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Business Insurance

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HOUSE VOTES TO EXTEND MENTAL HEALTH PARITY LAW, WORKS ON BROADER BILL / PAGE 3

In Brief

Wal-Mart to expand in-store health clinics

Wal-Mart Stores Inc. plans to expand its in-store retail health clinic model in cooperation with local community hospitals across the country. Wal-Mart will partner with retail health care provider RediClinic L.L.C. and local hospital systems to open co-branded walk-in health clinics under the name "The Clinic at Wal-Mart" in 200 Wal-Mart Supercenters. The company expects to open 400 co-branded clinics nationwide by 2010. Wal-Mart already has convenient care clinics in place at 78 of its stores, 13 of which are operated by RediClinic.

D&O insurance to fund HCC options settlement

HCC Insurance Holdings Inc. said it has reached a settlement with plaintiffs in a class action lawsuit

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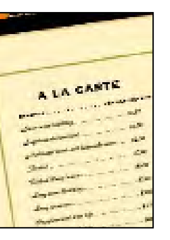
BENEFITS MANAGEMENT

VOLUNTARY BENEFITS

Employers widen benefits choices with growing menu of voluntary options; cost-shifting trend pushes bigger portion of disability coverage costs on to workers; life insurance remains a top voluntary benefit; employers spend more time educating employees on available benefits selections. **Page 9**



Finite risk trial draws to a close

Closing arguments to begin as testimony ends

By DOUGLAS McLEOD

HARTFORD, Conn.—After five weeks of often grueling testimony, the atmosphere in a Hartford, Conn., federal courtroom relaxed palpably last Wednesday as Assistant U.S. Attorney Eric Glover rested the prosecution's case against five former executives of General Re Corp. and American International Group Inc.

In a break that followed, the five defendants chatted outside the courtroom with family members, friends and lawyers; by noon the next day, the defendants had rested their own cases, calling only a handful of character witnesses and introducing a small number of documents.

Any sense of relief over the end of the trial's evidence phase likely is temporary, though.

Last Thursday, defense lawyers lost several post-trial motions, including one to exclude dozens of e-mails and recorded phone conversations among the defendants introduced by the prosecution.

Closing arguments begin today in the case over an allegedly fraudulent 2000 reinsurance deal between Gen Re and AIG. Jury deliberations are expected to begin Wednesday.

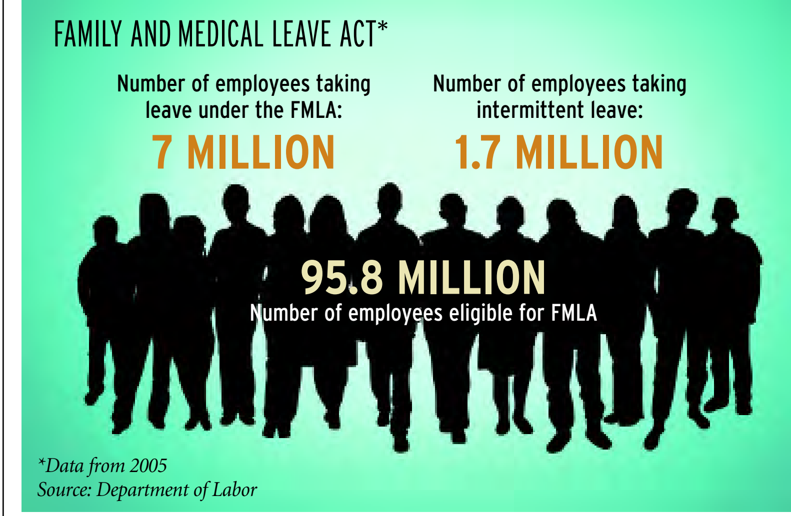
GEN RE FINITE TRIAL

ONLINE: Daily reports, other resources available at *www.businessinsurance.com/GenReTrial*

Charged with conspiracy and fraud in the case are Ronald E. Ferguson, Gen Re's former chief executive officer; Christopher P. Garand, former senior vp in charge of U.S. finite underwriting for Gen Re; and Robert Graham, former senior vp and legal counsel for the reinsurer; Elizabeth Monrad, Gen Re's former chief financial officer; and Christian M. Milton, AIG's former vp for reinsurance.

Prosecutors allege that the defendants engineered a bogus loss portfolio deal that was intended to help AIG inflate its loss reserves by $500 million in 2000 and 2001 to counter stock analyst concerns about AIG's reserve levels. While the deal appeared to transfer $100

See **GEN RE** page 21



Proposed FMLA rules resolve key issues

Notification, doctor contact rules clarified

By JERRY GEISEL

WASHINGTON—Newly proposed Labor Department regulations governing the Family and Medical Leave Act will ease many administrative problems that employers have faced in trying to comply with the law, experts say.

The proposed FMLA regulations, released late last week, would update rules that the Labor Department published following enactment of the 1993 law, which requires employers to provide up to 12 weeks of unpaid, job-protected leave in a year after the birth or adoption of a child; to care for a sick child, parent or spouse; or when an employee has a serious illness.

The 477 pages of proposed regulations are a response to many of the issues employers raised after the Labor Department asked for public comments late in 2006.

The revised rules "are trying to

See **FMLA** page 20

RRG fights attempt to limit coverage options

Battle over state's move to bar group from writing medical stop-loss may have broad impact

By JERRY GEISEL

SACRAMENTO, Calif.—In a case with far-reaching consequences for the risk retention group market, a small Montana-domiciled RRG that provides medical stop-loss coverage to auto dealers is challenging the California Insurance Department's effort to stop it from operating in the state.

Next month, U.S. District Court Judge Frank Damrell Jr. will hear arguments on whether the state's insurance regulator had the authority to issue a cease-and-desist order against Auto Dealers Risk Retention Group Inc., which Montana licensed in April 2007 and has 13 policyholder-owners.

The Department of Insurance took the step, which is on hold under a temporary restraining order, maintaining that neither California law nor the federal Liability Risk Retention Act permits the RRG to write medical stop-loss coverage. In its order, the Insurance Department said under California law the RRG is writing "an excess layer of disability/health insurance coverage" which the Risk Retention Act does not allow.

In subsequent legal papers, the Insurance Department said the RRG is providing "contractual liability," in which it provides coverage for contributions auto dealers make to their health plans when claims exceed certain levels. That "is not the type of liability contemplated" by the Risk Retention Act for RRGs to cover, the department said.

If the arguments made by the agency are allowed to stand, it could severely restrict how RRGs, which are multiple-owner captives, are used by policyholders, RRG

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GEN RE/AIG TRIAL

Complete Gen Re/AIG trial coverage online

The criminal fraud trial of five former executives of Gen Re and American International Group got under way Jan. 7 in federal court in Hartford, Conn. The case centers on a finite reinsurance deal between Gen Re and AIG that prosecutors allege was a sham transaction. *Business Insurance* is following this trial closely and will update readers on the latest developments, witnesses and evidence presented at *www.BusinessInsurance.com/GenReTrial.*

CONFERENCE EXTRA

Read more from the ABA conference online

Business Insurance offers additional coverage from the 2008 American Bankers Assn. Insurance Risk Management conference, Go to *www.BusinessInsurance.com/extra.*

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Business Insurance®

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Industry awaits federal review of regulation

Treasury set to reveal reform proposals for financial services

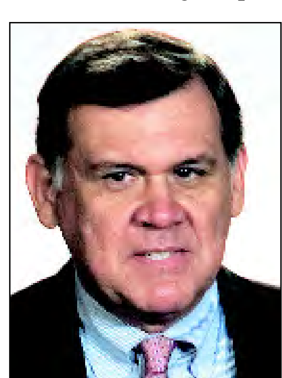
By MARK A. HOFMANN

NEW YORK—Insurance industry observers are divided over what practical impact the Treasury Department's upcoming broad blueprint for financial services regulation reform is likely to have.

A high-ranking Treasury official said last week that the final report is likely to be issued by the end of March.

"While our work is still ongoing and no final decisions have been made, we expect to release our regulatory blueprint within the first quarter of this year," Undersecretary for Domestic Finance Robert K. Steel said in a speech to the New York Society of Security Analysts, according to a copy of his prepared remarks.

Meanwhile, a prominent senator predicted last week that the Senate Banking, Housing and Urban Affairs Committee will hold hearings on the Nonadmitted and Reinsurance Reform Act this spring or early summer. But Sen. Mel Martinez, R-Fla., also told attendees at the Council of Insurance Agents & Brokers legislative summit that the bill's backers would have to educate lawmakers of its positive impact on consumers to get it passed.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Sen. Mel Martinez, R-Fla., expects a Senate committee to hold hearings on the Nonadmitted and Reinsurance Reform Act this year.

The Treasury initiative to enhance the competitiveness of U.S. financial markets—including insurance—began more than a year ago. The effort involves depository institutions and securities and futures markets as well as insurance.

While not explicitly endorsing an optional federal charter for insurers, Mr. Steel noted in his remarks that the state-based insurance regulatory system has led to inconsistency within the compliance process and price approval within the industry.

"Furthermore, with a network of over 50 separate regulators, there is no single regulator with a comprehensive view of the insurance market. There is also no single national regulator to address international insurance issues," Mr. Steel said.

A representative of an insurer group opposed to the OFC predicted that the report would not have a major impact.

"It's not going to have significant impact on this legislative year for this Congress," said Jimi Grande, vp-federal and political affairs in the National Assn. of Mutual Insurance Cos.' Washington office.

See **REFORM** page 6

Court rules for worker fired after bias charge

Timing of dismissal sufficient to warrant retaliation claim

By JUDY GREENWALD

CINCINNATI—A worker who was fired immediately after his employer discovered he had filed an age discrimination complaint with the Equal Employment Opportunity Commission can claim retaliation without having to produce further evidence of retaliatory activity, a federal appeals court has ruled.

Observers say the decision will make it easier for workers in comparable situations to successfully file retaliation claims.

According to the recent decision by a 6th U.S. Circuit Court of Appeals panel in Cincinnati in *Charles D. Mickey vs. Zeidler Tool & Die Co.; Harold DeForge*, Mr. Mickey had worked at the Fraser, Mich.-based firm for 33 years.

Beginning in 1997, Zeidler's owner, Harold DeForge, started lowering Mr. Mickey's salary. In 2002 and 2003, he also began asking Mr. Mickey about his retirement plans.

Mr. Mickey, now 67, filed an age discrimination complaint with the EEOC on Oct. 7, 2004. The EEOC sent a notice of Mr. Mickey's charge to Zeidler on Oct. 14 while Mr. DeForge was out of the office. He returned to the office on Oct. 19.

According to the opinion, Mr. Mickey "testified that when he arrived for work at 7:30 a.m. that morning, DeForge followed him into his office, told him that he was laid off, and that he should pack up his belongings."

Afterwards, Mr. Mickey filed a retaliation charge with the EEOC.

A lower court granted summary judgment and dismissed both the age discrimination and retaliation charges brought by Mr. Mickey.

While the appeals court panel upheld the dismissal of the age discrimination charge, it reversed the lower court's dismissal of the retaliation claims.

The appeals court said case law has established "that temporal proximity alone may not establish a causal connection" between a protected activity such as filing an EEOC charge and a retaliation claim.

But "in those limited number of cases—like the one at bar—where an employer fires an employee immediately after learning of a protected activity, we can infer a causal connection between the two actions, even if Mickey had not presented other evidence of retaliation," the appeals panel ruled. One justice disagreed with the other two justices' reasoning in that point of the ruling, but did agree with remanding the retaliation charge for further action.

Mr. Mickey's Bingham Farms, Mich.-based attorney, Teri Gorman, who has a solo practice, said the court's decision "opens the door for retaliation claims where all the employee has is temporal proximity, in those circumstances where the employer acts very swiftly and there isn't time to have any other additional action other than the temporal proximity."

Commenting on the ruling, plaintiff attorney Frederick M. Gittes of Gittes & Schulte in Columbus, Ohio, said the decision is a "major change in the jurisprudence for the 6th Circuit." The court now "clearly and unequivocally states that when you've got extremely close proximity" between knowledge of a EEOC charge or other protected activity and dismissal of an employee who brought the charge, "it's enough on its own."

Even so, Mr. Gittes said the ruling

See **RETALIATION** page 21

GETTY IMAGES

Rep. Frank Pallone Jr., D-N.J., sponsored the mental health parity extension bill that was passed by the House last week. The bill would extended the federal law through the end of 2008.

House votes to extend mental health parity law

Lawmakers still working on broader measure

By JERRY GEISEL

WASHINGTON—The House of Representatives last week passed legislation to extend through the end of 2008 a federal law that bars group health care plans from providing lower annual and lifetime dollar limits on mental health care services than other medical services.

The House action comes as House sponsors of a broader mental health care benefits parity measure have been working to drum up enough support to bring up that measure for a vote on the House floor.

That broader bill, which several House committees approved last year, would mandate equitable coverage for mental health care services listed in the psychiatric industry's compendium of mental disorders.

The Senate has passed a narrower measure. While that bill also mandates equitable coverage, it leaves it to employers to decide which mental health care disorders they will cover in their plans. If a condition is covered, though, coverage would have to be on the same basis as coverage for other medical conditions.

Both the House and Senate versions represent a big change from the federal parity law that was extended last week, which expired at the end of 2007.

While that 1996 law, which legislators have previously renewed several times, bans discriminatory dollar limits for mental health care expenses, it allows employers to discriminate in other ways. For example, it is legal for a health care plan to limit the number of annual outpatient visits for treatment of mental health disorders it will cover, while not imposing a comparable limitation for other medical conditions.

The 1996 law also permits such designs in which group health care plans will reimburse 80% of medical expenses but only 50% of expenses related to treating a mental disorder.

The House one-year extension bill, H.R. 4848, was sponsored by Rep. Frank Pallone Jr., D-N.J.

Damage extensive from swarm of Southern tornadoes

Initial estimates put insured losses above $40 million

BY ROBERTO CENICEROS

JACKSON, Tenn.—Insurers were determining the extent of damage caused by dozens of deadly tornadoes that slammed half a dozen states last week, but even initial assessments put insured losses beyond $40 million.

The Jersey City, N.J.-based Insurance Services Office Inc.'s Property Claim Services unit declared the tornado-spawned damage to be a catastrophe, meaning insured property losses are likely to exceed $25 million.

While damage estimates were not available last week from either state insurance officials or catastrophe modeling companies, and the PCS had not issued its damage report, much of the commercial property hit by the storms should be covered by insurance, some sources said.

The Federal Emergency Management Agency issued major disaster declarations for several counties in Tennessee and Arkansas.

Damage to Union University in Jackson, Tenn., where as many as 70 buildings were damaged, likely will exceed $35 million, said Jeff Michael, vp of Clay & Land Insurance Inc., a Memphis, Tenn. brokerage that placed coverage for the university.

Coverage limits for the university exceed that amount, Mr. Michael said.

The university is insured by Charlotte, N.C.-based Montgomery Insurance, a regional insurer and a unit of Liberty Mutual Group Inc., said Michael Plavnicky, president and chief executive officer for Montgomery.

Montgomery also insures a large Tennessee church complex that had several buildings destroyed, Mr. Plavnicky said. But the university represented Montgomery's largest loss.

"The tornado seemed to have elected a path that could not have been more effective," Mr. Michael said. "It went through the heart of the university."

In Oxford, Miss., a Caterpillar

See **TORNADO** page 6

BILL BOSTIC

Apartments in Jackson, Tenn., were heavily damaged in last week's storm that spawned dozens of tornadoes.

Aon Corp. consolidates worldwide retail units

Execs shift in consulting, reinsurance divisions

By REGIS COCCIA

CHICAGO—Aon Corp. has consolidated its worldwide retail operations under a single banner, Aon Risk Services, the brokerage announced last week as it reported 2007 results that included a 9% increase in revenues.

The move to place all of Aon's retail operations within one unit is "the next logical step for Aon. We're taking it now because our colleagues have been incredibly effective in building the global Aon," said Greg Case, president and chief executive officer of the Chicago-based brokerage.

"Aon Risk Services is a name we've used before, but it now has a very different meaning. It represents the global business" of Aon's retail operations, Mr. Case said.

Previously, Aon Risk Services was an umbrella organization for various divisions such as Aon Global, Aon Global Affinity and Aon Network Solutions, he said.

Aon Risk Services now combines all of those prior divisions under the leadership of Aon Risk Services CEO Steve McGill, who will take on the additional duties of chairman, and Ted Devine, who will serve as president. Mr. Devine last August was named CEO of Aon Re Global, the company's reinsurance intermediary, after serving two years as a senior manager in the retail operation.

"Ted and I are working as a team to drive the business forward," Mr. McGill said.

"This really is focused on three key things: client leadership and delivering excellent service, working much more effectively in partnership with our key markets, and operating efficiently by looking at the global risk and insurance business," Mr. McGill said.

Succeeding Mr. Devine at Aon Re is Andrew Appel, CEO of Aon Consulting. Mr. Appel will remain chairman of the consulting unit and will be succeeded by Kathryn Hayley and Baljit Dail as co-CEOs. Ms. Hayley previously was CEO of Aon Consulting U.S., while Mr. Dail was and will remain Aon's chief information officer.

"Our reinsurance group is in a wonderful place. Our colleagues have built a pre-eminent group, and (Aon Re Global Chairman) Michael O'Halleran will continue to be the face of Aon to our markets, working in partnership with" Mr. Appel, Mr. Case said.

These changes are about "delivering client service and client value in a way that raises the bar," Mr. Case said. He added that Aon will make significant additional investments in its global capabilities.

Meanwhile, Aon reported revenues of $7.47 billion for 2007, compared with $6.88 billion in 2006.

The brokerage reported a 20% increase in profits for 2007 to $864 million.

Mr. Case said Aon's results "are fully on schedule with the second year of our three-year improvement plan. Our expenses initiatives and restructuring programs are delivering meaningful margin improvement."

In December, Aon announced that it had signed separate definitive agreements to sell its Combined Insurance Co. of America subsidiary to Bermuda-based insurer ACE Ltd. and its Sterling Life Insurance unit to Munich Re Group, for total proceeds of about $2.6 billion.

Judy Greenwald contributed to this report.

Climate change broadens scope of risk

Property, investment, liability concerns rise as warming continues

By JUDY GREENWALD

INDIAN WELLS, Calif.—Climate change and the risk it creates can alter risk management practices by broadening their scope, observers say.

It should also lead to the coordination of risk management on an enterprisewide basis, said Warren Isom, Philadelphia-based senior vp at reinsurance intermediary Willis Re Inc., who spoke at a session on climate change risk implications at the annual American Bankers Assn.'s Insurance Risk Management conference in Indian Wells, Calif., last month.

Mr. Isom pointed to the Geneva-based Intergovernmental Panel on Climate Change's Fourth Assessment report, which was issued in November and included assertions that climate change was linked to human activities.

"Greenhouse gas emissions have increased dramatically" over the past 35 years, he said. And even if emissions were eliminated, the consequences of what has happened so far will still be reflected in the next decades, he said.

The IPCC report provides information on many of the effects of climate change, said Mr. Isom, including increased rainfall, changes in both ocean currents and salinity, changes in wind patterns and shifts in plant and animal habitation.

Furthermore, "there are things we do to make the impact worse," including urbanization, development, land use and population shifts, said Mr. Isom.

For instance, urbanization throughout Europe, including construction in flood plains, exacerbated the problems caused by the February 1995 floods in the Netherlands, said Mr. Isom. "We put ourselves in the path of climate disasters," he said.

The most destructive hurricane to hit the United States was in Miami in September 1926 when "there was not that much there." At that time, the hurricane caused $100 million in damage, which would amount to $157 billion today, he said.

We have also put our primary food sources "where water is scarce," said Mr. Isom. "If the IPCC is correct, water will become increasingly scarce in the future," which reflects on our ability to feed

See **CLIMATE** page 20

ABA COVERAGE:
Banks must prepare for disasters that hit back-up sites and other facilities. Read more online at *www.businessinsurance.com/conferenceextra.*

Bank to seek recovery from insurer

Fremont General accused of draining workers comp claims account

By DAVE LENCKUS

SAN FRANCISCO—The California-based parent of an insolvent workers compensation insurer may have interfered in the insurance unit's contract with a New York bank by withdrawing $14 million in funds that the bank had to replenish to cover claims, a federal appeals court has ruled.

The Feb. 1 decision, reversing a lower court ruling, sends the Bank of New York's case against Santa Monica, Calif.-based Fremont General Corp. back to a trial court, where the bank does not have to provide direct evidence of intentional interference to recover damages. It must provide only enough information from which the court could infer that Fremont General intentionally interfered in its subsidiary's bank contract, explained a three-judge panel of the 9th U.S. Circuit Court of Appeals.

In addition, the Bank of New York is entitled to seek recovery of the $14 million it agreed to pay New York insurance regulators in March 2004 to settle litigation over the missing funds, the appellate panel ruled.

Fremont General argued that the Bank of New York is not entitled to any recovery, because the bank was responsible for ensuring the $14 million was maintained in a special account that Fremont General emptied in violation of New York rules.

Alternatively, because regulators later used only $3.8 million of the settlement to cover workers comp claims and returned the rest to the insolvent insurer's estate, the bank's damages should be capped at that amount, Fremont General argued.

At the root of the dispute is the form of securities that regulators allowed Fremont General to put in a special custodial account at the Bank of New York for subsidiary Fremont Indemnity Co. New York regulators typically require companies domiciled in other states to set up

See **FREMONT** page 21

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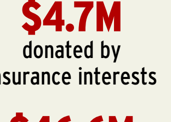
Insurance lobby spreads campaign donations

By MARK A. HOFMANN

WASHINGTON—Insurance interests donated nearly $4.7 million to U.S. presidential candidates last year, according to the Washington-based Center for Responsive Politics.

Using data released Feb. 1 by the Federal Election Commission, the nonpartisan group found that insurance interests tended to favor Democratic presidential candidates by an overall margin of 53% to 47%. But that Democratic edge was "pretty consistent with what we saw with other industries" over the year, said a spokesman for the center.



$4.7M donated by insurance interests

$46.6M donated by lawyers and law firms

But the $4.7 million was barely one-tenth of the amount raised by the economic sector that proved to be the most generous to presidential candidates—lawyers and law firms. Lawyers and law firms donated $46.6 million to presidential contenders, and supported Democrats by a 77% to 23% margin.

In fact, insurance interests ranked 14th among industries in terms of giving to presidential candidates, according to the center.

Three candidates who have since dropped out of the race received the most insurance-related largesse during 2007. Senate Banking, Housing and Urban Affairs Committee Chairman Christopher J. Dodd, D-Conn., was tops in insurance-related money at $804,837. Second on the list at $797,045 was former New York Mayor Rudolph Giuliani, who left the race for the Republican nomination after the Florida primary and endorsed Sen. John McCain, R-Ariz.

The third dropout—former Massachusetts Gov. Mitt Romney, a Republican—ranked third with $726,338. He was followed by Sen. Hillary Clinton, D-N.Y., at $711,399.

Sen. Barack Obama, D-Ill., received $499,609, placing him fifth, and Sen. McCain ranked sixth at $323,831.

Former Arkansas Gov. Mike Huckabee, a GOP contender, ranked 12th at $66,815, behind Rep. Ron Paul, R-Texas, who held 10th place at $96,238. The only other active candidate listed—Mike Gravel, a former Democratic senator from Alaska—ranked last among insurance interest donations, in 20th place with $500.

The Center for Responsive Politics calculated the totals from political action committees and individuals giving more than $200, as reported to the FEC. Further information can be found at *www.opensecrets.org*.

Reform: Industry awaits proposals

CONTINUED FROM PAGE 3

"It's always relevant when Treasury decides to take a look at how the nation's financial services sector should be regulated. It may be as much about putting down some markers, because when those who run Treasury now leave, and the new folks come in, they leave behind a record," he said. "What the next people decide to do with that record will be up to them."

"It can't be anything but a good thing," said Joel Wood, senior vp at the CIAB, which supports the OFC. "To the extent that here is a growing consensus that fairly radical reforms are needed, the voice of a conservative presidency will be meaningful in the ongoing debate.

"My sense of this is…very significant progress has been made in moving the dynamic toward a national regulatory structure. The votes aren't there and aren't particularly close yet," he added.

Meanwhile, Senate movement on the bill to reform surplus lines and reinsurance regulation appears likely.

"I really don't think there's any entrenched opposition" to the Senate version of the surplus lines bill, said Sen. Martinez, who cosponsored the measure with Sen. Bill Nelson, D-Fla. The House passed its version of the bill by a 417-to-0 margin last year.

Sen. Martinez attributed the lack of movement on the measure to apathy and lack of understanding of the issues involved by some lawmakers, rather than outright opposition.

He urged those attending his address to stress the regulatory reform aspects of the bill to Republican members in particular. He said all lawmakers need to learn how passage of the measure would help consumers.

Tornado: Damage estimates top $40 million

CONTINUED FROM PAGE 4

Inc. plant that supplied necessary parts to other company manufacturing facilities suffered a "direct hit" during work hours and partially collapsed, said a spokesman for the Peoria, Ill.-based heavy equipment manufacturer.

Employees evacuated to two storm shelters within the plant and only minor injuries resulted, the spokesman said. But the impact on Caterpillar's production remained unclear last week as design and construction crews evaluated the losses.

Caterpillar, which owns a Bermuda-based captive, is insured for the loss, the spokesman said without providing further details.

Sears Holdings Corp. also has insurance arrangements for a store that was damaged when a tornado struck the Hickory Ridge Mall in Memphis, lifting off portions of the store's roof, said a spokeswoman for the retailer.

Moreover, small businesses also suffered losses.

For instance, Jared Standridge, a vp at Steve Standridge Insurance Inc., an independent insurance agency in Clinton, Ark., said he expects his clients alone will file about $8 million in commercial claims, including damaged county buildings and destruction of a fishing boat manufacturing facility owned by River Trail Inc.

Catastrophe modeling companies said that although approximately 70 tornadoes were reported across portions of Alabama, Arkansas, Kentucky, Mississippi and Tennessee, the actual number was likely lower. Additionally, reports of severe wind and hail storms stretched across nine states from Texas to the Ohio River Valley.

"Tuesday's severe weather was caused by a strong, developing low pressure system that moved out of east Texas during the day," said Tim Doggett, senior research meteorologist at AIR Worldwide, a catastrophe modeling unit of ISO. "A dynamic jet stream located above the system provided the wind shear that fueled the numerous tornadoes."

The death toll exceeded 50—including additional fatalities on Wednesday—from the storms that also destroyed hundreds of homes.

Enron plan shortfall is Hewitt's fault, DOL says

Consulting firm blamed for overpayments

By JOANNE WOJCIK

WASHINGTON—The U.S. Labor Department is asking a federal district court in Houston to hold consultant Hewitt Associates Inc. in civil contempt for failing to comply with a court-approved allocation formula for payments to participants in now-defunct Enron Corp.'s Employee Stock Ownership Plan.

The Labor Department asserts Hewitt erroneously paid out too much to some participants at the expense of the remaining participants, resulting in a $9.15 million shortfall in the fund that the court created to settle numerous lawsuits related to Enron's demise. Lincolnshire, Ill.-based Hewitt had served as administrator of the settlement fund.

In its motion, which must be approved by the U.S. District Court for the Southern District of Texas, the Labor Department seeks to force Hewitt to make up the shortfall without seeking repayment from the plan participants who were overpaid.

In response to the motion, Hewitt said in a statement that it is reviewing the Department of Labor's motion.

"Hewitt has been working closely with both Enron and the Department of Labor since the error in this first distribution from the settlement trust was discovered," the statement notes.

"We are surprised that the Department of Labor is pursuing this action against Hewitt since Enron is, in fact, the defendant in this order. Our primary goal has always been to find a solution that is in the best interest of the plan participants, and this continued legal action is likely to further slow down that process," the Hewitt statement said.

The Labor Department action follows two other similar motions filed Jan. 23 against Hewitt by the Enron Creditors Recovery Corp. that also seek to compel Hewitt to fund the shortfall created as a result of the consultant's misallocations.

Thousands of Enron employees lost much of their retirement savings when Enron, amid allegations of fraud, failed in 2001 and its stock became worthless.

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Business Insurance OPINIONS

California misguided in RRG regulation bid

MANY YEARS AGO, naively it appears, we thought the issue of how risk retention groups were to be regulated was settled.

Simply put, after meeting the licensing requirements of one state, risk retention groups could provide coverage to member-owners in any state, with minimal interference from out-of-state regulators.

However, not all regulators saw it that way. The National Assn. of Insurance Commissioners, in a truly misguided effort, passed a model law stipulating that for groups providing product liability coverage—the only risk the groups could cover at the time—each state's definition of product liability would apply.

Of course, since state definitions vary, such a requirement would have made it impossible for a risk retention group to operate in multiple states.

> *As California regulators see it, the coverage the RRG is writing isn't the kind of coverage an RRG is permitted to offer under both California law and the Risk Retention Act. Not true.*

Later, in the face of adverse court rulings, the NAIC backed off and rescinded its model law and individual state regulators seemed to accept limits on their authority to decide what risk retention groups could and could not write.

But now, as we report on page 1, the issue is not over. California insurance regulators are trying to stop a Montana-domiciled risk retention group from providing medical stop-loss coverage to California auto dealers.

As California regulators see it, the coverage the RRG is writing isn't the kind of coverage an RRG is permitted to offer under both California law and the Risk Retention Act.

Not true. It isn't up for California regulators to make such a determination. That decision is up to the state that licensed the group, and Montana determined that the group met the requirements for a risk retention group. The federal law is absolutely clear on that point.

We hope California sees the light.

Coverage cost reporting proposal not useful

WHEN ANALYZING a Bush administration proposal to require employers to report the cost of health insurance coverage they provide to employees on W-2 wage and income statements, there is the theory and then there is the reality.

The theory, the administration explains, is that employees are unaware of the cost of health plans, which causes them to make inefficient choices, such as selecting plans that provide more coverage than they really need.

While the administration's proposal is well-intentioned, the reality is that it would extraordinary difficult for employers to comply.

How, for example, would employers determine the cost of coverage? Would employees' premium contributions be included? In the case of self-funded employers, what about fees charged by third-party claims administrators? For employers that self-fund, how would they determine annual plan costs when late-year claims often are paid the following year?

Many other cost questions would have to be resolved with regulations. Given that a cost disclosure requirement wouldn't accomplish anything, we don't think developing such regulations would be a good use of federal policymakers' time, or employers' time to understand and comply with the rules.

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:

Agents/brokers: Sally Roberts.

Benefits—health care and ancillary benefits: Joanne Wojcik.

Benefits—retirement savings/pensions: Jerry Geisel.

Canada—risk management and benefits: Gloria Gonzalez.

Employment practices: Judy Greenwald.

Environmental risk management: Sally Roberts.

Federal regulation/ legislation—benefits: Jerry Geisel.

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Latin American markets: Roberto Ceniceros.

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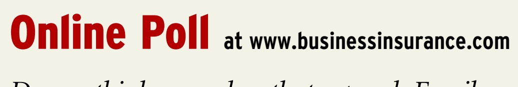

Online Poll at www.businessinsurance.com

Do you think a new law that expands Family and Medical Leave Act coverage for family members of employees called up for military service will significantly complicate FMLA administration?

NEXT WEEK'S POLL: *Is the insurance industry adequately involved in the political arena, particularly in this election year?*

***BI* Online Poll tool sponsored by Wausau Insurance Cos.**

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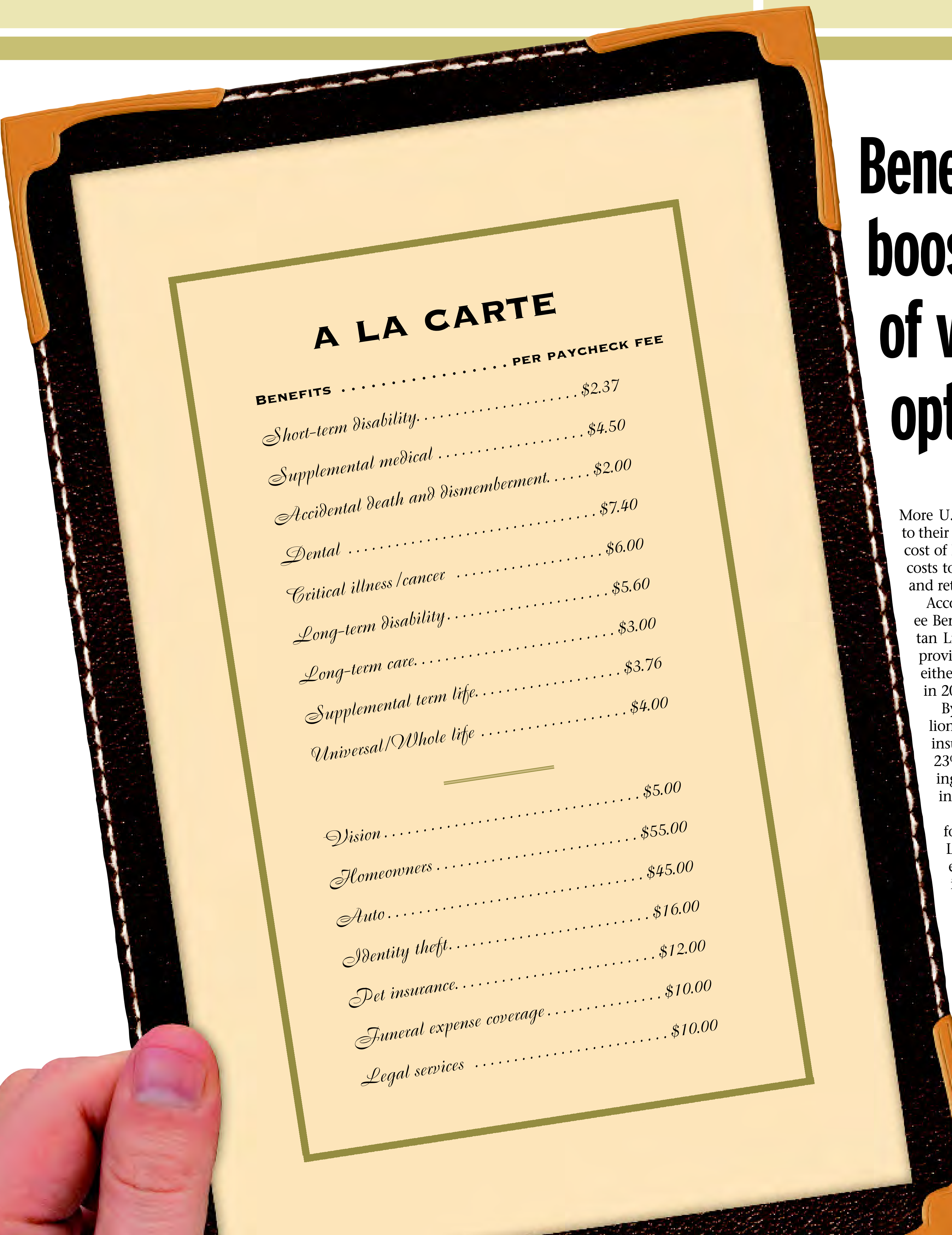
BENEFITS MANAGEMENT-VOLUNTARY BENEFITS

Employers weigh second enrollment cycle for voluntary benefits / Page 11

More employers shift disability benefit costs to workers / Page 12

Life insurance remains a top voluntary benefit offering / Page 14

BENEFITS MANAGEMENT



Benefits menu boosted by mix of voluntary options

By JUDY GREENWALD

More U.S. employers are offering voluntary benefits to their employees for two main reasons: the growing cost of health care, which has led employers to shift costs to voluntary benefits, and the desire to attract and retain employees, experts say.

According to the fifth annual "Study of Employee Benefits Trends" by New York-based Metropolitan Life Insurance Co., 39% of employers ranked providing a wider array of voluntary benefits as either "extremely important" or "very important" in 2006, up from 31% in 2005.

By line of business, with an estimated $4.72 billion in voluntary benefit sales in 2006, disability insurance accounted for the largest share with 23%, followed by life insurance at 21%, according to Avon, Conn.-based Eastbridge Consulting Group Inc.

A voluntary benefit program is "an easy way for employers to address" employee needs, said Lawrence Singer, senior vp at Segal Co., a benefits consultant in New York. "The employer's involvement is marginal, the investment is zero or quite low, and employees get the protection by buying the product with their own money."

Randall Stram, Bridgewater, N.J.-based vp, employee paid products for MetLife, said employers today are in a "conundrum." They want to retain employees, help them with their work/life issues and increase job satisfaction, but they also want to control benefit costs. "The answer that many employers are coming to is that voluntary benefits are a very cost-effective way to supplement their employer-paid benefit offerings," he said.

"Many employees are interested in (voluntary benefits) when they're hired," said Kathy Croley, payroll administrator for Laurel, Del.-based Johnny Janosik Inc., a furniture retailer with about 300 employees that works with Voluntary Benefits Systems Inc., an Ellicott City, Md.-based voluntary benefits marketer.

"Also, we like to help take care of our employees. It's more

See **VOLUNTARY** next page

Voluntary: Benefits enhance total package

CONTINUED FROM PREVIOUS PAGE

beneficial to us in the long run," said Ms. Croley of the retailer, which offers voluntary benefits that include short- and long-term disability, life, critical illness, dental and accident insurance.

Voluntary benefits also help employee recruitment, said Marjorie Teague, human resource manager of Mattawan, Mich.-based Ralph Moyle Inc., a 135-employee trucking firm. It "definitely gets them more motivated to come here rather than somewhere else," said Ms. Teague, who works with Columbus, Ga.-based American Family Life Assurance Co. of Columbus, which is known as AFLAC.

Kathy McPhillips, director of benefits for Bensalem, Pa.-based Charming Shoppes Inc., which operates 2,400 retail stores in 48 states, added homeowners, auto and pet insurance and a computer purchasing program to its existing voluntary benefits last year for its 33,000 employees.

The goal was "to really enhance our overall benefits package and some things we thought would be of particular value to our associates, full- and part-time," said Ms. McPhillips, who works with consulting firm Watson Wyatt Worldwide in Washington.

Furthermore, a voluntary benefits program gives employees "access to benefits at better rates" because they are part of a group. "Then it allows them to pay for it through payroll deductions," said Judy Hime, Jackson, Tenn.-based benefits manager for West Tennessee Health Care, which has about 5,600 employees.

Employees are less likely to miss a small sum taken out of their paycheck twice a month than "if they had to make a monthly or quarterly payment to the insurance company," said Ms. Hime of the hospital chain, which has coverage through Hartford, Conn.-based CIGNA Corp.

Employers also are using so-called mini-medical plans, which cover basic medical services that include physician visits and prescription drugs, as a tool to retain employees where they may not have had medical coverage before, said Phil Grece, New York-based vp and product manager in American International Group Inc.'s domestic accident and health division.

Increased medical costs are a factor as well.

"I think (voluntary benefits are) going to increase in popularity because the health insurance costs have continued to grow," and cutbacks in employer-paid programs are creating gaps in employees' health coverage, said Ted Bosse, president of Voluntary Benefit Systems.

"There's many more employers that are not paying for what maybe five, 10 years ago was a traditional employer-paid benefit," such as dental and disability insurance, said Mark Sylvester, vp of voluntary sales at Kansas City, Mo.-based Assurant Employee Benefits, an employee benefits marketer.

"Companies are not just offering benefits for the sake of offering voluntary benefits, but they are offering it for a reason that would fit into their company benefit strategy," said Garry Sullivan, senior vp at Aon Consulting, a unit of Chicago-based Aon Corp. "If they just had an increase in their health care contributions for employees," they may consider introducing an auto or homeowners program that would save employees money and help offset their higher health care costs, he said.

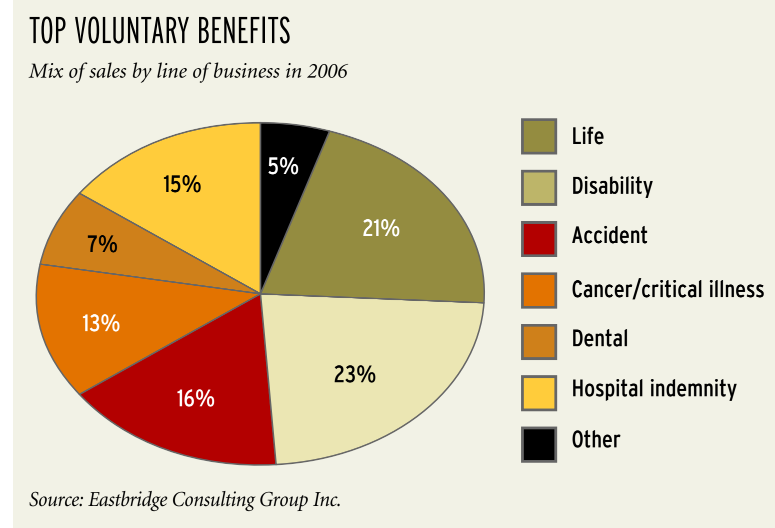
Additionally, employers have moved away from offering concierge-type products, such as discount movie tickets and take-home dinners, which were more common about 10 years ago, said MetLife's Mr. Stram. "We're seeing less of that, with more focus on the financial security, financial protection products," which is a reflection of employers' desire "to provide supplemental benefits to their employees."

The suite of benefits offered to the 3,800 employees at Boston-based Blue Cross Blue Shield of Massachusetts, however, includes group universal life and long-term care insurance, legal services, pet, auto, homeowners, renters, identify theft and travel insurance, as well as consumer product discounts for cell phones, electronics and movie tickets, said Debra Weafer, director of compensation and benefits.

There is "not a lot of opportunity to increase the benefits package" and voluntary benefits are a way to "add something new and different for our associates," Ms. Weafer said.

TOP VOLUNTARY BENEFITS

Mix of sales by line of business in 2006



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AGING U.S. WORKFORCE

Growth in national employment by age group, in unadjusted figures, for the past five years. Numbers of workers are in thousands.

Age group: 20-24, 25-34, 35-44, 45-54, 55+

Years: 2003, 2004, 2005, 2006, 2007

Source: Bureau of Labor Statistics

Too many benefit choices may confuse employees

By JUDY GREENWALD

One dilemma facing employers in designing a voluntary benefits program is whether offering too many choices leaves employees feeling overwhelmed.

Judy Hime, Jackson, Tenn.-based benefit manager for West Tennessee Health Care, which offers its 5,600 employees a variety of voluntary benefits, said, "If you offer too many choices for them it could overwhelm them, but I also like to have a good selection to help the employees with their expenses."

"The more you have, the more you're competing for people's energy as far as paying attention to things, and obviously you're also competing for dollars," said Lawrence Singer, senior vp at Segal Co., a benefits consultant in New York.

The optimal number of benefits depends on an employer's current offerings, said James T. Pettapiece, president of Vision Financial Corp., a Keene, N.H.-based third-party administrator. If an employer has a "real scaled-down health plan, then a pharmacy benefit could be appealing," he said. "It just depends first and foremost on what the employer is currently providing."

But Leonard Sanicola, compensation practice leader at WorldatWork, a Scottsdale, Ariz., human resources organization, said he does not believe the number of benefit programs is an issue, so long as the employer is not burdened administratively.

Employees may be overwhelmed by 25 choices in their 401(k) program because they are "trying to decide what's different" about each fund. But that is not an issue with voluntary benefits, where pet insurance is clearly different from life insurance, he said.

Debra Weafer, director of compensation and benefits at Blue Cross Blue Shield of Massachusetts in Boston, which offers a large suite of voluntary offerings to its 3,800 employees, said it avoids confusion by listing products by category on its intranet.

"You can go click on the insurance page and see just insurances. You can click on consumer items" and see those, she said. "We sort of bucketed it" into major topics "so people don't have to get stuck with lists and lists and lists of things and give up because it takes too long," Ms. Weafer said.

If a voluntary benefit has a low employee participation rate, though, an employer needs to determine whether it should be continued or if it "creates unnecessary noise or clutter," said Robert Maloney, vp and manager, national affinity sales, with Boston-based Liberty Mutual Insurance Co.

But patience can pay off, Ms. Hime said. While the hospital chain's long-term care and funeral expense voluntary benefits had few takers initially, "we've left them there and as people become aware of the benefit, and they hear other employees talk about it, there's been more interest."

Additionally, demographics are a factor in selecting voluntary benefits, observers say.

Employers want to "look at the population, their income, their underlying needs," Segal Co.'s Mr. Singer said. "There's some groups where long-term care makes a lot of sense" and others where it does not.

Furthermore, you "don't want to have somebody buying pet insurance and ignore the need to buy disability insurance," Mr. Singer said.

Diane Russell, assistant vp, marketing and product development, at CIGNA Group Insurance in Philadelphia, said voluntary benefits should be tailored to the employee population, "and those needs change on a yearly basis, so employers need to look at that and understand what would be more relevant to their population."

Should voluntary benefits enrollment be separate?

Employers advised to balance desire for simplicity with need to adequately inform employees

By JUDY GREENWALD

To avoid confusing and overwhelming employees with choices, some consultants recommend holding separate enrollment periods for employer-paid benefits and voluntary benefits, although there has been little movement in this direction.

On the positive side, observers say a second enrollment period would give employees adequate time to carefully consider their voluntary benefits without the major distraction of worrying about their employer-sponsored medical plans. On the negative side, observers say separate enrollment periods could complicate matters administratively.

Lale Iskarpatyoti, group and health care practice leader for Watson Wyatt Worldwide in Philadelphia, said a separate voluntary benefits enrollment is a good idea.

"I would hate for someone to spend an inordinate amount of time thinking about whether or not to get pet insurance when they should really be focusing on their (medical) plan and understanding

See **CHOICES** page 12

Education essential to get more employees to sign up

To increase participation in voluntary benefit programs, some employers are spending more time educating their employees, observers say.

Lance Osborne, vp, field force development, for the American Family Life Assurance Co. of Columbus, in Columbus, Ga., said, "As health plan designs continue to evolve" and employers use voluntary plans "to enhance that plan design or offer more choices, the education that happens during open enrollment becomes more and more critical."

There is an "increased focus on personalized or customized benefit communications and additional decision support tools," said Randall Stram, Bridgewater, N.J.-based vp, employee paid products, for New York-based Metropolitan Life Insurance Co.

While there was a time when all employees would receive the same benefits communication letter, now it is much more common for the 45-year-old employee with three children to get a different letter "than the 30-year-old single employee," said Rich Fuerstenberg, a principal with Mercer Health & Benefits in Princeton, N.J.

"The rule of thumb is that the closer you get to the employee, the higher the percentage of people taking the program will be," said Garry Sullivan, senior vp at Aon Consulting, a unit of Chicago-based Aon Corp. Face-to-face meetings, for example, will result in a higher percentage of participation than using the mail, the Web or even the telephone, he said.

Mechanicsburg, Pa.-based Universal Protective Packaging Inc. used to send out letters informing the firm's 70 employees about its voluntary long-term disability policy. But when June Massey-Brown joined the firm last year as its human resources manager, she set up employee meetings with representatives to discuss the benefit, and enrollment jumped from 10 people to 40.

"If they don't have the right information, they don't really look at it or really think about it," Ms. Massey-Brown said.

—By Judy Greenwald

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Choices: Pros and cons of separate enrollments

CONTINUED FROM PREVIOUS PAGE

what plan options work for them," Ms. Iskarpatyoti said.

"Particularly if you're introducing a brand new set of benefits" and education is involved, employers would be "better off to have dedicated time to educate people so they can make a decision about it," said Mike Simonds, Portland, Maine-based senior vp and chief marketing officer, Unum U.S., a unit of Unum Group.

If it is a "simple or straightforward" benefit such as short-term disability, employers may be more comfortable offering it as part of the "core benefit conversation, so it depends a little bit on the product mix," Mr. Simonds said. "If time is tight, (employers) may be more likely to do it all at once."

One enrollment period is "concise from an administrative perspective. You have all the enrollment decisions captured at the same time," said Ron Gendreau, Simsbury, Conn.-based executive vp of Hartford Financial Services Group Inc.'s group benefits division. The downside is "employees are sometimes overwhelmed," he said.

It may be a good idea if employers do enrollments for a few voluntary programs "off-cycle," thus giving employees "a chance to really focus on those particular needs, as opposed to just getting swallowed up in the health care decisions they have to make," Mr. Gendreau said.

Few employers have moved in this direction, though, said Lawrence Singer, senior vp at Segal Co. in New York. "I can understand" why someone would advocate a separate enrollment period, but "frankly that's not what I've been seeing." Employers are "still offering it all at once."

"We felt it was better just to be consistent and do it once a year, when we have comprehensive open enrollment support with additional communications and additional meetings," said Kathy McPhillips, director of benefits for Bensalem, Pa.-based Charming Shoppes Inc. Even so, she said the company may reconsider that in the future.

"I do believe that some of the traditional voluntary products that aren't tied to health insurance," such as pet insurance and legal assistance, "are going to be moved off-cycle" into a second enrollment period, said Lance Osborne, vp, field force development, for the American Family Life Assurance Co. of Columbus, in Columbus, Ga.

Disability buyer, provider strategies shifting as employer budgets tighten

Insurers experiment with new designs to encourage employees to enroll

By ROBERTO CENICEROS

Employers are reshaping their voluntary short- and long-term disability offerings with the hope of providing an attractive package while using their limited funds to address rising health insurance costs, observers say.

One way employers are restructuring their short- and long-term disability benefits is by shifting the cost to employees, they add.

For instance, Unum Provident Corp., which changed its name to Unum Group last year, derived 18% of its revenue from sales of short-term disability products from employee-paid coverage in 2002. But by 2007, employees paid 55% of Unum's short-term disability sales dollars, said Neiciee Durrence, vp and voluntary practice leader for Unum in Chattanooga, Tenn.

Unum's short-term disability policies are sold to employees, with employees being the policyholder and paying the premium through employer payroll deductions. But similar changes also are occurring under group plans in which employers are the policyholders, observers said.

Some observers say the move to make short- and long-term disability benefits voluntary is occurring more with small and midsize employers that have fewer than 500 employees. Others see similar trends among large employers as well.

> 'The challenge you run into is most people think they will never be disabled for the long term.'
>
> Joe Wozniak, Disability Management Employer Coalition

More large employers, for instance, are offsetting their growing health care spending by reducing the amount of long-term disability coverage for which they pay, said Joe Wozniak, chief financial officer for the San Diego-based Disability Management Employer Coalition.

Where large employers traditionally paid for long-term disability insurance that provided about 66% of an employee's salary, now they may be paying for coverage that provides only 40% to 50% of a worker's salary, Mr. Wozniak said. At the same time, they are providing an opportunity for employees to further protect their salary by purchasing additional coverage, even as much as 80% of their salary, he said.

"It's a simple cost share because long-term disability is not nearly as expensive as the health care component," Mr. Wozniak said. "But the challenge you run into is most people think they will never be disabled for the long term, and people don't generally buy up on it."

Because of rising health care costs, large and small employers are increasingly looking to add more voluntary benefits, including short- and long-term disability insurance, said Sean Schubert, director of

See DISABILITY page 14

Health plan cost hikes stay at 6.1%

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October 29, 2007 – Business Insurance

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Nearly one-quarter of employers offer voluntary life cover

Programs paid by employees usually supplement a basic life insurance program paid by their employer

By LOUISE KERTESZ

Although growth in the voluntary life insurance market has remained essentially flat for several years, many employers continue to offer the programs as a way to enhance their benefit plans without the extra cost.

The percentage of employers offering voluntary life insurance remained virtually unchanged at 23% in 2006 vs. 22% in 2002, said Ronald Neyer, senior analyst at LIMRA International, a Windsor, Conn.-based financial services research and consulting organization. However, a higher percentage of employers offered life insurance for which they absorbed the entire cost—53% in 2006 vs. 45% in 2002, Mr. Neyer said.

"Carriers…are just trading clients between each other—there's not a lot of organic growth" in the market, said Richard Stover, principal at Buck Consultants L.L.C. in Secaucus, N.J.

According to Avon, Conn.-based Eastbridge Consulting Group, voluntary life insurance sales grew from $774 million in 2001 to $1.01 billion in 2006. Sales of voluntary term life, the most popular product, have outpaced sales of voluntary whole life and universal life and now represent 62% of premiums. While voluntary term life sales remained flat at $645 million in 2006, permanent life sales fell 8% to $366 million from 2005.

"Though voluntary life sales have remained stagnant overall, nearly half of the carriers (18 of 28) reported growth of at least 5% for the first nine months of 2007," according to LIMRA.

Most employers offer voluntary term life as a supplement to basic employer-paid group term life coverage. Confronted with the challenge of shrinking benefit dollars, employers have found they can offer a richer benefit at no cost to them by allowing employees to buy up from their basic group term life—from one to five years' salary. Some employers are increasing the amount of optional buy-up, Mr. Stover said.

'There's a need for these combination products in the employer setting as (baby) boomers are starting to retire.'

Mike Kaster, Watson Wyatt Worldwide

Employees generally can protect up to five years of salary by purchasing supplemental term coverage. To be competitive, "there's a lot of creativity" among insurers when underwriting this product, said Nazneen Vimadalal, vp, group market, Liberty Mutual Group Inc. in Boston, which offers basic group coverage and a supplemental buy-up. For example, some insurers minimize health questions they ask employees in an initial level of screening, she said.

Employees find that purchasing term coverage through a payroll deduction is convenient and inexpensive. Because mortality rates have improved, rates have declined for both term and permanent life insurance, according to 2006 LIMRA data. "The overall cost per thousand dollars of new group life coverage declined 5% from 2005. The cost for both term and permanent insurance coverage declined, with term insurance costing 4% less than in 2005," according to LIMRA.

"If rates are declining in other areas, we would think that voluntary rates would follow suit," Mr. Neyer said.

However, a worker can buy "more death benefit per premium dollar" in term coverage than in permanent insurance, said Frank J. Fimmano, senior vp with Aon Consulting in New York. The downside is that when the term ends, the policyholder is left with no benefit, and premiums rise with the employee's age.

Industry sources say healthy workers might be able to find less expensive term life coverage on their own, but most people buy through their employers because of the convenience.

"What I've seen is that permanent life…is relatively stagnant," said Mr. Fimmano. "Employers are not making universal life and whole life available to their employees at the rate that our society would appropriately warrant" to assure they are covered through retirement. Permanent life insurance has a steady premium and the advantage of accumulating a cash value that an employee can draw on, he said.

Many Americans are underinsured, Mr. Fimmano added. The most recent data from LIMRA show that in 2004 one-third of U.S. adults had no life insurance coverage and 36% had only basic group life coverage through their employer.

"We have seen a great demand for cash value products to complement the group term product," said Debbie Cecil, manager of product and market development at Unum Group in Chattanooga, Tenn. Sales to dependents have become "a significant portion of the worksite sale," she added.

Other major insurers in the voluntary life market include Hartford Life, a unit of Hartford Financial Services Group Inc.; CIGNA Group Insurance; ING Employee Benefits; Colonial Supplemental Insurance, a unit of Colonial Life & Accident Insurance Co.; and Lincoln Financial Group, the marketing name of Lincoln Financial Corp., according to Eastbridge Consulting.

As for product development, insurers about 10 years ago began offering policies with accelerated death benefits, and some insurers have made accidental death coverage available with voluntary life, Mr. Stover said.

New products that are not yet standard in the voluntary market include term life with a return-on-premium feature if the policyholder does not die during the term of the coverage and universal life with a long-term care rider, said Mike Kaster, senior consultant for Watson Wyatt Worldwide's insurance and financial services practice in Berwyn, Pa. "There's a need for these combination products in the employer setting as (baby) boomers are starting to retire," he said.

Mr. Fimmano added that individual term life programs—as distinct from supplemental buy-up policies—"are making their way into voluntary distribution, and a couple of carriers are offering hybrid products," in which half of an employee's payroll deduction could be spent on whole life and the other half on a term life rider, to make the coverage less expensive.

SIZE OF THE VOLUNTARY BENEFITS MARKET

About half of U.S. businesses with 10 or more employees offer voluntary benefits.

Total number of U.S. businesses	1,236,000
Overall voluntary benefits penetration	53%
Number of firms sponsoring voluntary benefits	648,000
Employees with option to purchase one or more voluntary products	81,700,000

Source: LIMRA International 2007

Disability: Market changes, competition push plan design experiments

CONTINUED FROM PAGE 12

client solutions in Dallas for Gallagher Benefits Inc., a unit of Arthur J. Gallagher & Co.

As a result, employers and insurers have begun to test new short- and long-term disability plan designs. The changes come after many years when plan designs remained static, Mr. Schubert said.

"Everybody is starting to experiment with different plan designs," Mr. Schubert said. "They have to. Where maybe before they were offering a more traditional 66 2/3% (salary replacement benefit) on the LTD with a $15,000 maximum, now they are starting to pull that down and maybe provide some carve-outs for the executives."

Enhancement despite cutbacks

Some employers that didn't provide short-term disability offerings previously are now making group coverage available for employees that choose to pay for it on a voluntary basis, Mr. Schubert said. There is no cost to employers, but it allows them to enhance their benefit offerings while cutting back in other areas.

With more employees funding disability insurance, insurers that traditionally sold employer-funded products have moved into the voluntary market, Unum's Ms. Durrence said.

"They are having to venture into that territory because the market has shifted," Ms Durrence said.

As the market has grown more competitive among insurers, product pricing, however, has not decreased, said Joe Sevcik, vp of marketing for Assurant Employee Benefits, a unit of Assurant Inc. in Kansas City, Mo. But the increased competition has helped keep disability insurance pricing stable, Mr. Sevcik added.

Insurers are also diversifying their group disability offerings, Mr. Sevcik said. To help increase sales, insurers are tailoring products to expand the number of smaller groups or higher risk groups to which they might sell.

For example, Assurant offers a hybrid, short- and long-term disability product with the employer as the group policyholder and employees paying the cost of the voluntary benefit.

The coverage's initial short-term disability payments are triggered when an employee spends at least 72 hours in a hospital or is diagnosed with a terminal condition. After six months of illness, the long-term coverage kicks in depending on rating the severity of the employee's impairment, Mr. Sevcik said.

Because the benefit is triggered only when a disability is serious, Assurant can provide it to groups that typically forgo disability benefits because their risk category might price them out of the market. While the product has been sold mostly to smaller groups, Assurant said it also has sold the voluntary product to groups with 1,000 or more employees.

As more employers offer voluntary disability products, insurers face greater marketing challenges as distribution system changes can be daunting for them, said Thomas Klett, senior consultant for Watson Wyatt Worldwide in Stamford, Conn.

Before, insurers had to sell only to employers, but now they must use retail marketing to reach employees, Mr. Klett said.

The shift to educating employees is huge, said Josh Logan, director of marketing services in Portland, Ore., for Standard Insurance Co. The challenges that insurers face include reaching populations that speak different languages and convincing employees of the importance of disability insurance.

It's an employer concern as well, Mr. Klett added. Group size usually impacts pricing. The larger the group of employees that take up voluntary disability benefits, the better the pricing.

Employers want to provide their employees a better price, so they, too, are concerned that their workers are well-educated about their voluntary disability benefits options, Mr. Klett said.

VOLUNTARY BENEFITS SNAPSHOT

Percent of employers that offer voluntary benefits, including disability benefits (marked with asterisks)

Benefit	Percent
Cancer	29%
Accident	24%
Short-term disability *	20%
Supplemental medical	20%
Accidental death	17%
Dental	17%
Critical illness	17%
Long-term disability *	16%
Long-term care	16%
Supplemental life	15%
Vision	9%
Life	8%
Prescription drug	5%
LTD buy-up *	4%

Source: LIMRA International 2007

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IRS GUIDANCE CLARIFIES TAX RULES FOR PREMIUMS TO CELL CAPTIVES / PAGE 3

ZURICH'S SCHIRO HONORED FOR HIS WORK / PAGE 4

JUDGE REJECTS ERISA CHARGES IN CLASS ACTION LAWSUIT OVER BROKER PAY / PAGE 4

In Brief

High court to hear retaliation case

The Supreme Court will determine whether employees who cooperate with an internal investigation of sexual harassment charges are protected from retaliation under the Title VII of the Civil Rights Act of 1964. The justices agreed to hear *Crawford vs. Metropolitan Government of Nashville and Davidson County, Tenn.*, a case brought by a school system employee who alleges she was terminated because she agreed to be interviewed about allegations of sexual harassment

Talk of Willis bid for Marsh returns

Questions abound on report of letter to MMC board

By SALLY ROBERTS

NEW YORK—Talk of Willis Group Holdings Ltd.'s interest in buying its much larger rival Marsh & McLennan Cos. Inc. resurfaced last week, with some analysts noting that such

involved in Willis' latest approach, according to the CNBC report.

Representatives from London-based Willis, New York-based MMC and New York-based KKR declined to comment.

News of the potential deal briefly sent MMC's share price up 11.8% last Thursday to $29.56. Shares later closed at $27.28, up 3.1% over Wednesday's closing price. Shares closed at $27.17 on Friday, up 3% from the previous week. Willis

Supreme Court curbs third-party liability

Stock fraud case doesn't preclude all claims

By DAVE LENCKUS

WASHINGTON—The victory the U.S. Supreme Court has handed to two companies facing securities fraud charges from another company's investors does not shield third-party defendants such as accountants and lawyers from all so-called "scheme liability" claims, legal and insurance experts agree.

In the high-profile Enron case, the future of which many experts predicted would hinge on the *Stoneridge* decision, investors also are advancing the scheme liability theory in an effort to recover $33 billion of losses from a group of investment banks. The investors charge the banks helped Enron deceive them about the energy trader's precarious financial condition

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Plan would require reporting health costs on employee W-2s

By JERRY GEISEL

WASHINGTON—Employers would be required to report the cost of health insurance coverage they provide to employees on annual W-2 wage and income statements under a recommendation by the Bush administration.

Such disclosure is necessary because many employees "are unaware" of the value of coverage, the administration said of the idea that was included in its fiscal 2009 budget proposal.

The current lack of transparency may result in "inefficient choices of health coverage, including overconsumption of health coverages by employees," the administration said.

Under the proposal, costs of health care-related plans in which employees are enrolled, such as medical, dental and vision plans, could be aggregated. Contributions, if any, to health savings accounts would be excluded.

Cost information would be reported based on "similarly situated" employees who receive the same level of coverage, such as individual or family coverage. Costs, however, would not be reported on a specific employee's use of health care services during a year.

Meanwhile, the Bush administration also recommended several changes to health savings accounts that it first proposed last year, but on which Congress took no action. Under one proposal, for example, HSAs could be set up without being linked to high-deductible insurance plans, as is the case now. Instead, HSAs could be paired with insurance plans that have a 50% coinsurance requirement.

Such a design would increase the appeal of HSAs to lower-income employees who now may be hesitant to enroll HSAs because they are worried that they could face big medical bills before insurance coverage kicks in.

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SOVEREIGN MARINE & GENERAL INSURANCE COMPANY LIMITED ("THE COMPANY")

NOTICE OF ANNUAL MEETING OF SCHEME CREDITORS

A meeting of the Scheme Creditors of the Company ("the Meeting") has been convened by the Scheme Administrators, pursuant to Clause 8.1 of the Original Sovereign Scheme between the Company and the Scheme Creditors ("the Scheme") for the purposes set out below.

The Meeting will be held at the offices of KPMG LLP, 1-2 Dorset Rise, London, EC4Y 8EN, England on 18 March 2008 at 2:00 p.m. (London time). A report concerning the progress made in implementing the Scheme and the conduct of the Company's affairs generally since the last such report was prepared ("the Report") shall be laid before the Meeting pursuant to Clause 8.1.2. Scheme Creditors will have the opportunity to address questions to the Scheme Administrators concerning the Report at the Meeting.

A copy of the Report is being sent to the latest addresses held, per the Company's records, for all known creditors, potential creditors and brokers of the Company. Any person entitled to attend the Meeting who has not received the Report by 18 February 2008 can obtain a copy free of charge from the Scheme Administrators of the Company at KPMG LLP, 8 Salisbury Square, London EC4Y 8BB, England.

Queries regarding Scheme Creditors' claims should be directed to the helpline on +44 (0) 1452 413 982.

J.M. Wardrop, Scheme Administrator

REQUEST FOR PROPOSALS

The Kansas State Employees Health Care Commission will issue a Request for Proposal (#11045) to obtain competitive proposals from qualified vendors for administrative service for self funded PPO plan and Qualified High Deductible Health Plan with HSA or HRA options. At a minimum, plan provider networks must be available statewide and nationwide coverage is preferred. As an alternative, proposals can be on a fully insured basis. The expected release date is February 21, 2008 with a closing date of April 4, 2008.

Approximately 35,000 active state employees, 6,000 non-state employees, and 9,500 retirees/COBRA members participate in the health plan. Total covered lives are approximately 90,000.

The RFP (#11045) will be posted to the Division of Purchases Internet website. The document and exhibits can be downloaded by going to the following website: **http://da.ks.gov/purch/RFQ/default.asp.** It is the vendor's responsibility to monitor this website on a regular basis for any changes or addenda. If you have problems accessing the site, please contact:

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International NEWS

HEALTH CARE COST SURGE EXTENDS BEYOND UNITED STATES

Percentage change in selected nations

Percent of cost increase

2006
2007
2008 projected

Saudi Arabia
Singapore
France
United Kingdom
Canada
Mexico

Source: Watson Wyatt Worldwide

Health costs also rising in Asia, Africa, Europe

By JOANNE WOJCIK

Many factors that have been driving up health care costs for U.S. employers—including increased utilization, expensive new medical technology and an aging population—also are affecting foreign employers, a survey by Arlington, Va.-based Watson Wyatt Worldwide shows.

Nearly three-fourths—71%—of insurers that provide medical insurance to employers throughout Asia, Africa, Europe and the Americas say they expect higher or significantly higher medical cost trends over the next five years. Moreover, 81% say medical costs have eclipsed the general rate of inflation in their countries.

In particular, most insurers operating in Asia and Africa are anticipating double-digit health care cost increases in 2008, with the exception of Hong Kong and Singapore, which project rate hikes of 9.1% and 7.5%, respectively.

The double-digit trend also is true in Latin America except Brazil and Chile, where costs are expected to increase 7%. Venezuela projects the biggest 2008 increase—25%—which follows increases of 25% in 2007 and 31.3% in 2006.

The "Global Medical Trends 2008 Survey of Medical Insurers," which included responses from 85 insurers, was conducted online in December.

To obtain a copy, visit *www.watsonwyatt.com.*

Canada's workers compensation rates flatten or decline slightly

Employers say despite reductions in Quebec, pricing is still too high

By GLORIA GONZALEZ

CANADA'S WORKERS COMPENSATION RATES

2008 employer premiums in Canadian dollars, as set by the provincial/territory workers compensation boards

Province	2008 Rates*	2007 Rates*
Alberta	$1.32	$1.43
British Columbia	$1.56	$1.69
Manitoba	$1.60	$1.68
New Brunswick	$2.05	$2.10
Newfoundland and Labrador	$2.75	$2.75
Northwest Territories/Nunavut	$1.71	$1.71
Nova Scotia	$2.65	$2.65
Ontario	$2.26	$2.26
Prince Edward Island	$2.15	$2.22
Quebec	$2.14	$2.24
Saskatchewan	$1.69	$1.84
Yukon Territory	$2.94	$2.64

**Per $100 Canadian of insurable earnings*
Source: Provincial/Territory workers compensation boards

Employers in Canadian provinces will pay steady to lower premiums for workers compensation insurance this year, although concerns persist about Quebec's program despite a second consecutive rate reduction.

Quebec's workers comp system has eliminated a deficit that had ballooned to $2.3 billion Canadian ($2.29 billion) and forced substantial premium increases from 2002 to 2006. The program now has a roughly $1 billion surplus due to good investment returns and greater employer premiums. In response, the provincial board has lowered this year's average employer premium by a dime to $2.14 Canadian per $100 Canadian of insurable earnings on top of an eight cent reduction last year.

Although the system is going in the right direction, Quebec employers still feel their premiums are too high, said Simon Prevost, the Montreal-based vp, Quebec, for the Canadian Federation of Independent Business, which represents more than 100,000 small to midsize employers across Canada. "It's one aspect that our members are still not happy about," he said.

While Quebec employers are pleased that the deficit has been eliminated, they remain concerned about the high level of benefits for injured employees, he said.

Eliminating the deficit "is the only good thing really," Mr. Prevost said.

Canadian workers comp coverage is provided largely by provincial and territorial workers comp boards and financed by employer-paid premiums set by the boards. Rates for each company in a given sector reflect the loss experience of that sector, though companies with low incident levels are eligible for individual rebates.

In Ontario, employer premium rates held steady at $2.26 Canadian per $100 Canadian of insurable earnings even though the provincial workers comp system has a $6.5 billion Canadian ($6.49 billion) deficit. Ontario employers are concerned that an amendment to the provincial workplace safety law that increased compensation for injured workers receiving partial benefits and allowed workers who are physically able to return to work to continue receiving benefits if they cannot find suitable employment will lead to higher rates in the future (*BI*, April 16, 2007).

The western provinces, meanwhile, have been extremely successful in reducing their workers compensation costs, said Laura Jones, vp, western Canada for the CFIB in Vancouver. Employers would like to see the boards reduce administrative hassles in processing workers comp coverage, but are pleased they have the lowest employer premiums in Canada, she said.

"In terms of the rating, things look very good right now across the west," Ms. Jones said. "The boards are in pretty good shape."

In Alberta, employers pay the least of any province at $1.32 Canadian per $100 Canadian of insurable earnings for their workers compensation coverage, down 11 cents from last year. It is the fourth straight year that premiums have declined amid good investment returns and an aggressive program aimed at decreasing injury rates and duration with built-in rebate or discount incentives for employers to improve workplace safety.

Alberta employers say they have been rewarded for taking initiative

See **CANADA** next page

Caribbean cat facility lowers premiums, broadens coverage

By MICHAEL BRADFORD

The Caribbean Catastrophe Risk Insurance Facility is lowering premiums that it charges government policyholders and broadening its coverage.

Governments that are participating in the multicountry risk pool will pay 10% less for coverage. In addition, available per-peril limits have been increased to $100 million from $50 million.

Payouts also will be faster, so that claims are settled in as few as 14 days, the facility said in a statement.

The CCRIF, which began operations last June, is designed to backstop the small countries that are often financially unable to rebuild following hurricanes and other catastrophes.

The nations pool their natural disaster risks and potentially cut individual premiums by as much as 40%, according to the World Bank, which backs the pool.

Sixteen nations are members of the CCRIF. Thirteen members are in the Caribbean region as well as Bermuda, Anguilla, and Turks and Caicos.

The first payments by the facility were made last month, when the CCRIF paid nearly $1 million to Dominica and St. Lucia in response to a November undersea earthquake that damaged homes and water lines on the islands.

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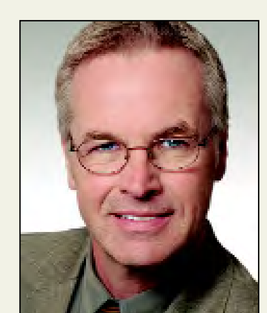
Commentary

Simple legislation or simply a waste of time?



DAVE
LENCKUS

Senior Editor Dave Lenckus can be reached at: dlenckus@businessinsurance.com

The beauty of some brilliant ideas is their simplicity.

You can see it in a bill that a Mississippi legislator has just introduced. The core concept of the measure is something that risk and benefit managers can apply to reduce their organizations' risks and improve their employees' lives.

The bipartisan Mississippi legislation, HB 282, would prohibit state-licensed restaurants from serving obese people. In determining whom to usher out of their establishments without serving even a salad with a low-calorie dressing, restaurants would have to comply with a set of state-established criteria. Mississippi's health department would monitor them to ensure compliance, and repeat offenders would face the revocation of their state licenses.

The bill's primary sponsor, Republican Rep. W.T. Mayhall Jr. of Jackson, did not return calls or an e-mail. Neither co-sponsor, a Republican and a Democrat, responded to e-mails.

No matter. The brilliant simplicity of the bill is evident:

Ban what we know is not good.

Some Web sites and blogs that focus on health and discrimination issues already are panning the bill, but I think those are just misguided, though well-intended, knee-jerk reactions.

To a certain extent, we already engage in this kind of society-handcuffing for the greater good. For example, many communities nationwide ban smoking in public buildings, including restaurants.

True, you can't contract obesity by eating near an overweight individual as you would risk respiratory problems by breathing secondhand smoke, but the core concept is still there—prohibiting the facilitation of unhealthy and undesirable behavior.

Of course, we still allow smokers—even those who are obese—to eat, for now.

Another example is the liability that bars in many communities face for serving intoxicated patrons who injure others or damage property after leaving the bars in drunken stupors.

The problem is that we just have not applied this concept broadly enough. If risk and benefits managers and politicians had the will and creativity to really attack society's ills, we all would be healthier, wealthier and safer.

Here are just a few ideas on how we could expand on the Mississippi legislators' approach:

- Require home improvement stores to boot out customers who do not look intelligent enough to figure out how to use a can opener, let alone a power tool. This would reduce product liability claims and free up valuable court time.
- Ban car dealerships from allowing even window-sticker shopping by drivers with apparently heavy right feet. Police and sheriff departments across the country no longer would have to worry about when they should pursue speeders and risk liability if the speeder or an innocent party is injured.
- Prohibit employers from hiring newlywed men unless they have a gym membership they use and belong to a weight-watching organization. We all know that many guys beef up to an unhealthy weight during the first year or two of wedded bliss.

If risk and benefits managers had the will to really attack society's ills, we all would be healthier, wealthier and safer.

But, that's only the start. I think we could be even more imaginative.

For example, on the health side, mandate that department stores sell every overweight customer a treadmill or stationary bike.

On the risk management side, ban financial institutions from hiring shifty-eyed risk-takers who would concoct deals that generate loads of revenue in the short-run but, like any Ponzi scheme, eventually fall apart—or, in the case of subprime mortgages and securities, detonate and send a mushroom cloud of financial woe over the economy.

And, among the tens of thousands of bills and resolutions that states and Congress introduce every year, maybe our representatives could slip in 51 that would outlaw really dumb, time-wasting measures.

Products & Services

Travelers provides access to MSDSonline services

ST. PAUL, Minn.—Travelers Cos. Inc. has partnered with MSDSonline, a provider of on-demand material safety data sheet management services, to offer Travelers' policyholders online access to MSDSonline's database of 3.5 million documents.

This alliance also allows Travelers' policyholders to access MSDSonline's comprehensive suite of MSDS management, deployment and reporting tools at reduced prices. These management and compliance products allow companies to build, organize and maintain a customized electronic MSDS library.

MSDSonline benefits include: an Occupational Safety and Health Administration-compliant electronic MSDS management system, on-demand access to MSDS management tools, right-to-know access for employees, built-in comprehensive regulatory reports and multisite administrative capabilities.

Access to MSDSonline is available to Travelers policyholders through the Risk Control Web site at *www.riskcontrol.com*.

Liberty Mutual expands middle-market coverage

BOSTON—Liberty Mutual Group Inc. has enhanced its general liability offering to middle-market businesses and is expanding general liability coverages for 10 industry segments.

All middle-market general liability customers will get automatic coverages that address common gaps, including unintentional failure to disclose, mental anguish included in bodily injury, coverage for health care professionals as insureds and coverage for injuries to coworkers as a result of Good Samaritan acts.

Additionally, Liberty Mutual has enhanced its general liability coverages for Liberty Direct Solutions, its property/casualty products designed for select industries. The following industries receive the automatic coverage enhancements: contractors, manufacturers, fabricated metals manufacturers, wholesale distributors, retailers, food processors, restaurant owners, real estate and commercial property managers, professional service providers and janitorial service providers. The program includes expanded coverage for additional insured obligations:

For more information, go to *www.libertymutual.com*.

RMS launches platform for wholesale brokers

NEWARK, Calif.—Risk Management Solutions Inc. has launched the Wholesale Broker RiskBrowser platform, which provides access to RMS' catastrophe risk models in a format tailored to wholesale brokers.

The platform allows users to analyze specific catastrophic exposures on behalf of retail brokers and their policyholders, providing hazard information for each insured location and running exposure data through the RMS U.S. hurricane and earthquake models. It automatically creates a complete risk assessment report that includes detailed exposure analysis, hazard data analysis and modeling results.

The platform provides risk assessment reports as Excel spreadsheets. In addition, the models are installed and maintained on RMS-hosted servers, accessible via a secure Internet connection. Licensed users need to install a small file on their computers to use the system.

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

AIG Executive Liability offers e-discovery services

NEW YORK—AIG Executive Liability, a division of American International Group Inc., has released AIG e-Discovery Solutions, a program of electronic discovery-related products and services to help clients, including directors and officers and errors and omissions policyholders, manage the e-discovery process.

In the event of a claim, the program will assist clients and their defense counsel in constructing a strategy for collecting electronically stored information and will supervise that strategy throughout litigation.

A panel of e-discovery consultants will be available at preferred rates for clients. Additionally, as an enhancement to AIG Executive Liability's primary D&O insurance, an optional endorsement is offered to cover as much as $25,000 in first-dollar costs to retain one of these firms to help manage the e-discovery process.

For more information about AIG e-Discovery Solutions, e-mail *managementliability@aig.com* or visit *www.aigexecutiveliability.com*.

Schinnerer offers coverage for international travel

CHEVY CHASE, Md.—Victor O. Schinnerer & Co. Inc. has launched an insurance program designed to protect employees of U.S.-based businesses who travel, even infrequently, to locations outside the United States.

ACE USA will provide the coverage as part of its International Advantage program offered through ACE American Insurance Co.

Eligible companies include those that do business internationally, have international offices; advertise or sell products on the Internet; export products; have foreign licensees selling their products; have employees either temporarily or permanently stationed in other countries; or have employees that go on tours, trips or participate in studies abroad.

The program features coverage that can include commercial general liability, commercial auto, commercial property and business income, international medical, and accidental death and dismemberment. Premiums start at $2,500.

Also included is the ACE International Advantage Executive Assistance Services, which provide emergency, medical, personal, travel and security assistance to those traveling or stationed abroad.

For more information on the program, go to *www.schinnerer.com/intl-advantage.html*.

TO SUBMIT ITEMS

Please send products and services announcements to: Joe Walker, *Business Insurance*, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; *jwalker@businessinsurance.com*.

Canada: Yukon premiums increase

CONTINUED FROM PREVIOUS PAGE

to improve workplace safety.

Mammoet Canada Western Ltd. has been cited by workers comp officials for having one of the best safety records of Alberta employers due to a comprehensive program that emphasizes thorough training, constant reviews to ensure that employees have the proper equipment and field-level risk assessments, said Rick St. Pierre, health and safety manager for the Edmonton-based heavy equipment and related services company. In addition, management and supervisors are required to complete independent health and safety courses while employees are required to show they are certified to use the equipment before they are allowed to operate such machinery, he said.

The company's units have received a 38% to 40% discount on their workers compensation rates, Mr. St. Pierre said.

The only Canadian employers to pay higher premiums this year are those based in the sparsely populated Yukon Territory, where the workers comp board has been gradually phasing out its subsidy program.

The subsidies began in 1999 when the workers comp program featured a substantial surplus, but rising claims costs and lower investment income forced the board to phase out the subsidies.

The average employer premium in the territory has risen from $1.74 Canadian in 2005 to $2.94 Canadian this year. Prior to the increases, the Yukon—population 31,100—had the lowest employer premiums in Canada.

"That's the one exception in western Canada," Ms. Jones said. "It's definitely something that our members up there are concerned about and would like to see come down."

CFIB has about 200 employer members in the Yukon, she said. Stakeholders are beginning to discuss the need to evaluate potential solutions, such as consolidating the system with the other territorial workers comp system of the Northwest Territories and Nunavut or perhaps one of the provinces to better spread the risk, she said.

Business Insurance

PERSPECTIVE

California court complicates lawsuit settlements

By John E. Heintz

A recent decision by a California Court of Appeal has made it a whole lot harder for policyholders to settle lawsuits when insurers have denied coverage.

In *Aerojet-General Corp. vs. Commercial Union Insurance Co.*, the court held that even if an insurer has denied coverage before the settlement, the insurer is not liable under standard comprehensive general liability policies to indemnify policyholders for the settlement. The decision runs counter to the established law in most other jurisdictions, which holds that when an insurer has denied coverage, the policyholder is entitled to settle the claim for a reasonable amount without jeopardizing its right to coverage.

John E. Heintz is a litigation partner and the chair of the insurance recovery practice group in the Washington office of law firm Kelley Drye & Warren L.L.P.

According to the California court, however, insurers only have to indemnify policyholders for amounts the policyholders are ordered to pay by a court. As a result, a policyholder that decides to settle litigation against it, instead of allowing the suit to proceed to judgment (or voluntarily allowing a judgment to be entered against it), in effect forfeits its rights to coverage for the claim.

Before popping open the Champagne, however, insurers should think hard about the long-term, big-picture costs of this kind of rule.

Any policyholder who knows that a settlement will result in a forfeiture of coverage will be far less willing to consider the possibility of settlement. If the policyholder does consider it, it will only be for an amount the policyholder knows can be paid on its own, which in most cases will be lower than a settlement offer if insurance is potentially available. Such discounted offers may run into resistance both from plaintiffs attorneys and any mediators trying to mediate the dispute. The likely result is that whenever insurance is potentially available, settlements will become the exception rather than the rule.

In cases where a settlement is not pursued, the *Aerojet* decision leaves policyholders with two choices, neither of which should be particularly appealing to insurers.

First, the policyholder can litigate the case to judgment. But this is an incredibly risky venture. An adverse judgment in the underlying suit could result in massive liabilities and would be sure to rack up substantial defense costs. The insurers' coverage obligations for those liabilities and defense costs would then have to be decided in a parallel or subsequent coverage case.

Is this a win for insurers? No. It just puts the insurers in the exact same place they would have been without the *Aerojet* rule (i.e., in coverage litigation), except now the stakes will be much, much higher.

The second alternative is for the policyholder to let a judgment be entered against it as part of a settlement. The *Aerojet* decision suggests this may be permissible. The problem with this approach is that a judgment often acts like an advertisement to the plaintiffs bar. The judgment can trigger a surge of copycat suits, with other plaintiffs invoking the prior judgment to try to prevent relitigating the policyholder's defenses. This increases risks not just for policyholders but also for insurers that might ultimately be required to pay indemnity and defense costs for all those new suits.

Is this a win for insurers? I don't think so. Here again, the insurers are in no better position than they would be without the *Aerojet* rule, except they now face the risk of mounting suits and skyrocketing defense costs.

The fundamental problem with the *Aerojet* rule is that it will discourage—and in many cases foreclose—mediation and settlement of underlying claims. This is going to hurt insurers, because even when an insurer has denied coverage, mediation and settlement serves insurers' interests by reducing the insurers' potential exposure for claims. Insurers might believe there's only a 10% chance they will lose a particular coverage dispute, but they're better off with a 10% chance of having to pay $10 million in settlements, than a 10% chance of having to pay $100 million in judgments.

If the overall effect of the *Aerojet* rule is to drive up liability and defense costs as a whole, across multiple policyholders and multiple liability streams, insurers are necessarily going to end up paying some portion of those higher costs in the long run. And those increased costs may dwarf any savings.

Insurers might be inclined to support the *Aerojet* rule anyway, because they believe it will help prevent unreasonable or collusive settlements between policyholders and plaintiffs. But there are already sufficient protections available to insurers that don't undermine mediation and settlement. In California and most other states, insurers can challenge a settlement on the grounds of unreasonableness, fraud or collusion. Or, the insurer can take over the defense of the underlying claim under a reservation of rights while it proceeds to litigate its coverage obligations in a declaratory judgment proceeding.

At the end of the day, it's pretty clear that the *Aerojet* rule, if upheld, will serve to discourage mediation and settlement and drive up liability and defense costs. This is simply bad policy. It runs counter to the objectives of the mandatory mediation and settlement conferences that many courts have adopted. And it runs counter to many insurers' express endorsement of alternative dispute resolution protocols as an alternative to more expensive litigation. Unless the insurance industry achieves a perfect record in the inevitable coverage litigation that will follow *Aerojet*, insurers are going to have to shoulder some of the burden of those increased liability and defense costs. Even if the rule works to the insurers' benefit in a few isolated cases, insurers should consider whether the savings, in the long run, are going to outweigh the costs.

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January 28, 2008

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Labor Department seeks military FMLA rule input

By JERRY GEISEL

WASHINGTON—The Labor Department is seeking employer input before finalizing regulations on a new law that expands the Family and Medical Leave Act for employees whose family members are in the military.

That expansion, signed into law last month, changes the FMLA in two ways for military families.

Under the first expansion, employees are allowed to take up to 12 weeks of leave when a spouse, child or parent is on active duty in the armed forces or is called up for active duty. Leave is allowed for any "qualifying exigency."

Members of the U.S. military who become seriously ill or injured could get up to 26 weeks of care from their "nearest blood relatives" under proposed rules expanding the FMLA.

Under the second expansion, spouses, children, parents or "nearest blood relatives" can take up to 26 weeks of FMLA leave to care for a servicemember who is injured or becomes ill while on active duty. The illness or injury must be severe enough that the servicemember is unable to perform his or her duties.

The first expansion has raised the most questions, because the law leaves it to the Labor Department to define "qualifying exigency."

As part of its proposed regulations of FMLA as a whole (see story, page 1), the Labor Department said its initial view is that that not every situation will entitle employees to take leave when a family member is called for active military duty.

In the broader FMLA proposal, the Labor Department is asking for comments on whether several situations would qualify for leave for employees whose family members are in the military. Situations include making arrangements for child care, making financial and legal arrangements to address the servicemembers' absence, attending counseling related to the active duty of the servicemember, making farewell or arrival arrangements for a servicemember, and attending to matters related to the death of a servicemember or to one missing in action.

The Labor Department noted that the FMLA's definition of a child is an individual 18 or younger or one who is incapable of self-care because of a physical or mental condition. That definition would be a severe limitation if it were to be applied to the new law allowing parents of children in the military to take leave for any exigency.

That is because the minimum age for enlistment is 17 and the overwhelming majority of armed forces members are 18 and older.

In light of that, the Department of Labor wants to know whether it would be appropriate to use a different definition of "child" for the military-related FMLA regulation than for the FMLA as a whole.

Another issue the Labor Department will deal with in its final regulations is how often an employee can take 26 weeks of military-related FMLA leave. The law says an employee is entitled to a total of 26 weeks of FMLA leave during a 12-month period to care for a covered servicemember.

That wording, said Amy Kohn, a consultant with Hewitt Associates Inc. in Lincolnshire, Ill., needs regulatory interpretation.

The Labor Department notes that questions have been raised on whether an employee is entitled to more than one 26-week leave.

Under one interpretation, 26 weeks would be the total amount of leave that could be taken, regardless of how many family members are injured while serving in the military, the Labor Department said.

Under another interpretation, the Labor Department said, employees could be entitled to 26 weeks of leave for each family member who is injured or becomes ill while on active duty.

Labor also is seeking comment on the number of times an employee can take leave related to a single servicemember. If a servicemember is receiving chronic care, for example, should the employee receive another 26 weeks of leave after the first 12-month period?

"This is clearly an area where guidance is needed," said Debra Friedman, a partner with the law firm Cozen O'Connor in Philadelphia.

FMLA: Many employer issues resolved

CONTINUED FROM PAGE 1

restore balance to the FMLA," said Marc Freedman, director of labor law policy at the U.S. Chamber of Commerce in Washington.

One of the biggest gripes employers have had with the current rules is that employees can take up to two days after an absence begins to notify employers that the time already taken off was under the FMLA.

Under the proposal, though, except in emergency situations, employees would have to follow procedures employers have established for notification.

"Providing advance notice is a huge benefit for employers" in planning and scheduling, said Jason Straczewski, director of human resources policy at the National Assn. of Manufacturers in Washington.

"This is a big issue. It makes it a lot easier for employers to anticipate and schedule," Mr. Freedman said.

In addition, the proposed regulations would allow employers to directly contact employees' doctors when employers have questions about FMLA medical certification forms that the doctors have filled out.

By contrast under the current rules, employers are required to find doctors, who, in turn, would contact employees' physicians.

"This is a huge deal," said Matt Morris, a consultant with Hewitt Associates Inc. in Lincolnshire, Ill. In some cases, employers have been spending thousands of dollars each year on fees that doctors have charged for contacting the physicians who filled out FMLA certification forms, he said.

> **'Providing advance notice (of FMLA leave) is a huge benefit for employers' in planning and scheduling.**
>
> Jason Straczewski,
> National Assn. of Manufacturers

If the proposed rules are finalized, that expense could be eliminated since employers could directly contact employees' physicians on FMLA certification issues.

Other provisions in the proposed regulations would allow employers to require employees to obtain certification twice a year—rather than annually—of medical conditions entitling them to FMLA leave while simplifying the definition of what constitutes a serious medical condition.

But not all issues were resolved in the revised regulations to employers' satisfaction, with perhaps the biggest being the minimum amount of unscheduled intermittent leave that employees can take. In some cases, employees can take as little as a few minutes of leave under the FMLA, resulting in a big recordkeeping burden on employers.

To address that problem, employers wanted the Labor Department to set a minimum amount of time—perhaps a few hours—whenever an employee requested leave under the FMLA.

The Labor Department, though, said it lacks the authority because of the way FMLA is written. If such a requirement were to be imposed, it would have to come from Congress, the agency said.

Additionally, the Labor Department largely dodged providing guidance on legislation Congress passed last month that expands the FMLA for employees in military families, with the department requesting comments rather than issuing rules (see story).

"They are throwing it back" to the the public, said Sanders Lowery, a Hewitt Associates consultant in Lincolnshire, who added that the Labor Department is raising issues that benefit experts already have asked about the expansion of the federal law.

Climate: Banks face rising weather risks

CONTINUED FROM PAGE 4

ourselves, Mr. Isom said.

Discussing the challenges created by climate change, Mr. Isom pointed to reports on the topic issued by Boston-based Ceres, a coalition of investors, environmental groups and other public interest organizations that address issues including climate change. Ceres rated banks on their sensitivity to climate change, said he said.

Investors "expect corporations to take strategies" that address the issue of climate change, said Mr. Isom, who noted that a company's response to climate change creates exposure to directors and officers liability.

"It changes the scope of risk management," he said, including the risk associated with the financial institution's physical plant, how they manage their own risk and the effect of climate change on the bank's investment portfolio.

Companies must take "an enterprisewide view of their risk," said Mr. Isom. As companies look at their existing programs, they should ask, "How do they respond to climate?" he said.

The one point that the scientific community is in agreement about is that the greenhouse effect is causing changes in weather patterns, said Joseph L. Boren, chairman and chief executive officer of AIG Environmental, a unit of American International Group Inc. in New York, who also spoke during the session.

If you look at insured property values "it's just staggering," said Mr. Boren. Insured coastal property in Florida and New York totals $1.9 trillion each, while Northeast states' insured coastal exposure totals $3.73 trillion, he said.

A "nightmare scenario" would be a Katrina-type hurricane hitting the New York area. "It would be devastating," he said.

"There's a growing acknowledgement that the impact of climatic changes are likely to be profound," he said. He noted that more than 30 lawsuits have been filed against companies for climate change issues.

He referred to a decision last November, in which the 9th U.S. Circuit Court of Appeals ruled in favor of 11 states and others in litigation brought against the National Highway Safety Administration over the issue of fuel economy standards for light trucks and sport utility vehicles. "The courts are now taking a very close look at this issue," he said.

Mr. Boren said there are now 422 examples of climate-related products and services from 190 insurers, reinsurers, brokers and insurance organizations in 26 countries across all product lines.

"There will be plenty of opportunity for insurance companies to provide new products," Mr. Boren said.

The session was moderated by William F. McAllister, manager vp at PNC Insurance, a member of the Pittsburgh-based PNC Financial Services Group.

Bank risk conference draws 400

INDIAN WELLS, Calif.—About 400 participants attended the American Bankers Assn.'s Insurance Risk Management Conference and Meetings for the financial services industry in Indian Wells, Calif. last month.

The conference featured Todd Buchholz, former White House director of economic policy and a former hedge fund manager, as the keynote speaker, who discussed the current economic outlook, among other topics.

Conference sessions included evolving international issues, creative use of captives, liability issues for directors and officers, and climate change.

Next year's session is set for Jan. 25-28, 2009, at the Hyatt Regency Bonaventure in Weston, Fla.

For more information, contact the association at 800-226-5377 or visit *www.aba.com/events/irm.*

—By Judy Greenwald

Gen Re: Final arguments in finite reinsurance trial begin this week

CONTINUED FROM PAGE 1

million of risk, the defendants had an unwritten side agreement that AIG would not be billed for losses and that AIG would refund Gen Re's $10 million premium and pay it a $5 million fee, the government charges.

After defense lawyers completed their cases last week, they failed in an effort to convince U.S. District Judge Christopher F. Droney to exclude e-mails and recorded calls that formed a large part of the prosecution's case. That effort challenged a powerful prosecutorial weapon: The ability to introduce statements by co-conspirators before a final ruling on the statements' admissibility.

A federal rule in conspiracy cases—801(d)(2)(E) in the federal rules of evidence—allows a statement by a co-conspirator to be considered as evidence against other co-conspirators, rather than being barred as hearsay.

Under procedures followed in federal courts under the 2nd U.S. Circuit Court of Appeals, which include federal courts in Connecticut, judges may allow jurors to hear such evidence while ruling later on its admissibility, based on whether the prosecution has met its burden of showing that a conspiracy existed, that the defendants participated in it, and that the statements were made during—and in furtherance of—the conspiracy.

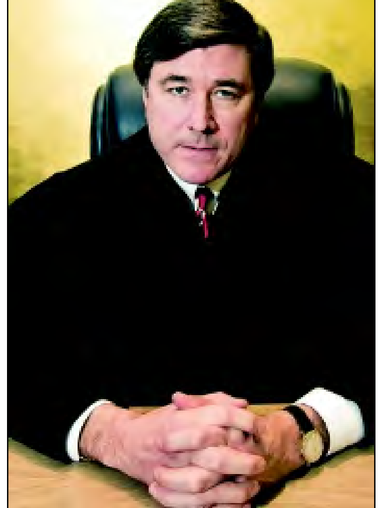
As Mr. Glover and three other prosecutors presented volumes of e-mails and recorded calls over the past five weeks, defense lawyers took turns objecting on grounds that the evidence should not be admitted under 801(d)(2)(E).

Judge Droney overruled those objections provisionally throughout the trial. After the defense rested, he concluded that the government had presented sufficient evidence to show that a conspiracy existed and that the defendants participated, and let his admission of the e-mails and recordings stand.

Prosecutors presented most of the evidence during weeks of testimony by two cooperating witnesses, former Gen Re Senior Vp Richard Napier and John Houldsworth, former CEO of Gen Re's Cologne Re Dublin unit. Both men have pleaded guilty to conspiracy charges.

Mr. Houldsworth finished several days of cross-examination last Monday, with defense lawyers seeking to raise doubts about the existence of Gen Re's alleged side agreement not to transfer any risk to AIG in the loss portfolio deal.

Noting Mr. Houldsworth's earlier testimony that Cologne Re Dublin had already reinsured $315 million of the $500 million in reserves transferred to AIG, a lawyer for Mr. Milton questioned why a side agreement was necessary when the loss portfolio was already virtually guaranteed not to produce a loss.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Judge Droney concluded that the government had presented sufficient evidence to show that a conspiracy existed and that the defendants participated, and let his admission of the e-mails and recordings stand.

"Does that strike you as somewhat ridiculous, that a side agreement had to be fabricated based on a fiction?" asked the lawyer, Frederick Hafetz, who is with Hafetz & Necheles in New York.

Mr. Houldsworth replied that he wasn't certain that AIG officials understood the portfolio was likely risk-free.

Also testifying last week was Martin Flumenbaum, a lawyer hired by AIG in 2005 to investigate the loss portfolio deal after AIG was subpoenaed by the Securities and Exchange Commission and the New York attorney general.

Mr. Flumenbaum described a February 2005 interview of Mr. Milton, during which Mr. Milton acknowledged that AIG did no underwriting analysis before entering the deal. Mr. Milton was also unable to explain why AIG refunded Gen Re's $10 million premium or how AIG could have made money on the transaction, according to Mr. Flumenbaum, who described Mr. Milton as uncomfortable and hesitant about answering some questions. Mr. Flumenbaum is a partner with Paul, Weiss, Rifkind, Wharton & Garrison L.L.P. in New York.

Mr. Hafetz noted during cross-examination that Mr. Milton's demeanor may be explained by the fact that he was being asked about a transaction that was more than four years old.

Also last week, prosecutors introduced a Dec. 22, 2000, e-mail in which Gen Re's Mr. Graham warned his boss, former General Counsel Timothy T. McCaffrey, that regulators may "attack" the loss portfolio deal.

"Our group will book the transaction as a deposit," Mr. Graham wrote. "How AIG books it is between them, their accountants and God; there is no undertaking by them to have the transaction reviewed by their regulators."

Referring to Mr. Ferguson, Mr. Graham added: "Ron et al. have been advised of, and have accepted, the potential reputational risk that U.S. regulators, insurance and securities, may attack the transaction and our part in it."

Questioning U.S. Postal Inspector James Tendick, the prosecution witness who testified about the e-mail, Mr. Graham's lawyer asked, "Are you aware of any evidence that Mr. McCaffrey told Mr. Graham that there was anything unlawful about the transaction?"

"I'm not aware of any, no," Mr. Tendick told the lawyer, Alan Vinegrad, who is with Covington & Burling L.L.P. in New York.

Last Thursday, Judge Droney denied a mistrial motion by Mr. Ferguson. Defense motions for acquittal on various grounds were still pending as of Friday morning.

Fremont: Ruling involving insolvent workers comp insurer overturned

CONTINUED FROM PAGE 4

such accounts to ensure claims are paid.

Typically, insurers fund those accounts with securities. New York regulators usually allow only interest-bearing instruments so that insurers can take the interest from accounts without touching the principal.

But Fremont General in 2000 sought to replace the interest-only bearing securities in Fremont Indemnity's account with mortgage-backed securities from the Government National Mortgage Assn. The Ginnie Mae securities, however, provided periodic principal repayments as well as interest.

The regulators approved the October 2000 securities swap only after Fremont Indemnity's board agreed not to touch the Ginnie Mae securities' principal before replacing those securities in the custodial account.

In September 2000, however, Fremont General issued a standing order to the Bank of New York to transfer all cash in the custodial account to a Fremont Indemnity account at another bank.

In November 2000, the California Insurance Department put Fremont Indemnity under supervision, citing its deteriorating finances, and barred it from making disbursements to its parent without regulatory approval. When Ginnie Mae's periodic payments began in May 2002, however, the Bank of New York began transferring money out of the custodial account.

Two months later, California regulators put Fremont Indemnity into runoff and barred it from engaging in any transaction with its parent company.

Transfers continued

But the transfers out of the custodial account did not stop. At the Bank of New York's request, however, Fremont General replaced its standing transfer order in October 2002 with monthly orders.

The transfers, which totaled $14 million, continued until April 2003. California regulators placed Fremont Indemnity into conservation in June 2003, and a California court shortly afterward ordered the insurer liquidated.

New York regulators discovered the custodial account had been emptied after the California order prompted them to confirm the account's balance.

A Bank of New York internal investigation concluded the bank was partially at fault, court papers say. The bank said an employee was unaware that the account contained both principal and interest payments.

Regardless of Fremont General's intent, the custodial account funds were drained because of the Bank of New York's failure to obtain approval to move the funds, a lower court ruled. Because the transfers resulted from the bank's own errors, it did not sustain damages, and Fremont General did not intentionally interfere with its subsidiary's bank contract, the court ruled in June and August 2005 decisions.

But the 9th Circuit panel ruled the district court erroneously failed to employ California's "substantial factor," or "but for" test for determining damages causation. Under that test, the transfers would not have occurred without Fremont General's role, the appellate panel ruled.

The district court now must consider factors from which it could infer that Fremont General intentionally interfered with its subsidiary's custodial account contract with the Bank of New York, the 9th Circuit ruled.

Attorneys for Fremont General and the Bank of New York did not return calls seeking comment.

Bank of New York vs. Fremont General Corp., 9th U.S. Circuit Court of Appeals, No. 05-56653: Feb. 1, 2008

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Retaliation: Worker wrongly fired after EEOC complaint

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would not "open some huge floodgate" of litigation. There are "very few cases where an employer acts on a charge within hours" of learning of it. "That just isn't typical," he said.

"Under the facts of the case, I think it was the right decision," said Jonathan T. Hyman, an employer attorney with Kohrman Jackson & Krantz P.L.L. in Cleveland. "Just because the timing of (the firing) was so close, it was hard to draw any inference other than the fact that the president of the company made the decision because the complaint had been made."

Under the circumstances, "it was the only decision I think the court could reach," he said.

"The concern I have is, where do you draw the line, and how close is too close," said Mr. Hyman. In this case, it may have been a matter of only hours between the employer learning of the EEOC charge and the retaliatory action. Now "we'll start to see employees trying to push that line further and further back" as to when temporal proximity alone is sufficient.

Priscilla Hapner, a Columbus, Ohio-based employer attorney with a solo practice, also said the court was "absolutely right" in its ruling. "You're always having to counsel (employers) how to treat people, because (employees are) much more likely to prevail on the retaliation claim than they are on the underlying discrimination case, and that's certainly what happened in this case."

Zeidler's attorney could not be reached for comment.

Charles D. Mickey vs. Zeidler Tool and Die Co.; Harold DeForge, 6th U.S. Circuit Court of Appeals, No. 06-1960; Jan. 31, 2008

CONTINUED FROM PAGE 1

relating to the company's historic stock option granting practices. Terms of the settlement, which includes no admission of liability or wrongdoing by HCC or any other defendants, provides a release of all claims in the litigation and payment of $10 million into a settlement fund, to be funded by the company's directors and officers liability insurers, HCC said in a statement. The company would not identify the insurers. The settlement is still pending approval from the U.S. District Court of the Southern District of Texas.

S&P overhauls rules for analysts

A set of broad actions designed in part to respond to criticism over its handling of the subprime issue will have some impact on Standard & Poor's Corp.'s insurance financial strength ratings, an S&P official said. For instance, S&P now plans to rotate its company analysts every five years to obtain a "fresh set of eyes" and "maintain the appropriate level of objectivity," said Paul Coughlin, executive managing director for corporate and government ratings for the New York-based rating agency. Among the changes that may affect S&P's insurance ratings sector are the appointment of an ombudsman to handle any complaints, an external audit process to make sure various standards are complied with, and the establishment of an advisory council to obtain "a high level of appropriate feedback on ratings overall," said Mr. Coughlin.

Montana adds to captive rolls

Montana licensed a record 10 captives during 2007, boosting the number of captives in the state to 30. In recent years, Montana has taken several steps to increase its appeal as a captive domicile, including capping the maximum premium tax, lowering capitalization requirements for cell captives, and allowing captives and branch captives to fund a parent's employee benefit risks, assuming the arrangement is approved by the U.S. Department of Labor.

Oriska exec indicted on fraud charges

A New York grand jury has indicted the president of Oriska Insurance Co. and another individual on charges that they fraudulently marketed workers compensation policies to professional employer organizations. Federal investigators raided Oriskany, N.Y.-based Oriska Insurance in 2006, where they seized documents and computers. The New York Insurance Department then seized control of the insurer, but a judge later returned control to its president, James M. Kernan. The indictment states that since 2002, among other charges, Mr. Kernan and Robert J. Anderson induced PEOs in Arizona, California, New York and Pennsylvania to pay premiums by fraudulently representing that Oriska was authorized to write workers comp policies with deductibles of $250,000.

Ex-Max Re chief Cooney joins Aon

Robert J. Cooney has been appointed managing director of Aon Capital Markets and will serve as vice chairman of Aon Re Global-Bermuda. His responsibilities as managing director of Aon Capital Markets include originating capital market and financial advisory transactions in Bermuda and the United Kingdom. As vice chairman of Aon Re Global-Bermuda, Mr. Cooney "will work with current management to build and expand Aon Re Global's Bermuda platform," Aon said in a statement. Mr. Cooney founded Max Re Capital Ltd. in 1999 and stepped down as its president and chief executive officer in late 2006.

P/C rate decline slows in January

The average reduction in property/casualty rates slowed somewhat to 15% in January compared with a year earlier, MarketScout reported last week. December showed a 16% reduction in average P/C rates across the board compared with the previous year, according to the Dallas-based electronic insurance exchange. January's lesser decline of 15% was largely attributable to directors and officers liability prices that were related to the subprime crisis, MarketScout said in its analysis. "D&O rates adjusted 3% to a reduction of minus 14% as compared to minus 17% in December," Richard Kerr, MarketScout's chief executive officer, said in the statement.

RRG: State seeks to limit group's coverage options

CONTINUED FROM PAGE 1

advocates say. The Risk Retention Act, which Congress passed in 1981, allows RRGs licensed in one state to operate in other states with minimal interference from local regulators.

"If California's position is accepted, it would undermine the entire regulatory structure created by the Risk Retention Act," said Jon Harkavy, vp and general counsel for RRG and captive manager Risk Services L.L.C. in Washington. If 50 states could decide what RRGs could and could not do, "it would be virtually impossible to operate a national RRG," he said.

"The implications are very broad and very serious," added Wendy Fisher, corporate secretary-regulatory and business affairs in Denver for National Home Insurance Co. (a Risk Retention Group).

But the industry is fighting back. The National Risk Retention Assn. filed an amicus brief in the auto dealers' suit, challenging California's actions.

"The issues are of national significance," said Robert H. Myers, NRRA's Washington counsel and a partner with Morris, Manning & Martin L.L.P. in Washington.

In the amicus brief, NRRA argues that California's definition of what is and what is not liability coverage is irrelevant, because the Supremacy Clause of the U.S. Constitution clearly says that if there is a conflict between federal and state law, federal law prevails, the brief says.

That federalism principle is particularly relevant to the operation of RRGs, the NRRA said. Two years after Congress passed the original Risk Retention Act that limited the coverage RRGs could provide to product liability, federal legislators passed a measure—named the Kasten Amendment after sponsor and then-Sen. Robert Kasten, R-Wis.—to make clear that the federal definition of product liability would preempt any state definition, NRRA said in its brief. In 1986, when Congress expanded the Risk Retention Act to allow the groups to write all commercial liability coverages except workers compensation, it broadened the Kasten Amendment to say that a state's definition of liability would be disregarded for recognition or qualification of risk retention groups.

The California Department of Insurance's "reliance upon its state law and experience to interpret liability and to ignore the determination of the chartering state (Montana) is precisely the kind of abuse that the Kasten Amendment was designed to prevent," the NRRA brief said.

> **The legislative history is clear that an 'RRG may provide any type of liability insurance...including excess liability insurance in the form of stop-loss coverage.'**
>
> NRRA, Brief

As a result, in determining whether an RRG can write stop-loss insurance, the only liability definition that matters is that contained in the Risk Retention Act, NRRA said in the brief. The legislative history is clear that an "RRG may provide any type of liability insurance...including excess liability insurance in the form of stop-loss coverage," it said.

Additionally, while a non-chartering state can challenge an RRG's action, the Risk Retention Act makes clear that it must do so in court and not through a cease-and-desist order, NRRA said.

"Only an independent court may impose an injunction against an RRG on the basis of its formation or governance," the NRRA brief said.

California regulators disagree, saying they didn't have to go to court because the auto dealers program is not, in fact, an RRG.

"We didn't have to go to federal court because the insurer isn't a risk retention group qualified for preemption of California's insurance law," said Jill Jacobi, a California Department of Insurance attorney in San Francisco. Additionally, "Only particular actions against risk retention groups require a state or federal court injunction," she said.

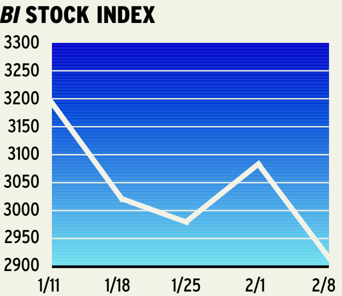
Since the first RRG was licensed shortly after enactment of the 1981 legislation, RRGs have emerged as a major alternative risk financing vehicle. Currently, 260 RRGs are operating, according to the Risk Retention Reporter, an industry newsletter in Pasadena, Calif., which said RRGs last year generated an estimated $2.7 billion in premiums.

Stock Index

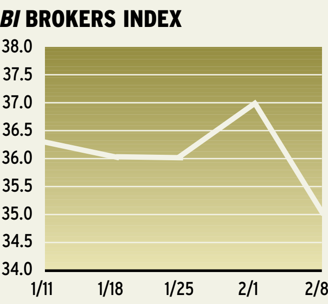
[2/4- 2/8]

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

BI STOCK INDEX



BI BROKERS INDEX



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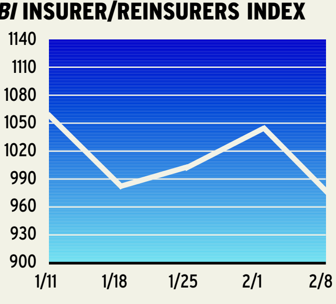
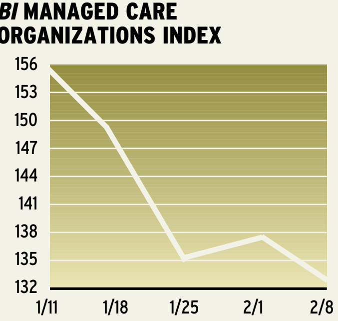


BI MANAGED CARE ORGANIZATIONS INDEX



Percentage change of BI Stock Index vs. key indicators

Index	Value	Change
BI STOCK INDEX	2913.56	-5.48%
DOW JONES	12182.13	-4.40%
S&P 500	1331.29	-4.60%

LARGEST GAINS

Company	Change
Aspen Insurance Holdings	3.87%
IPC Holdings Ltd.	2.90%
Endurance Specialty	2.86%
American Safety Insurance	2.22%
Berkshire Hathaway	1.99%

LARGEST LOSSES

Company	Change
Ambac Financial Group	-16.74%
AXA	-13.48%
Unitrin Inc.	-12.39%
Citigroup Inc.	-12.33%
ING Group N.V.	-11.31%

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END PAGE

Contributing: Jeff Casale, Roberto Ceniceros, Dave Lenckus

The StormStruck attraction at Epcot will simulate the impact of severe weather on structures.

Epcot exhibit to feature storm, stress

Leave it to the insurance industry to cross catastrophe risk education with Disney-style entertainment.

Bermuda-based RenaissanceRe Holdings Ltd. and its U.S. unit, WeatherPredict Consulting Inc., announced that they will launch an attraction scheduled to open this summer at Epcot at the Walt Disney World Resort in Florida.

"StormStruck: The Tale of Two Homes" intends for park visitors to experience the feel of severe weather—think hurricane simulation—while learning of the potential risks and how to safeguard their homes.

Understanding severe atmospheric hazards and property vulnerability has been part of RenaissanceRe's mission, the reinsurer says. Now it plans to share its loss mitigation knowledge to help Disney fans learn how to protect their communities.

StormStruck will be part of Epcot's Innoventions attraction—and it's not the first insurance-related attraction to be featured within Innoventions.

Liberty Mutual Group Inc. of Boston sponsors an Innoventions interactive attraction called "Where's the Fire?" that allows guests to search for home fire hazards.

Judge in dispute serves up some poetic justice

A state appellate court waxed poetic in overturning a jury's $2.35 million defamation award sparked by a carpenters union's limerick about a nonunion Antioch, Ill.-based homebuilder.

The case began in May 2006, when John Maki, owner of J. Maki Construction Co., filed suit against the Chicago Regional Council of Carpenters and certain union officials, alleging that handbills they distributed defamed him by calling his work "crappy."

The rhyming critique was part of an effort that began in 2005 when union leaders learned that Mr. Maki, a union member who later resigned, was operating a nonunion company, court records state.

In a September 2006 trial, a Lake County, Ill., jury agreed that the limerick defamed Mr. Maki and awarded him $2.35 million in damages.

However, the 2nd District Illinois Appellate Court earlier this month sided with the union in ruling that "the handbill's 'crappy' limerick was obviously used in a 'loose, figurative sense,' intending to demonstrate the union's disagreement with plaintiffs' failure to pay the area standards" in wages and benefits.

Writing for the court, Justice John J. Bowman began the limerick ruling by responding in kind.

"There once was a union that called plaintiffs' work crappy; this made plaintiffs quite unhappy; at trial, the jury filled plaintiffs' purse; but, alas, on appeal, we must reverse."

Actress Sienna Miller is at the center of a lawsuit filed by Pepe Jeans against a private jet service for failing to get her to a photo shoot on time.

ALPHA/LANDOV

Flight comes between Sienna and her Pepes

Pepe Jeans says it took a costly hit when a private jet service was unable to get "the face" of the apparel company to a photo shoot.

The Barcelona, Spain-based company last week reportedly filed a lawsuit against a private jet service that was supposed to fly British actress Sienna Miller from London to New Jersey in time for the shoot, but failed to do so when the flight was delayed six hours.

In the suit, reportedly filed last week in U.S. District Court in New York, Pepe Jeans is demanding $160,000 for what it paid for the flight and other unspecified costs from Jet Set Private Air Service L.L.C.

Ms. Miller has been a spokesperson for Pepe Jeans since 2006 and has worn its products and participated in an extensive advertising campaign for the company.

The flight was initially delayed and then eventually canceled when Ms. Miller and her entourage failed to provide the proper paperwork to enter the United States, the suit said.

Pepe Jeans was then forced to hire a "replacement model" for the ad, which had a "significant negative impact" on the company's marketing efforts.

Ms. Miller, 25, has starred in various films including "Factory Girl" and "Alfie."

'My life. My card.' My slogan! says plaintiff

A consultant who claims he coined American Express Co.'s "My life. My card." advertising tagline cannot claim it is his slogan, his trademark, a federal appeals court says.

New York-based American Express does not have to stop using the slogan even if the consultant developed it first and used it later to promote his own service, a 2nd U.S. Circuit Court of Appeals panel ruled on Feb. 4.

Unanimously upholding a lower court's ruling, the three-judge appellate panel found that American Express linked the slogan to its services in the public's mind before the consultant did. In addition, a slogan writer with no products or services cannot trademark a tagline, the panel ruled.

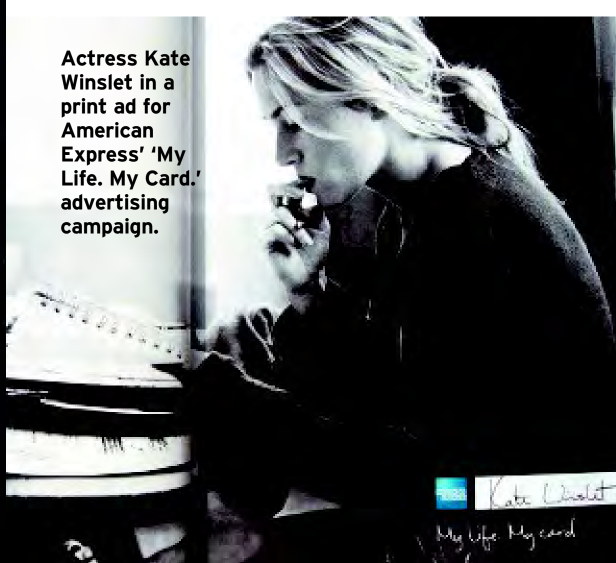
The consultant, Stephen G. Goetz, pitched his business plan to American Express and other credit card companies in a mailing dated July 30, 2004, according to court papers.

Mr. Goetz's idea of allowing cardholders to personalize their cards with photographs included the disputed advertising slogan.

But a week earlier, New York-based Ogilvy Group proposed an advertising campaign with the same slogan, American Express argued. The company decided to run that campaign and filed a trademark application for the slogan on Sept. 15, 2004—a week after Mr. Goetz filed his application, according to court papers. Mr. Goetz later became president of a company, San Francisco-based Gardner Design Group L.L.C., that uses the slogan to promote its personalization service to credit card companies.

After allowing limited discovery of American Express' and Ogilvy's electronic records to confirm the timeline of events in the case, the lower court ruled that Mr. Goetz did not contest that American Express independently developed the slogan.

American Express will pursue its "legal opportunities" related to Gardner's continued use of the slogan, a spokeswoman said. Mr. Goetz is evaluating his appeal options and use of the slogan, said attorney Keith Vogt, a partner at Stadheim & Grear Ltd.



Actress Kate Winslet in a print ad for American Express' 'My Life. My Card.' advertising campaign.

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