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In Brief

More health plans adopt doctor ranking model

UnitedHealth Group Inc. and New York-based insurers Group Health Inc. and Health Insurance Plan of Greater New York last week adopted New York Attorney General Andrew Cuomo's doctor ranking model, agreeing to fully disclose the cost and quality metrics they use to rank doctors. They join units of CIGNA Corp., Aetna Inc., and WellPoint Inc. in committing to implement the model.

Gallagher seeks new commission in London

Gallagher London, the London arm of Arthur J. Gallagher & Co., has approached insurers and clients concerning its plan to charge insurers an additional 1.5% commission for placing London-market business, a spokesman said. Other big brokers are exploring similar plans in the United Kingdom.

BENEFITS MANAGEMENT

RETIREE BENEFITS: PENSIONS & SAVINGS PLANS

Automatic enrollment in 401(k) plans grows in popularity and meets little resistance from employees; tougher rules for 403(b) plans means more work for nonprofit employers; financial services firms in line to take over frozen defined benefit plans; *BI's* ranking of 401(k) plan administrators.

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Weighing wellness

Corporate health drive has faced obstacles

By JOANNE WOJCIK

The road to wellness may have been paved with the best of intentions, but for many employers, the route proved too long and too complicated, so they either changed directions or turned back.

Some say a significant roadblock was the lack of measurable returns on investment, which made it difficult to get support of upper management, which abandoned many wellness initiatives as soon as health care costs seemed to be getting under control.

Moreover, many employers, particularly those with high employee turnover, saw no point in investing in the future of their employees not likely to stay with them long enough to reap the benefits. The fact that employee response was often lackluster also led to the early demise of many wellness programs.

Wellness is based on promoting healthier lifestyles through employee education to boost productivity and worker morale. Employer offerings range from smoking cessation and weight loss programs to onsite fitness centers and exercise incentives, among others.

The term "wellness" was "a bad word during the '80s and '90s," according to Cheryl Larson, director of membership and education at the Midwest Business Group on Health in Chicago. "It was a word that did not resonate with senior management" because wellness programs were perceived to be "warm and fuzzy initiatives that never provided any outcomes," she added.

"The term probably got a little bit tired and stale and everyone was using 'wellness programs' and 'wellness centers' to mean any number of things," said Dr. Brent Pawlecki, corporate medical director at Stamford, Conn.-based Pitney Bowes Corp.

The lack of demonstrable return on investment was perhaps the biggest obstacle to continued corporate interest, said Andrew Webber, president and chief executive officer of the Washington-based National Business Coalition on Health. "The biggest concern has been how do we quantify the return on investment over time?" he said.

Although some employers pursued wellness programs primarily based on faith, "it wasn't until there were published ROIs that others began to adopt it," said Lissa Thomson, senior vp and practice leader in the San Diego office of Lockton Cos. "But, even then, it was slow for the same ROI issue."

There was debate how return on investment should be measured, she said. While some

DEVELOPING A WELLNESS CULTURE: Part two of the series appears next week.

See WELLNESS page 20

PBGC deficit narrows, but dangers remain

Pension reforms, economy fuel improvement

By JERRY GEISEL

WASHINGTON—When the federal agency that guarantees employees' and retirees' benefits reported this month that its deficit dropped \$5 billion to just more than \$13 billion—its lowest point in four years—the reaction of top Pension Benefit Guaranty Corp. officials was one of caution.

PBGC Interim Director Charles E.F. Millard said the 2007 results were no more than a "snapshot," largely attributable to a robust economy, higher interest rates used to value liabilities and the absence of any major pension plan failures.

That was echoed by American Benefits Council President James Klein, who described the results as a "snapshot in time" and the byproduct of normal changes in interest rates and market values.

But others say pension reform legislation passed by Congress last year will lead to better funded pension plans and reduce the PBGC's exposure to big losses.

Even so, experts warn that even with the enactment of that legislation—the toughest set of pension

plan funding reform standards approved by Congress in three decades—the PBGC still could face blockbuster losses if the economy slips and the stock market plunges.

Such a scenario "could very well happen again," said Mike Archer, chief actuary with Towers Perrin in Parsippany, N.J.

"A small number of claims can result in huge losses," said Rob Reiskytl, a consultant with Hewitt Associates Inc. in Minneapolis.

In the wake of a nearly \$10 billion reduction in the PBGC's deficit in the last two years and the enactment of pension plan funding reform legislation, caution is appropriate after the optimism that followed passage of earlier reform measures and the swelling of agency's surpluses proved unfounded.

In 1994, Congress passed what was seen as a major reform measure, and PBGC officials said the reforms could erase its then-\$2.9 billion deficit in the single-employer insurance program over the next decade.

The deficit did indeed fall. By 1996, the PBGC had a surplus and by

See PBGC page 21

Securities fraud trial makes it to jury stage

Outcome of rare court battle may spark change

By DAVE LENCKUS

OAKLAND, Calif.—Settlements in securities fraud lawsuits and the willingness of litigants to go to trial could be influenced immediately by a verdict in a rare securities fraud trial that heads into its first full day of jury deliberation today, legal and insurance experts say.

But experts do not anticipate that the case against JDS Uniphase Corp. of Milpitas, Calif., and another trial that recently began in a different case would trigger a flood of trials.

While both cases involve typical

securities fraud claims of failing to disclose essential information to investors and inflating earnings, they are unusual in that less than 1% of securities fraud claims go to trial.

If a federal court jury in Oakland, Calif., rules for the plaintiffs in the JDS case and accepts their method for calculating losses, the company could face \$18 billion of damages, said lead plaintiffs attorney Barbara J. Hart, a partner with Labaton Sucharow L.L.P. in New York. The

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On the Web

RISK MANAGER OF THE YEAR® Deadline for 2008 award extended to Nov. 30

The deadline to nominate someone for the 2008 *Business Insurance* Risk Manager of the Year® award has been extended to Nov. 30. The winner will be profiled in a future issue of the magazine. Download a nomination form at www.BusinessInsurance.com/RMOY or request a form from *BI* Editor Regis Coccia at rcoccia@businessinsurance.com.

BI AUDIO

Podcast of interview with Dr. Hettler online

Business Insurance Senior Editor Joanne Wojcik interviews Dr.



William Hettler, president of the National Wellness Institute and one of the founders of the National

Wellness Conference, in a podcast available online at www.BusinessInsurance.com/audio.

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Business Insurance®

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Treasury reviews financial services regulation

Industry supporters of federal charter plan hope effort gets boost

By MARK A. HOFMANN

WASHINGTON—A comprehensive Treasury Department review of the regulatory structures of financial institutions could further the drive for an optional federal charter for insurers, say supporters of the OFC concept.

The opportunity came in a department solicitation for comments in the Oct. 17 Federal Register, which had a deadline of last week. The department said it is "undertaking a broad review of the regulatory structure associated with

financial institutions."

In its comments, the Washington-based American Insurance Assn. made clear that its members believe the current state-based insurance regulatory system's costs outweigh the benefits.

The state regulatory system created by the McCarran-Ferguson Act of 1945 "has lost its focus on solvency and instead has evolved into a bureaucratic maze of government price and product controls, accompanied by complex and inconsistent rules regarding virtually all aspects of market conduct, many of which create cost and delay but do little to protect the consumer," wrote Debra Ballen, AIA's executive vp-public policy management.

While state regulation may have been appropriate when instituted,

rapid technological change plus internationalization of the economy have made it obsolete. "The delays that are inherent in the insurance regulatory system mean that it may take months (and sometimes years) for new products to be approved, and some innovations never make it into the market at all," Ms. Ballen wrote. "We urge Treasury to develop an ambitious blueprint for regulatory modernization that includes as a linchpin OFC for property/casualty insurers."

In an interview last week, Ms. Ballen called the OFC issue "very live."

"I think it's very real," she said. The Treasury Department "has the real potential to be a catalyst" for consideration of an OFC. "It has the potential to be an important means

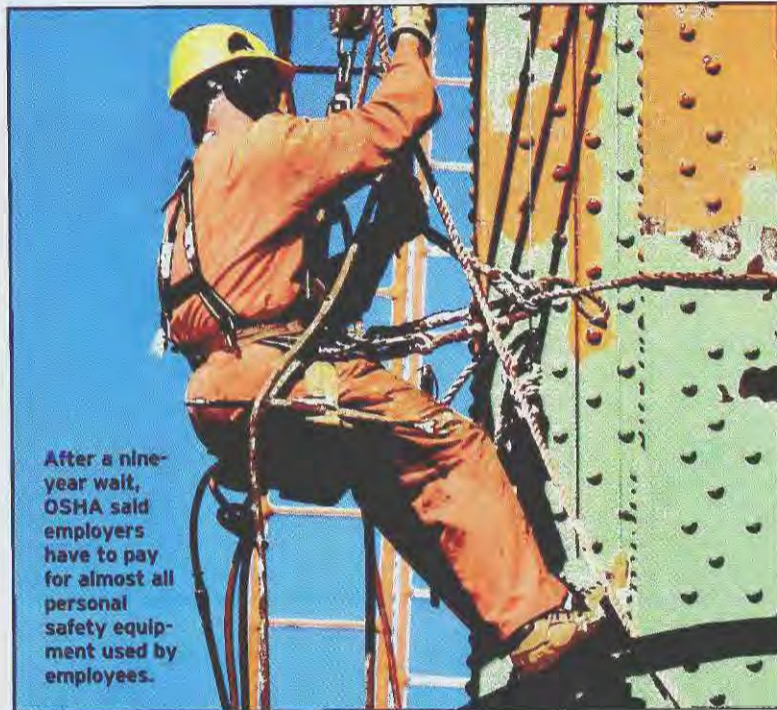
of moving forward."

Another OFC supporter said Treasury "has been moving the ball forward on progressive regulatory reform" in a "very cautious, orderly way," said Joel Wood, senior vp of the Council of Insurance Agents & Brokers in Washington.

"This Treasury Department is very progressive-minded," Mr. Wood said. He credited Treasury Secretary Hank Paulson's experience as a former chief executive officer of Goldman Sachs for his understanding of financial markets and modernization.

"Political obstacles remain in place for creation of the OFC in the near future," said Mr. Wood. "There has been more progress this year

See CHARTER page 6



OSHA says employers must pay for safety gear

By JEFF CASALE

WASHINGTON—After nearly nine years, the U.S. Occupational Safety and Health Administration has issued a final rule that says employers will have to pay the full cost for almost all personal safety equipment used by their workers.

OSHA made the announcement last week that it had adopted the final form of its original 1999 standard. This requires employers to pay for personal protective equipment—clothing and gear—for workers, which advocates say will prevent thousands workplace injuries.

Currently, workers are paying for their own safety equipment—boots and safety goggles, for example—when it was not provided by the employer.

The decision comes about 10 months after two labor groups—the AFL-CIO and United Food and Commercial Workers International

Union—filed a lawsuit in the U.S. Court of Appeals for the District of Columbia. The lawsuit was in response to OSHA's failure to issue the standard and claimed workers were being endangered as a result.

The rule will go into effect May 2008.

OSHA said in a statement that the rule creates a clear and consistent policy and reduces confusion about what employers are required to pay for. It added that the rule will result in at least 21,000 fewer occupational injuries per year. In 2006, the Bureau of Labor Statistics reported more than 4 million worker injuries and more than 5,700 deaths in the private sector.

Advocates for the rule said they are pleased that rule was issued, but in a joint statement, the AFL-CIO and UFCW said they will be reviewing the rule to determine if it provides workers with the level of protection that is needed and required by law.

Hedge fund strikes back in dispute with Fairfax

ICP suit says company, law firm harassed staff

By SALLY ROBERTS

NEW YORK—Fairfax Financial Holdings Ltd. and law firm Kasowitz, Benson, Torres & Friedman L.L.P. engaged in an intentional campaign of harassment and intimidation in connection with their pending racketeering suit against a group of hedge funds, a New York-based investment management company that is a named defendant in the suit charged in a counter-complaint announced last week.

Institutional Credit Partners L.L.C. and one of its portfolio managers, William Gahan, filed the suit Nov. 16 in Superior Court in Morris County, N.J., in conjunction with a separate motion to dismiss them from Fairfax's pending Racketeer Influenced and Corrupt Organizations suit in the same court.

Fairfax filed a \$6 billion lawsuit against a group of prominent hedge funds in July 2006 alleging the defendants conspired to manipulate Fairfax's share price (*BI*, July 31, 2006).

The complaint charges that the hedge funds engaged in "a massive, illegal and continuing stock market manipulation scheme, which has targeted and severely harmed Fairfax, among other companies, and which has resulted in immense ill-gotten profits for" the more than 20 funds.

The hedge funds allegedly intended to profit from the destruction of Fairfax by "short selling" the company stock, or taking positions in the market that would be profitable in the event Fairfax's stock price declined, according to the complaint, which alleges violations of various state laws, including the New Jersey RICO Act.

ICP and Mr. Gahan were added as defendants in Fairfax's second amended complaint filed last month.

According to the counter-complaint, beginning in 2006 after Mr. Gahan began researching Fairfax, he received a "threatening" letter from New York-based KBTF demanding that he hand over any information and analysis he had done regarding Fairfax. Soon thereafter, KBTF, with full knowledge of Fairfax, began following ICP employees and officers, including Mr. Gahan.

"These members lurked outside the ICP office and followed ICP employees to their homes," causing ICP and Mr. Gahan to take emergency measures to protect their and their employees' property and families, the complaint says.

Mr. Gahan suffers from "severe emotional distress" and ICP's employees have sought medical care for their injuries, according to the complaint.

In addition to intentional infliction of emotional distress, KBTF also defamed ICP when it made false published statements to the media about ICP, linking the firm to short trading of Fairfax unit Odyssey Re Holding Corp.'s shares, the lawsuit says.

The plaintiffs are seeking compensatory and punitive damages.

Fairfax discounted the lawsuit, describing it as "nothing more than a weak and transparent effort to distract attention from the racketeering charges against defendants ICP and Gahan."

Attempts to reach KBTF for comment were unsuccessful.

IPC/Gahan attorney, John P. Lacey of Connell Foley L.L.P. declined to comment.

Employer not liable for fired worker's vacation pay: Court

State Supreme Court overturns costly ruling for Minn. employers

By JUDY GREENWALD

ST. PAUL, Minn.—A Minnesota Supreme Court ruling that companies have the contractual right to determine their unused vacation pay policies clears up an issue that has been hanging over Minnesota employers for more than a year, say observers.

The 6-1 decision by the court in *Susan Lee vs. Fresenius Medical Care Inc.* overturns a lower court decision

that, if upheld, could have been costly for employers in the state, observers say.

The case centers on 182 hours of unused vacation time accrued by Ms. Lee before she was terminated as a dialysis patient care technician for Fresenius Medical Care Inc. in Duluth, Minn. She was fired because of a "pattern of behavior" that resulted in "performance and patient safety issues," according to the opinion.

According to Fresenius' company handbook, an employee who is terminated for misconduct is ineligible for earned but unused "paid time off."

But Ms. Lee contended she was

entitled to be paid for the unused time under a state statute regarding termination of employment that says that when an employee is discharged, earned but unpaid wages "are immediately due and payable upon demand of the employee."

In August 2006, a state appellate court concluded that under this statute, an employer must compensate a terminated employee for earned but unpaid wages. The appellate court said Minnesota case law has determined that unused vacation pay constitutes wages for the statute's purposes.

In its Nov. 15 decision, the Minnesota Supreme Court said, "To the extent we have not spoken explicit-

ly on this rule, we now conclude that paid time off or vacation pay constitutes wages" for purposes of the statute.

However, the court ruled, the statute does not prohibit the specific provision in Fresenius' employment contract with Ms. Lee that states a worker terminated for misconduct is not entitled to vacation pay.

The statute "is a timing statute, mandating not what an employer must pay a discharged employee, but when an employer must pay a discharged employee," according to the decision.

Employers have "considerable discretion in choosing how and

whether to compensate employees for vacation time," the opinion says.

If an employer does offer an employee paid time off, what is earned during the accrual period is "not a right to a direct monetary payment" but a right granted by the employer to take time off in the future but still be paid, the opinion says.

Citing an amicus brief submitted in the case by an employer group, the Minneapolis-based Minnesota Employment Law Council, the opinion says a ruling establishing that employees earn an "absolute

See **VACATION** page 6

After the scandals that rocked WorldCom Inc. and Enron Corp., 'Americans weren't going to let corporate officers get away with something like this.'

Michael Oxley, Baker & Hostetler L.L.P.



AP PHOTO

Companies see benefits from Sarbanes-Oxley

Compliance costly, but law has improved corporate governance

By DAVE LENCKUS

WASHINGTON—The Sarbanes-Oxley Act has worked well, though not perfectly, in the five years since its enactment and has led to some unanticipated benefits, according to a panel of experts.

Even chief executive officers say Sarbanes-Oxley, the difficult-to-comply-with law enacted in the wake of the fraudulent accounting practices that led to meltdowns of Enron Corp. and WorldCom Inc., might have been worthwhile, said insurance underwriting executive Tony Galban.

"Has it been worthless? No. Has it been worthwhile? Maybe. Was it worth it? I don't know," is how CEOs analyze the law's impact so far compared with the cost of compliance, Mr. Galban said during a panel discussion at the Professional Liability Underwriting Society's 20th annual international confer-

ence, held Nov. 7-9 in Washington.

But none of the executives he has discussed the law with has called it worthless, said Mr. Galban, a senior vp and the global D&O underwriting manager for Warren, N.J.-based Chubb Corp.

Former Congressman Michael G. Oxley, who co-sponsored the act, was far more certain about the law's positive impact on corporate governance. "I think we succeeded," he said.

Mr. Oxley, now vice chairman of the NASDAQ Stock Exchange and an attorney with Cleveland-based Baker & Hostetler L.L.P., said the only objective way to measure how the law changed corporate governance is to analyze the stock market response. Since the law's enactment on July 30, 2002, the Dow Jones Industrial Average has "almost doubled," he said.

During the first 10 weeks after Sarbanes-Oxley was enacted, the Dow fell hundreds of points to 7,286.27—its lowest level since several years before the Sept. 11, 2001, terrorist attacks—but then nearly

See **SOX** page 19

Medical directors seen as key players in health care cost control efforts

Companies urged to make better use of such executives

By JOANNE WOJCIK

SCOTTSDALE, Ariz.—Corporate medical directors could play a valuable role in helping employers address escalating health care costs through health management programs, but many are relegated to overseeing occupational health and safety programs or are being eliminated entirely.

"Corporate medical directors can be the key to redefining the value and the meaning of health in your corporations," said Thomas Parry, president of the San Francisco-based Integrated Benefits Institute, during

a panel discussion at the National Business Coalition on Health's 2007 annual conference, held Nov. 11-13 in Scottsdale, Ariz.

Corporate medical directors "all understand that health-related benefit programs can't be managed in silos. They all understand that cost-shifting and risk-shifting from one silo to another, from employer to employees, from employer to vendors," will not solve the nation's health care crisis, said Mr. Parry, who moderated the panel.

Indeed, Dr. Jack Mahoney, former medical director of Stamford, Conn.-based Pitney Bowes Inc., was named to the new post of director of strategic health initiatives as the company recognized it needed to pay more attention to employees' health to ensure their continued productivity, Dr. Mahoney said. He

also attributed his promotion to Pitney Bowes' Chief Executive Officer Mike Critelli's prior experience as a human resources executive.

"But while it's great to have the CEO on your side, it really doesn't get you through the palace politics," Dr. Mahoney said, pointing out how medical directors often are given short shrift by middle management.

As an example, he cited Pitney Bowes' decision several years ago to launch an in-house disability management program.

"The middle management had a gazillion reasons why this just wasn't going to work," Dr. Mahoney said. "And I come in with a presentation that is all about how much money we'll save. Well, it

See **MEDICAL DIRECTORS** page 18

Most HSA plans offer first-dollar cover for preventive services: Study

By KRISITN GUNDERSON HUNT

Most high-deductible health plans linked to health savings accounts provide first-dollar coverage for many preventive services, including immunizations, mammographies and physical exams, research from America's Health Insurance Plans shows.

Among the individual and group markets, 84% of HSA/HDHP policies provide coverage for services falling within Internal Revenue Service HSA guidelines for preventive care, without requiring individuals to first meet their deductible.

"These results demonstrate these new products are doing what consumers expect them to do in terms of covering their preventive benefits," Karen Ignagni, president and CEO of the Washington-based asso-

ciation, said in a statement. The HSA products "are providing not only a safety net on the back end for catastrophic expenses, but they can help on the front end as well."

The survey results found 100% of the HSA/HDHP policies offering first-dollar coverage for such preventive care services as adult and child immunizations, well-baby and well-child care, mammographies, pap tests, and annual physical exams and screenings.

Screenings covered by such policies include adult blood pressure and cholesterol tests, children's vision tests, bone mineral density testing for women, and prostate cancer screening for men aged 50 or older.

Fifty-two percent of the 1.7 million enrollments evaluated for the study do not place any annual dol-

lar limits on coverage of those services, while 24% have annual dollar limits of \$500.

Survey responses included information from 36 companies with average HSA/HDHP enrollments of 48,300.

The three largest companies responding to the survey had between 200,000 and 300,000 HSA/HDHP enrollees.

The responses also included information from 25 companies with policies covering 607,735 lives to evaluate preventative care in HSA/HDHP policies in the individual market.

Small-group data came from responses from 35 companies covering 351,235 lives.

The survey is available at www.ahipresearch.org/pdfs/HSA_Preventive_Survey_Final.pdf.

Errors & omissions

A chart in the Nov. 12 issue, "Largest rehabilitation service providers," included an incorrect revenue figure for Intracorp. In 2006, Intracorp. reported revenues from rehabilitation services of \$133,500,000. A corrected version of the chart can be viewed at www.businessinsurance.com/directories.

Vacation: Employer not liable in PTO suit

CONTINUED FROM PAGE 4

right of compensation" for unused vacation time would "create uncertainty and potentially serious collateral consequences for many employers' vacation-benefit policies."

These would include "use-it-or-lose-it" policies, where employees lose unused vacation time after a determined period of time, and policies where employers place a cap on the amount of vacation time employees may accrue. The legality of both policies "would be called

into question," said the opinion.

Marko J. Mrkonich, an attorney with Littler Mendelson in Minneapolis, who represented Fresenius, said the decision "means that Minnesota employers are free to set their vacation time off policy in a way they see fit."

Anne M. Radolinski, an attorney with Fredrikson & Byron P.A. in Minneapolis, who was not involved in the case, said the high court's decision puts "the law back to where it was" before the appellate court decision, which is "that vacation pay is basically a creature of the

employer policy."

Pending the Minnesota Supreme court decision, some employers in the state had either continued their pre-existing vacation pay policy, while others paid for any accrued time, "but everyone had kind of been in a holding pattern waiting for this decision," said Ms. Radolinski.

Ms. Lee's attorney could not be reached for comment.

Susan Lee vs. Fresenius Medical Care Inc., Minnesota Supreme Court, A05-1887

Charter: Supporters hope effort gets boost

CONTINUED FROM PAGE 3

than in any since the Dingell inquiry in building the consensus that major reforms are necessary," said Mr. Wood in reference to the 1990s hearings by House Energy and Commerce Committee Chairman John Dingell, D-Mich., into failures of state insurance regulation. "The defenders of the status quo are very uneasy about where the Treasury Department is going this year."

For example, the National Assn. of Professional Insurance Agents in Alexandria, Va., which adamantly opposes the OFC, wrote Secretary Paulson questioning the department's impartiality on the OFC. Specifics of the published notice "raise critical concerns about the direction, purpose and intent of the review process itself, concerns we

are compelled to address directly to you at this time," PIA wrote Nov. 14. It said the comment request posed "loaded questions" designed to encourage predetermined responses.

"I think the Bush administration's approach towards this issue has taken a lot of people by surprise," said CIAB's Mr. Wood, who called the comment request "significant in the overarching political dynamics of insurance regulatory reform."

But other insurance industry groups said OFC is not the answer.

In written comments to the Treasury Department, President and CEO Robert Rusbuldt and Senior Vp Charles E. Symington Jr. of the Independent Insurance Agents & Brokers of America of Alexandria, Va., said while they supported "targeted legislation or federal legislative 'tools' to establish "greater interstate con-

sistency in key areas and streamline the often redundant oversight that exists today at the state" level, they remain opposed to the OFC.

"An OFC would result in the creation of a costly new federal bureaucracy on top of the current state-based system, thereby increasing inefficiencies and regulatory overlap," they wrote.

An insurer group took a similar position. "The states must continue to have the primary role in the regulation of insurance," wrote Charles M. Chamness, president and chief executive officer of the Indianapolis-based National Assn. of Mutual Insurance Cos. "NAMIC believes that a reformed state-based system offers the greatest chance to achieve the regulatory and market reforms necessary for the modern marketplace while addressing local conditions and needs."

Commentary

Buyers short-changed by slow policy issuance



REGIS COCCIA

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

Over the past 10 years, various studies of quality in the insurance industry have had a common finding: There's a lot of room for improvement. One measure of quality in such studies is the time it takes to deliver a complete policy.

A 2006 survey by the Risk & Insurance Management Society Inc., for example, found that only 5% of risk managers received policies within 30 days of inception, and the majority had to wait 90 to 120 days. Any way you slice it, that's a considerable delay. So why are insurers slow to give policyholders what they've paid for?

There are several reasons, underwriters and brokers note.

Partly, it's a function of the complexity of coverage. The more complex the risk, the more detailed the policy, which is simply harder to handle quickly. Widely varying state requirements also contribute. For example, some states require physical signatures on documents, and that takes time to procure; acceptance of electronic signatures would speed things up a lot, obviously.

Another significant factor, however, is policyholders' tardiness in supplying information. If an insurer requires a property schedule or detailed asset values before it will issue a complete policy, for example, then it needs to have those in hand.

RIMS' study reflects the policies purchased by professional risk managers, which do tend to be more complex than small commercial and many middle-market kinds of coverage. But even these types of policies, theoretically simpler to generate, take a good amount of time to deliver.

The following statistics from Willis Group Holdings Ltd., which developed the Willis Quality Index to help benchmark insurer performance on service, shed some light on the problem. For middle-market U.S. business, Willis has found that:

- The average time to deliver a property policy is 37 days.
- The average time to deliver any policy—property or casualty—is 36 days.
- 57% of policies are delivered within 30 days.

While Willis cautions that these stats may include some nonadmitted policy forms, which may be manuscript, one can conclude that a significant percentage of middle-market businesses are waiting more than a month to get their policy documents.

Reasons beyond those cited above that Willis found for why

policies generally aren't issued earlier include the fact that most excess insurers won't issue excess policies until they get a copy of the underlying form or forms. That's not surprising, whether the excess layers follow form or not. Umbrella policies, for example, often drop down to fill gaps in underlying coverage,

Why are insurers slow to give policyholders what they've paid for?

so an umbrella underwriter can't be expected to know where the gaps are without seeing the first-layer cover.

Another reason Willis offers for the delays is that many insurers have been slow to adopt new technology that would speed up policy issuance. Personal lines and some small commercial lines that are largely handled electronically can be issued very quickly, and usually accurately, too.

Business Insurance's Centers of Innovation report in the Nov. 19 issue described how some insurers have been able to issue complete policies at or before the coverage incepts. How is this possible? Use of technology is a big reason. For example, FM Global has a central platform for its policies that was developed years ago following the merger of the former Factory Mutual companies. Beazley USA rebuilt its commercial property underwriting system, not just to gather data but ultimately to deliver complete documents.

Greater efficiency at less expense, in order to boost profits, is the Holy Grail of all businesses. The insurance business can certainly benefit from joining that crusade—and fast.

Risk Manager OF THE YEAR 2008 Risk Management HONOR ROLL.

Honorees are announced and profiled in the annual Risk Manager of the Year, feature published by *Business Insurance* which is distributed at the RIMS annual Conference and Exhibition each spring. Awards will be presented at a special luncheon honoring these risk managers.

DEADLINE FOR NOMINATIONS:

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Call for Nominations

Nominations for the Risk Manager of the Year, and Risk Management Honor Roll, are now being accepted by *Business Insurance*.

The Risk Manager of the Year Award was created in 1977 by *Business Insurance* to increase recognition of the risk management profession and to recognize outstanding performance in the practice of risk management. The Risk Management Honor Roll was added in 1980 as a way to recognize worthy risk managers and risk management programs in industries not represented by the annual Risk Manager of the Year award winner.

Executives anywhere in the world who are involved in risk management for a corporation, not-for-profit institution or government entity can be nominated.

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Business Insurance OPINIONS

Employers, employees benefit from wellness

WELLNESS PLANS are a benefits program that have a great potential for both employers and employees.

As we report on page 1, once there was much corporate skepticism about the value of wellness programs. We can understand those doubts. The programs were new and studies on savings resulting from implementing wellness plans were hard to come by.

Now, the plans have become nearly universal. A study by Buck Consultants L.L.C., for example, found that nearly 90% of employers with more than 50 employees have some type of wellness or health promotion program, though the programs vary significantly in intensity and duration.

The programs' growth has been driven by an obvious fact: They work, leading to lower health care costs for employers and better health for employees.

The programs' growth has been driven by an obvious fact: They work.

Obviously, the programs can take many forms. Some employers have had success in giving employees financial incentives to take health risk appraisals, which often enable detection of conditions such as high blood pressure. Early detection of those problems can prevent expensive treatment later on.

More modest programs can also lead to healthier employees. Something as simple as providing a safe bicycle storage area can encourage more employees to cycle to work, improving their cardiovascular health.

Other approaches might not seem to be wellness programs, but in fact they are because they likely will improve employees' health. For example, some employers waive or significantly reduce employee cost-sharing requirements for those with chronic medical conditions. The expectation is that employees will be more likely to take needed medications and prevent the onset of more serious medical problems.

In short, the scope of wellness programs is nearly limitless. Employers' goal for 2008 should be a renewed examination of these vital programs.

Optional federal charter merits Treasury support

THE TREASURY DEPARTMENT has a unique opportunity to take a significant step toward bringing insurance regulation into the 21st century. We hope the department makes the most of it.

As we report on page 1, Treasury sought formal comments from stakeholders as part of an overview of financial services regulation. The deadline for filing comments was last week.

We believe that creating an optional federal charter for insurers and producers deserves careful consideration during Treasury's review. Even opponents of the OFC, such as the Independent Insurance Agents & Brokers of America, note in their filings that the current state-based insurance regulatory system has its shortcomings and that some degree of federal intervention can be justified in specific cases.

Proponents of the OFC, such as the American Insurance Assn., argue that the current system hasn't and can't keep up with the realities of a dynamic national and international marketplace.

We believe the more convincing argument rests with the OFC proponents. While we have no illusions that an OFC will be enacted tomorrow, we do believe that if Treasury heeds the pro-OFC comments and takes the next logical step of endorsing the OFC concept after it completes its review, we may see needed regulatory reform sooner rather than later.

Federal action, particularly on controversial reform, takes time, but allowing the OFC is long overdue.



BI beats list

In an effort to ensure continuing timely coverage of risk management, insurance and benefit-related news, Business Insurance has formalized a list of its reporters' assigned beats. This list is not intended to be exclusive but rather to represent core subject areas of importance to BI readers. BI welcomes ideas and tips from readers on these and other areas. Following is a list of the beats and the principal reporters for each:

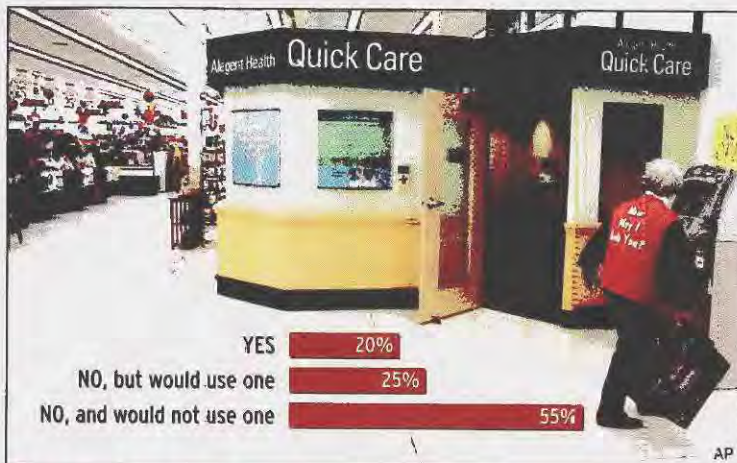
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NEXT WEEK'S POLL: How much do wellness programs reduce corporate health care costs?

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RETIREE BENEFITS: PENSIONS & SAVINGS PLANS

Automatic enrollment may not fix other problems related to 401(k) contributions / **Page 10**

Regulatory approval needed for transferring DB plans remains uncertain / **Page 12**

BENEFITS MANAGEMENT

More employers adopt 401(k) auto enrollment

Fears of employee rejection mostly unfounded

By **SALLY ROBERTS**

Contrary to employer concerns, employees are largely embracing automatic 401(k) enrollment plans, consultants and employers say.

That acceptance, coupled with recent legislative and regulatory relief around automatic enrollment, should result in even more employers implementing the feature, they note.

By automatically enrolling employees into a 401(k) plan, employers address a key issue: inertia on the part of those employees who don't take the time to enroll.

The adoption of automatic enrollment programs comes as more employers move away from traditional pension plans and want to increase the likelihood that employees have enough money saved for retirement.

But while automatic enrollment boosts employee participation, the conventionally low default contribution rate, generally 3%, in such automatic plans is too low to generate enough retirement income, consultants warn (see story, page 10).

Automatic enrollment is not new. It has been available since 1998 when the Internal Revenue Service gave its blessing, but it has been slow to catch on with employers in part due to fears of how employees would react to having a certain percentage of their salaries automatically deferred to a 401(k) plan.

Those fears, however, are largely unfounded, consultants and employers say.

"What companies...that have added automatic enrollment (have found) in the two to three years is a very high level of acceptance and no complaints, even from the people who have chosen not to participate," said David Wray, president of the Chicago-based Profit Sharing/401(k) Council of America. "I think the more than decade-old conversation with American workers about the need to save for retirement is having an effect."

"I think one of the reasons why (automatic enrollment is) spreading so fast is because the experience has been good," said Alan Vorchheimer,



a principal with Buck Consultants L.L.C. in New York. "In terms of employer relations, I haven't heard lots of complaints about this at all."

"With that said, this feature has gotten popular over the last couple of years and the equity markets have been up," Mr. Vorchheimer said. "Perhaps the true test will come when there's a large correction" in the market.

Indeed, a recent survey conducted on behalf of the Washington-based Retirement Made Simpler coalition found that of the nearly 700 surveyed adults enrolled in an automatic 401(k) plan, 98% said they were glad their companies offered the savings vehicle, with 79% expressing strong agreement.

In addition 95% of the surveyed adults agreed that automatic enrollment has made saving for retirement easy, while 85% said it helped them start saving earlier for retirement than they had planned.

And of those who were automatically enrolled, only 7% opted out of the plan, the survey found.

"A well-defined automatic 401(k) plan is going to benefit the employee, first of all by allowing them to enroll in a default investment that's appropriate for most employees and second of all, if they've got auto escalation, by increasing contribution rates as their pay increases," said John Gannon, senior vp for investor education at Washington-based FINRA.

Columbus, Ohio-based Nationwide Financial Services Inc., for one, held off on automatic enrollment

See **AUTO ENROLL** next page

Sponsors consider DB plan transfers

Financial services firms could take over pension administration

By **JUDY GREENWALD**

The first U.S. deal in which a financial services firm would take over the frozen defined benefit pension plan of an outside company could be just months away, observers say.

Under such a transaction, all of a plan's assets, liabilities and administrative duties would be transferred to a financial services firm, and proponents say many plan sponsors would welcome the method to relieve themselves of the responsibility for their frozen defined benefit plans.

Proponents say that would also benefit workers and retirees by putting plan management under the oversight of savvy financial managers rather than firms that may have limited investment expertise.

While there is general agreement that the idea is attractive, many issues have yet to be worked out and opposition could emerge from various fronts.

There are plenty of defined benefit plans that have been frozen. A

survey this year by Arlington, Va.-based Watson Wyatt Worldwide found that 138 out of 638 Fortune 1000 companies had frozen or terminated plans.

Whether the idea would have the blessing of the Pension Benefit Guaranty Corp., the Internal Revenue Service and Labor Department, must be worked out. Observers also say legislation may be needed (see story, page 12).

Another question is how such a deal would be structured. One possibility is the approach New York-based Citigroup Inc. used in establishing a nonbank subsidiary to acquire Thomson Regional Newspapers Ltd.'s U.K. pension fund earlier this year. The bank is "actively pursuing" such initiatives in the United States as well, a spokeswoman said.

Cost is another issue. Transferring the assets and liabilities of a plan is expected to be less expensive than buying annuities from insurers—assuming the employer terminated the plan—but whether it would be economically feasible to

do so has not been determined. That could depend on regulatory requirements.

Some observers question financial services firms' current willingness—and even competency—to run pension plans, considering the billions of dollars lost in subprime mortgages. But many say the idea's time has come.

"I think it's likely to happen sooner or later simply because it's a perfect convergence of public and private interests," said former PGBC Executive Director Bradley D. Belt, who is now chairman and chief executive officer of Washington-based Palisades Capital Advisors L.L.C.

Mr. Belt said he is holding discussions with potential business partners, plan sponsors and regulators about how to best structure these transactions. Palisades is affiliated with New York-based Reservoir Capital Group, a private investment firm with \$3 billion in assets under management.

See **PENSION** page 12

403(b) sponsors face tougher rules

IRS compliance regulations mean more work for nonprofit employers

By **JERRY GEISEL**

Many nonprofit employers that offer 403(b) defined contribution plans have plenty of work ahead of them to bring their plans into compliance with final Internal Revenue Service regulations.

The rules, which were published in July and generally go into effect on Jan. 1, 2009, will end the almost casual way many 403(b) plans have been administered. Most of these plans are funded solely through employees' salary deferrals, with no matching contributions from employers.

Now such plans must have official documents laying out administrative responsibilities and benefit features. That will end practices in which employers exercised little direct control over the plans, ceding that authority to mutual funds and insurers offering investment options, as well as to plan participants.

For example, it was not uncommon for an employee to ask the investment fund vendor for a hardship withdrawal of funds without the employer ever knowing of such a request or whether the employee was legally entitled to the distribution, experts say.

In other cases, employees with 403(b) plan accounts at several financial institutions might have requested hardship distributions from all investment providers. Even though the distributions may have violated IRS rules that limit such distributions, the funds still may have been distributed because of a lack of coordination among the funds.

"There was no central coordination," said Peter Gold, a principal in the Stamford, Conn., office of Buck Consultants L.L.C. "In many cases, administration was haphazard."

In some situations, the employer's sole function was transferring funds that employees contributed

through salary deferrals to mutual funds and insurers, said Glenn Poehle, a principal with Mercer L.L.C. in Richmond, Va.

Taking over administration from outsiders is "going to be a huge challenge" for some 403(b) plan sponsors, said Terri Vaughan, a vp with Aon Consulting in Winston-Salem, N.C.

"There is going to be a lot of work to do and a lot of attention to detail," Ms. Vaughan said.

Among other things, as employers take on more administrative responsibilities, they may, in some cases, retain one firm to manage different vendors and ensure that vendors share information with each other.

Some employers with 403(b) plans, though, already are in compliance with the IRS rules and will have to make, few, if any, changes. In general, small school systems will

See **403(b)** page 16

Auto enrollment may not fix low 401(k) contribution problem

By SALLY ROBERTS

While automatic enrollment addresses employee inertia and will increase overall participation rates in 401(k) plans, such passivity works in two ways, consultants warn.

Once employees are automatically enrolled in the plan at a low default rate—typically 3%—many stay there rather than take the initiative to increase their contributions, and that can lead to inadequate retirement savings, consultants say.

Automatic escalation features and effective communications play

a key role in preventing this from happening, consultants say.

Automatic enrollment “tends to anchor people around the default rate,” said Alan Vorchheimer, a principal with Buck Consultants L.L.C. in New York. “That’s why auto (escalation) is so important.”

Indeed, “One of the issues you do get is a downward pull on the high savers” who would normally save more if it weren’t for automatic enrollment, said Pamela Hess, director of retirement research at Hewitt Associates Inc. in Lincolnshire, Ill.

“We need to be rethinking the default. Most plans default at 3% and that’s not enough. We need to

get people beyond 3% to 4%, 5% and 6%. With contribution escalation, we can do that over time, but certainly there is that downward pull,” she said.

Typically, under automatic contribution escalation, employers increase employee contribution rates each year until employees are eligible for the full company match.

But it’s not just about auto escalation, according to Mark Dzierzak, a Chicago-based senior manager with Deloitte Consulting’s Human Capital Practice.

Employee passivity is “something that I think can get cured by more effective communications—doing a

better job of showing participants the power of the concept,” Mr. Dzierzak said.

“One of the greatest challenges is to make participants understand the concept of why they are in the plan, the power of the plan and the growth potential should they take a more active approach in the plan,” he said.

The Houston-based North American unit of Australian diversified resource company BHP Billiton Ltd., for one, does not encounter this problem. It set its deferral rate at 6% when it began automatically enrolling new hires into its 401(k) plan in 2002, said Cindy Barker,

retirement plan services manager.

“We were told that we were being aggressive at the time,” she said. But “since our purpose was to make sure people didn’t miss out on any matching contributions, we enrolled them at the full 6%.”

And the company has had few, if any, complaints, Ms. Barker said.

“Once they start the job, they’re not used to getting whatever that paycheck is, so they’re perfectly OK with it,” she said. “We’ve have very few people who go back and reduce it.”

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CONTINUED FROM PREVIOUS PAGE

until earlier this year due in part to concerns over how employees might react to it, said Mark Swanson, benefits planning consultant. “Absolutely, we were concerned. Doing this is in many ways a good step, but a huge change in our traditional culture,” he said. In the end, those concerns were largely unfounded.

Of the more than 4,000 employees who were affected by the company’s automatic enrollment program, Nationwide received only eight formal complaints from employees expressing disapproval, Mr. Swanson said.

In April, Nationwide began automatically enrolling any employee who was not contributing at least 3% of salary into the company’s 401(k) plan at a 3% default, unless they choose not to participate. Under the plan, those employees also will see their contributions automatically increase by one percentage point each year until it reaches 6%, which is the level at which Nationwide matches 50% of employee contributions, Mr. Swanson said.

Of 4,359 eligible Nationwide employees, about 1,000 enrolled on their own, 1,058 opted out and about 3,200 were automatically enrolled in the plan. Overall participation for its 33,440 eligible employees went from 77% to 95% with automatic enrollment, he added.

Others have also adopted the feature. Of more than 300 plan sponsors surveyed this year by Lincolnshire, Ill.-based Hewitt Associates Inc., 34% automatically enrolled employees in their 401(k) plans, up from only 19% in 2005.

Those numbers are expected to rise as regulatory and legal issues associated with automatic enrollment have recently been resolved.

Earlier this month, for instance, the IRS provided guidance on how 401(k) plans offering automatic enrollment can qualify for a safe harbor exempting employers from nondiscrimination tests to determine that average salary deferrals made by highly compensated employees do not exceed average deferrals of rank-and-file employees by a legally permitted amount (BI, Nov. 12).

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Pension: Frozen defined benefit plans may be shifted to financial firms

CONTINUED FROM PAGE 9

"I think it's an intriguing idea," said Larry Sher, a principal and director of retirement policy at Buck Consultants L.L.C. in New York. "On the surface, it would seem to have potential benefits for the employees, the employer, the PGBC."

Joe McDonald, Bridgewater, N.J.-based principal with Hewitt Associates Inc., said frozen defined benefit plans often drain a plan sponsors' resources, finances and credit rating, and shifting such plans would allow companies to "not have to deal with this

legacy pension obligation they have."

However, because financial services firms likely would have a significant cost advantage over heavily regulated insurers that offer annuities to employers that terminate their plans, the idea likely will incur insurance industry opposition, observers say.

Financial services firms would be acting like insurers, and "yet they don't have to pay all these premium taxes and have all the reserve requirements" and other regulations to follow, said Mr. Sher.

"The insurance industry probably is not going to be very happy about

this," he said.

Michael Gallo, senior vp, retirement income for annuity provider New York Life Insurance Co., said in a statement that "from a regulatory and compliance standpoint, it is important that noninsurance firms be held to the same capital and quality standards as the insurance industry."

"When today a plan sponsor wants to walk away from promises related to prior service," the sponsor must ensure that promises made to plan participants are kept, said Cynthia Mallett, Boston-based vp, U.S. Retirement Solutions, for New York-based Metropolitan Life

Insurance Co.

This is the key factor distinguishing annuities employers buy from insurers, which protect plan participants, from plans proposed by financial service companies, which would not protect participants, said Ms. Mallett.

If these transactions are "not priced meaningfully better than insured annuities, I suspect there wouldn't be a huge market," said Scott Macey, Somerset, N.J.-based senior vp and director of government affairs for Aon Consulting.

For instance, Mr. Sher said the IRS allows sponsors to make tax-deductible contributions to defined

benefit plans, but "it's not clear that from a tax policy standpoint" that financial institutions could take a deduction for contributions of acquired plans, which could increase their price.

The more options plan sponsors have "for dealing with any kind of benefit or pension issue, the more they like it," said Mr. Macey. "That doesn't mean they would necessarily end up doing it, but they would consider it."

Stuart Shears, treasurer for Wilmington, Del.-based Hercules Inc., a specialty chemical manufacturer, said the appeal would depend on the specific plan. "It makes sense to me if you had a plan that was very well-funded and was relatively small compared to the size of the company."

However, Pete Ronza, director of compensation and benefits at the St. Paul, Minn.-based University of St. Thomas, said, "I'd be very nervous if I was a participant" in such a plan or held a vested interest in it. "Are they just selling me as the next step of closing the plan down, or is this indeed a last hope to be able to resuscitate the plan? The only answer to that is how they write this thing up, because in some instances, plan participants may prefer to close to plan down" and get whatever they can, said Mr. Ronza.

Regulatory approval unresolved

By JUDY GREENWALD

A critical but unanswered question in determining whether financial services firms could take over frozen defined benefit plans is whether they will get regulatory approval and, if so, what the stipulations might be, observers say.

"Depending on what the feds do, that could have a massive impact on whether your good idea is still good or terribly awful," said Pete Ronza, director of compensation and benefits at University of St. Thomas in St. Paul, Minn.

Agencies with oversight of defined benefit plans include the Pension Benefit Guaranty Corp., Internal Revenue Service and Labor Department.

"These proposals merit serious consideration," Charles E.F. Millard, PGBC interim director, said in a statement. "Both retirees and the pension insurance program could benefit if underfunded pension plans are securely transferred from less secure plan sponsors to more sound financial institutions. Of course, many risks and regulatory issues will have to be ironed out."

Bradford P. Campbell, assistant secretary of Employee Benefits Security Administration, said in a state-

See **GUIDANCE** page 14

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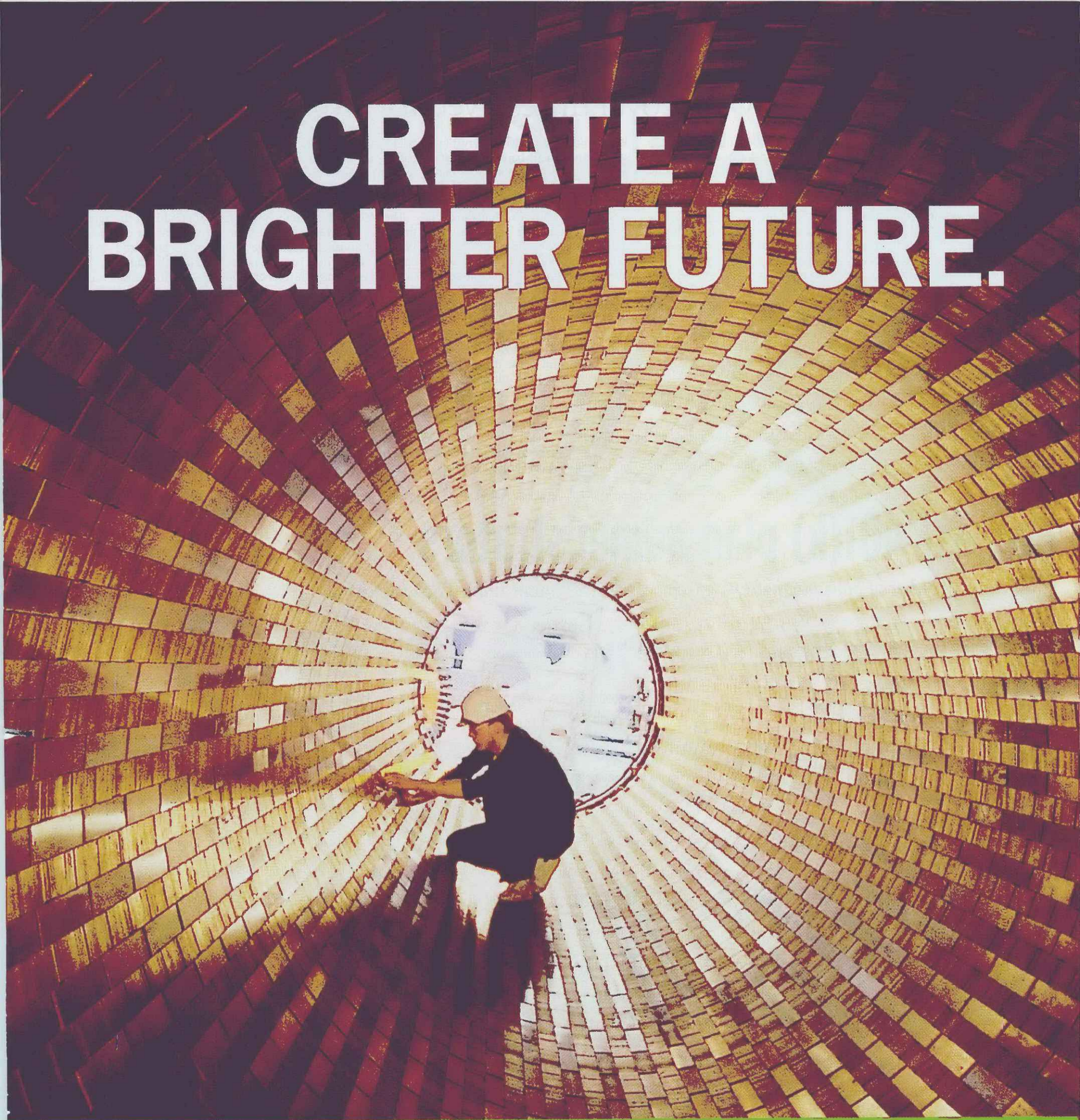
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403(b): Nonprofit defined contribution plans must meet new rules

CONTINUED FROM PAGE 9

face the biggest challenges in meeting the new rules; health care systems, which often have large benefits departments, generally will face the fewest compliance problems, consultants say.

For example, at North Shore-Long Island Jewish Health System, "We always have been proactive in our approach," said Joseph Cabral, chief human resources officer in Lake Success, N.Y.

To that end, the health care sys-

tem has a written plan document, with an investment committee that decides which funds to offer plan participants and a record-keeper who tracks employee information.

Other plan sponsors say they are well along in moving toward compliance.

For example, the Archdiocese of Chicago is working to finalize a plan document and is forming an investment committee to oversee investments offered to employees, said Chris Cannova, associate director of human resources.

At the same time, though, another IRS requirement—that, with very limited exceptions, all employees be offered the ability to make pretax contributions to the plans—isn't an issue for some plan sponsors.

"Whether an employee is a housekeeper or a highly paid clinician, the employee can make contributions," said the health care system's Mr. Cabral.

Opening the plan to all employees is especially important in attracting and retaining older employees, who may only want to

work part-time.

"We did not want to exclude employees from this opportunity to contribute, regardless of the number of hours they work," said the archdiocese's Mr. Cannova.

While the IRS rules will result in 403(b) plans more closely resembling 401(k) plans, they still will differ in a couple of ways.

One key difference is that employees' 403(b) plan salary deferrals are not subject to an IRS nondiscrimination test, which is run on 401(k) plans to determine that aver-

age deferrals made by highly compensated employees do not exceed those of rank-and-file employees by a legally set amount.

Additionally, employees enrolled in 403(b) plans with at least 15 years of service can make, in some situations, an extra \$3,000 a year in contributions, with a limit of up to \$15,000 in catch-up contributions.

"Those are some key advantages," said Robyn Credico, national director of defined contribution consulting at Watson Wyatt Worldwide in Arlington, Va.

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International NEWS



Higher P&I rates flow from boom in shipping

By BEN NORRIS

Ship owners face an increase in premium rates amid an increase in expensive protection and indemnity pool claims, with P&I clubs already imposing increases of between 10% and 20%, according to London-based brokerage Aon Ltd.

In its "P&I Pre-renewal Report 2007," the Aon Corp. unit notes that the total value of P&I claims is rising as booming shipping operations become more expensive.

Among the factors contributing to increases in operating costs are more sophisticated and expensive ships, high-value cargoes, advances in salvage technology, and environmental and personal safety legislation, Aon notes in its report. There is also a reported increase in smaller claims, according to Aon.

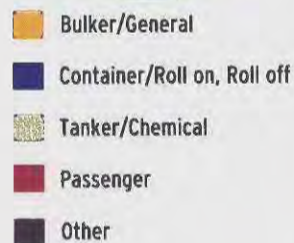
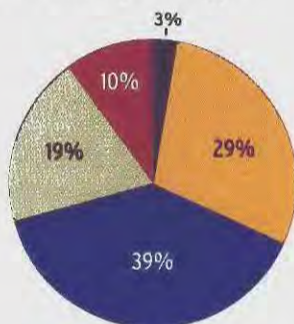
The broker projects that the current claims trend would produce 2006 claims of \$580 million, with an average claim value of \$18.1 million, nearly double the 2004 average of \$9.7 million.

The outlook for 2007 is "ominous," with \$84 million in claims after the first six months, more than the figures for 2006 over the same period, Aon said in a statement.

Rather than simply increasing premiums, P&I clubs could react to the claims surge by demanding increased levels of deductibles to reduce the burden of frequent, smaller claims, Aon said in the statement. Club retention has already been raised from \$6 million to \$7 million in 2007, the company

2006 P&I POOL CLAIMS

Claims according to vessel type



Source: Aon Ltd.

added.

"Precious premium dollars need to be shifted, and shifted up and away from the mundane and predictable and towards the less certain and volatile. The pool must be fully prepared to cope with the rigors of a more expensive operational environment and the evidence of 2006 would strongly suggest that the preparation needs to start immediately," Stephen Hawke, executive director at Aon, said in a statement.

Copies of the report are available at www.aon.co.uk/pre-renewal.

Increase in work-related stress pushes up U.K. illness figures

By STUART COLLINS

A reported increase in stress-related illness and back injuries for the year ending in April could mean that the U.K. health and safety regulator will miss its targets to reduce work-related ill health by 2010.

An estimated 2.2 million people in 2006/07 suffered ill health they thought was work-related—10% more than in the previous year, according to the "Health and Safety Statistics 2006/07," published earlier this month by the Health and Safety Commission and National Statistics.

An uptick in musculoskeletal and stress claims was behind the increase and reversed the downward trend in work-related ill health of 2001 to 2006. As a result, the HSC is not on track to achieve its "Revitalizing Health and Safety" target to reduce the incidence of work-related health problems by 20% between 1999 and 2009.

The incidence rate of self-reported work-related illness was 2,090 per 100,000 employees in the past 12 months, up from the 1,850 reported in the previous period. Further analysis is needed to understand the sudden rise in self-reported work-related ill health, the HSC said in its study.

The HSC also said that it does not expect to meet its target to cut the number of working days lost by 2010. The statistics showed an increase in working days lost in 2006/07, rising to 36 million from



U.K. officials say rising self-reported musculoskeletal and stress claims have reversed the previous trend of declining work-related ill health.

30 million in the previous period.

Labor organization the Trades Union Congress asserted that insufficient resources at the HSC contributed to the rise in work-related illness. "The health and safety executive cannot meet its targets for reducing occupational ill health by 2010 without a significant increase in the resources available," Brendan Barber, TUC general secretary, said in a statement.

The HSC highlighted the fact that the number of workplace health and safety cases prosecuted by the HSE, the enforcement arm of the HSC, had increased to 1,141 in 2006 from 1,056 in 2005. The number of convictions increased in 2006 to 848 from 840 in 2005.

HSC Chair Judith Hackitt said in a statement: "The rising enforcement figures show that negligence in workplace health and safety is not tolerated. The figures also show that where we have intervened with all industry partners, together we have and can make a difference."

The HSC said it is on track to meet its targets to reduce the incidence of fatal and major injuries. Some 28,267 major injuries were reported in 2006/07, down 3% on the previous period. There were 241 workers fatally injured in the United Kingdom in 2006/07, compared with 217 in 2005/06, but the trend for fatal injuries is still down from 1999/2000, according to the HSC.

Swiss Re takes \$900M write-down

Reinsurer vows closer oversight of future use of credit default swaps

By MATT SCROGGINS

ZURICH, Switzerland—Swiss Reinsurance Co. last week reported a nearly \$900 million aftertax write-down stemming from its exposure to credit default swaps related to mortgage-backed securities, prompting A.M. Best Co. Inc. to put the reinsurer's A+ rating under review.

Zurich-based Swiss Re last week reported a 1.2 billion Swiss franc (\$1.07 billion) loss—981 million Swiss francs (\$876.4 million) after taxes—from its exposure to two credit default swaps written for a client by its Credit Solutions unit.

"These investment grade credit default swaps were structured to provide protection against a remote risk of loss," the statement notes. "The unprecedented and severe ratings downgrades undertaken by the rating agencies in October and the lack of any truly liquid market for these securities has resulted in a significant and material reduction of the value of the underlying assets."

The reinsurer noted that it has taken steps to ensure better management of such financial market transactions.

Following the announcement, Oldwick, N.J.-based Best put its A+

rating of Swiss Re and its subsidiaries under review with negative implications. Best said it will discuss with Swiss Re's management the potential for more write-downs related to this exposure.

In addition, "although the loss does not exceed Swiss Re's credit risk tolerance, A.M. Best will further evaluate Swiss Re's enterprise risk management in light of this unexpected loss and the steps Swiss Re has taken to minimize such financial risks in the future," Best said.

Standard & Poor's Corp. said that its ratings of Swiss Re were not affected by the write-down.

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Medical directors: Can help control health care costs

CONTINUED FROM PAGE 4

turned on the CEO, but it totally tumbled off the business people because they didn't see how it worked."

"Lesson learned: The next presentation came through, and we didn't discuss dollars. We discussed productivity. We discussed how this would change available people, especially on production lines and in call centers," Dr. Mahoney said.

"You've got to find what the special interests internally are aiming at and then, to the extent that it's possible, be able to give them the information that will help them move the project forward," he said.

But Dr. Mahoney's experience is more of an aberration than the rule, according to the two other medical directors on the panel.

"Sometimes, the benefit people don't realize they need us," said Dr. Alberto Columbi, corporate medical director for Pittsburgh-based PPG Industries Inc.

Because of medical directors' scientific backgrounds, they can help benefits professionals discern between evidence and ideology when designing or selecting health

management programs, Dr. Columbi said.

"Some of us remember what health is," he said.

"I personally believe that the medical director and the health professionals have a role to play," said Dr. Joe Fortuna, medical director of Troy, Mich.-based Delphi Corp.

"But take a good look at us. We are a disappearing breed. There are fewer and fewer companies investing in corporate medical directors," he said. "Quite the contrary, you see people either outsourcing the medical facilities or putting them in the hands of people who are not medical professionals, and trying to get to the lowest direct cost instead of looking at the long-term value."

"Who in the company is responsible for health of the employees?" Dr. Fortuna asked. "If nobody is responsible or if the answer comes back, as it's come back to me recently... 'Oh, it's the benefits people; they're supposed to take care of it for us,' (then) that totally eliminates the concept of using the corporate environment, as many people have to really enhance the health of the population and maintain the health" of employees.

Nearly 500 participants attend NBCH conference

SCOTTSDALE, Ariz.—The National Business Coalition on Health celebrated its 15th anniversary as a "coalition of coalitions" at the organization's 2007 annual conference that was held Nov. 11-13 in Scottsdale, Ariz.

The organization was formed in 1992 to provide expertise, resources and a voice to its member coalitions across the United States. NBCH currently

includes 54 employer health care coalitions representing more than 10,000 employers and 34 million covered lives.

This year's conference attracted 498 participants—100 more than last year's. Next year's meeting will be held Nov. 9-11, 2008, in Washington.

For more information, visit www.nbch.org.

—By Joanne Wojcik

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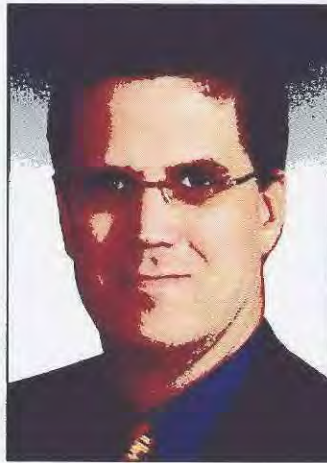
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UP CLOSE John Treacy



NEW JOB: Executive vp and chief financial officer, John B. Collins Associates Inc. in Minneapolis

START DATE: Oct. 15

OLD JOB TITLE AND COMPANY:

Senior vp and corporate controller, Zurich North America

REASON FOR THE SWITCH: Zurich is a great company, and I miss the people I worked with in Schaumburg, Ill., as well as those I met in other locations. However, I was commuting to my job weekly from Minneapolis and missed my family during the week, especially the kids' soccer games. Joining

Collins provided me with not only the opportunity to work in the Twin Cities, but a chance to work with an impressive group of energetic, entrepreneurial and experienced professionals in a company that's going places, in an industry that I'm very familiar with. That's an exciting opportunity that I couldn't pass up.

VITAL STATISTICS: Bachelor's degree from the University of St. Thomas in St. Paul, Minn.; various executive courses at the Carlson School of Management and the Wharton School of Business. I previously worked at Travelers Cos. Inc. and Ernst & Young L.L.P.

GOALS FOR NEW POSITION: With 18 years of insurance company experience, I want to bring a "ceding company perspective" to complement our broker, analytical and operational expertise. I believe this can add to our ability to understand and anticipate the needs of clients. I also hope to play a key role in continuing our 20%+ pace in annual revenue growth.

FIRST TIME IN THE JOB MARKET: I was one of 10 children, and we all started our jobs at a young age to help pay for our high school and college educations. I started caddying at age 11 and those early years led me to other

opportunities around the golf course and clubhouse. I only wish those jobs had a more positive impact on my golf game.

TOP ADVICE: My father was an insurance agent for more than 40 years—a great people person. His advice, given to me in my early career, was to "establish and maintain excellent relationships with all your fellow employees." That's still a top priority to me, and it complements other advice I heard early on, which was, "People don't work FOR you, they work WITH you." I'm a big fan of working hard and having a few laughs along the way.

OUTSIDE THE INDUSTRY, A DREAM

JOB: Before joining Collins, I seriously considered running my own business to provide care and companionship services to seniors. During my last two years in college, I lived with and cared for my grandfather, who had Parkinson's disease. With the help of other family members and me, he was able to enjoy the independence of living in his home for a longer period of time than others who suffer from Parkinson's. I think this type of home care service will continue to flourish in response to a booming demand. I believe such service is a great business opportunity and, most importantly, would be very personally rewarding experience.

Comings & Goings

BROKERS:



Ms. Coffman

Elaine Coffman has been promoted to practice leader for McGraw Hill's Wentworth of Troy, Mich. She will continue her duties as an account director.

INSURERS:

Zurich Financial Services Group has named Steven Bauman as the leader of the team developing captive strategy for Zurich's Global Corporate in North America unit. Mr. Bauman, who will be based in New York, previously was senior vp of Aon Corp.'s captive services group.

Houston-based HCC Insurance Holdings Inc. has promoted James A. Lauer as president of HCC's Avemco Insurance Co. subsidiary. Previously, he was executive vp-insurance operations and chief underwriting officer.

Also at HCC, Adam S. Pessin has been promoted to president of American Contractors Indemnity Co. Previously, he was a senior manager at KPMG L.L.P.

Nonprofits Insurance Alliance Group in Santa Cruz, Calif. has appointed Kim Aday treasurer and vp-finance. Before her promotion, she was controller.

REINSURANCE:

BMS Intermediaries Inc. has named Marie Wilkins senior vp and director of technical broking in Dallas. Previously, she was a team leader with Benfield Group Ltd.

Paula Smith has joined Guy Carpenter & Co. L.L.C.'s GCFac unit as senior vp and head of the London-based terrorism practice. Previously, she was divisional director of the terrorism team at HSBC Insurance Brokers Ltd.

Max Bermuda Ltd., the Bermuda operating company of Max Capital Group Ltd., has appointed Michael W. Dicker as senior vp-agriculture at Max Re Europe Ltd. in Dublin, Ireland. Previously, he was managing director and co-leader of the Guy Carpenter Group Agriculture Specialty Practice Ltd.

OTHER PROVIDERS:

Westport, Conn.-based LifeCare Inc., a provider of specialty care services, has named Joell Gray director of preventive health and wellness. Previously, she was a specialty consultant with Hewitt Associates Inc.'s health and productivity solutions group.

M. Joel Prather has joined Locke Lord Bissell & Liddell L.L.P. as of counsel in the firm's Atlanta and Washington offices. Before joining the firm, he was senior vp and general counsel of Maple Life Financial Inc.

Susan Minis has joined Buck Consultants L.L.C. as a director in its New York office. Previously, she was director of fixed income and rebalancing in the New York city comptroller's office.

Also at Buck, Ben Kemper has been named director in the Los Angeles office. Previously, he owned the consulting firm Kemper Strategy Consulting.

And Grace Yorke has joined Buck as a director in the New York office. Previously, she was a compliance manager for Building Service 32BJ Benefit Funds.

Stamford, Conn.-based Towers Perrin has made several senior-level appointments.

● Leo Magrath has joined as executive vp in New York. Previously, he was executive vp and manager of U.S. specialties at Willis Re.

● Lois Massa has been named senior vp in Stamford and will manage production for managing general agents, program managers and similar distribution channels. Previously, she was vp of sales Swiss Reinsurance Co.'s commercial insurance program division.

● Michael Brownsell, previously a senior vp at Willis Re, has been named senior vp in New York.

Atlanta-based Uni-Ter Underwriting Management Corp. has named Jeri Lambert senior vp-compliance. Before his promotion, she was a senior claims analyst.

TO SUBMIT ITEMS

Business Insurance would like to report on senior-level changes at commercial insurance companies and service providers. Please send news of recently promoted, hired or appointed senior-level executives to: Joe Walker, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; jwalker@businessinsurance.com. Photos should be sent to: Kathy Barnes 360 N. Michigan Ave., Chicago, Ill. 60601-3806; kbarnes@businessinsurance.com.

SOX: Far-reaching affect seen for landmark corporate governance law

CONTINUED FROM PAGE 4

doubled to its all-time closing high of 14,164.53 on Oct. 9 of this year. During the conference, the Dow was trading in the 13,000 range as investors' concern about subprime mortgage losses grew.

Mr. Oxley said unlike earlier corporate scandals, such as the 1980s "esoteric junk bond" scandal, the collapse of Enron and WorldCom resonated with Americans.

"We have changed from a nation of savers to a nation of investors," Mr. Oxley said. "Americans weren't going to let corporate officers get away with something like this. After all, how many financial advisers were not recommending that every portfolio have some investment in Enron and WorldCom in it?"

Over the five years that Sarbanes-Oxley has been in effect, albeit with different compliance dates for various organizations and deferments

for some, "SOX has led to greater uniformity and discipline in preparing financials and finding problems at an earlier stage," said corporate securities attorney Amy Goodman, a partner with Gibson, Dunn & Crutcher L.L.P. in Washington.

In addition, even though lawmakers never intended to mandate that private and nonprofit institutions comply with the law, the act "has led to them looking inward," Mr. Oxley said.

That is appropriate because "duties of directors are exactly the same" at private and public companies, said corporate securities attorney Gary Brown, a partner at Baker,

Donelson, Bearman, Caldwell & Berkowitz P.C. in Washington. "The risks may be a little different, but the duties are the same."

Some panelists suggested SOX has not always worked as intended.

For example, Mr. Galban said, the cost of complying with the act "has pushed money out of the country," as foreign-based companies have listed on foreign stock exchanges rather than U.S. exchanges.

But Mr. Oxley disagreed with that assessment. He said that foreign companies listing on non-U.S. exchanges reflects "a natural maturation" in the capital markets. "The capital markets have met globalization."

"The evidence is clear," Mr. Oxley added, that foreign companies still realize "a premium" for listing in the U.S. and that other countries have adopted corporate governance standards similar to those created by Sarbanes-Oxley.

Heather Fox, a senior vp and chief underwriting officer for New York-based National Union Fire Insurance Co. of Pittsburgh, Pa., asked whether the act should have revealed the subprime mortgage problem earlier than it did.

"I should think the answer should be, 'Yes,'" said Mr. Brown, who also served as a special counsel for a U.S. Senate committee during

its Enron investigation.

Given the size of subprime mortgage-related write-downs that banks have only recently announced, "it's difficult to believe" that a bank had not determined earlier this year that a write-down was necessary, he said.

"But, you can't depend on the law" to encourage earlier recognition of such losses, because "you can't legislate morality; you can't legislate trust," he said.

Mr. Brown said companies "have to concentrate on strong ethics compliance programs," because even strong internal controls designed to prevent accounting problems "can be circumvented."

2,000 attend PLUS 2007

WASHINGTON—More than 2,000 registrants attended the Professional Liability Underwriting Society's 20th annual international conference, held Nov. 7-9 in Washington. The conference featured sessions in educational tracks relating to executive liability, medical professional liability and other issues.

The association honored Maurice R. Greenberg, chairman and chief executive officer of C.V. Starr & Co., with its PLUS 1 Award for his contributions to the professional liability industry.

The next conference is scheduled Nov. 12-14, 2008, at the San Francisco Hilton in San Francisco. Information is available from Diane Dukes, director of marketing and events, at 800-845-0778, or online at www.plusweb.org.

—By Dave Lenckus



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Wellness: Weighing the ultimate benefits

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employers use only medical claims experience, "some groups have used absenteeism and short-term disability rates in determining ROI," she said. Still, others have tracked the reduction in the number of health risks found among employee populations.

Because demonstrating ROI often took several years, many employers gave up on the programs, said Shelly Wolff, national leader for health and productivity at Watson Wyatt Worldwide in Stamford, Conn.

A PODCAST with Dr. William Hettler, president of the National Wellness Institute, on the origins of the wellness movement, can be heard at www.businessinsurance.com/audio.

"If I look back 25 years ago, wellness was a nice thing to have, but as soon as other...corporate initiatives needed the resources, it was the first to go because there was never any business case made for it," said Tom Parry, president of the Integrated Benefits Institute Inc. in San Francisco.

And even after a wellness program received the CEO's backing, that did not mean middle managers would support it, said Dr. Jack Mahoney, director of strategic health initiatives at Pitney Bowes.

"People aim for senior management. It never hurts to have the CEO on your side. But really, the obstacle is

that line...unit manager who's trying to understand the trade-off between investments in wellness and their profit and loss sheet, he said.

While many employers today are willing to invest in wellness programs as a retention and attraction tool, that attitude was virtually unheard of 10 years ago.

"If you have a company that has an extremely high turnover (and) you've got a lot of young people churning through your company, you'll never get the payoff. So it doesn't make economic sense for them to be investing in wellness programs," said Dr.

William Hettler, president of the National Wellness Institute in Stevens Point, Wis.

Another reason for the slow uptake of wellness programs was the fact that previously, health care costs weren't as crippling to corporate America as they are today.

"It didn't catch on for a very long time because...we didn't have much of a problem," said Helen Darling, president of the Washington-based National Business Group on Health.

"Many of the people who were working 30 years ago were men, and we had a younger workforce. So it wasn't something people thought of. When I went to Xerox in the late 1980s, they were still talking about whether we should have flu shots at the worksite," said Ms. Darling, who is a former Xerox benefits manager.

The introduction of managed care also slowed the wellness movement, according to Dr. Mahoney.

"I think what happened is there was an earnest attempt to look at wellness or health improvement and then all of a sudden the silver bullet arrived. In the '80s it was second surgical options and utilization management, and then in the '90s, the biggie was HMOs. So most employers thought, 'if I can manage all of my costs through crashing all of my plans and going to an HMO and bring my costs down, I don't need to do this other stuff,'" he said.

Some employers abandoned initiatives after realizing that participation rates were too low to justify the cost. Early wellness program participation rates were usually less than 15%, and, in some cases, "as paltry as 7% or 8%," said Gregg Lehmann, president and chief executive officer of HealthFitness Corp., a Minneapolis-based wellness program vendor.

Lack of appropriate coverage to encourage the use of preventive health care services also may have stymied the wellness movement, said Marianne Fazen, executive director of the Dallas-Fort Worth Business Group on Health.

"As the costs were rising in the '80s and '90s, 95 cents of every dollar was spent on treating illness, rather than wellness and prevention," she said. "There was no money in wellness."

Wellness slow to catch on

The idea of promoting wellness has been around for decades, although it has taken a while for it to catch on with corporate America.

Dr. Halbert Dunn, known as the "father of wellness movement," introduced the concept in a series of lectures he gave at the Unitarian Church in Arlington County, Va., in the late 1950s. Those lectures provided the basis for his book, "High Level Wellness," which was published in 1961.

But Dr. Dunn's ideas didn't really take root until the mid-1970s, when others built on his concepts in founding organizations such as the National Wellness Institute Inc. in Stevens Point, Wis., as well as the mid-1980s journal "Health Values: Achieving High Level Wellness," which was later renamed the "American Journal of Health Promotion."

A September 2003 U.S. Department of Health and Human Services report, "Prevention Makes Common 'Cents,'" fostered greater interest in wellness within corporate America. Citing studies by several large employers that

demonstrated a measurable return on investment for investing in wellness programs, the report urged businesses to use the worksite to disseminate health information and provide access to preventive health care services.

Today, nearly 90% of U.S. employers with 50 or more employees offer some type of wellness or health promotion program, according to Buck Consultants L.L.C.'s October "Working Well: A Global Survey of Health Promotion and Workplace Wellness Strategies."

But the programs vary in comprehensiveness and duration.

For example, some worksite wellness programs focus on a single risk factor, such as smoking, while others encompass a variety of risk factors and diseases. Not all of these programs are directly connected to health benefits, while some integrate health promotion and disease prevention activities with other programs, including occupational health, safety, workers compensation and disability benefits, the Buck survey found.

—By Joanne Wojcik

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AGRICULTURE & FOOD PRODUCTION

Publishing: December 17
Ad Close: December 3

2008 SECTOR BRIEFING SCHEDULE:

- Sports & Leisure
Publishing: February 4
- Energy
Publishing: May 19
- Financial Institutions
Publishing: June 9
- Pharmaceutical & Chemical
Publishing: July 28
- Transport, Marine & Aviation
Publishing: September 15
- Construction
Publishing: December 8

BRIEFINGS

from the publishers of
Business Insurance & Business Insurance Europe

The editors of *Business Insurance* and *Business Insurance Europe* will collaborate their reporting in special Sector Briefings in response to readers' needs for analysis of risk management trends in specific global business sectors. Risk managers will now have access to information on new developments within their own fields, gaining critical insights into best practices and the risk management challenges and solutions facing other industries worldwide.

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PBGC: Deficit falls to four-year low, but caution urged

CONTINUED FROM PAGE 1

2000, the surplus had grown so large—to nearly \$10 billion—that benefits lobbying groups, such as the ERISA Industry Committee, called for a reduction in insurance premiums that employers paid the PBGC. Later, David Strauss, the PBGC's executive director at the time, called for a "holiday" in which premium payments for employers with fully funded or overfunded plans would be temporarily suspended.

The agency's surplus was so big, Mr. Strauss said at the time, that the economy would basically have to "crater" for the PBGC's robust financial position to be threatened.

The year 2000 proved to be the PBGC's high-water mark. While the economy didn't crater, it certainly wobbled following the Internet stock meltdown in 2000 and the Sept. 11, 2001, terrorist attacks. The value of pension plan assets—largely invested in stocks—sank, while interest rates also declined, turning many overfunded plans into underfunded ones. That resulted in employers having to make hefty contributions to their pension plans for the first time in many years.

It was more than some could afford, especially financially troubled companies. The PBGC's surplus soon disappeared, replaced by a mountain of red ink. The surplus was hammered by several multibillion-dollar losses from the takeover of pension plans from failed companies such as LTV Corp. and Bethlehem Steel Corp., and others such as United Airlines and US Airways Group that filed for bankruptcy protection.

Record deficit spurs action

In 2004, the PBGC's deficit hit a record \$23.3 billion, which served as a catalyst for what became the 2006 funding reform law.

While many say it will take years to know if the latest reform effort will do a better job of shoring up the PBGC's financial base, there is no disagreement that much is rid-

ing on the success or failure of that effort.

Employers with pension plans are directly affected. They already pay nearly \$1.5 billion a year in premiums to help fund the PBGC's single-employer insurance program. If the agency's financial problems once again worsen, Congress could assess them with yet higher premiums.

Plan participants also could be affected. If the PBGC's financial position slides, this could threaten the agency's ability to honor its commitments to participants in terminated plans, unless Congress intervenes with a taxpayer-funded bailout. Last year, the PBGC paid roughly \$4.3 billion in benefits to more than 630,000 participants in failed plans, a huge increase from a decade ago when it made \$800 million in payments to about 200,000 participants in terminated plans.

Unquestionably, the 2006 reform law increases the likelihood that the PBGC's financial position will continue to improve, experts say.

For example, that 2006 law, and one passed the prior year, ensures the PBGC will receive more premium income to help it meet its obligations, noted Mark Warshawsky, a former assistant secretary at the Treasury Department and now director of retirement research at Watson Wyatt Worldwide in Arlington, Va.

The 2005 law raised the PBGC's annual base premium to \$30 per participant from \$19 and put in place a new indexing method in which the premium now rises in tandem with the increase in the national average wage. In 2008, the premium will be \$33 per participant.

Additionally, the 2006 law eliminated loopholes in pension law that enabled many employers to avoid paying the extra premium contributions that normally are required if their plans are underfunded, a change that should significantly increase PBGC's premium income, Mr. Warshawsky said.

Other changes should improve

plan funding and reduce PBGC losses if employers later jettison their plans. For example, if plans are 80% funded, they cannot improve bene-

without those concessions, they would have had no choice but to terminate their plans, dumping billions of dollars of additional losses onto the PBGC. While Delta later folded one plan, it retained its other plans as did Northwest, though both airlines froze the remaining plans.

Congress approved those special breaks for airlines, reasoning that if they could keep the plans going, then the PBGC would be shielded, at least in the near future, from taking on the liabilities, said Tonya Manning, a senior vp and chief actuary for Aon Consulting in Winston-Salem, N.C.

But one critical reform Congress did not embrace was to give employers the ability to recapture pension plan surpluses. Under current law, except in very narrow situations and with many conditions, employers cannot remove surpluses from ongoing plans. And stiff taxes are imposed on reversions when an employer terminates an overfunded plan to wipe out the surplus.

Because of those restrictions and penalties, employers lack the incentive to contribute more to their plans than the minimum required amount, consultants say.

"Employers lack the incentive to fund at the highest level. They fear any surplus will be trapped," said Towers Perrin's Mr. Archer.

Building such surpluses is crucial to protect the PBGC from losses, experts say. Even a plan that is 100% funded can quickly become underfunded if investment results deteriorate and interest rates fall.

"You can go from 100% funded to 80% funded just like that, and then the employer can't afford to make the contributions. We have seen that cycle before," Mr. Archer said.

Giving employers more incentives to boost funding is "unfinished business" that Congress should address if legislators want to provide greater assurance that the PBGC's financial health will continue to improve, Mr. Warshawsky said.

ON THE ROAD TO RECOVERY?

How the PBGC's financial position is improving for single-employer insurance programs*



*In billions of dollars
Source: Pension Benefit Guaranty Corp.

fits; if they are below 60% funded, benefit accruals are frozen.

Additionally, the 2006 law shortened the period of time employers have to fund liabilities, in most cases. While companies previously had as long as 30 years to fund liabilities, the new law requires liabilities to be amortized over seven years.

Speeding up contributions will result in plans being better funded over time, Hewitt's Mr. Reiskytl said.

The 2006 law also makes special provisions for airline companies, giving them more time to fund their plans and allowing them to use a higher interest rate assumption to value liabilities, a provision that lowers their liabilities for reporting purposes and reducing their required contributions.

At the time Congress was considering the legislation, some airlines, such as Delta Air Lines Inc. and Northwest Airlines Corp., said

Securities: Rare trial over stock price fall heads to jury

CONTINUED FROM PAGE 1

lead plaintiff is the Connecticut Retirement Plans and Trust Funds, which claims it lost tens of millions of dollars.

Meanwhile, the Policemen's Annuity and Benefit Fund of Chicago is pressing its securities fraud class action case in federal court in Phoenix against Apollo Group Inc., a Phoenix-based company that offers higher-education programs to adults.

The two cases are only the 11th and 12th to go to trial among the more than 2,500 class actions that have been filed under the provisions of the Private Securities Litigation Reform Act of 2005, according to Adam Savett, director of securities class action services at financial risk management consultant Risk-

Metrics Inc. of Rockville, Md.

An "eye-popping" award of at least \$1 billion in the JDS case "would have a palpable effect" on future cases, Mr. Savett predicted. Plaintiffs would be emboldened to seek greater damages in settlement discussions, and defendants would be encouraged "to be a little looser with the purse strings" earlier in discussions to avoid going to trial, he said.

In addition, given the "increasing activism of public pension funds" as plaintiffs, a big verdict might prompt more plaintiffs to go to trial to seek greater damages than they could recover in a settlement, said Kevin M. LaCroix, a partner with executive liability brokerage Oak-Bridge Insurance Services L.L.C. of Beachwood, Ohio.

But while other plaintiffs likely

would use a big award in the JDS case as a negotiating tool in their own settlement discussions, the vast majority of cases still will not go to trial, predicted Steve Shappell, managing director of the legal and claims practice for Aon Corp. unit Aon Financial Services Group in Denver. Taking cases to trial is expensive and time-consuming and would erode plaintiffs attorneys' profits, he said.

But avoiding trial is of more interest to plaintiffs attorneys than to institutional investors that might conclude they have a fiduciary duty to reject an inadequate settlement offer and go to trial, Mr. LaCroix said.

Indeed, "most plaintiffs attorneys would certainly be willing to take that case to trial," said Carol Gilden, president of the Washington-based

National Assn. of Shareholder & Consumer Attorneys.

A defense verdict, however, could encourage defendants in other cases "to not roll over" and settle quickly, Mr. LaCroix said. Currently, "not many defendants are willing to take that path."

Some observers, however, said the JDS case would not significantly impact future cases.

"I'd be real hesitant to construct a trend out of a case going to a jury," said insurer attorney Arthur Washington, a partner at Mendes & Mount L.L.P. in New York.

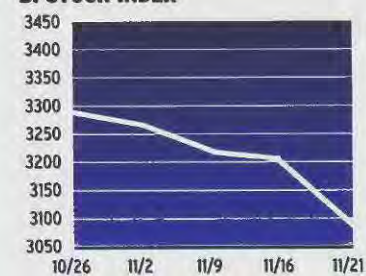
Claims "tend to be so fact-specific" that one case should not influence others, said Gary Dubois, president and chief executive officer of New York-based Valiant Insurance Co., a subsidiary of Bermuda-based Ariel Reinsurance Co. Ltd.

Stock Index

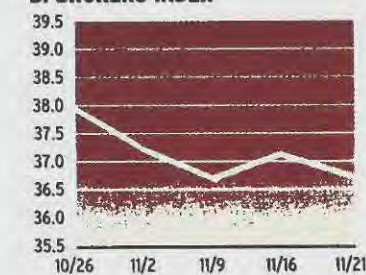
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Up-to-the-minute data for all 82 companies that comprise the BI Stock Index can be found at www.BusinessInsurance.com.

BI STOCK INDEX



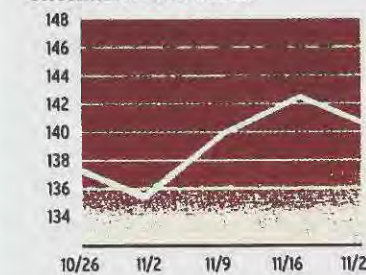
BI BROKERS INDEX



BI INSURER/REINSURERS INDEX



BI MANAGED CARE ORGANIZATIONS INDEX



Percentage change of BI Stock Index vs. key indicators

BI STOCK INDEX	3098.61	-5.71%
DOW JONES	12799.04	-3.26%
S&P 500	1416.77	-3.66%

LARGEST GAINS

Fairfax Financial Holdings	8.75%
Navigators Group Inc.	2.56%
AFLAC Inc.	2.03%
Unitedhealth Group Inc.	0.70%
Alleghany Corp.	0.64%

LARGEST LOSSES

XL Capital Ltd.	-24.80%
Ambac Financial Group	-20.75%
MBA Inc.	-19.17%
Citigroup Inc.	-14.73%
AIG	-13.43%

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

Business Insurance

END PAGE

Contributing: Judy Greenwald,
Kristin Gunderson Hunt,
Dave Lenckus, Douglas McLeod

Louis Vuitton barking up the wrong tree in suit over trademark

What's the difference between \$1,100 to \$4,500 leather handbags that are fashion staples for some celebrities and a \$20 dog toy that parodies the chic accessories?

In a trademark and copyright infringement lawsuit, Paris-based Louis Vuitton Malletier S.A. asserted that the dog toy maker has confused the distinction between the two product lines.

Fortunately for Las Vegas-based Haute Diggity Dog L.L.C., which makes pet products that sport names similar to famous labels, a federal appeals court in Richmond, Va., disagreed. In a Nov. 13 ruling, a 4th U.S. Circuit Court of Appeals panel ruled 3-0 that Haute Diggity Dog did not violate federal and state trademark and copyright laws in making and selling its Chewy Vuitton dog toy.

"No one can doubt that LVM handbags are the target of the imitation by Haute Diggity Dog's 'Chewy Vuitton' dog toys," the court's opinion states. "At the same time, no one can doubt also that the



Haute Diggity Dog's Chewy Vuitton toy cannot be confused with handbags by designer Louis Vuitton, a court ruled.

'Chewy Vuitton' dog toy is not the 'idealized image' of the mark created by LVM. The differences are immediate, beginning with the fact that the 'Chewy Vuitton' product is a dog toy, not an expensive, luxury Louis Vuitton handbag."

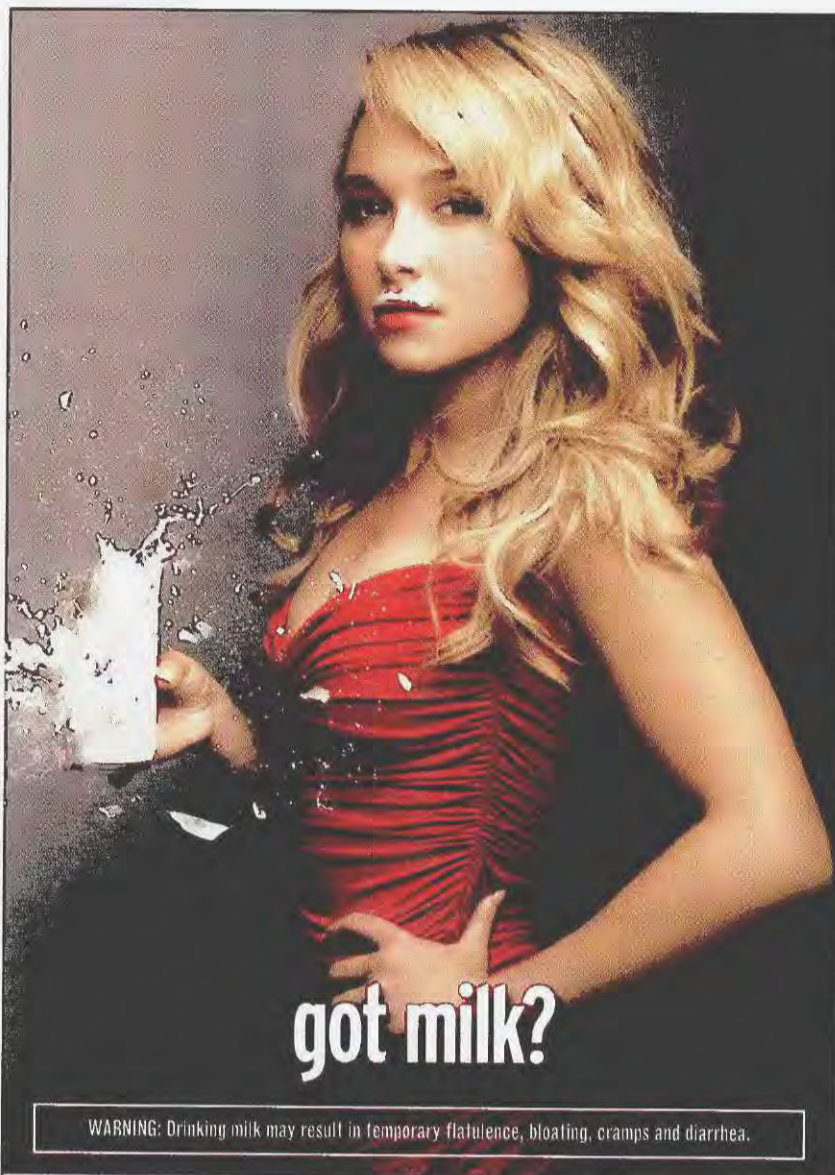
"In short," the panel said, "as Haute Diggity Dog's 'Chewy Vuitton' marks are a successful parody, we conclude that they will not blur the distinctiveness of the famous mark as a unique identifier of its source. It is important to note, however, that this might not be true if the parody is so similar to the famous mark that it likely could be construed as actual use of the famous mark itself."

In an e-mailed statement, Haute Diggity Dog founder Pam Reeder said other designers, unaware of the lawsuit, have sent her company cease and desist orders. After her attorneys informed them of the litigation, the designers decided to "wait for the judgment" before taking further measures, she noted.

The company's other parody brands include Timmy Holedigger, Chewnel No. 5, Dog Perignonn and Sniffany & Co.

Haute Diggity Dog attorney James Petruzzi of Mason & Petruzzi in Houston said the company had no insurance to cover its defense.

Louis Vuitton is considering its legal options, a spokeswoman said.



No use crying over milk risks, judges rule

Aren't there enough warning labels out there? Some people don't think so, and they'd like to put one on the most basic foods—milk. But a federal appeals court panel didn't swallow their claim.

The lawsuit, Milton Mills M.D. vs. Giant of Maryland L.L.C., was filed by a group of lactose-intolerant plaintiffs against seven dairy processors and two grocery retailers that sell milk in Washington.

Before they were aware of their condition, the plaintiffs said they suffered temporary "flatulence, bloating, cramps and diarrhea" as a result of drinking milk, according to the Nov. 16 decision by U.S. Court of Appeals in the District of Columbia. The plaintiffs said the sellers "were aware of the effects of milk on consumers who did not yet know they were lactose-intolerant, but the sellers failed to warn consumers about those effects."

Their suit sought class action status, damages and a permanent injunction requiring milk sellers to add milk packaging warnings.

But a three-judge appeals court panel, in upholding a lower court's ruling, dismissed the case and said a warning is unnecessary. "The risk that some people will get gas after consuming certain foods, such as milk, is widely known," the court said. "A bout of indigestion does not justify a race to the courthouse."

"Indeed, were the rule otherwise, a variety of food manufacturers as well as stadiums, bars, restaurants, convenience stores, and hot dog stands throughout the country would be liable to millions of would-be plaintiffs every day. Plaintiffs' novel claim falls far short of what D.C. law requires," the ruling stated.

Cell phone tool aims to ring up healthy results

Users of a new health and weight management program can now carry their personal trainers and nutritionists in their pockets or in their purses.

Boca Raton, Fla.-based Sensei Inc. recently launched a personalized health and weight management program in which cell phones serve as customers' weight loss coaches.

"It's like having a trainer or nutritionist with you all the time," said Dr. Robert Schwarzberg, president and CEO of Sensei Inc.

Sensei for Weight Loss is a holistic and personalized weight loss and management program, which delivers customized nutrition and fitness information to users' cell phones and personal Web pages.

Users start online by entering desired weight, food preferences, eating habits, meal times, exercise routines and other information from which Sensei nutritionists develop a plan.

The program sends interactive messages to users' cell phones with recommendations, reminders and motivational tips. Users' progress toward specific goals is tracked.

"When you're trying to empower and encourage people to take better care of themselves, the more personal and the more targeted the information, the more valuable it is," Dr. Schwarzberg said.

The program, which costs about \$25 a month, is available to Sprint and AT&T cell phone customers, and anyone can access the online program.

Sensei is a joint venture of Humana Inc. of Louisville, Ky., and Swiss health care technology firm Card Guard A.G.

Long Islanders not charmed by insurers

A Long Island, N.Y., property owner's group has pretty much summed up its attitude toward the insurance industry with its name: H.I.S.S. Homeowners Insurance Scam Stoppers was formed this year to push state legislators to do something about a spate of nonrenewals by property insurers concerned about their downstate New York catastrophe exposure.

"Why do they have super exposure? Because they wanted it," said Richard Boodman, a H.I.S.S. founder, noting that many homeowners paid premiums to the same insurer for years or decades before getting a cancellation notice. "They're being super greedy."

From March 2006 to August 2007, property insurers have nonrenewed 15,500 Long Island homeowners policies, 9,000 in Suffolk County and 6,500 in Nassau County, a New York Insurance Department spokesman confirmed.

Last month, Liberty Mutual Insurance Co. agreed to offer new policies to 3,305 homeowners

who received cancellation notices after New York regulators found it was improperly tying continuation of coverage to buying other products, such as auto insurance.

Allstate Insurance Co. has agreed to halt similar tying practices, though the terms of its agreement are still being worked out, the New York department spokesman said.

Liberty Mutual had planned the cancellations to bring its 8% homeowners market share on Long Island into line with its 5.7% statewide market share, a spokesman said. The number of nonrenewals was within the limit allowed by state insurance law, he added.

H.I.S.S. members, though, aren't happy. Mr. Boodman said New York should deny licenses to any insurers that refuse to write Long Island policies. Created by a group of homeowners at a coffee shop, H.I.S.S. is hoping to expand its membership throughout Long Island and eventually to neighboring states, Mr. Boodman said.



IN THEIR OWN WORDS

Wilma Miller, Insurance Administrator, Church of God Florida State Offices, Inc.



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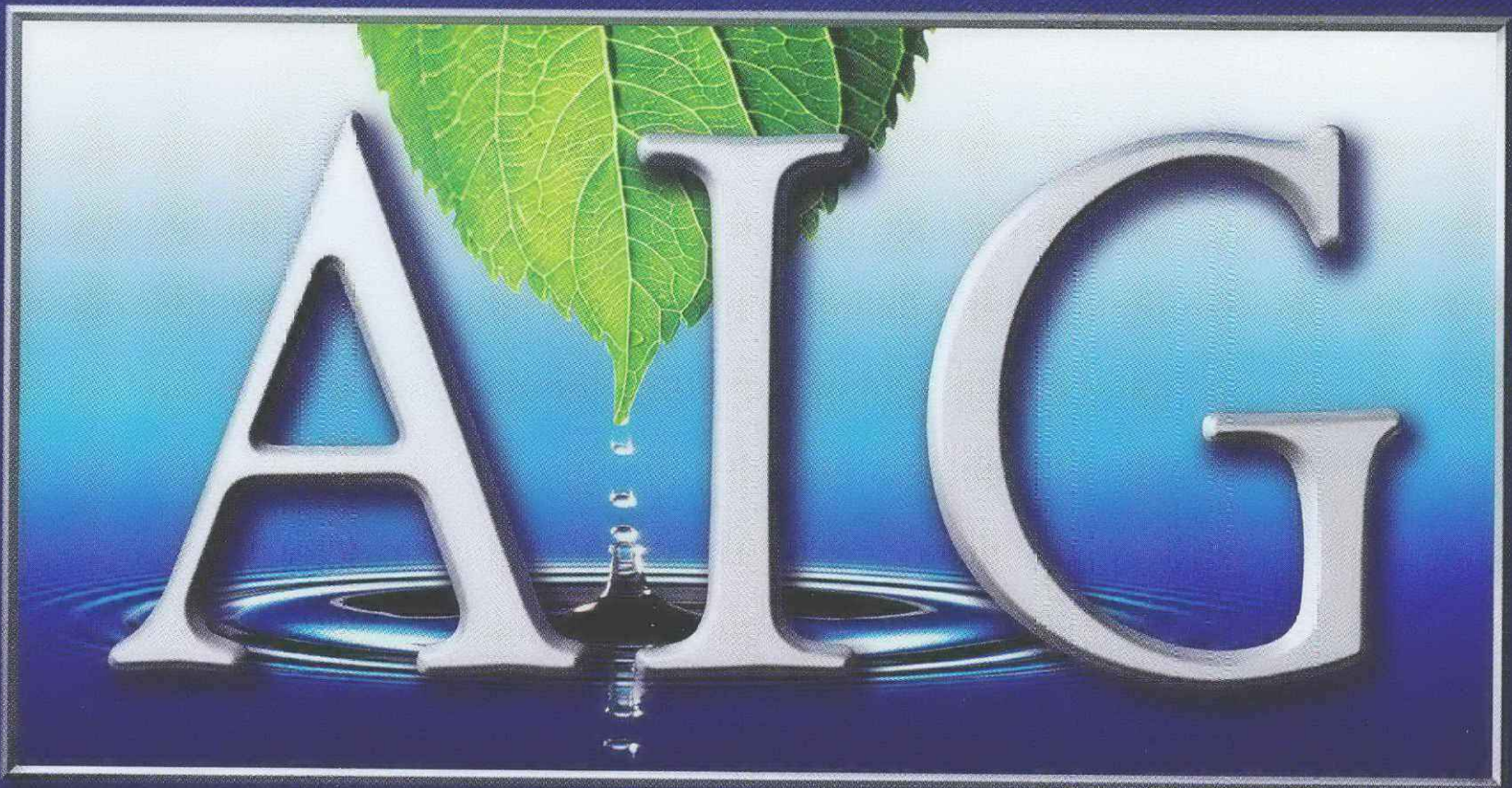
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