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PRUDENTIAL SETTLES SPITZER CHARGES FOR $19 MILLION / PAGE 3

FORMER AGENTS PLEAD GUILTY TO CHARGES OVER KICKBACKS PAID TO RISK MANAGER / PAGE 3

In Brief

Spitzer nominates Willis exec as NY regulator

New York Gov.-elect Eliot Spitzer has nominatec Eric Dinallo, general counsel of Willis Group Holdings Ltd., to be the state's insurance superintendent, Mr. Spitzer's transition team announced. Mr. Dinallo was appointed general counsel for London-based Willis in March. He previously served as managing director and head of regulatory affairs at Morgan Stanley and led the Investment Protection Bureau for the office of the New York attorney general. He will succeed outgoing superintendent Howard Mills.

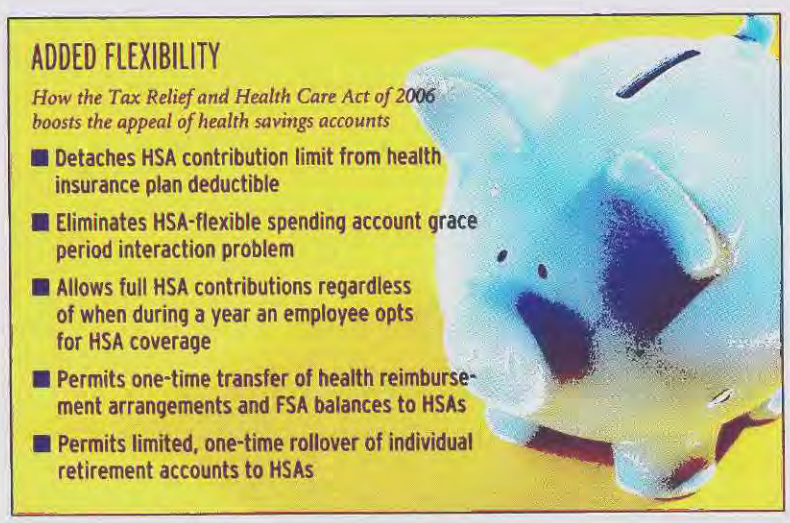
St. Paul withdrawal from La. coast on hold

St. Paul Travelers Cos. Inc. is re-examining a decision to stop renewing small and midsize commercial property risks in New

See **IN BRIEF** page 22

SECTOR BRIEFING
PHARMACEUTICALS

Product liability risks top concerns for drug makers; few options available on recall cover; risk financing alternatives sought for several lines as limits shrink; broker works to establish mutual insurer for pharmaceuticals.



Late-session accord boosts appeal of HSAs

Health accounts seen becoming way to save for needs of retirees

By JERRY GEISEL

WASHINGTON—Legislation to boost the appeal of health savings accounts, given up for dead just a few weeks ago, is on its way to President Bush for his signature.

The HSA provisions, incorporated in a broader tax bill that received congressional approval during this month's brief post-election session, will allow significantly bigger contributions to HSAs, as well as ease grace period flexible spending account-HSA interaction problems.

Additionally, the legislation will pave the way for employers to replace first-generation consumer-driven health care plans with HSAs and ensure that the maximum contributions can be made to employees' HSAs, regardless of when during a plan year they became eligible for coverage.

The legislative changes, especially the one boosting maximum HSA contributions, "will boost the appeal of HSAs enormously. They are of critical importance," said Jeff Munn, a consultant in the Falls Church, Va., office of Hewitt Associates Inc.

The HSA legislation approved by Congress in the closing hours of the session is identical to a measure passed by the House Ways and Means Committee in late September.

At that time, HSA advocates said their strategy was to lobby congressmen to attach the HSA bill to a "must-pass" bill, such as legislation to extend expiring tax code provisions, that Congress was expected to act on during the session.

Advocates acknowledged they faced an uphill battle for two reasons: the staunch opposition of key congressional Democrats plus the more general problem of the HSA measure competing with others to win a place on the broader tax extender bill.

That strategy appeared even more precarious after the November elections put Democrats in line to control the House and Senate when the new session starts in January. Busi-

See **HSA** page 21

Reinsurer collateral reforms advance

NAIC supports rating-based approach

By MEG FLETCHER

SAN ANTONIO—After years of debate, U.S. insurance regulators have committed to overhaul the nation's regulatory regime for reinsurance with the introduction of a rating-based system that may eliminate collateral requirements for some non-U.S. insurers and impose collateral requirements on some domestic companies.

SURPRISE MOVE: Past NAIC President Alessandro Iuppa to join Zurich. Page 21

In a key move in a nearly 12-year on-and-off discussion, the National Assn. of Insurance Commissioners' Financial Condition Committee last week agreed to refine a proposal to establish a Reinsurance Evaluation Office, which is intended to be the foundation for a risk-based evaluation process that would amend state laws concerning credit for reinsurance.

Under the proposed process, the REO would review each reinsurer doing business in the United States using rating agencies' financial assessments as well as other information about each reinsurer, including its claims-paying history. The REO then would assign one of six ratings to a reinsurer (see chart, page 21). The rating would determine, in increments of 20%, whether the reinsurer must post collateral that would range from zero to more than 100% of its U.S. liabilities.

The move, which will take at least several months to finalize, has been condemned by many U.S.-based

See **COLLATERAL** page 21

Tort 'Hellholes' tally holds steady in 2006

Legal environment for defendants continues to improve

By MARK A. HOFMANN

WASHINGTON—The American Tort Reform Foundation's annual list of "Judicial Hellholes" held steady at six this year, according to a report released last week by the Washington-based nonprofit organization.

But political changes in some jurisdictions could result in attempts to role back existing legal reforms, warned Victor E. Schwartz, general counsel of the American Tort Reform Assn., which is affiliated with ATRF and also based in Washington.

"Judicial Hellholes: 2006" is the fifth annual report examining the state of the U.S. civil justice system on a jurisdictional basis. The report defines judicial hellholes as "places where judges systematically apply laws and court procedures in an unfair and unbalanced manner, generally against defendants in civil lawsuits."

All of the jurisdictions in this year's list appeared on last year's list as well, although their order changed to reflect what the researchers considered to be deterioration or improvement in their legal climate. The 2006 list named West Virginia as the worst judicial hellhole; followed by South Florida; the Rio Grande Valley and Gulf Coast of Texas; Cook County, Ill.; Madison County, Ill.; and St. Clair County, Ill.

The fact that the list is barely half as long as the original 2002 list of 11 jurisdictions represents a wider improvement of the civil justice system, according to the report.

"Overall, the type of extraordinary and blatant unfairness that sparked the Judicial Hellholes project and characterized the report over the past few years has decreased across the board," accord-

See **HELLHOLES** page 22

INDEX

How can you protect your assets in unpredictable global markets?

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WHITE PAPERS

Kaiser white paper views health care

"The State of Health Care," a Kaiser Permanente-sponsored white paper, outlines where the U.S. health care system is today, how it got here and what's being done to address the growing crisis. Based on a survey of benefits and HR professionals and employer executives, the white paper can be accessed in the White Papers area of *www.BusinessInsurance.com.*

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Rx relief webinar now on demand

How can employers reduce the high cost of prescription drug benefits? This was the subject of last week's live *Business Insurance* Online Executive Forum "Hard to Swallow: Why Prescription Benefit Costs Are So High." To view this free archived discussion and download the speakers' slides, visit *www.BusinessInsurance.com/webinars.*

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Prudential settles broker payment charges

Insurer, Spitzer agree to $19M in fines, policyholder payout

By RUPAL PAREKH

NEWARK, N.J.—Prudential Insurance Co. of America last week settled allegations of improper business practices by two states, agreeing to pay a total of $19 million, halt contingent commissions and enhance disclosure for clients.

Under its settlement of fraud and anti-competitive practices leveled by New York Attorney General Eliot Spitzer, the unit of Newark, N.J.-based Prudential Financial Inc. agreed to cease payment of contingent commissions and back-end "overrides" to brokers on group insurance products, including disability, life and long-term care.

The group life insurer—which did not admit or deny the allegations as part of the settlement—also said it would pay restitution of $16.5 million to policyholders and civil penalties of $2.5 million (see box), and provide employers with full disclosure of any broker compensation.

The settlement ends investigations into Prudential's broker compensation practices launched by Mr. Spitzer in 2004.

Those probes found that between 1999 and 2005, the company paid almost $60 million in volume-based overrides to brokers on nearly $18 billion in insurance premiums, Mr. Spitzer's office said in a statement. Prudential additionally paid some brokers specific overrides or so-called "single case overrides" to close a deal or promote future business, at times building the cost of those overrides into premiums, the office said.

Among the companies Prudential maintained override agreements with are: Aon Corp.; Marsh & McLennan Cos. Inc.; Pacific Resources; Universal Life Resources; and USI Holdings Inc., settlement documents say.

The settlement reached with New York's attorney general further resolves allegations against Prudential in a November 2004 contingent commissions and steering lawsuit filed by Mr. Spitzer against defunct life and disability broker Universal Life Resources Inc. ULR in January paid $2 million to settle the suit.

"This settlement resolves the investigation and is in the best interest of Prudential and its policyholders," Prudential said in a statement.

See **PRUDENTIAL** page 22

POLICYHOLDER RESTITUTION

Under Prudential Insurance Co. of America's settlement with New York Attorney General Eliot Spitzer last week, the insurer agreed to pay a total of $19 million in fines and restitution. The settlement agreement requires that Prudential:

- Pay the state of New York a penalty of $2.5 million and deposit $16.5 million into a fund for policyholders no later than Dec. 19.
- Propose to the attorney general a plan for distribution of the fund to eligible policyholders no later than Feb. 15, 2007. Eligible policyholders are those who were represented by producers receiving contingent compensation or other service fees between Jan. 1, 2002, and Dec. 31, 2005.
- Calculate the amount of money each eligible policyholder may receive no later than 60 days after the attorney general approves the distribution plan.
- Pay proportionally each policyholder within 60 days of the claim deadline. Eligible policyholders have until 120 days from when the settlement notices are sent out, or Oct. 1, 2007, whichever is later, to request a distribution.

Mr. Spitzer

Employers still taking subsidy for retiree Rx

Long-expected shift to other options yet to catch on

By JERRY GEISEL

Most large employers in 2007 will continue taking a federal subsidy that is available to organizations offering retiree prescription drug coverage that meets a certain level, according to a survey.

Nearly 80% of 302 large employers surveyed by the Kaiser Family Foundation and Hewitt Associates Inc. said the organizations will take the subsidy, which is available to employers that retain prescription drug coverage that is at least equal to Medicare Part D benefits.

The subsidy provides 28% of each retiree's prescription drug costs between $250 and $5,000 as tax-free reimbursement to employers.

The percentage of large employers that expect to take the subsidy next year is almost unchanged from this year, when Medicare was expanded to cover prescription drug costs and the employer drug cost subsidy went into effect.

Many benefit experts predicted the percentage of employers taking the subsidy would quickly trail off in favor of what could be more cost-effective strategies, such as providing drug benefits through a plan that supplements Part D or dropping drug coverage and paying premiums for so-called Medicare Advantage plans that provide cov-

See **RETIREES** page 18

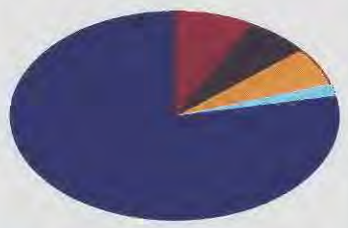
RETIREE HEALTH CARE COVERAGE COSTS

*Average monthly premiums for retiree plans**

**Single coverage for individuals retiring on or after Jan. 1, 2006*

EMPLOYERS AND MEDICARE PART D

*How employers are responding to the Medicare drug law**



Taking the subsidy	78%
Stopped providing coverage in 2006	8%
Contract with Medicare Rx or Medicare Advantage plan	6%
Supplementing Medicare Part D	6%
Become a Medicare Rx plan	2%

**Strategy for 2007*

Source: Kaiser Family Foundation/ Hewitt Associates Inc.

Ex-agents plead guilty in Big Easy investigation

Intermediaries admit paying kickbacks to risk manager

By SALLY ROBERTS

NEW ORLEANS—Two former insurance agents pleaded guilty to federal extortion charges earlier this month in an alleged kickback scheme involving the former risk manager of a New Orleans public school system, said Jim Letten, the U.S. Attorney General for the Eastern District of Louisiana.

Independent agents Glenn Davis and Charles Swanson admitted to giving "thousands of dollars" in kickbacks over several years to Carl Coleman, the former risk manager of the Orleans Parish School System who demanded the illegal payments in order for the agents to retain their highly lucrative health insurance contracts with the system.

The health insurance contract with Coventry Health Care of Louisiana Inc., which has not been charged with any wrongdoing associated with the alleged scheme, generated as much as $100,000 a year in commissions for the agents, according to Mr. Letten's office.

Messrs. Davis and Swanson, who were indicted in June, were charged with two counts of violating the federal Hobbs Act, each count of which carries a maximum statutory penalty of 20 years in prison.

Mr. Davis also pleaded guilty to tax evasion for failing to report more than $150,000 in income in 2000, which carries an additional three-year sentence. Sentencing is set for March 29, 2007.

Attempts to reach Messrs. Davis' and Swanson's attorneys were not successful.

According to court papers, Messrs. Davis and Swanson conspired with Lillian Smith Haydel, another independent agent on the school system's Coventry Health Care contract, who pleaded guilty to conspiracy in October 2004 and awaits sentencing.

Beginning in August 1997, the three insurance agents met covertly to discuss kickback payments to Mr. Coleman, according to Messrs Davis' and Swanson's indictment. In the beginning, the three individually paid Mr. Coleman cash kickbacks of approximately $1,000 a month, but later decided as a group that it would be easier to hide payments to Mr. Coleman if just Mr. Swanson made the payments.

Mr. Coleman pleaded guilty to Hobbs Act conspiracy and income tax violations in February 2004 in connection with a $300,000 cash kickback deal he orchestrated on contracts to repair four schools damaged by three fires and a flood over a three-month period. He awaits sentencing.

The guilty pleas by Messrs. Davis and Swanson are the latest development in the large-scale investigation by federal officials into corruption at the Orleans Parish Public School System. Authorities so far have brought charges against 24 people, 22 of whom have pleaded guilty.

"The task force is still operating in full force, and several new corruption indictments are expected in 2007," the U.S. Attorney's office said in its statement.

Despite the risks, more employers holding holiday parties

Some organizations go alcohol-free to avoid problems

By LOUISE ESOLA

Employer-hosted holiday parties are on the upswing and businesses are spending more money on the festivities than they have in recent years, surveys show.

But despite steps employers have been taking for years to mitigate the risks associated with such galas, issues such as drunkenness and unprofessional behavior continue to be as common as an olive in a martini.

According to a survey of 400 human resources professionals conducted by Vault Inc., a New York-based career information company, 66% percent of companies are sponsoring holiday parties this year, up from 55% in 2003.

In a separate annual survey, the Washington-based Bureau of National Affairs found that median holiday party spending this year is $7,000, up from $5,000 in 2005. It is the highest employer holiday party spending since the BNA's survey began 12 years ago.

Meanwhile, not much has changed when it comes to the risks employers face in hosting such events, despite the now-common practice of educating employees on appropriate workplace behavior and taking steps to mitigate liabilities that arise when an employee has too much to drink or gets too comfortable around colleagues, workforce attorneys say.

"It seems to me that while there is a greater awareness now than there has ever been regarding alcohol, sexual harassment and inappropriate behavior, there continue to be issues that arise out of business-related social events," said William J. Milani, a New York-based attorney with Epstein, Becker & Green P.C.

Mr. Milani and other attorneys say calls to their firms this time of year regarding an incident at a holiday party are common.

"One can just imagine all the problems associated with these things," said Jim Salzman, a partner with Matkov Salzman Madoff &

See **HOLIDAY** page 20

Employers can face liability for employees' behavior during office holiday parties, employment law experts warn.

EXTENDING BENEFITS TO RETIREES IN CANADA?

Employers in Ontario were asked if they would extend benefits to employees 65 and older:

	Already offer same benefits	No, not adding to all workers	Yes, regardless of age post-65 benefits	Yes, with age/benefit restrictions
Medical	51%	14%	16%	10%
Dental	50%	15%	16%	10%
LTD	2%	81%	3%	4%
STD	31%	34%	13%	10%
Life insurance	29%	31%	8%	22%

Source: Hewitt Associates Inc.

Canada retirement rule raises benefit questions

Employers consider extending coverage to workers over 65

By GLORIA GONZALEZ

TORONTO—An amendment to Ontario law that bars mandatory retirement at age 65 has spurred employers in the Canadian province to consider the viability of extending benefits to post-65 employees.

As of Dec. 12, an amendment to the Ontario Human Rights Code prohibits mandatory retirement except in specific situations where forced retirement could be justified due to the nature of the job.

For employers, major benefits questions related to the end of mandatory retirement arise in relation to health care, life insurance and disability benefits because most of those insurance plans terminate for employees at age 65, said Jolanta Morowicz, a lawyer for Mercer Human Resource Consulting in Toronto. Employers that want to extend benefits to employees beyond age 65 have to discuss this issue with their insurers and consider the costs of extending benefits, she said.

A recent study by Hewitt Associates Inc. found that the majority of employers either already offer the same medical and dental benefits or were willing to extend the same coverage to employees 65 and older (see box).

Ten percent of employers were willing to extend medical and dental coverage to post-65 employees with restrictions, such as ensuring that their benefit plans do not pay for prescription drug coverage that the government already provides to citizens 65 and older, said Linda Byron, a principal in Hewitt's Toronto office.

Employers, though, were less

See **RETIREMENT** page 20

ERRORS & OMISSIONS

Due to an editing error, a chart of the world's largest employee benefit consultants in the Dec. 11 issue of *Business Insurance* listed the incorrect principal officer of The Segal Co. The president/CEO of the company is Joseph A. LoCicero.

Derivative deal aids comp funding

N.C. self-insurers gain alternative collateral through capital markets

By ROBERTO CENICEROS

RALEIGH, N.C.—In an arrangement under consideration in other states, the North Carolina Self-Insurance Security Assn. has arranged a $510 million derivatives deal to bolster its fund that pays workers compensation benefits for insolvent employers.

The move earlier this month follows a similar structure set up in 2003 by the California Self Insurers' Security Fund, which now provides about $5.5 billion in collateral for 335 self-insured employers in the state.

Employer members of California's security fund have suggested the success in that state could be replicated in other states where they also self-insure, including North Carolina.

Supporters praise such capital market arrangements, saying they help security funds shore up reserves while relieving self-insured employers from having to post collateral—such as letters of credit—that can compromise a company's ability to borrow for other purposes.

State regulators typically require employers that self-insure their workers comp risks to post collateral that can be tapped to pay a portion of their outstanding liabilities should they be unable to pay workers comp claims.

Instead of requiring employer participants to post such collateral, California's Alternative Security Program and, more recently, North Carolina's Collateral Replacement Program allows security fund administrators to charge each employer member a fee based on its credit rating and a proportional share of its liability.

The fund can use the fees to post employers' state-mandated collateral requirements, pay outstanding claims or build the security fund's surplus.

Meanwhile, credit derivatives, such as credit default swaps and collateralized debt obligations that are provided by capital market investors to guarantee credit, would be triggered should the security fund experience a large loss.

The capital market arrangements essentially allow state security funds to become a fourth form of credit for posting employer collateral, said Quentin Hills, global head of financial risk products in San Francisco for MMC Securities Corp., a unit of Marsh Inc. The other three are letters of credit, sureties and cash.

The funds take on the employer's credit exposure—making it a credit risk addressing an insurance problem rather than an insurance risk,

See **WORKERS COMP** page 20

Electronic discovery rules revised

Risk managers can play a central role in safeguarding documents

By JUDY GREENWALD

Risk managers can play an important role in helping their firms comply with new federal court rules governing the handling of electronic communications, including e-mail and attachments, during discovery in litigation, say observers.

Amendments to the Federal Rules of Civil Procedure went into effect Dec. 1. The rules call for early attention by the courts to the issue of electronic discovery, and cover issues including required disclosures, scope and limitations of discovery, requests for data and subpoenas.

Among other provisions, the rules say a company does not need to provide discovery of electronically stored information "from sources that the party identifies as not reasonably accessible because of undue burden or cost."

The rules also prohibit sanctions against companies for information that is lost "as result of the routine good-faith operation of an electronic information system."

James Koenig, Philadelphia-based co-leader of PricewaterhouseCoopers L.L.P.'s privacy practice, said the rules provide clarification to companies involved in litigation. Under the previous rules of civil procedures that were designed for paper records, there was uncertainty as to what electronic records could be required, said Mr. Koenig.

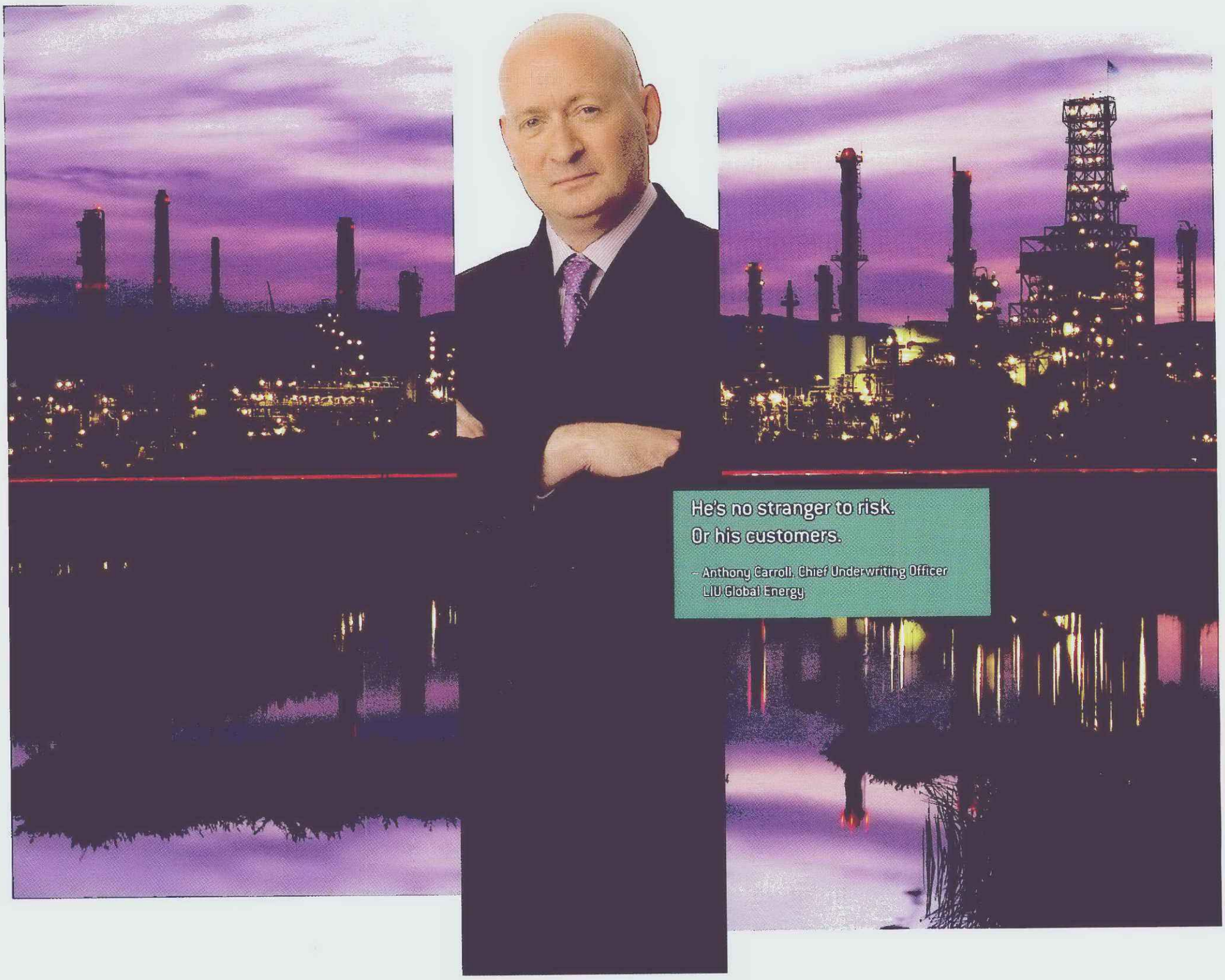
As a result, "courts were inconsistent about the degree that they would go to make companies produce electronic information, or to the extent they would let companies off because electronic information was hard to produce. The new rules add certainty" to the process, he said.

David K. Isom, an attorney with Greenberg Traurig L.L.P. in Denver, said the new rules require firms "to have their electronic data available and accessible more quickly than before, and that has all kinds of implications" for document retention programs.

"It suggests that document retention needs to be done with litigation accessibility clearly in mind and makes it so that that's one of the goals of a retention program that ought to be given consideration," Mr. Isom said.

Risk managers should be involved in the process, observers say.

See **DISCOVERY** page 6



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Discovery: E-document rules revised

CONTINUED FROM PAGE 4

The effort should be led by general counsel, but "I'd sure want to know the risk management folks are involved, or at least keeping an eye on making sure the right people are involved," said Richard S. Betterley, president of Sterling, Mass.-based Betterley Risk Consultants Inc.

Mr. Betterley said he would advise risk managers "to be discussing and potentially meeting with corporate counsel to set up a plan to implement compliance" with the federal civil litigation requirements.

"Risk managers need to be involved in working with their companies to make sure that everyone is aware of the new requirements," said Mark Charron, a principal with Deloitte Consulting L.L.P. in Hartford, Conn. "I would see the risk manager linking and coordinating with the office of general counsel of their particular company to make sure, in fact, programs are in place and that policies and procedures have been developed and have been rolled out."

Mr. Isom said, "It seems to me that the primary role of the risk manager is to make sure that these people are being brought together so that everyone can understand the risk, and both try to control the risk and insure it," through directors and officers liability coverage.

"The first impact of the rule will be felt by legal departments," Mr. Koenig said. But risk managers "will increasingly be playing a part in helping to strike the balance between longer retention for business purposes" vs. shorter retention periods to avoid potential litigation risks.

Michael Rodman, a principal with Needham, Mass.-based J.H. Albert International Insurance Advisors Inc., said risk managers "need to make sure that they have protocols that fall within the rules in terms of destruction and elimination of electronically stored documents so they don't get accused of spoliation of evidence."

The process is "obviously risky" because they could be fined and, even more importantly, face "the implications of guilt if there is a discovery process and it's found that they have eliminated documents" they should have kept, said Mr. Rodman. Risk managers also must be concerned with the inadvertent disclosure of confidential or privileged information during this process, he said.

Ann Longmore, New York-based executive vp and product leader for D&O, fiduciary and employment practices with Willis Group Holdings Ltd.'s executive risk practice for North America, said the risk manager can determine the D&O insurer's preferred vendors to conduct e-discovery and help set a budget for the work in the event of litigation.

"I think if the risk manager is not in this process, it's going to be far more difficult for the organization itself to understand what its mandates are from an insurance coverage perspective" and to determine "the reasonable and necessary costs" associated with settlement or defense of a claim, said Ms. Longmore.

She noted that such expenses, which could run into the millions of dollars, must be approved by the insurer to assure coverage.

Commentary

Reflect on the gifts that 2006 bestowed

REGIS COCCIA

Editor Regis Coccia's commentary appears periodically. He can be reached at: rcoccia@businessinsurance.com

Gift-giving is never far from my mind at this time of year, and it has made me think about the gifts that the past year has brought to all of us.

One could be forgiven for thinking that only Christians and Jews practice gift-giving, but in fact gifts are encouraged by other major religions of the world, including Islam, that also celebrate holidays in December.

No matter what one's faith, year's end is always a good time for reflection. What gifts did 2006 leave us and what are we going to do with them? What should remain on our wish lists for the coming year?

Insurers and reinsurers received a huge gift in the form of a light catastrophe year. That was a welcome change from 2005, when a string of hurricanes—including evil sisters Katrina, Rita and Wilma—cost insurers more than $61 billion. So far in 2006, estimated cat losses have totaled one-tenth of that figure. With higher property rates and fewer losses, insurers stand to make solid financial results for the year.

What will insurers make of this gift? Will they bank the proceeds and stick to prudent underwriting or go back to competing on price, contributing to rate volatility? Sorry to say, on all but catastrophe-exposed business, insurers appear eager to cut deals. Stay tuned. *Business Insurance* will report on that in-depth in our annual Property/Casualty Market Report on Jan. 9.

No doubt the industry is breathing a sigh of relief that its most aggressive prosecutor is moving on.

Most risk managers would welcome reasonable rates that remain stable, rather than have to budget for—and explain to their bosses—the peaks and valleys of the historical underwriting cycle. Offering less volatility isn't a bad gift to investors, either.

Speaking of investors, private equity continued to pour into insurance entities this year, replenishing some of the capital depleted after the catastrophes in 2005. This gift does come with strings attached, though. Investors will want to see healthy returns from the insurers and reinsurance vehicles they're backing.

Recently, the Occupational Health and Safety Administration offered a gift to employers, in the form of an online risk management tool for disaster cleanup operations that will help evaluate hazards and provide guidance to workers. OSHA's generosity has not always been welcomed, though, and a few years ago employers forced the agency to take back its "gift" of an ergonomics standard. Perhaps the workplace safety watchdog is better at responding to businesses' needs these days.

On the benefits front, employers offering health savings accounts got a gift this month when Congress approved changes that make contributing to an HSA easier and more advantageous. HSAs and the high-deductible health plans that accompany them are good tools for employers to reduce the cost of health care benefits, but they still don't really address the underlying causes of rising health care costs. That will have to stay on the wish list for '07.

A big gift for pension plan sponsors came earlier in 2006, with the Pension Protection Act. This sweeping legislation is the most significant pension benefit law in decades. It will help to shore up underfunded plans and create certainty for hybrids such as cash balance plans, which previously were in limbo.

Voters in New York gave insurers and brokers a present in November by electing Attorney General Eliot Spitzer as governor. While his successor promises to stay the course Mr. Spitzer set, no doubt the industry is breathing a sigh of relief that its most aggressive prosecutor is moving on. Mr. Spitzer's gift to insurance consumers is greater transparency and disclosure, something we hope insurers and brokers will keep on giving.

In the meantime, have a happy and safe holiday season.

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Perseverance pays off in HSA reform battle

EMPLOYERS' LOBBYING EFFORT in Congress to win passage of legislation to make health savings accounts work better is a fine example of the importance of perseverance.

As we report on page 1, federal legislators included a series of HSA reforms as part of a broad tax bill that received congressional approval during the closing hours of the current session of Congress.

The HSA package did not come out of nowhere. It is the same one cleared by the House Ways and Means Committee in September that was given up for dead by some Washington observers following the November elections that put Democrats in line to take control of Congress.

Fighting for a good cause—and not giving up—can lead to success

The reasoning for the gloomy assessment is that, in general, Democrats have opposed HSAs and would resist efforts to expand them. What those pundits didn't understand is the nature of politics. Yes, congressional Democrats generally don't like HSAs, but there are many legislative proposals they do want.

So what happened was simple. It is called horse trading. The Democrats relented on the HSA legislation, while Republicans gave in on some proposals, most notably federal support of health care benefits promised to retired coal miners.

We'll leave it to others to say whether such deals are good or bad policy. But we know that the HSA changes would have had no chance to be included in the broader tax bill had not business lobbying groups kept up the pressure on legislators to fight for their inclusion.

The HSA changes, while modest, are welcome and needed. Among other things, they will allow bigger contributions to HSAs, increasing the likelihood that employees will not only have enough to pay for current uncovered medical care expenses, but also enough to build up savings they will need to meet future health care expenses.

The saying it isn't over until it's over certainly is true, and that fighting for a good cause—and not giving up—can lead to success.

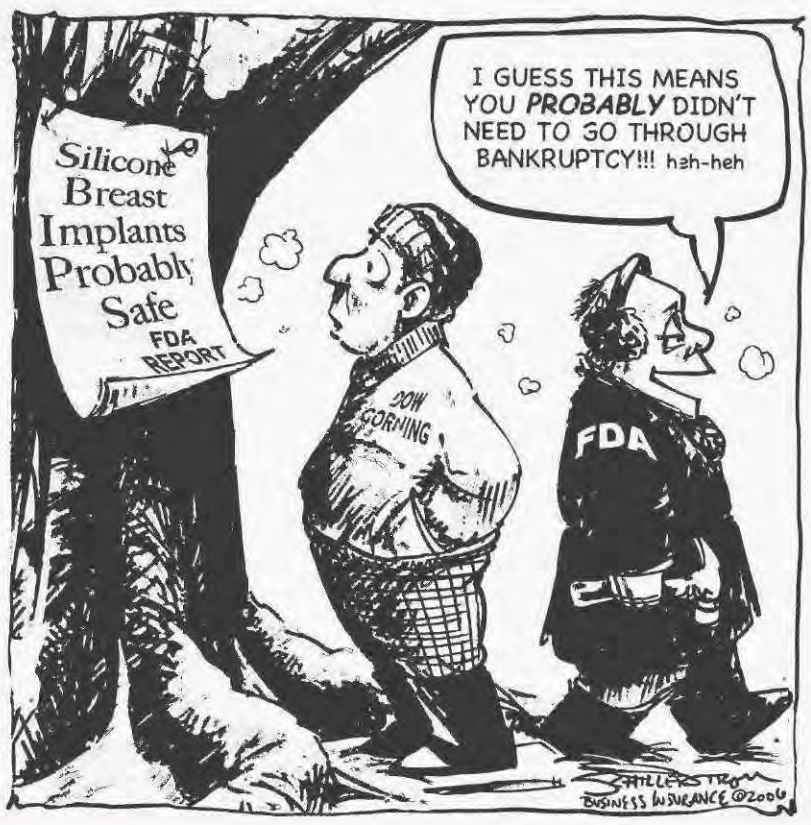
'Hellhole' report shows positive development

IN WHAT HAS become a year-end tradition, the American Tort Reform Assn. has released its list of "Judicial Hellholes," an ugly term for an ugly legal situation. And this year's report has some good news in that the situation didn't get any uglier.

As we report on page 1, the list of hellholes remained steady at six. All six appeared on last year's list as well, albeit in a different order. That no new jurisdictions have earned the designation of judicial hellhole—which the report defines as places where "judges systematically apply laws and procedures in unfair and unbalanced ways, generally against defendants in civil lawsuits"—is a positive development.

Unfortunately, there's no guarantee that the list will shrink—or even remain static—during the coming year. Jurisdictions have been added to the report's watch list "due to suspicious or negative developments in the litigation environment." The results of last month's elections will no doubt bring new assaults on reform. These will almost certainly include efforts to roll back enacted reforms while broadening definitions of liability.

No one should dispute that, as a whole, the news in the report is good. But what's also beyond dispute is that there's no reason to believe that such good news will simply keep generating itself. The challenges for reform advocates are likely to grow more formidable. Only continued efforts to maintain gains already made while pushing for reform in jurisdictions that have continued to resist reform will render those challenges surmountable.



Letters

Patient involvement critical in care quality

To the editor: Joanne Wojcik's Dec. 6 article, "Patient-centered care fosters safety," shows the importance of patient safety and satisfaction in improving the state of health care in America.

The aging baby boomer generation, increased attention on consumer-driven health care and nursing shortages are putting service and quality pressure on the health care system. Hospitals are turning to technology for the answers, but solutions such as electronic medical records and health spending accounts are not the complete solution to helping the average American become an active participant in their health.

My own experiences as a cancer survivor exposed me to the importance of taking part in your own health care. New, interactive patient care technology at the bedside is helping progressive hospitals directly engage patients by providing valuable patient education, pain assessment/management, medication teaching, and doctor feedback and interaction that directly contribute to the patient experience. Many of the top hospitals in the country are empowering patients with these tools through bedside television monitors. Patient engagement is a critical component in driving consumers toward better care and ultimately reducing costs.

Michael B. O'Neil Jr.
Founder & Chief Executive Officer
GetWellNetwork Inc.
Bethesda, Md.

Write us

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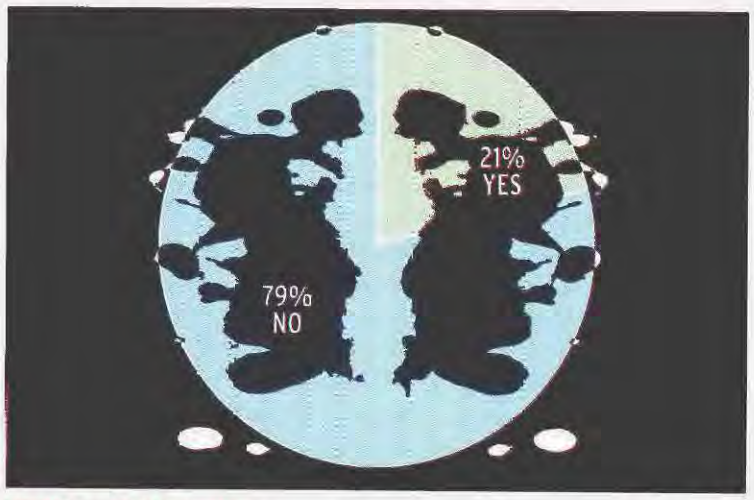
Online Poll at www.businessinsurance.com

Does your company provide the same coverage for mental health care expenses as it does for other medical conditions?



NEXT WEEK'S POLL: *During the next year, do you expect the civil justice environment to improve or deteriorate?*

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SECTOR BRIEFING

PHARMACEUTICALS

RISKY BUSINESS

Perils soar for makers of drugs

By TONY DOWDING

The pharmaceutical industry has undergone a transformation in the past decade, with continuing merger and acquisition activity and globalization that has combined with a steep decline in the image of the industry.

It is perhaps no wonder, therefore, that an analysis of pharmaceutical companies' key performance measures by Wayne Guay, associate professor of accounting at The Wharton School of the University of Pennsylvania, showed during the past 13 years that pharmaceutical companies in the aggregate have become as much as "50% riskier" than the overall Standard & Poor's 500.

He analyzed the volatility of data such as cash flow, net income and return on investment, among other factors, in his 2005 study.

"Positive and negative events in this industry are extraordinarily pronounced, with dramatic effect on shareholder value and reputation," Professor Guay's report concluded.

A KPMG L.L.P. report, "Pressure Points: Risk Management in the Pharmaceuticals Industry," concluded that the risk profile of the pharmaceutical industry has changed dramatically during the past decade. By looking at risk factors disclosed by 18 major pharmaceutical companies and medical device manufacturers in their 2003 Securities and Exchange Commission 10-K filings, KPMG found that 100% of the companies cited both legal liability and price controls as risks—vs. 88% and 63%, respectively, in 1998—followed by an underdeveloped product pipeline, product supply and changes in their competitive environment.

Other important risks faced by the industry from an insurance perspective include intellectual property (covering legal costs and business continuity), directors and officers liability, environmental risks and trade credit risks. However, two of the most important insurable risks are product liability and business interruption.

Product liability

Product liability is the industry's key insurable risk and yet it is, paradoxically, the one for which the insurance industry is failing to provide the best solution, experts say. Product liability is an area for which many pharmaceutical companies either cannot buy insurance or won't buy it because it is prohibitively expensive.

Bruce Belzak, Marsh Inc.'s life sciences practices leader in the United States, based in Philadelphia, says: "As far as product liability is concerned, what has happened over the last five years is that losses continued to occur with increasing frequency and severity, and under-

See **RISKY** next page

Risky: Drug makers' premiums and retentions go 'through the roof'

CONTINUED FROM PREVIOUS PAGE

writers basically said that they did not know how to underwrite this risk, so they began increasing deductibles or retentions, raising rates, reducing limits and started excluding actual products that the companies make.

"As a result, premiums and retentions have gone through the roof and the limits have gone down, so a significant number of the jumbo pharmaceutical companies—those with more than $10 billion in annual revenue—are going completely self-insured," Mr. Belzak said.

The self-insured route

Going self-insured means a variety of approaches that range from putting the risk through a captive, using alternative risk transfer or "taking it on the balance sheet," one observer said. The effort could use actuarial estimates or be as simple as "paying a check and writing it out of cash flow."

For some pharmaceutical risk managers, taking the self-insured route is seen as a positive choice rather than a reaction to the failure of the insurance market.

KEY POINTS

- **Pharmaceutical companies are up to 50% riskier than the overall Standard & Poor's 500.**
- **Product liability and business interruption are key insurable risks for the industry.**
- **Product liability coverage comes under ever-rising pressure.**
- **Business continuity planning is critical.**

"For many companies, insurance provides a sound solution as a hedge against large losses that could negatively impact the financial picture of an organization," said Gary Nelson, vp, risk management and legal administrative services for Medtronic Inc., based in Minneapolis.

"In theory, insurance provides a key source of critical cash to an organization when it needs it the most. However, insurance may not be the best solution for a company when trying to hedge against mega-catastrophic losses, when insurance coverage is limited or significantly restrictive, or when insurance premiums are significantly higher than the expected losses of the entity," he said.

"Companies which analyze their insurance needs by reviewing their profit and loss, balance and cash flow along with their expected losses and premium costs may be surprised to find out that they could easily afford to take on more self-insurance as a part of their risk management program," Mr. Nelson said.

Retaining more risk often goes hand-in-hand with a greater focus on risk management, and in the product liability arena this is tied in with the research and development phase.

It also ties in with a robust legal defense, as pharmaceutical companies and their directors are major targets of plaintiffs' lawyers, especially for class actions in the United States.

Business interruption

Business interruption is the other major insurable risk that pharmaceutical companies face, industry experts say.

Alex Hindson, former risk services manager at AstraZeneca P.L.C. and now Weybridge, England-based associate director of the enterprise risk management unit of IRMG, the integrated risk consulting practice of Aon Captive Services Group, says pharmaceutical companies face a huge potential business interruption risk.

"A typical pharmaceutical company's property exposure is 80%-90% business interruption, with the remainder related to actual physical damage. The focus in this industry needs to move from physical protection towards effective supply chain management and the establishment of business continuity strategies across sites," Mr. Hindson said.

Business continuity planning is essential, but the industry needs to go much further than simply having one's own plan. The industry is moving toward more complex business models with significant outsourcing, joint ventures, strategic alliances and partnerships—often with much smaller biotechnology companies. This has important consequences for issues such as assumption of liability, but also, more importantly, business continuity.

"A lot of pharmaceutical and biotech companies rely heavily on sole suppliers," Marsh's Mr. Belzak said.

"We tell them they need to go to key suppliers and ask them what they would do if they were unable to supply the key ingredient that we need in a particular drug," he said.

"It is important that pharmaceutical companies have their business continuity plans, but it is also important that the people that they are dealing with have their business continuity plans as well," Mr. Belzak said.

Product recall insurance scarce for pharmaceutical companies

Alternative market the only option for large organizations

By MICHAEL BRADFORD

Large pharmaceutical companies in need of insurance to cover the cost of product recalls have no options in the traditional market.

Needing a line of coverage made extinct by heavy losses and underwriting mistakes, large drug companies are forced to fund the product recall risk in captives or other alternative market vehicles, or simply assume the expense of a recall as a cost of doing business.

Smaller risks—pharmaceutical companies with sales of less than around $10 billion—have a somewhat easier time finding recall coverage. But those policyholders can turn to just a handful of insurers that are writing the coverage with some significant restrictions.

"If you have a recall, any insurance product is going to help, but it will not replace the entirety of the loss of reputation and everything else."

Jim Walters, Aon Corp.

"For the large research-based pharmaceutical company, there really is no market; that market has been gone since the turn of the century, around 2000 or so," said Tom Coughlin, chief executive officer of Willis Risk Solutions in New York. "For the smaller companies, there still is something of a market available, but not a huge amount of capacity."

The recall risk for many large pharmaceutical companies is considered a cost of doing business, experts point out. Recalls happen fairly frequently, they explain, and often are related to relatively innocuous blunders such as packaging mistakes, rather than design errors that can cause harmful side effects.

Some pharmaceutical companies fund the recall risk in captive insurers or other self-insurance vehicles while others simply plan to absorb the expense if a recall occurs, sources say.

Bruce Belzak, Philadelphia-based managing director and head of Marsh Inc.'s life sciences practice, said he discussed with one risk manager the idea of establishing a captive to cover recalls. "His view was that by putting a captive in place, it adds a layer of cost," Mr. Belzak said of the risk manager.

The risk manager decided that "we're not even going to bother doing that; we'll just write a check" for recall expenses, said Mr. Belzak.

For many companies, product recall is the least of their worries, sources say.

Strategy

"From my experience, European pharmaceutical companies deal with such costs through their risk management programs," rather than insuring the exposure, said Rudiger Seitz, Zurich-based global head of Allianz Global Corporate & Specialty, PharmChem Solutions. "They are more concerned that they have sufficient coverage for product liability exposures. The cost of a recall appears to be manageable for pharmaceutical companies," he noted, but not the expense related to product liability litigation. Allianz does not offer recall coverage, Mr. Seitz said.

"It's not the cost of a recall that should be a concern of pharmaceutical companies," he said, but the expense related to litigation, which is covered by product liability insurance.

Even when recall insurance was available several years ago for large pharmaceutical companies, many passed on the coverage because the cost was so high, said Mr. Coughlin. "Some of them bought it, but it was not a staple for every manufacturer."

"Seven or eight years ago there were a handful of markets that would write it," said Bill Harrison, managing director with Aon Crisis Management, a Somerset, N.J., unit of Aon Corp. "Even some of the large companies did buy it. But there were quite a few large losses," he said. And because underwriters "didn't understand the size of the risk or where the deductibles should be placed, they got hit pretty hard," Mr. Harrison said.

When the losses piled up, "every insurer got out," he said.

The cost of a pharmaceutical recall has been "ingrained as a cost of doing business" as premiums rose to a point at which large companies "were not able to transfer it any cheaper than they can retain it," said Mr. Coughlin.

Today's market is around a dozen insurers for smaller companies. There are a handful in the United States and several more in Europe that are willing to take on the expo-

See **RECALL** next page

Recall: Coverage is pricey, even with significant retention of risk

CONTINUED FROM PREVIOUS PAGE

sure, but they are not covering every facet of the recall risk, market experts noted.

The coverage is not cheap, Mr. Coughlin said. "This is not a commodity buy. "It's a very strategic buy and is going to have relatively large retentions."

"The market as a whole in recall is very small," said Julie Ross, London-based vp and product contamination and recall specialist with Marsh Inc. Available limits amount to around €45 million to €60 million ($59.5 million to $79.3 million) of primary coverage for recalls as a result of accidental contamination, she said, and for recalls due to malicious tampering, availability rises to more than €150 million ($198.2 million).

Recall insurance does not cover drug design errors, which could cause health problems, said Jim Walters, managing director and head of the pharmaceutical and life sciences practice at Aon Corp. in Philadelphia.

"It is important to remember that the reasons for recalls are somewhat limited" in insurance policies that cover them, Mr. Walters noted. Malicious tampering, accidental contamination and product extortion are coverage triggers in recall policies, he said. Other types of recalls, such as those begun because a counterfeit product enters the market, are not typically covered.

Other, less extensive coverages also are available.

Among the insurers offering coverage to small and midsize pharmaceutical companies, Chubb Corp. offers a product withdrawal and expense policy that covers, among other things, expenses related to taking a product off the market, disposal and communication efforts to publicize the move.

Policyholders that purchase the coverage typically are middle-market and smaller drug companies for whom a "$1 million expense would be kind of hard on them," said Jill Wadlund, vp and worldwide life sciences casualty manager with Chubb in Whitehouse Station, N.J. "Larger companies are willing to absorb that," she said.

Large pharmaceutical companies are hesitant to talk about how they handle product recalls. Companies such as Merck & Co. Inc., which faces lawsuits over the market withdrawal of its Vioxx product, and Bristol-Myers Squibb, the maker of Plavix, which prevents blood clots, refused to discuss how they finance or manage the recall risk. Several others did not respond to requests for information.

A spokeswoman for Amgen Inc., which produces drugs for kidney patients that develop anemia and for rheumatoid arthritis, would confirm only that the company has a "risk management strategy in place and certainly a recall mitigation strategy," but would not publicly discuss those controls.

Managing the risk, particularly for large pharmaceutical companies with no insurance, calls for superior quality control to prevent recalls and a loss control program that considers how to soften the blow to the company's reputation and profits if a recall does occur, industry sources agree.

Quality control includes careful packaging and labeling to ensure that mistakes don't trigger a recall, Ms. Wadlund said. Chubb takes a look at its policyholders' recall risk management plan to "see how comprehensive it is," she noted.

The insurer wants to know that the drug maker has up-to-date contact information for hospitals and physicians that use their products, a plan for sending out notices if recalls occur and procedures for communicating recalls to the public, among other recall-related steps that might have to be taken, Ms. Wadlund said.

Recall roster

Most insurers require such pre-recall steps be taken, said Ms. Ross of Marsh. They want to see a "recall response" that outlines who needs to be involved, whether it is the chief financial officer, risk manager or other executives, she said. There also needs to be clear direction as to who will deal with the press and public during a recall, she stressed.

"Once they have a recall, insurers expect to see them invoke that crisis system," said Ms. Ross. That could include a "war room" from which the recall effort would be directed, she said.

Proper communication with the public is critical in a recall, according to Mr. Walters of Aon. "If you have a recall, any insurance product is going to help, but it will not replace the entirety of the loss of reputation and everything else," he said.

While much of the financial loss will be mopped up by the policy, only a careful response will help save a drug maker's reputation, Mr. Walters said.

Ms. Wadlund said policyholders should routinely test their recall response procedure to make sure it can be carried out. "Hopefully, they will never have to use it."

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Drug, medical device makers seek risk financing alternatives

Greatest challenges seen in D&O liability and product liability

By ROSEANNE WHITE GEISEL

Premium increases and extensive policy exclusions are driving pharmaceutical manufacturers and medical device companies to search for risk financing alternatives.

Adding to the industry discomfort in the U.S. insurance market, capacity has shrunk considerably and companies with annual revenues of $10 billion or more are being asked to accept huge retentions.

The situation varies by line of insurance and size of the policyholder. Product liability and directors and officers liability present the greatest challenges, while other lines, including property, business interruption and cargo coverage, are less difficult. Smaller and midsize companies are finding more capacity with lower retentions than larger companies with greater potential exposures.

So far, there are few risk financing alternatives.

"It's a split buying pattern in the pharmaceutical industry," said Bruce Belzak, managing director and head of the life sciences practice for Marsh Inc. in New York. "The 'megapharmas' basically have gone bare on product liability."

A trend to avoid buying even excess liability layers in the traditional market began about three years ago. Several factors created the impetus for this trend, he said.

"The capacity available has been cut in half," Mr. Belzak said. Insurers are offering $500 million to $600 million in capacity today vs. $1.3 billion in 1999.

Retentions that once were $25 million to $35 million have ballooned to $400 million while premiums have tripled or quadrupled to reach 10% of liability.

"The megapharmas are saying, 'We have a very strong balance sheet. We're just not going to buy insurance,'" Mr. Belzak said. While most big companies once financed retentions through captives, after leaving the market even funding just some of the risk through their captive becomes too costly, he said.

Jim Walters, managing director of the life sciences and chemical group for Aon Corp. in Chicago, said, "Clearly, there has been a sea change. We used to start negotiations with a blank sheet of paper. Now there is a big long list of exclusions." Drugs that have had product liability problems or entire classes of drugs that have generated concern, such as hormone replacement therapy, are being excluded, he said.

Even with these exclusions, policyholders were being asked to retain more than $500 million in risk, he said. "We used to be able to put together $1 billion pretty easily. Now a major U.S.-based company is lucky to get $300 million to $400 million in coverage."

The picture is different for medical device companies, said Scott Bayer, senior vp of general liability for Liberty International Underwriters in Boston, a unit of Liberty Mutual Group Inc. LIU writes primary coverage for all liability exposures for small to midsize companies.

"The hard market is not affecting medical devices," Mr. Bayer said. Coverage is widely available and rates are stable, he said.

However, Mr. Bayer pointed out, LIU avoids writing coverage for any type of permanent implant. Most insurers avoid those products that have the potential to result in class action litigation, he said.

Insurance market conditions reflect, in large part, underwriters' difficulty in forecasting product liability exposure, Mr. Belzak said. "No one knows how to understand this risk," he said. "Their solution has been raising prices and raising retentions."

"Frankly, when you have problems like Phen-Fen, how do you finance a problem of that magnitude?" Mr. Walters said. "For companies any smaller (than the large pharmaceutical companies), it would be life threatening to have this amount of litigation."

The situation is similar for directors and officers liability coverage. "Disappointment in clinical trials or product withdrawals cause stock to take a nose dive," said Mr. Walters. That, in turn, exposes directors and officers to liability.

Some large companies are using actuaries to study their products and calculate what would be a reasonable amount to set aside for the exposure, Marsh's Mr. Belzak said.

'Numbed by the cost'

Many pharmaceutical companies with $1 billion to $5 billion in revenue cannot afford to go without cover, so they are still in the market, he said. However, those companies "are increasingly feeling numbed by the cost of it." For example, a $5 billion medical device company said it will not purchase liability insurance at the end of its current program because it is having good claims experience and is choosing to leave the market, he said.

Another company with $3 billion in revenue is "playing hardball with underwriters" and worked out a quota-share arrangement, Mr. Belzak said.

Companies with less than $1 billion in annual revenue are getting retentions between $1 million and $10 million, he said.

"The picture changes dramatically when you're talking about a start-

See ALTERNATIVES page 16

London broker seeks support to create pharmaceutical mutual

By ADRIAN LADBURY

A mutual insurer could provide the answer to the liability coverage problems of global pharmaceutical companies, according to Neil Campbell, a partner with broker JLT Risk Solutions in London.

And the former AstraZeneca P.L.C. risk manager is busy at work trying to garner support for his idea from risk managers and reinsurers.

Global liability capacity for large pharmaceutical companies has plummeted over the past several years as result of spiraling claims and as a result, buyers have deserted the market.

Mr. Campbell

Neither buyers nor insurers and reinsurers are particularly happy with the situation, according to experts, but given the volatility and high risk nature of the modern drug manufacturing and marketing business, they have found it a difficult problem to solve.

According to Mr. Campbell, a mutual insurer could be structured to offer significant capacity to drug companies provided it is structured to offer significant new capacity with realistic attachments at a competitive price. It would also need a long term approach with perhaps five-year terms and provide coverage for whole product portfolios, rather than on a product-by-product basis.

"We are developing a much more complex proposal than a simple mutual.... It is long-term, experience-based, removes post-loss sharing of claims and ensures there is a sufficient limit to meet all claims," Mr. Campbell said.

The broker said that he is a "long way down the road" with the concept, but admits that it is "very tough." Large pharmaceutical companies have become used to retaining a significant amount of their liability exposures, he said.

"It is really down to whether people decide that insurance is adding value or whether their balance sheets are really big enough," Mr. Campbell said.

And the concept should make sense for the insurance and reinsurance companies that are holding a tough line on a business that can wreck their earnings, but also one that still offers huge potential premiums, he said.

"For insurers and reinsurers, it's potentially a way to get away from trying to write this on a product-by-product basis," Mr. Campbell said.

But Robert Corbet, pharmaceutical specialist with Aon Risk Services in London, is not sure that the mutual concept can really be applied to pharmaceutical liabilities.

"Look at the dynamics of (the mutual concept) and it is difficult. The buyer says 'I won't put my balance sheet with someone who I don't think is as well run as my own company....' In the current market I think it is unlikely," said Mr. Corbet.

Chris Bryce, European chemicals and life science practice leader for Marsh Inc. in London, said he likes the idea in principle but is also skeptical, particularly of the European response.

"It's a great idea and it has been debated for some time, but it will be difficult in Europe. In North America, there is a far greater acceptance of the mutalization concept. Europeans are more cynical and the argument always goes back to who is the first one to swoop the pot," he said.

Whether the mutual concept for the pharmaceutical business will fly this time around should become clear over the next several months, according to Mr. Campbell of JLT.

"We should know in the next couple of months. We are currently looking for reinsurance support for the structure. The problem is many buyers have philosophically decided not to buy insurance and we have got to overcome that," he said.

If You Purchased or Renewed Commercial Insurance or Reinsurance From August 26, 1994 Through September 1, 2005 From Zurich Insurers, Insurer Defendants, Broker Defendants (Listed Below), and/or Any Other Broker, You Could Be Entitled to Monetary Relief By Participation in a Class Action Settlement

Court-Ordered Legal Notice

IF, DURING THE PERIOD FROM AUGUST 26, 1994 THROUGH SEPTEMBER 1, 2005, INCLUSIVE, YOU

ENGAGED THE SERVICES OF ANY OF THE BROKER DEFENDANTS (AS IDENTIFIED BELOW) IN CONNECTION WITH ONE OR MORE PURCHASE(S) OR RENEWAL(S) OF COMMERCIAL INSURANCE OR REINSURANCE FROM ANY OF THE ZURICH INSURERS (AS IDENTIFIED BELOW), FROM ANY OF THE INSURER DEFENDANTS (AS IDENTIFIED BELOW) OR FROM ANY INSURANCE COMPANY THAT IS NOT AN AFFILIATE OR SUBSIDIARY OF A ZURICH INSURER

and/or

ENGAGED THE SERVICES OF ANY OTHER BROKER IN CONNECTION WITH ONE OR MORE PURCHASE(S) OR RENEWAL(S) OF COMMERCIAL INSURANCE OR REINSURANCE FROM ANY OF THE ZURICH INSURERS.

YOU COULD BE ENTITLED TO PARTICIPATE IN A CLASS ACTION SETTLEMENT PURSUANT TO WHICH YOU WOULD RECEIVE MONETARY RELIEF.

If you believe that you are eligible to participate in the class action settlement described in this Court-Ordered Legal Notice but did not receive in the mail a detailed Notice describing the settlement, please visit www.insurancebrokerageantitrustlitigation.com, where you can obtain the Notice, or contact the Court-approved Settlement Administrator as set out below to request a copy of the Notice.

A settlement has been reached with the Zurich Insurers (the "Zurich Settlement") in a class action lawsuit alleging violations of federal and state antitrust laws, the Racketeer Influenced and Corrupt Organizations Act, and common law arising out of (*i*) practices by which certain insurers provided quotations to policyholders and prospective policyholders through certain brokers in connection with the placement and renewal of insurance contracts and (*ii*) contracts, agreements, arrangements and understandings about the payment of commissions that are contingent upon, among other things, a broker placing a particular number of policies or dollar value of premium with the insurer.

The term "Zurich" is used throughout this Court-Ordered Legal Notice to include some or all of the Zurich Insurers listed below, depending on the context in which it is used.

In addition to policy purchases and renewals through Broker Defendants, purchases and renewals of policies issued by Zurich through any other broker – even if such broker is not named as a defendant in this Class Action – may also be covered by the Zurich Settlement if the policies were purchased or renewed within the Class Period.

If the Zurich Settlement is finally approved by the Court, a settlement fund with at least $121,800,000 (plus applicable interest) will be created by Zurich and will be distributed to those policyholders who fit within the description of the settlement class that is described above ("Settlement Class Members"). In addition to this settlement relief of $121,800,000, Zurich will also pay a Court-approved award of attorneys' fees and expenses and *all* administrative costs incurred to implement the Zurich Settlement – including the cost of establishing a toll-free telephone center to respond to Settlement Class Members' inquiries. ***None of these costs will be deducted from the settlement relief.***

If you are a Settlement Class Member and you do not wish to participate in the Zurich Settlement, you must request exclusion from the Settlement Class postmarked or delivered no later than January 11, 2007.

If you think that you might be a Settlement Class Member, you can obtain more information – including a copy of the Notice which provides additional detail – by calling the Court-approved Settlement Administrator at **1-866-722-3544** (international – 001-612-359-7999), by e-mailing the Settlement Administrator at **zurichadmin@completeclaimsolutions.com** or by visiting ***www.insurancebrokerageantitrustlitigation.com***.

WHAT DOES THE ZURICH SETTLEMENT PROVIDE?

At least $121,800,000 will be distributed in connection with the Zurich Settlement – with a possibility under certain circumstances (described below) that Zurich will be required to fund up to an additional $29,900,000 in connection with the Zurich Settlement.

- Zurich has already funded $70,100,000 of this amount into an escrow account set up under the Zurich Settlement Agreement (the "Class Action Escrow Account").
- In addition, under a settlement agreement that Zurich entered into with the Office of the Attorney General of the States of California, Florida, Hawaii, Maryland, Oregon, Texas and West Virginia and the Commonwealths of Massachusetts, Pennsylvania and Virginia, the Chief Financial Officer of the State of Florida and the Office of Insurance Regulation of the State of Florida, and parallel settlement agreements with certain departments of insurance, including (to date) the Departments of Insurance for the States of California, Oklahoma, Delaware, Nebraska, Iowa, Nevada, Arkansas, Missouri, Montana, Illinois, Connecticut, Indiana and Oregon and for the Commonwealths of Pennsylvania and Massachusetts (collectively, the "Multi-State Agreement"), Zurich has agreed to fund, and has already deposited, an additional $51,700,000 into the Class Action Escrow Account in conjunction with the settlement relief provided for under the Zurich Settlement Agreement.
- If the Zurich Settlement is finally approved, the amount that has already been deposited into the Class Action Escrow Account – $121,800,000 (plus applicable interest) – will be distributed to Settlement Class Members (after deductions for any limited expenses (if any) relating to tax liabilities or the maintenance of the Class Action Escrow Account) – pursuant to a Court-approved Plan of Allocation.
- In addition, under the Zurich Settlement Agreement, Zurich will be required to fund *up to* an additional $29,900,000 into the Class Action Escrow Account if *less* than that amount is distributed through a settlement agreement that Zurich has executed with the Office of the Attorney General of the States of New York, Connecticut and Illinois and with the Superintendent of Insurance for the State of New York (collectively, the "Three-State Agreement").
- In other words, Zurich will be required to pay into the Class Action Escrow Account the difference between what is distributed under the Three-State Agreement and $29,900,000 if the amount that is distributed under the Three-State Agreement is less than $29,900,000. Thus, for example, if only $27,000,000 is distributed under the Three-State Agreement, Zurich will be required to pay an additional $2,900,000 into the Class Action Escrow Account. If, on the other hand, $41,000,000 is distributed under the Three-State Agreement, Zurich will not be required to pay any portion of the $29,900,000 into the Class Action Escrow Account. Neither the Plaintiffs nor Zurich are able to predict at this point whether Zurich will end up paying any portion of the additional $29,900,000 into the Class Action Escrow Account.

Under the terms of the Zurich Settlement Agreement and the Multi-State Agreement, Zurich has already funded a total of $121,800,000 into the Class Action Escrow Account – with the possibility of being required to fund up to an additional $29,900,000 under the conditions described above.

Finally, Zurich must pay certain additional amounts – the amount awarded to cover attorneys' fees and expenses for Plaintiffs' Counsel and the amount required to pay the administrative costs associated with administering the Zurich Settlement (including the costs of providing this Court-Ordered Notice to you) – in addition to providing the settlement relief described above. ***Thus, such administrative costs will not be paid out of the settlement relief.***

WILL PARTICIPATION IN THE ZURICH SETTLEMENT AFFECT PARTICIPATION IN OTHER SETTLEMENTS?

If you participate in the Zurich Settlement, you will also participate in the Multi-State Agreement. The settlement amounts paid in both of these settlements will be aggregated and distributed through the Court-approved Plan of Allocation.

However, if you purchased or renewed excess casualty insurance policies issued by Zurich (other than excess workers' compensation policies) through Marsh & McLennan Companies, Inc. or Marsh Inc. (collectively, "Marsh") during the period from January 1, 2000 through September 30, 2004, you are eligible to receive settlement relief under the Three-State Agreement. Under that agreement, Zurich has set up an $88,000,000 settlement fund If you are eligible to receive settlement relief under the Three-State Agreement, you will have to determine whether you want to receive settlement relief under the Three-State Agreement or under the Zurich Settlement Agreement for those particular policies. You will not be allowed to receive relief under both the Zurich Settlement Agreement and the Three-State Agreement for such policies (though you might be able to receive settlement relief under the Zurich Settlement Agreement even if you receive relief under the Three-State Agreement if you have policies that are covered by the Zurich Settlement Agreement but not by the Three-State Agreement). The Notice provides additional details (at paragraph 17) regarding your options for policies covered by the Three-State Agreement.

WHO IS PAYING THE ATTORNEYS' FEES AND EXPENSES THAT ARE BEING SOUGHT?

After Plaintiffs and Zurich agreed on all other terms of the Zurich Settlement Agreement, counsel for Plaintiffs ("Class Counsel") and Zurich negotiated the amount of attorneys' fees and expenses that Zurich will, subject to Court approval, pay to Class Counsel. Class Counsel will seek an award of attorneys' fees and expenses of no more than $29,950,000. Zurich has agreed that it will not oppose and, subject to Court approval, that it will pay fees and expenses up to that amount. The award of attorneys' fees and expenses to Class Counsel is subject to Court approval. Class Counsel intends to apply to the Court for permission to pay up to ten thousand ($10,000) to each class representative Plaintiff from the amount of attorneys' fees and expenses awarded by the Court based upon the effort that each class representative Plaintiff has devoted to this litigation. Zurich will pay attorneys' fees and expenses in addition to the other amounts it is required to pay under the Zurich Settlement Agreement. *Thus, you will not be responsible for any of Class Counsel's fees or expenses, and none of those fees or expenses will be deducted from the settlement relief.*

WHAT ARE THE LEGAL EFFECTS OF PARTICIPATING IN THE ZURICH SETTLEMENT?

If the Court approves the Zurich Settlement, Plaintiffs and Zurich will seek the entry of a Judgment and an Order Approving Settlement that, among other things, will:

- find that the settlement is fair, reasonable and adequate;
- finally certify the class for settlement purposes;
- dismiss the Class Action with prejudice as to Zurich, meaning that no Settlement Class Member (unless they timely exclude themselves) will be able to bring another lawsuit or proceeding against any of the Releasees (as that term is defined in the Zurich Settlement Agreement) based upon the claims that have been raised or that could have been raised in the Class Action;
- incorporate the Release that is found in the Zurich Settlement Agreement as part of the Order Approving Settlement;
- permanently bar Settlement Class Members from filing or participating in any lawsuit or other legal action against any or all Releasees arising from or relating to any and all claims that have been raised or that could have been raised in this Class Action;
- enter a bar order that will:
  - prevent any person or entity from commencing, prosecuting or asserting any claim (including any claim for indemnification or contribution) against any Releasee where the alleged injury to the barred person or entity is based upon that person's or entity's alleged liability to the Settlement Class or a Settlement Class Member, and
  - prevent any Releasee from commencing, prosecuting or asserting any claim (including any claim for indemnification or contribution) against any person or entity where the Releasee's alleged injury is based upon the Releasee's alleged liability to the Settlement Class or a Settlement Class Member;
- award attorneys' fees and expenses to Class Counsel; and
- retain jurisdiction over all matters relating to the administration, enforcement and interpretation of the settlement.

As noted, if the Court approves the Zurich Settlement, the Release that is found in the Zurich Settlement Agreement will be incorporated into the Court's Order Approving Settlement. The Release describes the claims that Settlement Class Members will give up, as well as the identity of the Releasees – *i.e.*, the people and entities that will be released. As discussed below, you can obtain a copy of the Release (including the definition of Releasees) from the Court-approved Settlement Administrator or from the websites of certain Class Counsel.

HOW WILL SETTLEMENT PAYMENTS BE MADE IF YOU PURCHASED A ZURICH POLICY?

If the Zurich Settlement is approved and you are a Settlement Class Member who purchased or renewed one or more insurance policies issued by Zurich, you will *not* have to do anything to receive the benefits under the Zurich Settlement Agreement regarding your Zurich policies. A check in the amount of settlement relief due to you under the Plan of Allocation will be mailed to you at your last-known address. If your address has changed since you purchased or renewed your Zurich policy, please contact the Settlement Administrator as set out below.

HOW WILL SETTLEMENT PAYMENTS BE MADE IF YOU PURCHASED A POLICY FROM AN INSURER OTHER THAN ZURICH?

If you are a Settlement Class Member who purchased or renewed one or more insurance policies issued by a non-Zurich insurance company through a Broker Defendant and you want to make a claim based on that policy, you will have to fill out a claim form and submit it to the Settlement Administrator at Insurance Brokerage Antitrust Litigation, c/o Complete Claim Solutions, LLC, P.O. Box 24721, West Palm Beach, FL 33416, postmarked by no later than June 12, 2007. You can obtain the claim form by visiting the website of the Court-approved Settlement Administrator at *www.insurancebrokerageantitrustlitigation.com*, by calling **1-866-722-3544** (international – 001-612-359-7999), Monday through Friday from 8:00 a.m. to 7:00 p.m. Central, by writing to Insurance Brokerage Antitrust Litigation, c/o Complete Claim Solutions, LLC, P.O. Box 24721, West Palm Beach, FL 33416, or by sending an e-mail to zurichadmin@completeclaimsolutions.com.

WHAT OPTIONS ARE AVAILABLE TO SETTLEMENT CLASS MEMBERS?

If you fall within the definition of Settlement Class Member, you may either (*i*) participate in the Zurich Settlement (and receive settlement relief if the Court approves the Zurich Settlement Agreement) or (*ii*) request exclusion from the Zurich Settlement.

If you want to participate in the Zurich Settlement, but you object to any term of the Zurich Settlement Agreement, you may submit an objection to the Court. All objections must be filed with the Court and served on Class Counsel, Zurich's Counsel and the State Attorneys General who are parties to the Multi-State Agreement received by no later than January 11, 2007. The Notice provides details (at paragraph 24) about how to object.

If you want to exclude yourself from the Zurich Settlement, you must submit a written request to the Clerk of the Court (at the address that is in the Notice). Your request must be ***postmarked or delivered no later than January 11, 2007***. The Notice provides details (at paragraph 25) about how to exclude yourself.

WILL THE COURT HOLD A HEARING REGARDING THE ZURICH SETTLEMENT?

The Court will hold a hearing in this case on January 26, 2007 at 11:00 a.m. in Courtroom No. 1 in the United States Courthouse located at U.S. Post Office and Courthouse Building, Federal Square, Newark, New Jersey 07101, to consider whether to approve the Zurich Settlement including, among other things, the Plan of Allocation, and whether to grant Class Counsel's request for fees and expenses. If you file an objection, you may appear at this hearing and ask to be heard by the Court, but you do not need to do so. If you (or an attorney hired at your expense) intends to appear at the hearing, you (or your attorney) must file a notice of intention to appear. The Notice provides details (at paragraph 26) about filing a notice of intention to appear and serving it on Class Counsel, Zurich's Counsel and the State Attorneys General who are parties to the Multi-State Agreement by January 11, 2007.

The Court may choose to change the date and/or time of the hearing without further notice of any kind. If you intend to attend the hearing, you should confirm the date and time with the Class Counsel identified below or the Court-approved Settlement Administrator prior to going to the Courthouse.

HOW CAN A SETTLEMENT CLASS MEMBER GET ADDITIONAL INFORMATION?

The Zurich Settlement Agreement sets out the details of the Zurich Settlement, including the terms of the Release by which Settlement Class Members will be bound if the Zurich Settlement is approved. A complete description of the Plan of Allocation and the Release is also attached to the Notice (which is being mailed to the last-known address of Settlement Class Members). Both the Zurich Settlement Agreement and the Notice (which includes the Release and the claim form) are available at the Court-approved Settlement Administrator's website, *www.insurancebrokerageantitrustlitigation.com*, by calling **1-866-722-3544** (international – 001-612-359-7999), Monday through Friday from 8:00 a.m. to 7:00 p.m. Central, by writing to Insurance Brokerage Antitrust Litigation, c/o Complete Claim Solutions, LLC, P.O. Box 24721, West Palm Beach, FL 33416, or by sending an e-mail to zurichadmin@completeclaimsolutions.com. The Notice is also available at the following Class Counsel websites:

www.whatleydrake.com, www.millerfaucher.com, www.lerachlaw.com, www.zsz.com, www.foote-meyers.com, www.lfsblaw.com, www.ldgrlaw.com, www.furth.com, and at Zurich's website, www.zurichna.com.

Additional information regarding this Class Action and the Zurich Settlement may also be obtained by contacting the following Class Counsel or the State Attorneys General who are parties to the Multi-State Agreement:

Edith M. Kallas, Esq. *or*
Joseph Guglielmo, Esq.
Whatley, Drake & Kallas, LLC
1540 Broadway, 37th Floor
New York, New York 10036
Telephone: (212) 447-7070
Facsimile: (212) 447-7077
E-mail:
EKallas@whatleydrake.com

Bryan L. Clobes, Esq.
Ellen Meriwether, Esq.
Miller Faucher and Cafferty LLP
One Logan Square
18th & Cherry Streets
Philadelphia, Pennsylvania 19103
Telephone: (215) 864-2800
Facsimile: (215) 864-2810
E-mail:
bclobes@millerfaucher.com

or Mark Tobey, Esq.
Chief, Antitrust and Civil Medicaid Fraud Division
Office of the Attorney General – State of Texas
300 W. 15th Street, 9th Floor
Austin, Texas 78701
Telephone: (512) 463-1262
Facsimile: (512) 320-0975
E-mail: Mark.Tobey@oag.state.tx.us

PLEASE DO NOT CONTACT THE COURT OR THE CLERK'S OFFICE FOR INFORMATON

DATED: December 14, 2006

BY ORDER OF THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW JERSEY

The Zurich Insurers

*The Zurich Settlement involves the **Zurich Insurers**, which are the following companies:*

American Guarantee and Liability Insurance Company
American Zurich Insurance Company
Assurance Company of America
Colonial American Casualty and Surety Company
Empire Fire and Marine Insurance Company
Empire Indemnity Insurance Company
Fidelity and Deposit Company of Maryland
Maine Bonding and Casualty Company
Maryland Casualty Company
Maryland Insurance Company
National Standard Insurance Company
Northern Insurance Company of New York
Steadfast Insurance Company
Universal Underwriters Insurance Company
Universal Underwriters of Texas Insurance Company
Valiant Insurance Company
Zurich American Insurance Company
Zurich American Insurance Company of Illinois
Zurich Financial Services
Zurich International (Bermuda) Ltd. (ZIB)
Zurich Insurance Bermuda Branch (ZIBB)
Zurich Specialties London, Ltd. (ZSL)

The Insurer Defendants

*The other insurers involved in the action (the "**Insurer Defendants**") are:*

ACE American Insurance Co.
ACE INA Holdings, Inc.
ACE Limited
ACE USA, Inc.
AIU Insurance Co.
American Alternative Insurance Corp.
American Casualty Co. of Reading, PA
American Home Assurance Co.
American International Group, Inc.
American International Insurance Co.
American International Specialty Lines Insurance Co.
American Re Corporation
American Re-Insurance Co.
Athena Assurance Co.
AXIS Reinsurance Company
AXIS Specialty Insurance Company
AXIS Surplus Insurance Company
Berkshire Hathaway, Inc.
Berkshire Hathaway Insurance Group
Birmingham Fire Insurance Co. of Pennsylvania
Chicago Insurance Co.
CNA Financial Corp.
Commerce and Industry Insurance Co.
Continental Casualty Co.
Crum & Forster Holdings Corp.
Executive Risk Indemnity Inc.
Federal Insurance Co.
Fireman's Fund Insurance Co.
General Re Corporation
General Reinsurance Corp.
Greenwich Insurance Co.
Gulf Insurance Co.
Hartford Fire Insurance Co.
Hartford Steam Boiler Inspection and Insurance Co.
Illinois Union Insurance Co.
Indemnity Insurance Co. of North America
Indian Harbor Insurance Co.
Lexington Insurance Company
Liberty Mutual Fire Insurance Co.
Liberty Mutual Holding Company, Inc.
Liberty Mutual Insurance Co.
Mt. Hawley Insurance Co.
Munich Reinsurance Co.
Munich-American Risk Partners, Inc.
National Surety Corp.
National Union Fire Insurance Co. of Louisiana
National Union Fire Insurance Co. of Pittsburgh, Pa.
New Hampshire Insurance Co.
Nutmeg Insurance Co.
Pacific Insurance Co., Ltd
RLI Corporation
RLI Insurance Co.
St. Paul Fire & Marine Insurance Co.
St. Paul Mercury Insurance Co.
St. Paul Travelers Companies, Inc.
The Chubb Corporation
The Continental Insurance Corp.
The Hartford Fidelity & Bonding Co.
The Hartford Financial Services Group, Inc.
The Insurance Company of the State of Pennsylvania
Travelers Casualty & Surety Co. of America
Travelers Indemnity Company
Twin City Fire Insurance Co.
United States Fire Insurance Co.
Vigilant Insurance Co.
Wausau Underwriters Insurance Co.
Westchester Surplus Lines Insurance Co.
XL Capital Ltd.

The Broker Defendants

*The brokers involved in the Action (the "**Broker Defendants**") are:*

Acordia, Inc.
Affinity Insurance Services, Inc.
Aon Broker Services, Inc.
Aon Corporation
Aon Group Inc.
Aon Re, Inc.
Aon Re Worldwide, Inc.
Aon Risk Services Companies, Inc.
Aon Risk Services, Inc. of Louisiana
Aon Risk Services, Inc. of Maryland
Aon Risk Services, Inc. of Michigan
Aon Risk Services Inc. U.S.
Aon Risk Services of Texas, Inc.
Aon Services Group, Inc.
Arthur J. Gallagher & Co.
Arthur J. Gallagher Risk Management Services, Inc.
BB&T Corporation
BB&T Insurance Services, Inc.
Branch Banking and Trust Company
Brown & Brown, Inc.
Hilb, Rogal & Hobbs Company
Hub International Limited
Marsh & McLennan Companies, Inc.
Marsh Inc.
Marsh USA, Inc.
Marsh USA Inc. (Connecticut)
Seabury & Smith, Inc.
Stewart Smith Group
Summit Global Partners of Florida, Inc.
U.S.I. Holdings Corporation
USI Insurance Services of Florida, Inc. (d/b/a USI Florida)
Wells Fargo & Company
Willis Group Holdings Limited
Willis Group Limited
Willis North America, Inc.
Willis of New York, Inc.
Willis Re Inc.

For More Information, Call: 1-866-722-3544 Visit: www.insurancebrokerageantitrustlitigation.com Email: zurichadmin@completeclaimsolutions.com

Alternatives: Shrinking limits putting pressure on drug makers

CONTINUED FROM PAGE 14

up and smaller biotech and medical device manufacturers and neutraceuticals," said Pamela Haughawout, Boston-based senior vp with broker Hilb Rogal & Hobbs Co.

Tom Heim, Atlanta-based national director of HRH's casualty and risk management practice, said venture capitalists who back many of the smaller companies won't risk going without insurance.

HRH recently renewed coverage for a $165 million neutraceutical company and was able to get $50 million in liability coverage in the United States, Ms. Haughawout said. Another $150 million was available using the Bermuda markets, but the client opted not to purchase it, she said.

Part of what makes risk financing for the pharmaceutical and medical products industry so different from others is the pressure created by being "out there to improve the human condition," said Mr. Walters. For that reason, other important lines such as business interruption and cargo insurance are available, but not always with sufficient capacity or the most favorable rates and terms.

Marsh is working with clients to write technical proposals and bring underwriters together with chief scientists from potential policyholder companies to try to make the exposure picture as clear as possible and elicit more favorable terms, Mr. Belzak said.

Drug makers, for example, cannot afford to have their operations interrupted. "If your facility or your supplier's facility burns, they have to be inspected by the (Food and Drug Administration) before reopening. We spend a fair amount of time helping (those companies) to get their arms around those risks," Mr. Walters said. In the case of a catastrophe, business interruption won't entirely cover losses, he said.

Cargo insurance also is needed because these companies are transporting highly regulated, high-value shipments that are sensitive to external factors such as temperature, Mr. Walters said.

Deductibles rise

In response to rising deductibles, several large pharmaceutical companies formed a Hamilton, Bermuda-based mutual insurance company, Pharmaceutical Insurance Ltd. Because their factory operations are located in Puerto Rico, property and business interruption deductibles were increasing significantly even though there had not been a major hurricane or similar event in that location, Mr. Walters said.

The facility, which also underwrites risks for medical device companies, provides coverage of $150 million excess of $50 million per loss, paying out a maximum of $300 million of claims. Swiss Reinsurance Co. reinsures the risk.

In the search for risk financing alternatives, nothing has turned up in the capital markets because of the difficulty in forecasting risks. "People are still out there pushing the envelope trying (to find ways) to use the capital markets," said Aon's Mr. Walters.

Mr. Belzak said Marsh's view is that creating an insurance facility for the megapharmas still makes sense. "Perhaps in the future a combination of capital markets with traditional markets" might work, he said.

International NEWS

FSA issues new warning to brokers that income must be transparent

All commissions, fees have to be revealed when buyers ask

By SARAH VEYSEY

LONDON—The United Kingdom's insurance regulator has stepped up pressure on brokers to fully disclose information on their compensation to their commercial clients.

The London-based Financial Services Authority said frequently there are insufficient measures to ensure transparency of remuneration and again has warned brokers that they must disclose all commissions when buyers request it.

In a letter to chief executive officers of property/casualty insurance brokers sent earlier this month, the FSA reiterated previous market notices highlighting brokers' obligation to tell buyers about commissions earned on their business, should the buyer ask.

The FSA also said that, in a recent study of the market, it had found "a widespread lack of formal process among intermediaries as to what remuneration would be disclosed to a commercial client on request, with not all intermediaries including all forms of remuneration" in their systems.

Pointed reminder

A spokesman for the FSA said the regulator sent the letter as a reminder to brokers of the rule that they must disclose to buyers details of remuneration linked to their business.

Under FSA rules, if asked by commercial buyers, brokers must disclose information about any commission received in connection with an insurance contract, "including payments to associated firms, arrangements for sharing profits, for payments relating to the volume of sales, and for payments from premium finance companies when arranging finance."

The FSA announced in October that it would consider making disclosure of commissions mandatory unless a satisfactory market-led solution is reached (*BI*, Oct. 9).

A so-called "thematic study" of the insurance brokerage sector revealed that most firms have a standard clause in their terms of business agreements, which tells clients of their right to request information about any commission received in the placing of business, prior to the conclusion of the contract.

Few commercial clients request commission disclosure, although some have sought confirmation from their brokers that they are not being remunerated under a profit-sharing arrangement

In conclusion, the FSA said, it found a widespread lack of formal processes to deal with questions from buyers about remuneration.

In the letter to CEOs, Hector Sants, managing director of wholesale and institutional markets at the FSA, said that brokers should establish and maintain systems to enable them to respond to a commercial buyer's request for information. He added that records should be maintained to demonstrate that brokers have complied with FSA disclosure rules.

The U.K.'s risk management association says it is satisfied that most of its members "are asking and getting" information about commissions, and in some cases, that information is being provided to buyers without them having to ask, its executive chairman, David Gamble, said.

Mr. Gamble said that major buyers in the United Kingdom—members of the Association of Insurance and Risk Managers—"are getting very good support from brokers" on this issue.

In October, John Tiner, chief executive of the FSA, reiterated his call for risk managers to use their buying power and collective muscle to force greater transparency and market reform.

There is a feeling in the market that some smaller insurance buyers have been less concerned than their larger counterparts about demanding commission information, sources said.

AIRMIC would prefer the entire market to move toward greater transparency, and avoid the need for the FSA to step in and make commission disclosure mandatory, Mr. Gamble said.

Steve White, head of compliance and training at the London-based British Insurance Brokers Assn., said that most brokers are addressing the issues raised by the FSA in its letter.

"The market is becoming more and more transparent by the day," he said.

He said that BIBA did not believe that regulatory intervention to make commission disclosure mandatory would be necessary.

U.K. plan for mandatory pensions sparks concerns over cutbacks

Even so, employers and labor endorse goals of the legislation

By JONATHAN GARDNER

LONDON—The U.K. government is forging ahead with a plan to create a mandatory low-cost pension plan despite concerns that the reforms may prompt companies with more generous plans to reduce their contributions to the government's minimum.

The pension reform white paper published last week by the Department for Work and Pensions formalizes proposals put forward earlier this year to establish low-cost pension plans, into which every employee would be automatically enrolled unless he or she is a member of a more generous employer-sponsored plan (*BI*, May. 29).

Under the proposal, workers between 22 years old and the pension eligibility age, now 65, would be enrolled if they earn more than £5,000 ($9,798) starting in 2012. They would contribute 4% of earnings up to £33,500 ($65,442) a year, matched by a 3% contribution from employers and 1% in the form of tax relief. The combined 8% contribution is an amount that the government estimates would yield 45% of working income during retirement.

The earnings band would be indexed to inflation.

The government estimates enrollment of between 6 million and 10 million in the new plans, with £8 billion ($15.63 billion) a year in total contributions. About 60% of that would represent new contributions.

NEWSCAST

Most U.K. workers would be enrolled automatically under a proposed mandatory pension plan.

The plans would be administered by a pension authority overseen by experts from the financial services industry. Plan participants would be able to select a pension fund, and those who do not would be assigned to a default fund.

The broad points of the bill gained the support of labor and employers.

If properly implemented, the proposals would boost pension participation rates for millions of people currently not saving for retirement, said John Cridland, deputy director-general of the Confederation of British Industry, in a statement. "But without a package of support measures, employers with existing (plans) might be tempted to cut their contributions to contain the extra expense; and firms without (plans) will see growth and employment affected."

The National Assn. of Pension Funds warned that creation of the low-cost pension plans might prompt employers offering more generous plans to reduce their costs by opting for the new plans.

The association is advocating that the government introduce financial incentives for employers to maintain their current commitments.

"Politically, that's quite a long shot," said an NAPF spokesman. "NAPF recognizes the government has a number of financial restraints."

Ultimately, the new plans' cost likely would be passed on to workers, said Paul McGlone, principal with Aon Consulting in London.

"This will have to be paid for somehow. Ultimately, it will affect take-home pay. Employers will pass costs along," Mr. McGlone said.

Brendan Barber, general secretary for the London-based Trades Union Congress, said in a statement that he "warmly welcomed" the proposals.

In proposing the National Pensions Savings Scheme, in which a centralized administrator would serve as the interface between the contributors and the investment community, the government rejected an approach supported by the pension industry in which existing pension providers would compete for workers' business.

The TUC's Mr. Barber described that proposal as a "battle of the brands that could only confuse savers and raise costs."

France weighs allowing class actions

Industry fears law could cause 20% hike in liability premiums

By RICK MITCHELL

PARIS—Proposed legislation that would allow class action lawsuits in France could cause liability premiums to spike by as much as 20% and could cost businesses and insurers a combined €1 billion ($1.32 billion) in its first year of application, some of France's biggest insurers say.

The French parliament in February is expected to take up a consumer rights bill that, among other things, introduces a modified form of class action suits.

And while analysts believe passage of that bill is unlikely before presidential elections next April, class actions were high on the list of discussion topics at this year's gathering of the French insurers association, the Fédération Française des Sociétés d'Assurance, held in Paris Dec. 11 and 12.

The Paris-based FFSA conducted a study to estimate the law's potential cost to insurers and businesses. It examined 40 recent consumer cases that could have been class actions under the proposed law, said Emmanuel Argod, director of institutional affairs at AXA Entreprises, a unit of AXA S.A.

Assuming 30 to 40 suits in the first year, the law would raise costs by €1 billion, in the form of additional liability claims, a cost that would be split by insurers and businesses, said Mr. Argod.

"Of course, not everything would be insured; there are certain limits," he said.

The bill creates a four-step process in which judges could hear class-action complaints for consumer goods linked to a contract, and only for cases filed by government-approved consumer organizations. It is expected to cap damages at €2,000 ($2,798), but this limit is not firm, insurers claimed.

Once a judge determines "professional fault," plaintiffs would have to individually negotiate with the company for compensation, then personally appear before the judge if the company refuses to settle.

Punitive damages barred

The bill would not allow contingency fees, punitive damages or civil jury trials. Actions for medical complaints, transportation accidents, or other personal injury or non-commercial disputes, would remain barred, said Nicole Bricq, a French senator who co-introduced the bill in April and served as moderator of a workshop on class actions at the FFSA meeting.

Ms. Bricq said that while the bill had been criticized by sections of the consumer and business community alike, there is a need to find a way to better resolve consumer disputes in France.

Business Insurance
PERSPECTIVE

Reinsurance collateral rule change won't benefit U.S. cedents, buyers

By Jack Shettle Sr.
and Jeffrey C. Peterson

Jack Shettle Sr. is chairman of the American Names Assn. in Rancho Santa Fe, Calif. He has 43 years' experience as an insurance and reinsurance broker, company executive and has served as an insurance/reinsurance consultant since 1996.

Jeffrey C. Peterson is the executive director of the American Names Assn., a post he has held for the past 12 years.

The current reinsurance collateral debate has been characterized as an effort to "level the playing field" for non-U.S. reinsurers.

But a level field already exists. Foreign reinsurers can forgo the 100% collateral rule by becoming admitted reinsurers. They need only submit to tri-annual audits and meet U.S. capital and surplus requirements.

Solvency, not free trade, is the heart of the collateral question. U.S. regulators are nonetheless being pressured to implement measures that could lead to "lawful insolvencies" and an exponential shortfall of funds on the balance sheets of U.S. insurers.

The National Assn. of Insurance Commissioners Reinsurance Task Force's response to this Lloyd's of London-led, pan-European lobbying effort—a plan to establish a new regulatory bureaucracy to rank nonadmitted reinsurers—has fundamental shortcomings. The proposed Reinsurance Evaluation Office:

- Is based on rating agencies' subjective analysis of unverified data from foreign reinsurers.
- Assumes incorrectly that current U.S. reinsurance solvency standards duplicate foreign reinsurers' home-country regulation.
- Extends an alternative collateral structure to foreign entities, even if they are not in compliance with U.S. law on reinsurance collateral.
- Permits collateral rules to diminish without requiring transparency to rise to the standard that U.S. companies meet.
- Provides loopholes for more of the special treatment that the Lloyd's syndicates and market have already been receiving from the New York State Insurance Department.
- Proposes rating Lloyd's as a whole, even though all of its syndicates do business on an individual basis.

Lloyd's is the prime mover and the least transparent participant in the effort to emasculate collateral rules. Yet nothing in the proposal requires an accurate portrayal of Lloyd's syndicates' financial condition to U.S. cedents, their policyholders or U.S. regulators.

Perhaps this is the result of Lloyd's seven-plus years lobbying the NAIC to relax U.S. collateral rules, and orchestrating the development of a straw-man U.K. insurance regulator.

Fact or fiction

The following points are offered to help sort out what is truth and what is fiction in the push to weaken trust fund collateral requirements for overseas reinsurers, and especially Lloyd's:

- When the NYSID conducted the first and only audit of Lloyd's U.S. trust funds in 1994 and published its report in May 1995, a deficiency of $18.5 billion had accrued. Repeated calls for the NYSID and/or the NAIC to conduct another independent examination of Lloyd's syndicates' actual financial data—not a review of practices and procedures—have been ignored.
- Advocates of collateral reduction portray it as a needed, prospective reform, when in actuality it is a cover-up for regulations that have already been effectively compromised.
- The NAIC has discussed collateral reduction since at least 2000. Meanwhile, the NYSID has quietly amended regulations on when cedents can take credit for reinsurance due from nonadmitted reinsurers.

"Effective on an emergency basis since 9/15/01, and adopted on a permanent basis effective 4/9/03, the 8th Amendment to Regulation 20 (11 NYCRR 125)" gives the New York superintendent discretion to grant U.S. cedents full credit for reinsurance from Lloyd's and others, whether or not those entities' U.S. reinsurance trust fund balances meet or exceed their outstanding liabilities.

- As of Dec. 31, 2005, U.S. cedents declared an aggregate of $11.7 billion in reinsurance recoverables from Lloyd's syndicates in Schedule F of their convention statements. Based on this verified measure of unmet reinsurance liabilities—not on Lloyd's self-serving estimates—funds in Lloyd's U.S. Credit for Reinsurance Trust Funds are far below its syndicates' outstanding reinsurance obligations
- According to Lloyd's Treasury Department, the USCRTF balance as of Dec. 31, 2005, was $8.2 billion. There is no public disclosure, however, of how much of that is funded by cash or letters of credit. The NYSID's 9th Amendment to Regulation 20, "adopted on a permanent basis effective 4/2/03," lets Lloyd's post letters of credit, instead of cash or equivalent, in its USCRTF. This permits double use of syndicates' funds, or its Central Fund, depending on which entity procures the letter of credit. An additional twist is that Citibank, the trustee of the USCRTF, is permitted to issue letters of credit to Lloyd's entities that then post them as collateral in Lloyd's U.S. trust funds at Citibank.
- The Berkshire Hathaway/Equitas deal doesn't change the fact that Lloyd's syndicates have huge unmet liabilities on coverage issued after 1992.
- Lloyd's executives state they "can do more with the money when it's not tied up in U.S. trust accounts." How? A transparent explanation of the alternate uses envisioned—and how such redeployment raises the likelihood that U.S. cedents' claims will be paid timely and in full—is needed.
- Accounting and regulatory standards in non-U.S. jurisdictions do not yet justify mutual recognition. For example, in 1998, the U.K. government issued plans to bring Lloyd's under "external regulatory scrutiny" for the first time.
- A careful reading of the Financial Services and Market Act 2000 and its subsequent modifications, though, shows the FSA's remit is merely to ensure that Lloyd's ruling council has guidelines for overseeing the agents, brokers and underwriters at Lloyd's. Rhetoric aside, the FSA delegates regulation of Lloyd's back to the marketplace itself.
- Following Sept. 11, 2001, and the U.S. hurricanes of 2005, Lloyd's said it was suffering "a temporary liquidity crunch," or cash-flow crisis. Lloyd's just-not-in-time capital structure required waivers of rules and extensions by U.S. insurance regulators to legitimize Lloyd's continued writing of coverage in the United States, while it figured out how to fund its syndicates' huge losses and unfulfilled collateral obligations.

Months after Katrina, Rita and Wilma ravaged the Gulf Coast, Lloyd's took its new U.K. GAAP accounting for its inaugural spin. Despite $15.06 billion in gross losses in 2005, and with $10.1 billion in reinsurance outstanding, Lloyd's declared by April 2006 that it had virtually broken even in 2005 (*BI*, April 10, "Lloyd's bent, not broken by '05 storms"). According to Lloyd's, its nominal net loss figure—announced prior to paying the bulk of claims or recovering reinsurance—"proved the resilience of the 300-year-old market."

Verifying reinsurers' solvency, not their competitiveness, is what best serves the interests of U.S. ceding insurers and their policyholders, not to mention their shareholders. No alternative to the current U.S. reinsurance regulatory regimen—admitted and audited under U.S. standards, or nonadmitted but fully collateralized—has been proposed that brings more benefit than risk to U.S. cedents and their policyholders.

Retirees: Employers take subsidy

CONTINUED FROM PAGE 3

erage for prescription drug and other health care-related expenses.

Such a shift has yet to develop for several reasons, said Frank McArdle, a Hewitt consultant in Washington and one of the authors of the survey. One reason employers are continuing to take the subsidy is that they see it as the least disruptive approach, allowing them to offer the same coverage to retirees as they did previously, Mr. McArdle said.

In addition, employers—based on prior experience—aren't sure about the long-term viability of other approaches, such as shifting retirees to Medicare Advantage plans. Such plans could become less attractive to retirees if, for example, Congress cuts funding for the Advantage plans, something that has occurred previously, Mr. McArdle noted.

EMPLOYER ACTION

Share of employers allowing retirees who enroll in a Medicare Drug Plan to re-enroll in an employer plan in the future

Source: Kaiser/Hewitt

Other employers, having previously put a lot of time and effort into doing the necessary paperwork to receive the drug subsidy, are reluctant, at least for now, to analyze other approaches, said Dale Yamamoto, Hewitt's chief health care actuary in Lincolnshire, Ill.

Still, down the road, many employers aren't certain whether they will continue to design their retiree prescription drug plans to qualify for the 28% subsidy.

Among the large employers that took the subsidy this year, 48% said it was very likely they would do so in 2008, but only 21% said it was very likely they would in 2010.

Meanwhile, the cost of retiree health care plans continues to climb, though at a much slower rate than recent years. Surveyed employers estimate their retiree health plans' cost increased an average 6.6% in 2006, down from an average 10.3% rise in 2005, Kaiser/Hewitt found in the survey.

Responding to those increases, 74% of employers in 2006 increased premium contributions for pre-Medicare eligible retirees, while 58% did so for Medicare-eligible retirees.

Additionally, 34% raised cost-sharing requirements, such as higher deductibles, for pre-Medicare eligible retirees, and 24% boosted cost-sharing requirements for Medicare-eligible retirees.

Copies of "Retiree Health Benefits Examined, Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits," and accompanying materials, are available at www.kff.org.

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Products & Services

Hartford Steam Boiler offers warranty program

HARTFORD, Conn.—The Hartford Steam Boiler Inspection & Insurance Co. has introduced an extended warranty program for new and used machinery.

The Select Machinery Warranty is provided by the seller and backed by HSB.

The warranty is applicable to all eligible inventory of participating new machinery manufacturers and used machinery dealers, providing extended coverage against mechanical or electrical breakdown. The warranty applies to machinery operated in North America after the seller's 30-day return privilege or a standard manufacturer's warranty expires. The program is administered and underwritten by Hartford Steam Boiler.

Production and process machinery covered under the program include computer numeric control machines, presses, injection molding, metalworking and measuring machines. The warranty is designed for machinery valued between $10,000 and $1 million.

Hartford Steam Boiler provides claims service, and works with the owner and the machinery dealer to repair damaged machines. Once the extent of a covered loss is determined, the insurer reimburses the machinery owner directly for the cost of the repair, including parts and labor.

For more information, contact Richard Williams, vp, at 860-722-5566 or by e-mail at *richard_williams@hsb.com*.

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For more information, go to *www.phly.com/products/employed-lawyers.aspx*.

Chubb updates handbook on fiduciary liability risks

WARREN, N.J.—Chubb Corp. has updated its Fiduciary Liability Loss Prevention handbook, which suggests step-by-step loss prevention procedures for publicly owned and privately held companies.

Research commissioned by Chubb has found that about two-thirds of private companies do not purchase fiduciary liability coverage, and 20% of these companies plan to reduce or eliminate some employee benefits this year, leaving them exposed to potential fiduciary liability lawsuits.

The handbook has been updated to reflect current fiduciary liability exposures. New sections address stock-drop litigation, blackout periods for the sale of company stock and bundled services fees.

The handbook can be found at *www.chubb.com/businesses/chubb3331.html*.

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Holiday: Avoid pitfalls of corporate parties

CONTINUED FROM PAGE 4

Gunn, a Chicago law firm that handles employment-related issues. "It's incredible how people that are very conservative and very aware of employment and liability issues seem to leave those concerns at the door when holiday parties arrive."

For some time, Mr. Salzman said, the trend has been for employers to forgo the festivities or replace nightly events with tamer luncheons, mostly to protect their companies from liability issues that an employer faces when an intoxicated employee drives home afterwards and gets in an accident or when an employee makes disparaging comments that could be grounds for sexual harassment and other complaints.

Often, alcohol and inappropriate behavior go hand-in-hand, Mr. Salzman said.

Michael Liebowitz, director of insurance and risk management for New York University and president of the New York-based Risk & Insurance Management Society Inc., said there's a simple way to remove much of the risk: Serve no alcohol.

In fact, the U.S. Department of Labor advises companies not to serve alcohol at holiday parties, mostly to avoid drunken driving and other incidents.

But that approach is not altogether realistic, Mr. Liebowitz said. "It is the holiday season and everyone wants to have a good time," he said.

Vault's recent survey also asked 400 nonmanagement employees about their holiday party expectations, and 37% listed an open bar as "essential."

'It's incredible how people that are...very aware of employment and liability issues seem to leave those concerns at the door when holiday parties arrive.

Jim Salzman,
Matkov Salzman Madoff & Gunn

The next-best practice, Mr. Liebowitz said, is to limit the offerings to beer and wine, which may not be as risky as serving stronger liquor. Other strategies include providing employees with drink tickets to limit the amount of alcohol they consume and providing clear guidelines for employee behavior at holiday parties.

"You can try to reinforce to employees and keep the party as festive and light as possible, with a degree of professionalism," Mr. Liebowitz said.

While trying to maintain professionalism at workplace parties remains a top issue, so is ensuring that intoxicated employees do not drive home, said Dave Dietsch, a Kansas City, Mo.-based claim manager for broker Lockton Inc.

Many businesses have adopted the practice of appointing designated drivers, hiring limousines or, as Lockton has done, issue complimentary "(taxi)cab cards" to employees during the holiday season.

Even so, the risks of an employee driving away drunk are still present.

Standard commercial general liability policies cover liquor liability associated with workplace functions, as long as the policyholder is not in the business of "manufacturing, selling, distributing, serving or furnishing alcoholic beverages," Mr. Dietsch said. Businesses such as bars and restaurants need to buy separate policies to cover such risk.

And if a company decides to hold its party outside its main offices, the liability doesn't end, Mr. Liebowitz warned.

"The last thing we tell employers and managers is that their responsibility (to their employees) doesn't end until their employee walks through the door of their home," he said.

Retirement: Post-65 benefits considered

CONTINUED FROM PAGE 4

willing to extend other benefits to the post-65 employee group. For example, 81% were not planning to add long-term disability benefits for post-65 employees, according to the study.

In choosing not to offer LTD benefits, employers are following an established legal precedent in Manitoba that employers are not obligated to offer LTD benefits for employees age 65 or older, she said.

Meanwhile, employers were divided on whether to offer life insurance benefits. While 29% said they would offer the same life insurance benefits to employees after age 65, 31% said they would not extend life insurance benefits to post-65 workers and 22% said they would do so with restrictions, such as implementing a maximum benefit amount or a higher age cap.

"They generally won't go indefinitely because of the insurance risks and the cost of that benefit," Ms. Byron said.

Regarding pension plans, the impact of ending mandatory retirement will be relatively minor because legislation in Ontario already covers older workers, benefit consultants say. Under Ontario law, employees can continue membership in pension plans and accrue benefits past age 65 subject to service or contribution caps. "The more difficult questions will come on the nonpension benefits side," Ms. Morowicz said.

Pension experts, though, are waiting for regulators to publish their interpretation of the amended law with respect to minor issues, such as whether a plan sponsor can structure its pension plan to specify that an employee who starts working for a company at age 65 or older is not eligible for a pension.

Workers comp: N.C. derivative deal backs insolvent employer benefits

CONTINUED FROM PAGE 4

said Mr. Hills, who helped California and North Carolina with their capital market arrangements.

In North Carolina, employers that have won state Department of Insurance approval to self-insure their workers comp risks must become members of the security association.

The association, created by North Carolina's General Assembly in 1986, has statutory authority to assess all security fund members to pay claims against members who are insolvent. The association's board of directors is made up of employer and industry associations.

It paid MMC an undisclosed fee to make the capital market arrangements, just as California did.

California faced about $55 million in unfunded liabilities when it created its program three years ago. The shortfall stemmed from several self-insured employers filing for bankruptcy just as several providers of sureties that employers relied on for collateral arrangements also filed for bankruptcy (*BI*, April 28, 2003).

North Carolina's fund did not face a deficit when it began transforming its collateral system, said James L. Stuart, principal at Stuart Law Firm P.L.L.C. in Raleigh and general counsel for the state's Self Insurance Security Assn.

"We were looking at it prospectively" to ensure that the fund could pay claims should several employers simultaneously go into bankruptcy, start liquidation and stop paying their claims, Mr. Stuart said.

Approximately 150 employers that participate in North Carolina's fund have combined workers comp claim liabilities of $510 million, but more than 60% of that liability is concentrated in about a dozen companies, Mr. Stuart said.

Apart from ensuring that North Carolina's fund can meet future obligations, it is also hoped the new system will allow enough reserve buildup to lower fees charged to employer participants, Mr. Stuart said.

Other states also are looking to California's success, said Andrew Morrison, general counsel for the Minnesota Self-Insurers' Security Fund in St. Paul.

Today, California's fund has $187 million in assets with only $45 million in liabilities, said Jeff Pettegrew, executive director of California's SISF.

Member savings

Members of the California fund are saving about 50% on their costs for obtaining collateral, Mr. Pettegrew said. The fund currently assesses members $43 million in fees annually, far less than the estimated $75 million it would cost employer members to obtain letters of credit for the $5.5 billion in collateral they must post.

"Obviously, in a matter of four years we have made tremendous strides," Mr. Pettegrew said.

California's surplus is largely due to its alternative collateral system arrangement, Mr. Pettegrew said. But he acknowledged that an improved economy and state workers comp reforms also helped.

Still, regulators and fund administrators from states such as Minnesota and New York have visited California to see how they might implement a similar strategy.

Minnesota is moving cautiously, but a consultant has completed one study and the fund has hired a financial consultant for additional analysis, Mr. Morrison said.

HSA: Bill will increase appeal of savings plans

CONTINUED FROM PAGE 1

ness lobbyists reasoned that Democrats would be unlikely to allow HSA legislation to pass during the lame-duck session knowing that they would control the agenda next year.

Still, business lobbyists kept up the pressure and the HSA provisions were included as part of an agreement on a tax extender measure hammered out by, among others, Ways and Means Committee Chairman and longtime HSA advocate Rep. Bill Thomas, R-Calif., and Senate Finance Committee Chairman Charles Grassley, R-Iowa.

Washington observers say the deal was cemented when House Republican leaders agreed to allow provisions—sought by Sen. John D. Rockefeller IV, D-W.Va.—to help fund retired coal miners health benefits and clean up abandoned mines. Democrats, in turn, dropped opposition to the HSA provisions.

The House overwhelmingly approved the bill, H.R. 6111, on a 367-45 vote and the Senate cleared it by a 79-9 margin. President Bush is expected to sign the bill shortly.

The most significant HSA change involves the maximum annual contribution. Under current law, the maximum contribution is the lesser of either the deductible in the health insurance plan to which HSAs are linked or a statutory indexed amount, which in 2007 will be $2,850 for single coverage and $5,650 for family coverage.

With plan deductibles often in the $1,500 range for single coverage and $3,000 for family coverage, the link between deductible levels and maximum contributions prevented employees from putting more into the accounts.

And raising deductibles wasn't a practical solution since many employees couldn't afford such a significant exposure to uncovered medical expenses.

The legislation addresses this issue by removing—effective in 2007—the link between the maximum HSA contribution and the plan deductible. Instead, the maximum contribution will be the statutory maximum. That will mean, in many cases, that employees will be able to pump hundreds of additional tax-free dollars into their HSAs.

"It is a big plus for those with higher incomes or families with dual incomes," said Randy Abbott, a senior consultant with Watson Wyatt Worldwide in Wellesley Hills, Mass.

Indeed, some observers say the higher contribution limit will help broaden HSAs' appeal so that they become vehicles to save money to pay for current health care expenses as well as those incurred during retirement.

With an HSA much less likely to be depleted by current-year expenses, employees will be able to save for post-employment expenses, said Andy Anderson, of counsel with Morgan, Lewis & Bockius L.L.P. in Chicago. "This moves HSAs to also being a retiree medical savings vehicle."

Solves contribution problem

The legislation also resolves other problems that prevented maximum contributions being made to HSAs, such as the link between HSA and grace period FSAs. Under Internal Revenue Service rules, employers can adopt FSA grace periods so employees can tap FSA balances that remain in the plan at the end of the year to pay for health care expenses incurred during the first 10 weeks of the next plan year.

The problem for HSA enrollees is another IRS rule that says HSA contributions can't be made during the FSA grace period, even if the FSA balance was exhausted at the end of the prior plan year.

The legislation solves that problem by permitting HSA contributions during the grace period if there is a zero FSA balance or if the FSA balance is transferred to the HSA at the end of the prior plan year.

Another problem the legislation resolves is one faced by employees, such as new hires, who become eligible for HSA coverage later in a year. Under current law, the maximum annual contribution to an HSA is pro-rated to reflect when the employee became eligible for coverage.

The latest legislation allows the maximum HSA contribution—regardless of when an employee became eligible for coverage.

Additionally, the bill will allow rollovers from FSAs and/or health reimbursement arrangements on a one-time basis for a limited time. The amount to be transferred cannot exceed the balance in the HRA or FSA at the time of the transfer or as of Sept. 21, 2006, whichever is less.

The rollover provision is aimed at employers who established HRAs, which the IRS approved in 2002, but now want to scrap that in favor of HSAs, which became available in 2004.

While HRAs and HSAs have certain similarities, such as being linked to high-deductible health insurance plans, they have one key difference: While only employers can contribute to HRAs, both employers and employees can contribute to HSAs.

Collateral: Reinsurance rating system

CONTINUED FROM PAGE 1

insurance and reinsurance groups, cautiously supported by the Risk & Insurance Management Society Inc. and welcomed outright by several non-U.S. reinsurance groups.

Under the current system, reinsurers authorized in the United States do not have to post collateral, but unauthorized reinsurers must post collateral worth 100% of liabilities to allow a ceding insurer to take credit. The NAIC estimates that the proposal would eliminate $55.09 billion in collateral from the top 60 unauthorized reinsurers, but require U.S. authorized reinsurers to post $20.26 billion. That would mean a decrease of nearly $34 billion in collateral supporting U.S. reinsurance business.

"U.S. insurance regulators recognize the need to move from the current system of reinsurance regulation...(which) is too simplistic, has arbitrary barriers...and ignores differences within and outside the United States," said Alessandro Iuppa, immediate past-president of the NAIC and Maine's insurance superintendent.

On Jan. 15, 2007, Mr. Iuppa will join Zurich Financial Services Group as a senior government affairs representative for two units (see box).

During the NAIC's winter meeting in San Antonio, the organization's Reinsurance Task Force voted 15-5 to adopt the REO proposal and send it on to its parent committee—the Financial Condition Committee—for refinement and development of "commercially reasonable" implementation plans, but only through September 2007.

Financial Condition Committee Chair Al Gross, the Virginia insurance commissioner, said he plans to oversee a broad-based review of the reinsurance regulation and seek participation by relevant NAIC subgroups. While he considers the proposal's deadline important, he said "we can't have a bad proposal."

The plan is for the Financial Condition Committee to present a final proposal to the NAIC's membership for adoption in December 2007, Mr. Iuppa told the committee last week.

Among the issues that regulators are expected to consider are the legal basis for delegating authority to the REO, affiliate transactions and the effect of downgrades on reinsurers who are required to post collateral.

Risk managers are "cautiously supportive" of the proposal, said Janice Ochenkowski, vp of New York-based RIMS and a managing director of Jones Lang LaSalle Inc. in Chicago.

"The theoretical outline of the REO and its safeguards is very positive," she said. It imposes "what seem to be good standards on reinsurers," while providing safeguards such as using rating agencies' financial analysis and requiring non-U.S. reinsurers to sign a form accepting the authority of U.S. courts.

"If we have a more open market with proper safeguards, risk mangers should benefit because there will be additional capacity and competition," Ms. Ochenkowski said.

But U.S.-based insurance and reinsurance organizations generally disagree with the idea of reducing collateral for unauthorized reinsurers.

"This is the most contentious issue the NAIC has dealt with regarding reinsurance in recent years," said Debra J. Hall, vp and regulatory counsel for Swiss Re America Holding Corp. based in Armonk, N.Y., who co-chaired the task force's interested persons group. A majority of participants in that group "have serious concerns about the REO proposal," Ms. Hall said in letter to task force chair Julianne Bowler, the Massachusetts insurance commissioner.

Representatives of ceding insurers and guaranty funds have voiced their opposition to Ms. Bowler. They include major trade associations as well as individual insurers.

"We oppose the reduction of collateral in any way, shape or form. It is a solvency issue and will ultimately affect the ceding companies," said Michael Koziol, assistant vp and counsel of Des Plaines, Ill.-based PCI.

Martin F. Carus, AIG's senior state relations officer, wrote in a recent letter to Ms. Bowler that "the proposed collateral requirements will decrease the viability of reinsurance programs provided to small to midsized and regional carriers and will reduce the overall reinsurance capacity in the U.S. marketplace."

The proposal "will increase costs to guaranty funds because of the inability to collect reinsurance from some foreign reinsurers," said Kevin Harris, senior vp and general counsel of the Indianapolis-based National Conference of Insurance Guaranty Funds. U.S. policyholders ultimately will bear those increased costs, he said. If enacted, the REO plan will cause a flight of capital from the U.S. to lower-cost jurisdictions, Mr. Harris said.

Meanwhile, non-U.S. reinsurers were generally pleased with the actions.

"It's a significant step forward—a breakthrough after many years of debate," said Dave Matcham, London-based chief executive of the International Underwriting Assn.

The task force's support of the REO structure "represents an important affirmation" that is the appropriate way to proceed, said Joseph P. Gunset, general counsel of New York-based Lloyd's America Inc.

Announcement raised eyebrows

Zurich Financial Services Group announcement last week that Alessandro Iuppa would become a senior government affairs representative for the insurer raised eyebrows among some industry sources.

Mr. Iuppa

The announcement came just days after Mr. Iuppa, the immediate past-president of the National Assn. of Insurance Commissioners, spearheaded a successful effort to encourage NAIC regulators to commit to overhaul the nation's regulatory structure for reinsurance by establishing a Reinsurance Evaluation Office.

An analysis by industry sources estimates that the proposal's impact on Zurich—which would be placed in the REO 3 category requiring 40% collateral, rather than the current 100%—would result in a $1 billion reduction in collateral in the future. The actual dollar value is much less than that, though, because of financing arrangements like letters of credit, according to the NAIC's October 2005 white paper.

Mr. Iuppa denied any impropriety. "There is absolutely no relationship between my support of the collateral reduction and my new job," he said. "I take some offense if that is what is being suggested out there."

The REO proposal is broad-based and not company specific, Mr. Iuppa said. If Zurich had been more specifically involved, he would have recused himself, he said. Also, he has been a longtime advocate of modernizing U.S. collateral requirements.

"I have conducted myself in an honest and ethical way throughout my 20-year regulatory career and I certainly wouldn't stop now," Mr. Iuppa said.

A Zurich spokesman declined to comment on the impact of the proposal.

—By Meg Fletcher

COLLATERAL PROPOSAL

Current ratings matrix proposal

RATINGS	BANDS	POTENTIAL COLLATERAL	AM BEST	S&P	FITCH	MOODY'S
Secure	REO-1	0%	A++	AAA	AAA	Aaa
Secure	REO-2	20%	A+	AA+, AA, AA-	AA+, AA, AA-	Aa1, Aa2, Aa3
Secure	REO-3	40%	A, A-	A+, A, A-	A+, A, A-	A1, A2, A3
Secure	REO-4	60%	B++, B+	BBB+, BBB, BBB-	BBB+, BBB, BBB-	Baa1, Baa2, Baa3
Vulnerable	REO-5	80%	B, B-, C++,C+	BB+, BB, BB-, B+, B, B-	BB+, BB, BB-, B+, B, B-	Ba1, Ba2, Ba3, B1, B2, B3
Vulnerable	REO-6	100% or more	C, C-, D, E, F	CCC, CC, C, D, R, NR	CCC+, CCC, CCC-, DD	Caa, Ca, C

Source: NAIC

News In Brief

CONTINUED FROM PAGE 1

Orleans and other Louisiana coastal areas. The insurer announced intentions earlier this month to stop renewing those coverages in 2007. But the insurer last week met with Louisiana Gov. Kathleen Babineaux Blanco, Insurance Commissioner James Donelon and agents and brokers in the state. It has now put its plan to stop providing coverage on hold while considering a variety of options proposed by the commissioner, a St. Paul spokeswoman said.

Cash balance plans discriminate: Judge

Rejecting the reasoning of a federal appeals court, a federal district court judge says cash balance pension plans discriminate against older employees. The plans are age discriminatory because when an account balance is converted to a retirement annuity, "cash balance plans are not age-neutral," wrote Judge Shira A. Scheindlin of the U.S. District Court for the Southern District of New York. Judge Scheindlin's ruling came in a suit filed against Citigroup Inc. by several employees of the New York-based financial services giant. In her opinion, Judge Scheindlin said when an account balance is converted to a retirement age annuity, younger workers are credited with more interest on their accounts.

Final HIPAA guidance issued for wellness programs

Federal agencies have issued final rules providing employer guidance in complying with the nondiscrimination provision of the Health Insurance Portability and Accountability Act and the implementation of wellness programs. The final regulations in general do not change the 2001 interim rules issued by the departments of Labor, Health and Human Services and the Treasury, which allow employers to provide incentives of up to 20% of the cost of coverage to encourage participants to participate in wellness programs. The final regulations do, however, clarify some issues under the HIPAA nondiscrimination provisions and provide the first examples of wellness programs that are not subject to additional standards.

Max Re to launch surplus lines unit

HAMILTON, Bermuda–Max Re Capital Ltd. is setting up a U.S. excess and surplus lines unit. The Richmond, Va.-based unit, to be called Max Specialty Insurance Co., is expected to launch in the first quarter of 2007. Stephen J. Vaccaro has been named president and chief executive officer for Max Specialty. Max Re has existing insurance and reinsurance operations in Hamilton, Bermuda and Dublin, Ireland.

Health care plan proposed for all Calif. workers

A Democratic leader in the California Senate has unveiled a health care plan intended to provide working adults and their families with access to affordable health insurance. Under the plan proposed by Senate President Pro Tem Don Perata, D-Oakland, all employers would have a choice of either providing health insurance or contributing to a state purchasing pool called the Connector, according to a statement issued by Sen. Perata. The Connector would negotiate the best rates and offer employees a choice of plans. The state's Major Risk Medical Insurance Board would be responsible for establishing the Connector and administering the program.

Brit launches Bermuda retro insurer

Brit Insurance Holdings P.L.C. has reached an agreement to launch a joint venture Bermuda-based reinsurance company, Norton Re Insurance Ltd. to write catastrophe retrocession business. The move overseas is the first for Brit, which operates at Lloyd's of London and through its London-based insurance company. Brit is the lead investor in Norton Re with a 19.6% holding. Norton Re will use the underwriting expertise of Brit's existing retrocession team operating from Hamilton, Bermuda. The remainder of Norton Re's initial $107.7 million capital is provided by institutional investors.

Court rejects most of slavery reparations suit

The 7th U.S. Circuit Court of Appeals last week rejected most claims by slave descendants that they deserve reparations from some of the nation's largest companies and insurers that may have benefited from slavery more than a century ago, according to reports. The court–saying the "statute of limitations would be toothless"–ruled descendants have no standing to sue for reparations for injustices experienced by their ancestors. It did, however, let stand part of the lawsuit claiming that companies may be guilty of consumer fraud if they hid their past ties to slavery. Defendants include Aetna Inc.

Brandywine reserves show increase

Hamilton, Bermuda-based ACE Ltd. said an annual internal review of the company's Brandywine runoff operations indicated that its gross loss reserves increased by about $200 million, while it concluded that its net loss reserves were adequate and therefore no change to the carried net reserve was required. The insurer said also that the conclusions of a biennial external review, which is required by the Pennsylvania Insurance Department, provided estimates of ultimate gross and net Brandywine liabilities that are lower than the same study two years ago.

Hellholes: Tort reform group cites improvements

CONTINUED FROM PAGE 1

ing to the report. "This improvement is a shared result of shining the spotlight on litigation abuse with this report and wise corrections by both the judicial and legislative branches of state governments. It may also indicate that litigation formerly concentrated in a single jurisdiction has dispersed across wider areas."

But the report also identified new trouble spots.

For example, Miller County, Ark., headed the report's watch list because it "hosts more personal injury cases per capita than any other county in the state, and the number of filings continues to increase."

Even Delaware, which the report notes has a reputation for judicial fairness, remained on the watch list because it is continuing to experience a "growing wave" of asbestos liability suit filings.

"This is not an indictment of judges, not an indictment of our legal system," stressed ATRA President Sherman Joyce during the Washington news conference at which ATRF released the report. The "overwhelming majority" of judges and court personnel do a good job, he said.

Mr. Schwartz said he thought there could be change in the judicial environment in jurisdictions where the trial bar enjoyed political success in last month's elections. He said this could manifest itself in efforts to repeal tort reforms that have already been enacted or in legislation designed to expand liability and create new ways to sue.

Report called 'propaganda'

The chief executive officer of the Washington-based American Assn. for Justice, which represents the plaintiffs' bar, dismissed the report as "propaganda" in a statement issued a day before the report's issuance.

"To further pad their profits, big corporations, using their front group ATRA, are once again misleading the public with propaganda to support their case that America no longer needs a civil justice system to hold them accountable for negligence," said Jon Haber.

"The civil justice system is the last resort for those who are injured and the only place every person can get justice when up against the most powerful corporations," said Mr. Haber.

The full report is available at *www.atra.org*.

Prudential: Insurer settles with New York, California

CONTINUED FROM PAGE 3

The settlement "compensates nationwide employers seeking to provide group benefits for their employees" and "helps restore integrity to the insurance marketplace by mandating complete disclosure of payments to brokers," Mr. Spitzer said in the statement.

Also last week, Prudential agreed to a nonmonetary settlement over business practices with California Insurance Commissioner John Garamendi.

Prudential was one of five insurers and brokers named in a 2004 lawsuit by Mr. Garamendi, alleging the insurer and others violated state law by hiding hundreds of millions of dollars in kickbacks paid to ULR to get business.

The Prudential settlement follows settlements reached with Messrs. Spitzer and Garamendi by Chattanooga, Tenn.-based UnumProvident Corp., which last month, agreed to pay more than $17 million in policyholder restitution and fines and change the way the disability insurer compensates brokers and consultants (*BI*, Nov. 6).

"Prudential should be commended for following the example set by UnumProvident and agreeing to do what is right for California employers and employees," Mr. Garamendi said in the statement.

According to a statement from the California Insurance Department, Prudential, as part of its settlement, vowed to uphold certain business practices on its group life, accidental death and dismemberment, disability, health, dental and vision insurance coverages.

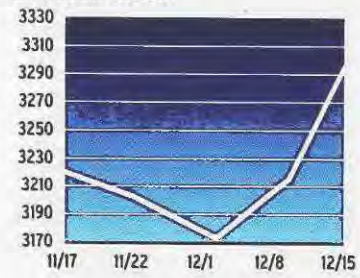
Under the settlement terms, Prudential must: disclose the commissions paid on employee benefits business; provide an estimate of contingent commissions paid; provide training and oversight for its employees on compliance with the settlement; cooperate with the department in other ongoing investigations; make its broker compensation practices available on its Web site; not enter into any financial relationships, including equity ownership, with brokers: and not sponsor broker production contests.

Stock Index

[12/11 - 12/15]

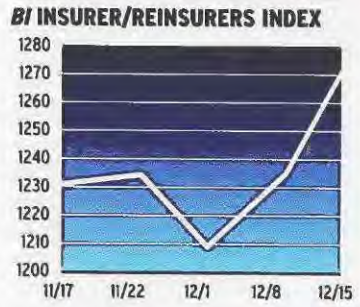
Up-to-the-minute data for all 82 companies that comprise the BI *Stock Index can be found at www.BusinessInsurance.com.*

BI STOCK INDEX

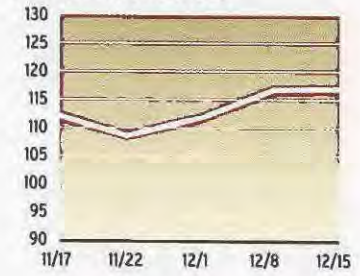


BI BROKERS INDEX

BI INSURER/REINSURERS INDEX



BI MANAGED CARE ORGANIZATIONS INDEX



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

BI STOCK INDEX	▲	
3294.07		2.58
DOW JONES	▲	
12445.52		1.12
S&P 500	▲	
1427.09		1.22

LARGEST GAINS

Berkshire Hathaway	6.21%
Hartford Financial	5.83%
ING Groep N.V.	5.53%
Gainsco Inc.	4.53%
MBIA Inc.	4.46%

LARGEST LOSSES

Fairfax Financial	-5.01%
Meadowbrook Insurance	-3.96%
MMC	-2.48%
Aspen Insurance	-2.45%
Humana Inc.	-2.41%

Source: Financial Content Inc. http://financialcontent.com

Business Insurance
END PAGE

Contributing: Louise Esola, Mark A. Hofmann, Rupal Parekh and Sally Roberts

AP

Warren Buffett, known as the Oracle of Omaha, reportedly lost his shirt in a recent charity poker event.

Buffett goes broke in the name of charity

Warren Buffett may be an ace at investment strategies and play a mean hand of bridge, but poker is a whole different game.

The billionaire and Berkshire Hathaway Inc. chairman earlier this month joined a group of amateur, celebrity and professional players for a charity poker tournament in Omaha, Neb., and reportedly went broke in under an hour.

Following the event, Mr. Buffett was quoted in media reports as having said: "It's different than bridge....I was confused. I thought the low score won."

'American' fix in port brouhaha

American International Group Inc. hasn't been a stranger to controversy in recent years. But that didn't stop the New York-based insurance giant's AIG Global Investment Group unit from helping to end an international controversy by agreeing to buy P&O Ports North America from P&O Holdings Inc.

While the name P&O might not register with most people, the business happens to be a wholly owned subsidiary of Dubai Ports World, a Dubai, United Arab Emirates-based port operator.

DP World stirred heated rhetoric early this year when it acquired the U.S. assets of British port operator Peninsular & Oriental Steam Navigation Co. Lawmakers wasted no time in condemning the deal, which would have given an Arab company control of U.S. port facilities on the East and Gulf coasts, thus raising questions of national security.

DP World offered to divest itself of the properties, provided that it could find a suitable buyer. Last week, DP World announced that it had indeed found a U.S. buyer, and entered into an agreement to sell port facilities, operational rights and stevedoring operations for an undisclosed sum to AIG.

The sale should end the controversy over a foreign company having control of a piece of U.S. security. After all, what could be a more appropriate owner than one whose name begins with "American"?

Holiday snacks put office 'grazers' at risk

The goodwill holiday sugar cookies in the office lounge could do more harm than good for employees, according to ComPsych Corp., an employee assistance and wellness program provider.

Forty percent of employees reported being "grazers" at work by eating small meals and snacks throughout the day, according to a recent poll by ComPsych, which says an employee's healthy eating habits may be sabotaged by the holiday candy and cookie buffet.

"It becomes easier for employees to graze on the junk food, which causes them to stop bringing in their own healthy snacks," said Dr. Richard A. Chaifetz, chairman and chief executive officer of Chicago-based ComPsych in a statement. The issue is a "liability" for companies that wish to encourage healthy habits among employees, he said.

As a result, Dr. Chaifetz said many companies are now requesting that outside business partners and vendors send fresh fruit baskets as gifts rather than the calorie-laden snacks.

REUTERS/LANDOV

Tom Brady of the New England Patriots has taken Yahoo! to task for using his image in fantasy football ads.

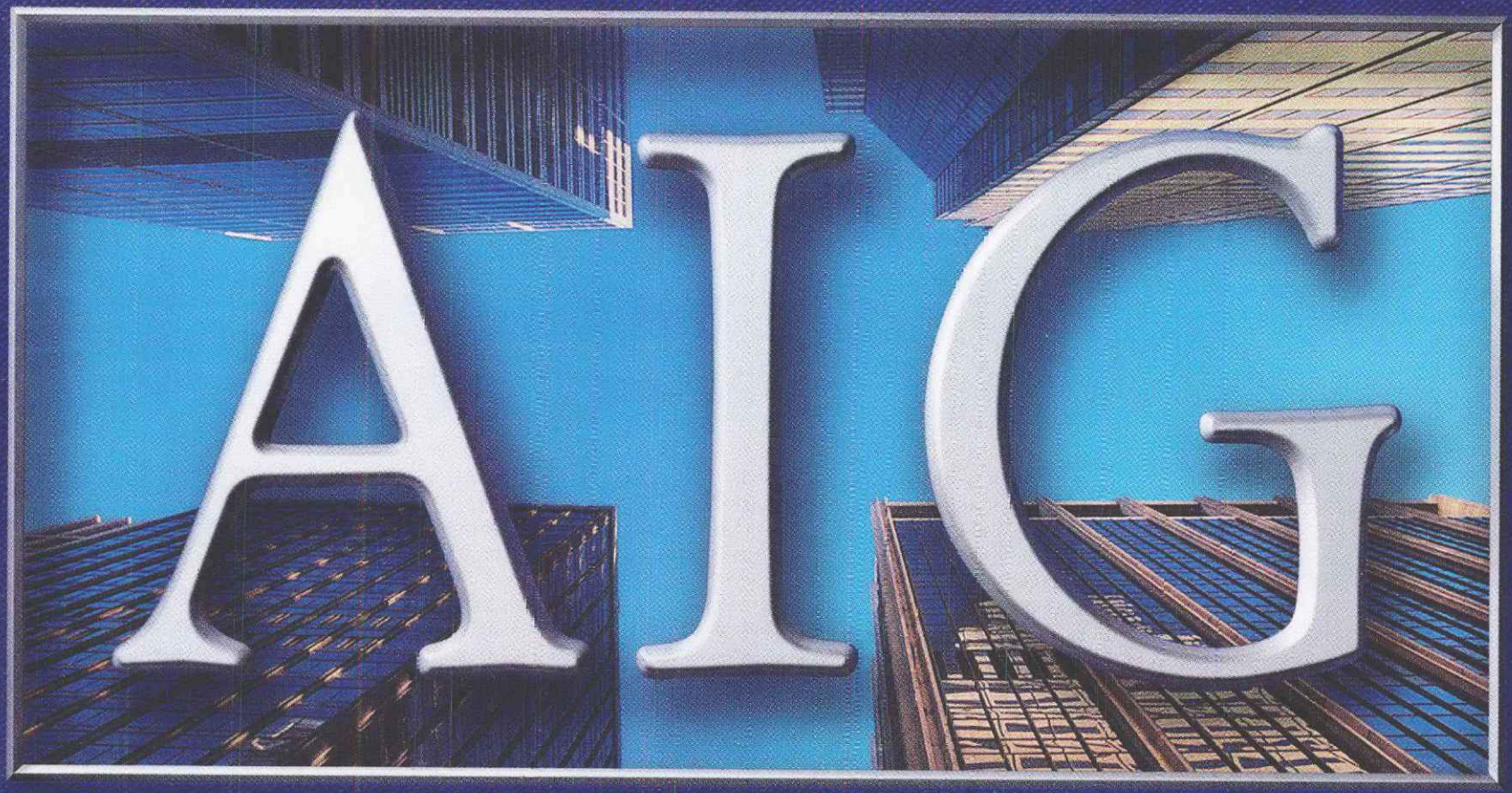
QB Brady snaps fantasy football with real suit

New England Patriots quarterback Tom Brady has thrown a penalty flag on Yahoo! Inc., alleging illegal use of his photo in a fantasy football advertisement.

TEB Capital Management L.L.C., which owns the publicity and endorsement rights of Mr. Brady, filed suit in U.S. District Court for the Central District of California in Los Angeles last month claiming that Mr. Brady's image was used without permission in advertisements for Yahoo!'s fantasy football goods and services in Sports Illustrated, other sports publications and on the Internet.

Fantasy football is a $4 billion industry with more than 8 million participants, according to the suit, which seeks unspecified compensatory and punitive damages. It describes Yahoo!'s Web offering as the most popular fantasy football site, with an estimated 4.4 million unique users in 2005.

Mr. Brady was drafted by the New England Patriots in 2000. Subsequently, he has led the team to three Super Bowl championships, won two Super Bowl MVP awards and been selected to participate in three Pro Bowls.



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