will specialize in commercial excess and umbrella liability insurance.

Check out BusinessInsurance.com

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.

Reservists: Proposed regs for reintegration

Continued from previous page

Under defined benefit plans in particular, each year there is an actuarial calculation of the amount of contributions the company must make to fund the promised future benefits to all participants, according to the benefits council. Contributions are not determined on an individual basis. "It would be very expensive process" to go through in response to just one individual coming back, said Ms. Jacobson. "We're not proposing that they don't fund for it at all," just that it be done at the next annual evaluation, she said.

Mr. Fischer also pointed to a provision that says reservists must provide either verbal or written advance notice that they are leaving for military service. But the provision does not specify how much notice must be given. There are situations where the employee does not give notice "until the last possible minute, and the employer has no redress in that situation. It wouldn't hurt to require employees to give notice as soon as they become aware they're going to be called up," said Mr. Fischer.

Benefits that are not based on seniority also are problematic. The proposed regulation says the returning reservist "must be given the most favorable treatment accorded to any comparable form of leave."

But, said Mr. Fischer, "it's never been clear how exactly you're supposed to match benefits for people on military leave with benefits other people on other kinds of leave" have, said Mr. Fischer. "I don't know what that means, and they don't define what this means," he said.

"I think they've overstepped their boundaries a little bit here," said Fran Bruno, a consultant with Mercer Human Resource Consulting in New York. Group. "I think it goes a little bit beyond what the law actually requires."

Another area of concern is the application of USERRA's "escalator principle," which provides that employees are entitled to re-employment in the job position they would have attained had they not been absent because of military service. There are still questions that arise from this, said Mr. Greenberg.

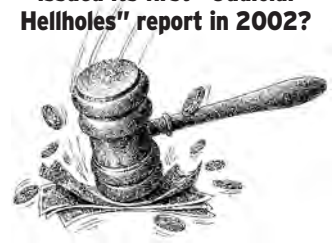
For instance, if someone in the accounting department would have put in the time required to become a certified public accountant and earned a promotion if he had stayed, he may not be eligible to become a CPA upon his return, but does he still get the promotion? Mr. Greenberg asked.

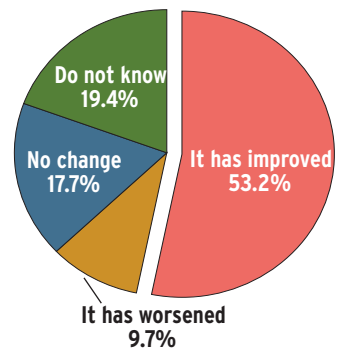
There are other issues as well, and still more may emerge, say observers. Kaye Pestaina, vp-national health compliance with The Segal Co. in Washington said that as reservists begin returning from Iraq and Afghanistan, "I assume we'll see administrative issues that haven't been addressed."

Online Poll

[12/20-12/23]

How has the civil justice system changed since the American Tort Reform Assn. issued its first "Judicial Hellholes" report in 2002?





BI Stock Index

[12/20 - 12/23]

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

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

***BI* Stock Index**	2373.61	1.85
Dow Jones	10827.10	1.13
S&P 500	1210.13	0.58

Largest gains

Unico American Corp.	13.00%
EMC Insurance Group Inc.	5.61%
SCPIE Holdings Inc.	5.31%
Unum Corp.	4.44%
Philadelphia Consolidated	4.43%

Largest losses

Gainsco Inc.	-3.33%
Unitrin	-2.88%
Argonaut Group	-2.51%
Aspen Insurance Holdings	-2.40%
MBIA Insurance Group	-2.25%

Weekly change by market segment

Brokers	0.70%
Insurers/Reinsurers	0.99%
Managed Care Organizations	0.20%

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

Commissions: Aon revamps fees

Continued from page 1

clients. We provide important services on behalf of underwriters; however, certain current compensation models must change."

Last week, however, Aon executives in London stressed that the plan to charge a percentage of premiums on some London placements may not be a model for all Aon placements.

The size of the charge that would be imposed on London specialty placements had not yet been determined, according to Aon. Max Taylor, deputy chairman of Aon Ltd., said that the percentage would vary depending on the nature of certain classes of business, it would be subject to an upper limit and would be fully disclosed. Mr. Taylor said that the brokerage expected to have "robust discussions with the marketplace about the cost of those services."

Mr. Taylor said that the model for specialty business broker payments was similar to a model that Aon Ltd.'s Risk Services division has been using since 2001.

Mr. Taylor said that although Aon Corp. is currently looking at ways to change its overall broker remuneration model, for London market specialty business a "localized" model was appropriate.

The proposed model is particularly suited to the subscription nature of the London specialty market within which brokers have traditionally performed services for underwriters—such as the preparation and issuing of policy wordings and claims handling services—which in other markets are often performed by the underwriters themselves, Aon said in a statement.

Aon Ltd.'s specialty division places business such as aviation, marine, energy, property/casualty, terrorism and professional risks in the London insurance market, representing premiums of about $5 billion to $6 billion each year, a spokesman said.

According to Mr. Taylor, Jan. 14 had been chosen as the start date for the implementation of the charges because, in part, it is the date when the Financial Services Authority will assume regulatory responsibilities for the U.K. broking industry. Aon believes that its new approach for specialty business will "pass regulatory muster" and will be consistent with the FSA's emphasis on transparency, he said.

Business currently in the market for the Jan. 1, 2005, renewals will not be subject to the new approach, he noted.

Dennis Mahoney, chairman and chief executive of Aon Ltd., said the measure "will help ensure complete transparency and a level playing field for clients and underwriters."

Risk managers and insurers generally welcomed the proposals but said they were interested in seeing the finer details of how charges will be structured.

"The Assn. of Insurance & Risk Managers welcomes Aon's announcement as a further step towards the transparency that the clients seek," said David Gamble, executive director of AIRMIC.

Ralf Oelssner, director of corporate insurance at Cologne, Germany-based airline Lufthansa A.G., said that Aon's announcement "offers an intention but nothing substantial."

He noted that, as yet, Aon has not detailed the charges it will make for the various services offered. "I am looking forward to the finer details of the approach being rolled out," he said.

The Lloyd's Market Assn., which represents businesses underwriting at Lloyd's of London, said it welcomed any move toward greater transparency. "Underwriters at Lloyd's favor full disclosure to the client and we have invited the broking community to agree with us on a new standard for disclosure covering all London market business," it said in a statement.

Bill Rendall, head of underwriting and claims at the LMA, said the association was now awaiting greater details of Aon's new remuneration model. He added that the LMA would like to see a similar model extended across all lines of business.

"Our members want to be in a position where they can see what the charges are and whether there are any alternatives," such as providing services themselves," said Mr. Rendall.

David Foreman, chief underwriting officer at Wellington Underwriting P.L.C. in London, said that he "applauded transparency." But, he said, "the devil is in the detail."

He noted that underwriters would like to see a consistent approach by all brokers on remuneration and service standards.

Other insurance brokers have indicated that they are looking for alternative broker-payment models since the decision by many to eliminate contingent commission arrangements.

A spokesman for Marsh said that the company will unveil a new business model in January. "We have already announced that we are committed to providing full disclosure on our fees and commissions to our clients across all business lines. We welcome the move by others to do the same," the spokesman said.

A spokesman for London-based Willis Group Holdings Ltd. said: "On Oct. 21, we announced the client bill of rights including a very clear commitment to transparency. That commitment has not changed."

Benefits: Dental, vision help spot illnesses

Continued from page 1

Beyond promoting good dental hygiene and helping to correct refractive errors, access to affordable dental and vision care can help uncover symptoms of more serious and costly medical problems, dental and vision care experts say.

While it has long been known that mouth cancer is often detected by dentists during routine oral exams, new research is finding that the dental office may hold even further potential for the early detection of and intervention for other diseases, such as hypertension, coronary artery disease and osteoporosis.

For example, a study published in the Journal of the American Dental Assn. reported that X-ray technology used by dentists can detect arterial blockage in the neck that could lead to stroke. Two other studies recently reported in General Dentistry, the peer-reviewed journal of the Academy of General Dentistry, found that a connection exists between osteoporosis and periodontal disease, and that dentists may be able to detect Lyme disease in patients much earlier, which could make it easier to treat.

Likewise, regular eye exams may turn up early signs of diabetes, hypertension and multiple sclerosis.

Despite this potential for ensuring wellness among employees and their families, many employers have been cutting back on dental and vision benefits, benefit consultants say, which could prove to be disastrous in the long run if these diseases are left unchecked.

"Primarily because of the health care cost increases continuing for many, many years at double-digit rates, we are seeing more employers pull back from their subsidy if they've been offering one or moving to pure employee-pay-all plans," said Bill Sharon, a senior vp at Aon Consulting in Tampa, Fla.

"Health care costs have been rising so rapidly, it's forcing employers to make decisions about what they will pay for and what they won't," agreed Kurt Rothrock, president and chief executive officer of CompBenefits Corp. in Atlanta. CompBenefits provides dental and vision benefits to 17,000 employer groups, representing 4.5 million participants, primarily in Florida, Georgia, Illinois, Ohio and Texas.

According to statistics gathered by Mercer Human Resource Consulting, currently about 67% of employers overall and 96% of large employers offer dental coverage to their employees, while 21% of employers overall and 58% of large employers offer vision benefits.

Of that group, 42% of all employers and 23% of large employees pay 100% of the premium for employees, while 5% of all employers and 15% of large employers also pay the full freight for dependent coverage.

When employers require employees to contribute to the cost of dental coverage, the employees pay, on average, about 30% at employers overall, and about 49% at large employers. Employee contributions for dependent coverage average about 26% for employers overall, and 43% for large employers, Mercer found. The firm did not have statistics on contributions for vision plans.

These figures are in stark contrast to a decade ago, when most employers paid 100% of the premiums for employee-only coverage in dental plans and about 50% for dependents, according to James Gimarelli, vp of dental marketing at Assurant Employee Benefits in Kansas City, Mo. Assurant offers group dental coverage on both an employer-subsidized basis—which Mr. Gimarelli refers to as a "true group" basis—and a voluntary basis to about 29,200 employers, representing about 2.7 million covered individuals nationwide.

"In a true group situation, contributions have been falling," he said. "I would say it's evolved over the last 10 or 15 years."

In addition, Mr. Gimarelli said, there has been a shift from employer-subsidized to voluntary plans, in which employees pay all of the cost. "I would say we're half and half, group vs. voluntary," he said.

A five-year study by the National Assn. of Dental Plans found that the percentage of employer-sponsored dental plans offered on a voluntary basis has climbed to 28% from 14%.

While shifting to a voluntary format may reduce premiums for employers, it has had an adverse impact in other ways, benefit experts say.

For example, while typically 75% to 80% of an employee group will enroll in dental plans when they are offered on a subsidized basis, participation rates fall to 40% to 45% for voluntary plans, Mr. Gimarelli said.

And when employees are not covered by dental insurance, they are less likely to seek preventive care, he said, citing a report published in Oral Health in America.

"If you have dental insurance, there's a 70.4% chance that you're going to visit the dentist for preventive care, vs. 50.8% if you don't," Mr. Gimarelli said.

And because every dollar spent on preventive care services saves between $8 and $50 on restorative services, that could negatively affect overall plan costs, he said.

Moreover, because only those employees most likely to use the plans will likely enroll if the plans are offered on a voluntary basis, adverse selection may occur, further spiking plan costs, benefit experts say.

"On a voluntary basis, employees don't buy it if they don't plan to use it," said Mr. Sharon. "As a result, there is adverse selection. And that's built into the cost of voluntary benefits."

"We've called these 'utilization benefits,' as opposed to insurance benefits," said Mr. Rothrock. "You think of life insurance, and that's for a catastrophic event. If you get to the end of the year and you haven't used your medical benefits, you're happy. But you want to use dental and vision benefits."

In fact, "some voluntary carriers that are not managing the anti-selection risk are experiencing 20% to 30% rate increases," according to Mr. Gimarelli.

Chicago-based clothing manufacturer Hartmarx Corp.'s dental plan rates rose 12% in 2003, 9% in 2004 and may increase another 10% in 2005, said Mike Pikelny, employee benefits manager. This compares with medical plan rate increases of 8% in 2003 and 3% in 2004. He said he has not yet calculated the 2005 medical plan rate hike.

To reduce the cost of its dental plan, Hartmarx is adding a preferred provider organization feature, which will encourage employees to use lower-cost providers by reducing their copayments, Mr. Pikelny said.

Hartmarx also combats the potential for adverse selection by tying the dental plan to its medical plan, so "you can't get medical without dental, and you can't get dental without medical," he said.

"We purposely didn't want to separate dental to prevent people from signing up only when they needed it," Mr. Pikelny said.

Hartmarx does not offer a vision plan, instead offering employees a discount card provided by Twinsburg, Ohio-based Cole Vision Corp.

Denver Water also experienced a sizable increase in the cost of its dental plan last year, forcing it to require employees to contribute to the cost for the first time in 2005, according to Jim Crockett, the utility's risk and benefits manager. In addition, Denver Water is projecting a 7% to 8% increase in claims for 2005, he said.

"There previously was no cost for single coverage," he said. "But we now require a contribution" for both its indemnity and preferred provider plan.

The contributions for indemnity coverage now amount to $10 per employee per month, $20 per employee plus one per month, and $30 per employee plus family per month. Contributions for the PPO plan are $5, $10 and $20, respectively.

Despite the contribution requirement, participation is high in Denver Water's dental program—about 98% for 2005, according to Mr. Crockett.

By contrast, only 60% of Denver Water employees enroll in the vision plan, where premiums were actually reduced because claims weren't as high as expected, he said.

But under Denver Water's wellness benefits, employees are entitled to a free eye exam every three years if they are under the age of 40, every two years for those between the ages of 40 and 50, and annually for those over 50, Mr. Crockett said.

Employees without vision coverage, though, must pay for their own corrective lenses, if needed, he said.

"Sometimes health plans provide vision coverage," said Mr. Rothrock. "As medical insurers have tried to differentiate themselves, they've added benefits."

But it is rare for medical plans to include dental care services, he said.

It's ironic that, "in some areas of health care we're looking at things more holistically, but we're still treating dental and vision as separate products," said Mr. Sharon. "It's unfortunate, because we're learning there are connections between dental health and vision health and medical health."