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# Business Insurance

March 16, 2009

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COURT ALLOWS LIBEL CASE IN EMPLOYMENT DISPUTE DESPITE TRUTH DEFENSE / PAGE 3

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## In Brief

### Swiss Re taps ex-CEO Kielholz as chairman

Swiss Reinsurance Co. Ltd. has made another top management change, naming Walter B. Kielholz to replace Peter Forstmoser as chairman of its board, effective May 1. Mr. Kielholz, who is vice chairman of Swiss Re, was its chief executive officer from 1997 to 2002. The move comes after Swiss Re's appointment last month of Stefan Lippe as CEO. Mr. Lippe—the reinsurer's deputy CEO and chief operating officer and a longtime Swiss Re executive—replaced Jacques Aigrain.

### EEOC bias filings hit record last year

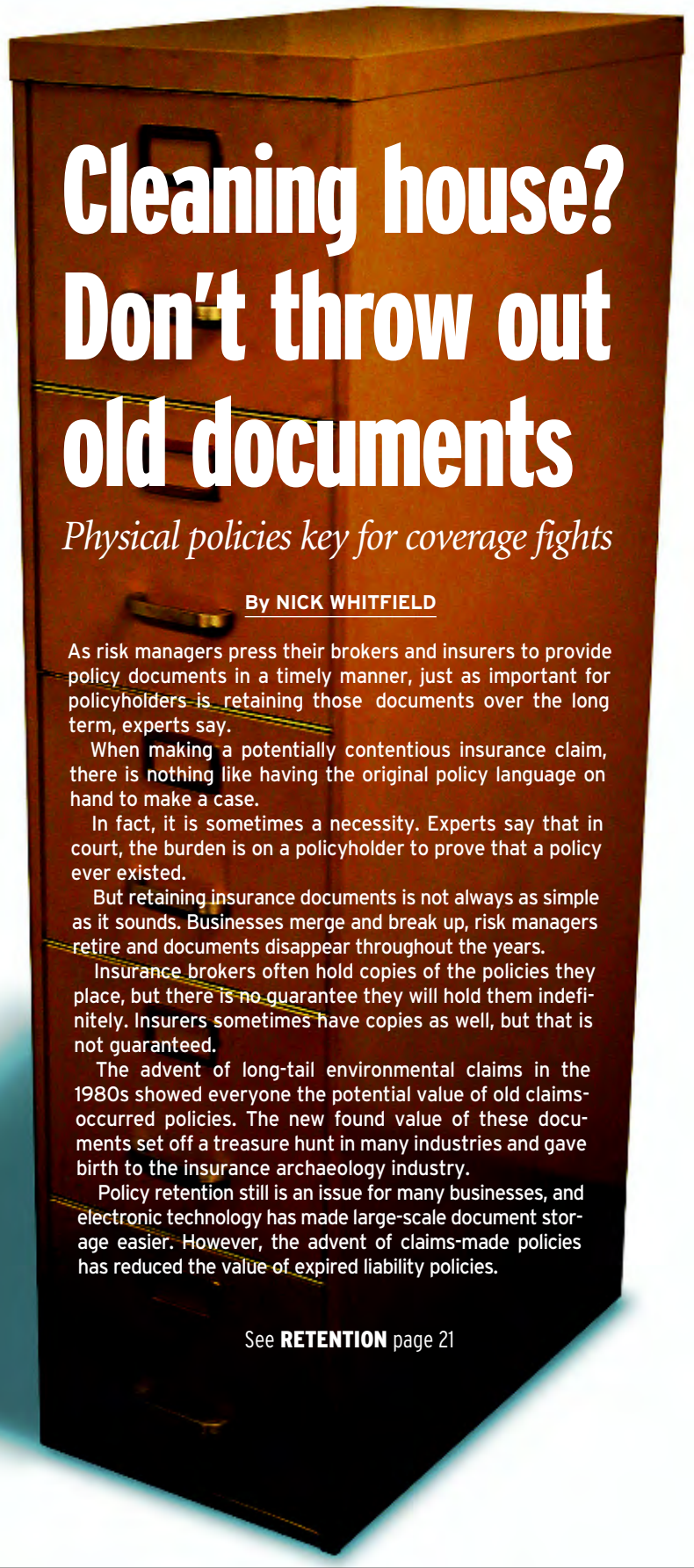
Charges of workplace discrimination filed with the U.S. Equal Employment Opportunity Commission for the fiscal year that ended Sept. 30, 2008, rose to an all-time high of 95,402, an

See **IN BRIEF** page 22

## SPOTLIGHT

**CLAIMS MANAGEMENT**

Outsourcing claims process requires management; states vary on provision of comp backstops for self-insureds; claims activity expected to rise as economies falter; *BI* ranks largest TPAs. **PAGE 9**



# Cleaning house? Don't throw out old documents

*Physical policies key for coverage fights*

By NICK WHITFIELD

As risk managers press their brokers and insurers to provide policy documents in a timely manner, just as important for policyholders is retaining those documents over the long term, experts say.

When making a potentially contentious insurance claim, there is nothing like having the original policy language on hand to make a case.

In fact, it is sometimes a necessity. Experts say that in court, the burden is on a policyholder to prove that a policy ever existed.

But retaining insurance documents is not always as simple as it sounds. Businesses merge and break up, risk managers retire and documents disappear throughout the years.

Insurance brokers often hold copies of the policies they place, but there is no guarantee they will hold them indefinitely. Insurers sometimes have copies as well, but that is not guaranteed.

The advent of long-tail environmental claims in the 1980s showed everyone the potential value of old claims-occurred policies. The new found value of these documents set off a treasure hunt in many industries and gave birth to the insurance archaeology industry.

Policy retention still is an issue for many businesses, and electronic technology has made large-scale document storage easier. However, the advent of claims-made policies has reduced the value of expired liability policies.

See **RETENTION** page 21

# Energy capacity fears drive early renewals

*Investment, cat losses lead to firmer market for risks in Gulf*

By ZACK PHILLIPS

Some risk managers for energy companies operating in the Gulf of Mexico this year are coming to market earlier than usual amid tightening capacity, brokers and observers say.

"The amount of activity…has definitely increased," said Jerry Garner, London-based managing director of marketing for Willis Energy, a unit of Willis Group Holdings Ltd. "The last couple weeks, underwriters have been inundated with client visits and client presentations."

Most Gulf of Mexico windstorm accounts renew in the second quarter. Hurricane season begins June 1.

"Historically, Gulf of Mexico business renewed all the way up to (July) 1; now, most people are talking about resolving renewals by the end of April," said Dominick Hoare, joint active underwriter at Watkins Syndicate at Lloyd's of London, a major Gulf of Mexico wind insurer. "It's (from) concern (that) there's going to be a significant shortfall in capacity."

Insurers' deteriorating investment income coupled with heavy losses in 2008—including Hurricane Ike, which recently surpassed Hurricane Ivan to become the third-costliest hurricane in U.S. history, —are among the factors driving what observers call a firming market.

Many say those factors will

See **GULF** page 20

# Calif. pollution ruling expands CGL coverage

*State high court rules insurers must pay when causes unclear*

By SALLY ROBERTS

**SAN FRANCISCO**—California policyholders are more likely to recover insurance for pollution cleanups as a result of a California Supreme Court ruling last week that shifts the burden of allocation onto insurers in certain circumstances and expands the scope of sudden and accidental clauses in commercial general liability policies.

**16**
The number of years California operated the Stringfellow hazardous waste site.

Ruling in the long-standing coverage dispute over the Stringfellow hazardous waste site near Glen Avon, Calif., the state high court said that when a pollution loss results from insured and uninsured causes, and the policyholder cannot distinguish between the covered and uncovered damages, the policyholder is entitled to coverage for the whole loss up to its policy limit if the covered cause contributed substantially to the damage.

At that point, it is up to the insurer to prove allocation, the court said.

The ruling is significant as it expressly rejects a 2001 California appeals court decision in *Golden Eagle Refinery Co. vs. Associated International Insurance Co.* that required policyholders to show the amount of damages resulted from covered causes in order to obtain coverage, policyholder attorneys say. It also is likely to affect insurance recovery cases beyond the environmental liability issues reviewed by the court, some say.

In the case, *State of California v. Allstate Insurance Co. et al*, the Cali-

See **STRINGFELLOW** page 20





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# Court won't review S.F. health care mandate

## *Controversial case may be headed to Supreme Court*

By JERRY GEISEL

**SAN FRANCISCO**—The 9th U.S. Circuit Court of Appeals' decision last week not to review a 2008 appeals panel ruling upholding a San Francisco health care spending law brings one step closer a potential U.S. Supreme Court review and perhaps a final resolution on the legality of employer spending mandates.

In a case followed by employers nationwide due to its potential impact on the design, cost and administration of corporate health plans, a majority of appeals court members rejected a request for the full appeals court to review a unanimous ruling by a three-judge panel of the court that the law could stand.

Under the law, San Francisco employers must spend as much as

**READ** documents from this case online at BI's Knowledge Center **www.BusinessInsurance.com**

$3,600 per employee annually on health care in order to avoid stiff fines. The Golden Gate Restaurant Assn., a San Francisco-area employer group that brought the case, argued that the law runs afoul of a provision in the Employee Retirement Income Security Act that pre-empts state and local ordinances that relate to employee benefit plans.

Under the ordinance, which went into effect in January 2008, employers with at least 100 employees have to make health care expenditures of at least $1.85 per hour for each employee working at least eight hours per week. Employers have a variety of options to satisfy the spending mandate, including payment of health insurance premiums, contributions to health reimbursement arrangements and health savings accounts, and payments to a city fund.

Judge William Fletcher, who also wrote last year's appeals court ruling, said ERISA pre-emption did not come into play. "Nothing in the ordinance requires the employer to establish an ERISA plan, and nothing in the ordinance interferes in any way with the uniformity of ERISA regulation," he wrote.

In a dissent, Judge Milan D. Smith Jr. wrote that the city ordinance strikes at the heart of what ERISA pre-emption was designed to prevent: the proliferation of varying state and local benefit laws and requirements.

As it stands, the decision will "undoubtedly serve as a road map in jurisdictions across the country on how to design and enact a labyrinth of laws requiring employer compliance on health care expenditures, thereby creating the very kind of health care expenditure balkanization ERISA was designed to avoid," he wrote.

See **MANDATE** page 21

# Employers urged to help develop health reform

## *Baucus sees play-or-pay as key component*

By JERRY GEISEL

**WASHINGTON**—The chairman of the Senate Finance Committee wants the business community to help him draft a workable play-or-pay system as part of comprehensive legislation to move the United States close to universal health care coverage, but he is getting a chilly reception from some employer groups.

Speaking last week in Washington before the annual meeting of the National Business Group on Health, Sen. Max Baucus, D-Mont., said he rejects a single-payer system and, instead, wants to build on the current employment-based system.

"My vision for reform is one of shared responsibility," Sen. Baucus said, noting that in an earlier position paper he endorsed requiring employers to either provide coverage or pay into a pool to provide health insurance premium subsidies for the uninsured, an approach Massachusetts took nearly three years ago that moved the state to near-universal coverage.

Sen. Baucus acknowledged there are many details yet to be resolved in structuring a play-or-pay system. One key concern is the minimum level of benefits employers would be required to offer to avoid paying into a pool. "How would that standard relate to what employers already are providing?" he asked.

But the Finance Committee chairman has come to other conclusions about an employer mandate. He said the smallest firms should be exempt, while federal tax credits should be available to partially offset premium costs for other smaller companies providing coverage.

Sen. Baucus asked the business community, which has largely opposed an employer mandate in the past, to keep an open mind until the legislation he is putting together is complete.

LANDOV

**Sen. Max Baucus, D-Mont., said there are many details yet to be resolved in structuring comprehensive health care reform legislation.**

"I urge all of us here to suspend judgment until you can see the whole picture. Wait until we can see all parts of the puzzle," he said.

And he appealed for employer input. "Help us to develop a...structure that works," he said.

But some employer groups say the first priority of reform legislation should be better control of health care costs.

"It is unacceptable to even talk about a mandate before doing anything to control costs. If something is done to control costs, you won't need a mandate," said Mark Ugoretz, president of the ERISA Industry Committee in Washington.

"The most important thing is to bring down costs," said Paul Dennett, senior vp with the American Benefits Council in Washington. In addition, once a mandate is put in place, the requirements imposed on employers could creep up and become onerous, he said.

# Truth not an absolute defense in libel: Court

## *Nonmedia companies may face exposure to Massachusetts law, observers say*

By JUDY GREENWALD

**BOSTON**—Dozens of media firms are questioning a federal appeals court ruling that concluded truth is not an absolute defense against libel in a case concerning an e-mail sent in the firing of an office products salesman.

Fifty-one news organizations last week sought a rehearing of a 1st U.S. Circuit Court of Appeals decision that relied on a 1902 Massachusetts law that says truthful statements can be libelous if there also is malicious intent.

The decision in *Alan S. Noonan vs. Staples Inc*. exposes a "dusty old corner of libel laws" in Massachusetts that "truth is not an absolute protection" in a libel action, said Jeremy Feigelson, an attorney with Debevoise & Plimpton L.L.P. in New York.

**The decision in *Alan S. Noonan vs. Staples Inc.* exposes a 'dusty old corner of libel laws' in Massachusetts.'**

Jeremy Feigelson,
Debevoise & Plimpton L.L.P.

While the ruling applies only in Massachusetts, observers say it means state residents may be able to bring suit against others living elsewhere, including those who have posted material online. Observers say the decision also could pose problems for nonmedia businesses.

However, Mr. Noonan's attorney says the entire issue has been overblown.

In its Feb. 13 decision, a three-judge panel of the 1st U.S. Circuit Court of Appeals said the salesman was fired from the Framingham, Mass.-based office supply company for allegedly padding his expense reports.

Subsequently, Staples Executive Vp Jay Baitler sent an e-mail to some 1,500 company employees stating Mr. Noonan was fired for failing to comply with company travel and expense policies. Mr. Noonan did not "seriously challenge" the e-mail's truthfulness, according to the opinion.

"A jury could permissibly infer that Baitler singled out Noonan in order to humiliate him," the court stated. "Even a true statement can form the basis of a libel action if the plaintiff proves that the defendant acted with 'actual malice,'" the panel said in citing the Massachusetts law.

The panel found factors that could lead a jury to conclude there was malicious intent, including sending the e-mail to a large number of employees and that Mr. Baitler never previously mentioned an employee by name in an e-mail in 12 years with Staples. The court overturned a lower court's ruling dismissing his case on this issue and ordered further proceedings.

See **LIBEL** page 22

# Securities class action settlements plunged in 2008

*But financial crisis expected to trigger surge in litigation*

By JEFF CASALE

**BOSTON**—The average securities class action settlement fell 50% to $31.2 million in 2008, according to a report released by Cornerstone Research last week, but authors of the report note this trend may not continue.

The report, "Securities Class Action Settlements: 2008 Review and Analysis," said the sharp drop can be attributed to the decline in multibillion-dollar settlements. The median settlement amount of cases in 2008 was $8 million, compared with $9 million in 2007, an all-time high for all cases settled between 1996 through 2007, according to Boston-based Cornerstone.

In 2008, more than half of the settlements were for less than $10 million, a trend that also was true in 2007, according to the report. The percentage of cases involving damages in excess of $1 billion, also known as "mega cases," fell to about 20%, the lowest rate in five years and well below the peak of 35% in 2006.

The total number of settlements in 2008 dropped to 99 from 110 the previous year. The decline, Cornerstone analysts said, is unlikely to be a trend in upcoming years.

Meanwhile, the average length of the class period reached a new high of 800 days in 2008, which is nearly a year longer than the average for all prior settlements through 2007, according to the report. That average is about 518 days.

"Plaintiffs are trying to extend the damage period and increase the damages amount as much as possible," said Laura Simmons, assistant professor at the College of William & Mary Mason School of Business in Williamsburg, Va., and co-author of the report.

What's unknown is how the recent financial market crisis will affect settlements in the future. Ms. Simmons and report co-author Joseph Grundfest, director of the Stanford Law School Securities Class Action Clearinghouse, said they anticipate an increase in litigation as a result of the meltdown and they expect those cases that already have been filed to have an impact on the settlement volume within the next year or two.

Moreover, with more companies and financial institutions taking federal money as a result of the government's bailout program, Mr. Grundfest said it's likely the taxpayer, rather than the company or financial institution, will pay the settlements.

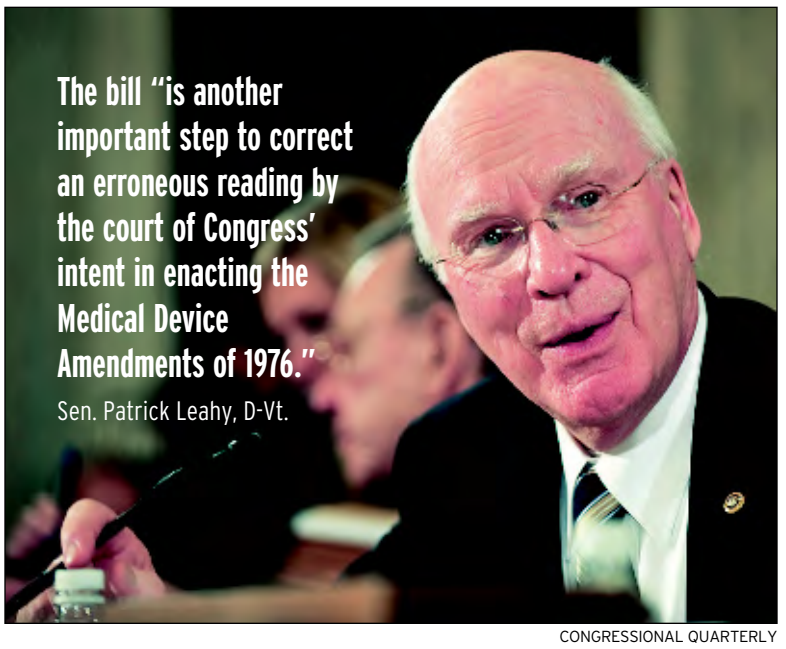
"Settlements of pending actions against (Troubled Asset Relief Program) recipients will raise novel public policy issues," Mr. Grundfest said in a statement. "Taxpayer dollars, will, one way or another, fund these settlements. This simple fact could set off a debate whether taxpayers should pay for these settlements, and about the effectiveness of the class action litigation mechanism altogether."

### AMOUNT OF SETTLEMENTS DOWN

*Class action settlement amounts since the passage of the Private Securities Litigation Reform Act was passed in late 1995, in millions of dollars*

| | 2008 | 1996-2007 |
|---|---|---|
| Minimum | $0.4 | $0.1 |
| Median | $8.0 | $7.4 |
| Average | $31.2 | $57.7 |
| Maximum | $800.0 | $7,700.0 |
| Total Amount | $3,100.0 | $53,600.0 |

*Note: Settlement dollars adjusted for inflation. 2008 dollar equivalent figures shown. Source: Cornerstone Research*




CONGRESSIONAL QUARTERLY

# Pre-emption opponents work to overturn ruling

*Bill would preserve state tort actions over medical devices*

By MARK A. HOFMANN

**WASHINGTON**—Backers of a bill that would end federal pre-emption of state tort law regarding medical devices say they think the political winds have turned in their favor.

They hope to overturn last year's U.S. Supreme Court decision in *Donna S. Riegel vs. Medtronic Inc.* by passing the Medical Device Safety Act of 2009, which was introduced in both houses of Congress earlier this month. The decision held that the pre-emption clause in the Medical Device Amendments of 1976 bars common law claims that challenge the safety and effectiveness of a medical device that has received premarket approval from the Food and Drug Administration (*BI*, Feb. 25, 2008).

Bills to void the ruling were introduced in both houses last year, but failed to move out of committee. But supporters are trying again, buoyed by the Supreme Court's recent ruling in *Wyeth vs. Diana Levine* that circumscribed implicit federal pre-emption of state product liability laws (*BI*, March 9).

"I am glad the court spoke clearly and decisively on this issue," Sen. Patrick Leahy, D-Vt., said upon introduction of the medical device bill in the Senate. "The court's decision was not only a vindication of Congress' primary authority to preempt state law, but a victory for every American who relies upon pharmaceutical drugs and entrusts the manufacturers of those drugs with ensuring their safety." The bill "is another important step to correct an erroneous reading by the court of Congress' intent in enacting the Medical Device Amendments of 1976," Sen. Leahy said.

The bills, S. 540 and H.R. 1346, would amend the Federal Food, Drug and Cosmetic Act to say that nothing in the section that deals

See **DEVICES** page 19

# Prices firming across D&O sector

*Other areas following financial services' lead to increased rates*

By ZACK PHILLIPS

**NEW YORK**—Pricing for directors and officers liability insurance has begun to harden for financial services firms and flatten for other lines amid the rise of securities lawsuits and the declining economy, observers say.

Rates for D&O coverage have risen dramatically in the financial services sector, according to brokers, underwriters and attorneys at the Professional Liability Underwriting Society's D&O Symposium, held Feb. 25-26 in New York. Now, D&O rates in other sectors have begun to flatten after several years of soft pricing, they say.

**MORE COVERAGE:** Make sure D&O coverage is "stress-tested for bankruptcy," speakers tell attendees of the Professional Liability Underwriting Society D&O Symposium. Page 18.

"Everybody is prepared and understands that we are definitely getting into a hard market," said John A. Kuhn, chief executive officer of AXIS Insurance Co.'s professional lines division. "Some of the price increases are probably even lower than what they need to go to on some of those accounts."

A recent pricing index by Chicago-based brokerage Aon Corp. showed that the average price of $1 million in D&O coverage was about 3% higher in the fourth quarter of 2008 vs. the fourth quarter of 2007—the first year-over-year rise in 21 consecutive quarters.

Aon said a 50% increase in D&O pricing for the financial services sector was the reason for the overall rise while the average D&O price for other sectors fell 6% in the final quarter of last year.

Symposium observers said that the remainder of the D&O sector soon will follow the firming already underway for the financial services sector.

"The global recession…is certainly going to have an impact on non-(financial institution) business, and it's a question of how much and when that puts pressure on underwriters," said Michael Smith, president of AIG Executive Liability in New York.

In spite of the increases, D&O rates remain off their peak in the fourth quarter of 2002. Underwriters said the extended soft market has left D&O coverage underpriced and too broad.

"The exclusions have been watered down through this whole cycle," said Jeffrey Klenk, senior vp

See **D&O** page 18

# Data breach threats growing within

*Tools still evolving to thwart insider thefts of company info*

By JEFF CASALE

Insurance and cyber security experts say a computer-savvy employee who thinks his or her job may be in jeopardy may be more inclined to tap the organization's database for information that may be useful in a new job with a competitor.

Worse, the employee could attempt to take revenge on his or her employer as job cuts abound during the recession, experts say.

"I think it's safe enough to assume that, as people are put under greater and greater emotional stress, additional people may lose their moral compass and do things and take data that, in normal circumstances, they might not," said Alan E. Brill, New York-based senior managing director of technical services for Kroll Inc., a consultant unit of Marsh & McLennan Cos. Inc.

"But we have to live with the circumstances that we're in; and if we're in a higher-risk environment of people doing that, I think we have to be able to respond to that and provide the tools and technology to do so," Mr. Brill said.

Mr. Brill said Kroll already is seeing a higher rate of incidents involving employees taking sensitive company data—either before or after they've been let go—that they intend to use to better themselves with another employer or start a competing business.

Brian Lapidus, a colleague of Mr. Brill and the New York-based chief operating officer of Kroll's fraud services division, said there were about 1,000 more data security inquiries to Kroll in December than just last July.

"We're seeing more (data) breaches and we're seeing more activity from those people who have been victims of a breach," Mr.

See **SECURITY** page 18

### DATA BREACH COSTS INCREASE

**The total average cost of a data breach increased 2.5% in 2008 to $202 per record compromised. On average, data breaches can cost an organization more than $6.6 million per breach, up from $6.3 million in 2007 and $4.7 million in 2006.**

*Source: Ponemon Institute L.L.C.'s 2008 U.S. Cost of a Data Breach Study*

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**Commentary**

# Could there be a silver lining in bad economy?

RODD ZOLKOS

*Senior Editor Rodd Zolkos can be reached at: rzolkos@businessinsurance.com*

Much of the discussion of the economic downturn has rightfully focused on just how widespread it's proven to be, affecting seemingly every industry and every region.

Still, even the worst of conditions seem to offer opportunity for some. And while many may be reluctant to speak about it too loudly, there are clearly some in and around the insurance industry who are poised to benefit from the circumstance.

It's no secret that the slumping worldwide economy—and with it, dramatic downturns in investment markets—has had a significant impact on many insurance companies.

Some suffered significant losses as markets declined, but for many, perhaps even more significant is the ongoing miserable state of investment returns, putting a sizable crimp in many insurers' business style.

As if any losses they might have suffered in the mortgage-backed security market weren't enough, for many life companies with large books of variable annuity business, the stock market downturn has taken a marked toll on their financial strength.

While the strain has been less pronounced on the property/casualty side, poor investment returns remain a significant concern for an industry that's historically looked to its investment success to offset underwriting losses. The answer seems obvious: Make an underwriting profit. However, doing so in a market where the fundamentals suggest an inevitable hardening but the reality suggests otherwise—for now at least—can prove challenging.

Illustrating that challenge, Dallas-based electronic insurance exchange MarketScout reported earlier this month that property/casualty rates fell 8% this February compared with prices in February 2007.

And, of course, all of this is occurring at a time when the credit and capital markets remain tight as drums, offering little assistance to a company looking to raise additional capital.

In such an environment, is there anyone involved with the industry who isn't losing sleep over his or her business prospects? Ah, it's an ill wind, etc., etc.

Firms and professionals involved in the runoff business, for example, see potential opportunity in today's market.

Likewise, many insolvency attorneys will tell you they expect to become increasingly busy as the year goes along. They're not wishing for anyone's demise, mind you, just recognizing cyclical and economic reality.

The threat of insolvencies posed by the economic climate provides other opportunities as well. Late last year Aon Risk Services announced it was partnering with Allianz Global Corporate & Specialty to offer a product providing coverage should a company's insurer become insolvent.

**Is there anyone involved with the insurance industry who isn't losing sleep over his or her business prospects?**

That came after Aon's introduction in October of its "Flex" suite of products, offerings providing coverage against insurer insolvencies in some lines and protection against pricing volatility resulting from insurer insolvencies and subsequent market disruptions in others.

With investment markets at the heart of much of the wave of industry angst, it's no surprise that many insurance company investment consultants are expecting their services to be in increasing demand.

With few exceptions, insurance companies have traditionally been conservative investors. Now, though, with returns ranging from slim to worse than none, many will no doubt be eager to listen to someone offering an investment approach that fits the requirements of the business, while offering the potential to eke out just a bit more than the paltry returns their portfolios are generating.

So, are there silver linings in the insurance industry's dark clouds? For some, undoubtedly.

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# Business Insurance OPINIONS

## Participation needed in health care debate

SHOULD EMPLOYERS heed the call made last week by Senate Finance Committee Chairman Max Baucus, D-Mont., and help him craft an employer play-or-pay mandate as part of comprehensive health care reform legislation?

This is a tough issue for employers. Many employers have a deep philosophical aversion to government benefit mandates. We're not fans of them either. But in very select and narrow instances in which the case for a mandate is overwhelming, we have endorsed them.

We're not yet ready to endorse a federal play-or-pay-type mandate, so-named because employers either would have to offer a health plan meeting certain standards or pay into a pool to help fund coverage for the uninsured.

*It is imperative that employers participate in the legislative process so their voices can be heard and their concerns are addressed.*

There still are too many unknowns. For example, we aren't sure it makes sense to impose a mandate before health care costs are brought under control.

Having said that, we think it is imperative that employers participate in the legislative process so their voices can be heard and their concerns are addressed.

When employers were able to present their views, every major piece of benefits legislation that Congress has passed in recent memory became a better bill as a result of that input. One obvious example was last year's mental health care benefits legislation, which employers helped improve by lobbying for a more reasonable effective date.

We hope employer objections to a play-or-pay mandate don't blind them to the necessity of being part of health care reform negotiations. Although employers still may not get the bill they want, they may be influential in making it more palatable.

## Libel ruling a concern for more than media

A MASSACHUSETTS APPEALS COURT ruling that the truth is not always a valid defense in libel actions should be a concern for many corporations, not just media companies.

As we report on page 3, the ruling holds that, even if it is true, a statement made with malicious intent still can be held to be libelous. In the case, a worker who was fired for allegedly padding his expenses successfully sued his employer after a widely distributed e-mail gave details on the reason for his dismissal. Although the worker did not "seriously challenge" the truth of the information in the e-mail, the court ruled that a jury could find that his former boss intended to humiliate him with the communication. The ruling includes a defense for matters of "public concern," but it is unclear what those would be.

While one could argue about whether holding up a person to the crowd as a bad example is an ethical employment practice, using libel law to rectify any harm that was done should be troubling for employers.

In the era of the Internet, any company with a Web site is a publisher and anything posted on the World Wide Web also is published in Massachusetts or one of the several other states that have similar libel laws.

If the Massachusetts ruling withstands further appeals, the consequences of telling the truth could be dire.


## WRITE

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### THIS WEEK'S RESULTS

Q Would a systemic risk regulator have averted the current economic crisis?

It would have prevented the problem.
8%

It would have lessened the problem.
45%

It would have no impact.
47%

### NEXT WEEK'S QUESTION

**Q:** For how long do you keep your/your clients' liability policies?

## READ

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## Enhanced readiness pays dividends

Risk managers and business continuity professionals may see themselves warning top management about a potential events that could jeopardize the business, but top managers see them as whistling into the wind about something that has only a remote chance of happening, says Michael Keating, a director at Navigant Consulting Inc. in Atlanta. It's up to risk management professionals to remind management of past efforts that reduced the company's exposures and the importance of ongoing business continuity efforts.

## LETTERS

### *Wyeth* just the start of pre-emption fight

TO THE EDITOR: The recent Supreme Court anti-pre-emption decision in *Wyeth vs. Levine* (*BI*, March 9) represents a setback for medical innovation and cost control, but does represent a windfall for personal injury attorneys. Lawyer James Beck is quoted in your article as speculating that this decision "might cool congressional ardor to scale back pre-emption." I wish! In fact, *Wyeth vs. Levine* has emboldened lawmakers to introduce the Medical Device Safety Act of 2009, which would undo the 2008 *Riegel vs. Medtronic* decision and eliminate the pre-emption defense for medical devices that were meticulously approved by the FDA. Far from dampening efforts at rolling back pre-emption, *Wyeth* is the appetizer and *Riegel* is the main course, making life even more challenging for risk managers in the life sciences arena.

**Kevin Quinley CPCU, ARM**
**Fairfax, Va.**



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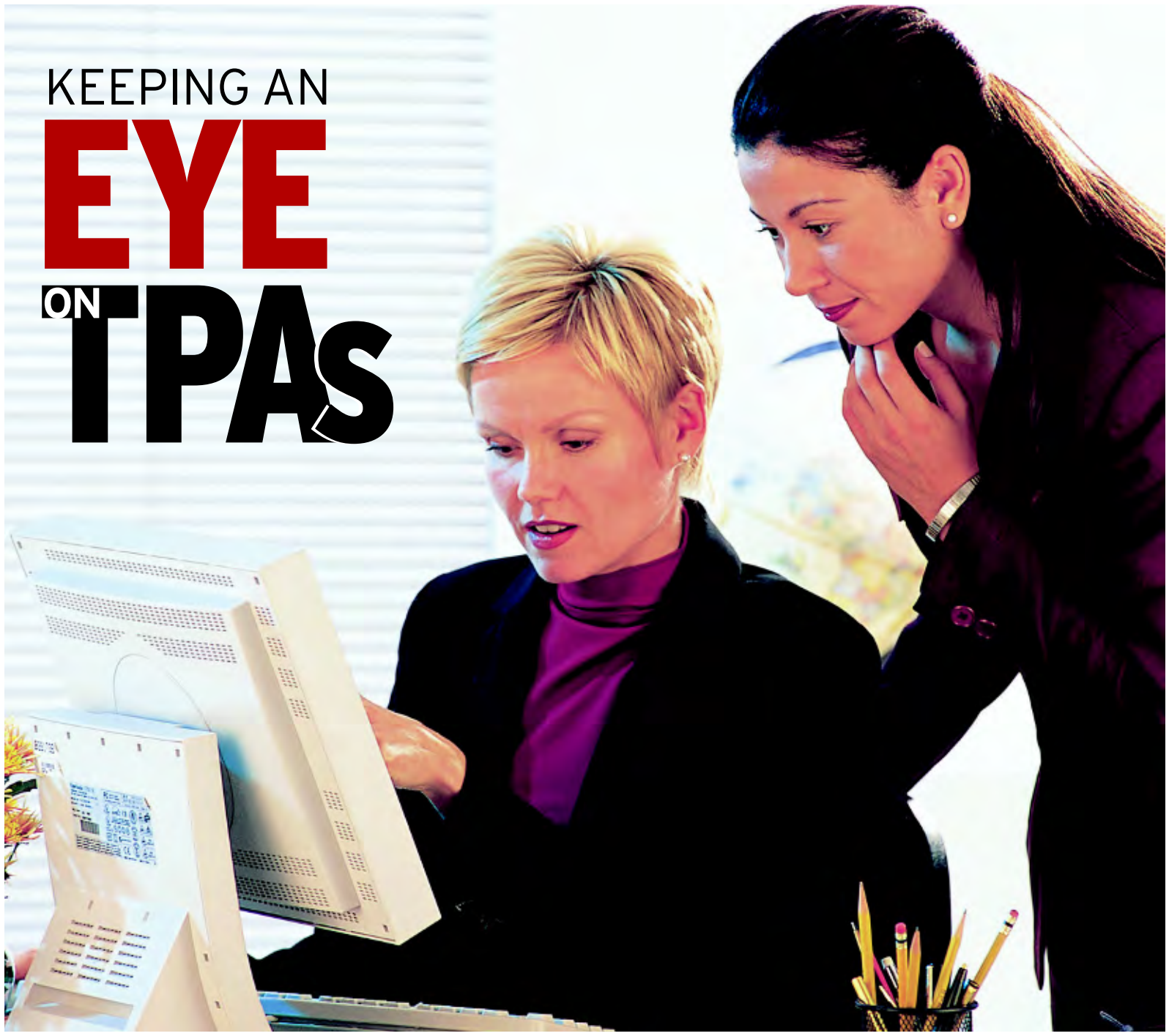
KEEPING AN

# EYE ON TPAs



# Outsourcing claims requires careful oversight

*TPAs can improve efficiency, but risk managers must be involved in the process, experts say*

By DAVE LENCKUS

While third-party administrators can deliver efficiencies for self-insured programs, risk managers should require protections and maintain vigilant oversight for instances when the claims process breaks down, risk managers say.

If "properly vetted," a TPA can provide great service and "enhance metrics and decision making," said Wayne L. Salen, director of risk management for Labor Finders International Inc. in Palm Beach Gardens, Fla.

Still, "there are a lot of things a good risk manager can do" to prevent claims problems and protect their organizations when problems occur, said Scott B. Clark, risk and benefits officer for Miami-Dade County Public Schools in Miami.

A lawsuit wending through California's courts illustrates how badly a claim can go.

The case involves a 1999 workers compensation claim against Bank of America Corp., which at the time self-insured the first $250,000 of every claim.

A former employee claimed he needed back surgery to treat an injury he sustained while working for the bank during the 1980s. Although the bank's TPA, Greenwich, Conn.-based Cambridge Integrated Services Group Inc., denied the claim based on an independent physician's recommendation, the TPA's outside attorneys inexplicably agreed in February 2000 to cover the procedure, court papers say.

The surgery, however, left the claimant a paraplegic, and his post-surgical medical costs totaled $1.5 million through March 2006. That is when the bank's excess insurer, National Union Insurance Co. of Pittsburgh, Pa., a subsidiary of New York-based American International Group Inc., was alerted by the bank's new defense counsel that Cambridge either concealed or negligently failed to disclose for six years that the TPA's medical expert had advised against the surgery, according to court papers. National Union demanded reimbursement and sued Cambridge in March 2007.

Reversing a lower court's decision, a California appellate court ruled Feb. 11 that a provision in Cambridge's contract with the bank does not preclude National Union from suing the TPA and remanded the case to a lower court.

The bank, National Union and Cambridge refused to comment.

But risk managers say there are protections against inappropriately handled claims and other potentially serious problems.

Before engaging a TPA, risk managers should insist the service provider shields its clients with contractual hold-harmless provisions that incept if the TPA fails to follow legal advice, said Mr. Clark, who also is a director and secretary for the New York-based Risk & Insurance Management Society Inc.

"They're supposed to be experts in this. They are responsible" for covering a claim if it is mishandled, said Mr. Clark, who retains a TPA to administer the Miami-Dade school system's various casualty claims.

A TPA also should provide proof that it has adequate professional liability insurance, Mr. Clark said.

Risk managers also should scrutinize whether service providers have adequate resources to deliver on their promises, said Terry Fleming, the Rockville, Md.-based risk manager for Montgomery County, Md. A TPA's resources—such as its staffing, oversight and size and functionality of its claims system—should be addressed in a risk manager's request for proposals, he said.

Mr. Fleming also recommends requiring a TPA to provide a complete list of clients. The risk manager then should contact many of them. Members of a local RIMS chapter also can be valuable sources of information on a prospective TPA, he said.

Meanwhile, the National Assn. of

See **TPAs** page 11

Claims Management

SPOTLIGHT



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## LARGEST EMPLOYEE BENEFIT TPAS

*TPAs that specialize in employee benefit claims administration*

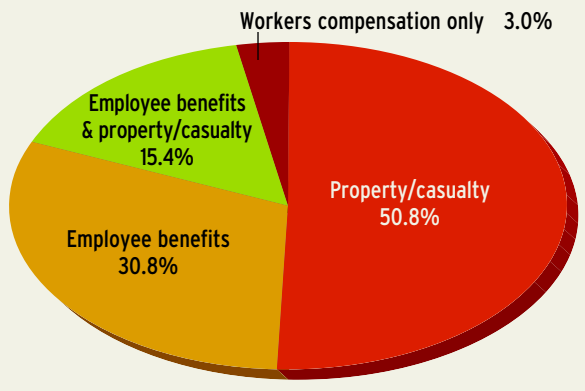
| Company | 2008 revenues from self-insured clients |
|---|---|
| UMR Inc. [1] | $400,000,000[2] |
| Meritain Health | $171,000,000 |
| CoreSource Inc. | $118,873,264 |
| Principal Financial Group/National Accounts | $112,319,546 |
| HealthSCOPE Benefits [3] | $55,000,000 |
| Group Resources | $42,989,956 |
| HealthSmart Holdings Inc. [4] | $42,798,000 |
| HealthNow Administrative Services | $30,586,000 |
| HealthPlan Holdings Inc. | $29,500,000 |
| Health Plans Inc. | $18,150,000 |

*1 Formed in 2008, includes Fiserv Health Inc., Midwest Security Insurance Cos. and United Medical Resources Inc. 2 BI estimate. 3 Formerly CenBen USA Inc. 4 Formerly The Parker Group*

*Source: BI survey*

## TYPES OF CLAIMS ADMINISTERED

*Types of claims handled by all companies listed in the directory*




*Source: BI survey*

## GROWTH OF TPAS

*As a group, the 10 largest TPAs' revenue from self-insured clients has risen in most of the last five years*


*Source: BI survey*

# Largest third-party claims administrators

*Ranked by 2008 revenues from claims handled for self-insured clients*

| Rank | Company/Address | Phone/Web site | Parent company | 2008 revenues from self-insured clients | 2008 claims paid | Total clients | Claims staff | Principal officer |
|---|---|---|---|---|---|---|---|---|
| 1 | **Sedgwick Claims Management Services Inc.**<br>1100 Ridgeway Loop,<br>Memphis, Tenn. 38120 | 901-415-7400<br>*www.sedgwickcms.com* | Fidelity Sedgwick Holdings Inc. | $601,946,333 | $7,367,313,597 | 960 | 5,944 | David A. North, president/CEO |
| 2 | **Gallagher Bassett Services Inc.**<br>The Gallagher Centre, 2 Pierce Place,<br>Itasca, Ill. 60143-3141 | 630-773-3800<br>*www.gallagherbassett.com* | Arthur J. Gallagher & Co. | $411,200,000 | $5,450,000,000 | 3,671 | 2,719 | Richard J. McKenna, president |
| 3 | **UMR Inc.**[1]<br>11 Scott St., Suite 100,<br>Wausau, Wis. 54403 | 866-881-0800<br>*www.umr.com* | UnitedHealthcare Group Inc. | $400,000,000 [2] | $11,284,631,873 | 1,189 | 2,276 | Jay M. Anliker, CEO |
| 4 | **Broadspire Services Inc., a Crawford Co.**<br>1001 Summit Blvd.,<br>Atlanta, Ga. 30319 | 800-726-8898<br>*www.choosebroadspire.com* | Crawford & Co. | $253,514,697 | $2,900,000,000 | 827 | 1,852 | Ken Martino, president/CEO |
| 5 | **Cambridge Integrated Services Group Inc.**[3]<br>340 Pemberwick Road, Second Floor,<br>Greenwich, Conn. 06831 | 800-662-1170<br>*www.cambridgeclaims.com* | – | $235,400,000 [2] | NA | NA | NA | Wesley O'Brien, president |
| 6 | **ESIS Inc.**<br>436 Walnut St.,<br>Philadelphia, Pa. 19106 | 215-640-1000<br>*www.esis.com* | ACE Ltd. | $202,660,000 | $2,348,000,000 | 719 | 1,201 | David Patterson, president |
| 7 | **Meritain Health**<br>300 Corporate Parkway,<br>Buffalo, N.Y. 14226 | 800-828-6922<br>*www.meritain.com* | Prodigy Health Group Inc. | $171,000,000 | $2,457,991,076 | 1,759 | 216 | Elliot Cooperstone, CEO |
| 8 | **Specialty Risk Services L.L.C.**<br>225 Asylum St., Goodwin Square,<br>16th Floor,<br>Hartford, Conn. 06103 | 888-236-4684<br>*www.specialtyriskservices.com* | Hartford Financial Services Group Inc. | $162,000,000 | $2,790,000,000 | 1,320 | 1,304 | Joe Boures, president |
| 9 | **CoreSource Inc.**<br>400 Field Drive,<br>Lake Forest, Ill. 60045 | 800-832-3332<br>*www.coresource.com* | Trustmark Insurance Co. Inc. | $118,873,264 | $2,753,903,000 | 683 | 1,034 | Paul Lotharius, president/CEO |
| 10 | **Principal Financial Group/National Accounts**<br>1275 N.W. 128th St., Suite 100,<br>Clive, Iowa 50325 | 877-273-0900<br>*www.principal.com* | – | $112,319,546 | $2,029,921,518 | 319 | 664 | Renee Schaaf, vp-national accounts |

*1 Formed in 2008, includes Fiserv Health Inc., Midwest Security Insurance Cos. and United Medical Resources Inc. 2 BI estimate. 3 Cambridge Integrated Services Group Inc. did not respond to the survey. Cambridge entered an agreement to be purchased by Xchanging P.L.C. in October 2008. NA = not available*

*Source: BI survey*

*Researched by Kevin Edison and Karen Tucker*

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## LARGEST MULTILINE TPAS

*Third-party administrators that offer both employee benefits and property/casualty claims administration*

| Company | 2008 revenues from self-insured clients |
|---|---|
| Sedgwick Claims Management Services Inc. | $601,946,333 |
| Wells Fargo Third Party Administrators and Wells Fargo Disability Management | $75,462,000 |
| Alicare Inc. | $56,285,000 |
| TRISTAR Risk Management | $49,153,000 |
| Keenan & Associates | $37,700,000 |
| Loomis Co. | $29,343,200 |
| Underwriters Safety & Claims Inc. | $8,600,000 |
| JI Specialty Services Inc. | $6,047,000 |
| Hewitt, Coleman & Associates Inc. | $4,000,000 |
| Total Captive Solutions | $600,000 |

*Source: BI survey*

## LARGEST WORKERS COMPENSATION TPAS

*Ranked by workers compensation claims paid in 2008*

| Company | Claims paid |
|---|---|
| Sedgwick Claims Management Services Inc. | $4,160,328,403 |
| Gallagher Bassett Services Inc. | $3,490,000,000 |
| Specialty Risk Services L.L.C. | $1,980,000,000 |
| Broadspire Services Inc., a Crawford Co. | $1,708,000,000 |
| ESIS Inc. | $1,650,000,000 |
| TRISTAR Risk Management | $751,000,000 |
| Cannon Cochran Management Services Inc. dba CCMSI | $616,500,000 |
| GAB Robins Group of Cos. | $500,000,000 |
| Avizent | $451,507,340 |
| Pinnacle Risk Management Services | $450,000,000 |

*Source: BI survey*

# **TPAs:** Limits on claims outsourcing

CONTINUED FROM PAGE 9

Insurance Commissioners is working on a model contract that risk managers could use when retaining TPAs and excess insurers. It has not set a release date for the model contract language.

After a contract has been agreed on, abdicating claim oversight responsibility to a TPA would be "a gross error," Mr. Clark said. "You have a fiduciary duty to stockholders or taxpayers, so you have to be intimately involved in administering those claims, especially if you're self-insured."

Other risk managers agree.

"Surgeries are always reviewed and evaluated; and when back surgery is involved, there's even more scrutiny," Mr. Salen said. "No surgery should go unapproved by the client."

### *Frequent contact*

Working with a TPA is more efficient when its claims representatives are close enough so they and risk management can meet spontaneously, said Richard J. Roberts, the Simsbury, Conn.-based corporate risk manager for Ensign-Bickford Industries Inc.

He recalled how a former TPA's service dropped markedly when it moved out of Connecticut.

Eventually, Mr. Roberts retained Liberty Mutual Insurance Co. to write Ensign-Bickford's excess workers comp coverage as well as handle claims that fell within the company's deductible. The arrangement made claim servicing much easier for employees, because there is only one toll-free telephone number to call regardless of whether their claim falls within the company's self-insured retention or would be covered by Liberty Mutual, he said.

"We're heavily involved in the claims-adjustment process," Mr. Roberts said.

Close oversight of a TPA also is important to maintain a good reputation for your organization among excess insurers so the risk manager can negotiate reasonable terms for excess coverage, Mr. Clark said.

# Guaranty funds not guaranteed for self-insured comp claims

*Not all states agree on use of backup funds for recovering from failed excess insurers*

By MEG FLETCHER

What happens to self-insured companies if their excess property/casualty insurer is unable to pay workers compensation claims? The answer depends on the state, experts say.

Many states have laws that allow a self-insured employer to directly or indirectly recover some or all of their workers comp claim costs from guaranty funds that back up a defunct excess insurer.

Self-insured companies' ability to tap guaranty funds "has been litigated in a number of states," said Barbara Cox, vp-legal and regulatory affairs for the Indianapolis-based National Conference of Insurance Guaranty Funds. "There are decisions going both ways," she said.

Historically, judges and state policymakers have struggled to find balance between the desire of policyholders for coverage after an insurer becomes insolvent and the appropriateness and ability of a state's guaranty fund mechanism to provide coverage.

Property/casualty guaranty fund advocates say that policymakers established the funds to help small claimants obtain some recovery when their direct insurer became insolvent. Large companies, which have more resources, often are excluded by state law from recoveries through net worth thresholds, although monies due to injured workers often are not capped, experts say.

Having a state's guaranty fund pay the claims of self-insured organizations would require greater assessments of member insurers, which would pass those costs on to policyholders and to the state through premium offsets on the state taxes they owe, said Sam Sorich, vp of the Des Plaines, Ill.-based Property Casualty Insurers Assn. of America. PCI members participate in guaranty funds.

The situation would become clearer for self-insured organizations if the National Assn. of Insurance Commissioners adopts proposed model law amendments that would exclude coverage for self-insureds in nearly all situations. The changes would go into effect only if a state legislature adopts them.

The latest dispute over property/casualty guaranty funds coverage is in the Nevada Supreme Court, which heard oral arguments earlier this month.

Under guaranty fund law, the two Nevada-based self-insured companies have filed claims with the Nevada Insurance Guaranty Assn. seeking recovery of their workers comp claims after Pennsylvania declared excess insurer Reliance National Insurance Co. insolvent in 2001.

Las Vegas-based Steel Engineers Inc. purchased excess coverage from Reliance in 1993-94. After the insolvency, the reinforcing steel contractor was "forced to cover hundreds of thousands of dollars in workers compensation claims," according to its court brief.

In addition, Las Vegas-based MGM Mirage bought an excess workers comp policy from Reliance

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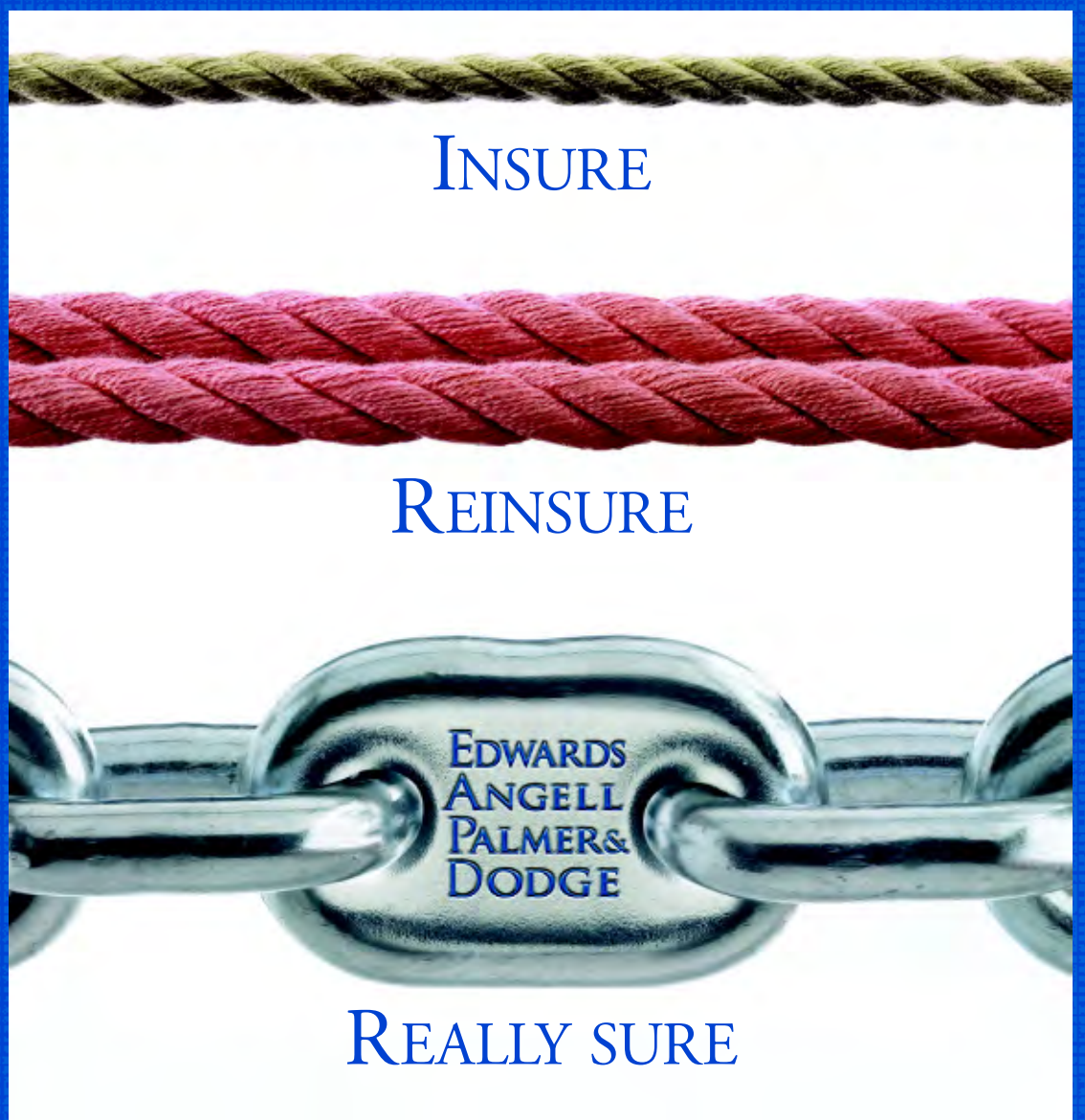

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in 1998-99 to meet Nevada's requirement that self-insurers purchase such coverage.

In April 2007, a Nevada district court judge ruled that the guaranty fund was not obligated to pay the self-insured companies' claims. Steel Engineers and MGM Mirage are appealing to the Nevada Supreme Court because the state has no intermediary appellate court system.

The Nevada Insurance Guaranty Assn., which brought the case, "is asking the court to interpret the statute, which is apparently ambiguous," said Bruce Gilbert, the Las Vegas-based association's executive director. For example, the state insurance code does not define what constitutes an insurer, but its workers comp law does have such a definition that includes self-insured companies.

Also uncertain is "whether excess policies of self-insured employers are policies of indemnity, direct insurance or reinsurance, and therefore excluded from the definition of a 'covered claim,' " according to PCI's amicus brief supporting the guaranty fund.

Officials of Carson City, Nev., which purchased Reliance coverage in 1998-99 as part of its self-insurance program, have been told the state guaranty fund would not pay its claims and have filed an amicus brief supporting the self-insured companies.

The city of 50,000-plus residents potentially faces huge costs from future heart- and lung-related claims of 28 police officers and firefighters who were employed during the coverage period, said Michele Cruz, the city's risk management coordinator.

Nevada law conclusively presumes that such ailments are work-related, so "these are lifetime benefits for any police officer or firefighter who has worked five years" and "could potentially go into the millions of dollars," she said.

"Those are costly kinds of claims," which can include bypass surgery and heart transplants, said Mark Forsberg of Scarpello & Huss Ltd. in Carson City, who represents the city.

"I don't think any self-insured employer in Nevada would have, or could have, concluded from the statutes that when they self insured, they were losing the NIGA coverage," Mr. Forsberg suggested.

Ann Wiswell, a risk management specialist with the Nevada Public Agency Insurance Pool and president of the state chapter of the Public Risk Management Society, disagreed. She said self-insured employers "absolutely" should have known there was no guaranty fund coverage because they never contributed to the state fund.

**'I don't think any self-insured employer in Nevada would have, or could have, concluded from the statutes that when they self insured, they were losing the NIGA coverage.'**

Mark Forsberg, Scarpello & Huss Ltd.

Guaranty officials in three key states summarized their coverage as follows:

- California: Guaranty fund coverage is provided for a specific or aggregate excess policy written to indemnify a permissible self-insured employer for liability to pay workers comp benefits in excess of a specific or aggregate retention, provided that the claims "are not considered workers compensation claims." Payouts are subject to policy terms and limited to $500,000 per claimant, but state law does not limit workers comp payouts.
- New York: Guaranty fund coverage is provided for a self-insured company's excess insurance policy that obligates the self-insurer to pay workers comp claims, but not for a reinsurance policy benefiting the employer.
- Texas: There is no guaranty fund coverage for certified self-insured organizations, but there may be some coverage for the excess workers comp claims of other employers in the state, which is unique among the states in that Texas law does not mandate that employers provide workers comp coverage.

## FACTS AND STATISTICS

*The property/casualty guaranty fund system at a glance*

- The nation's property/casualty guaranty funds were created by state statutes nearly 40 years ago to protect those least able to deal with losses associated with insurance company failure—the small business policyholder or claimant.
- There have been about 600 insolvencies of property and casualty insurers since 1976.
- The system has paid out about $21 billion, of which $10 billion has been in the past six years.
- Guaranty funds pay covered claims within limits set by individual state laws and the insurance contract. They typically pay the amount of coverage stipulated by the policy or $300,000, whichever is less. Yet, most guaranty funds pay 100 percent of their states' statutorily defined workers compensation benefits to injured workers.
- A separate guaranty fund system exists for the life, health and annuity insurance industry, but it operates independently.

*Source: The National Conference of Insurance Guaranty Funds*

# Tough economic times tend to boost insurance claims

*Insurers examining all claims more closely, mindful that some policyholders try to stretch the truth*

By MICHAEL BRADFORD

Hard times are expected to breed more insurance claims as policyholders look for cash in every corner and, in some cases, stretch the truth when reporting losses, experts say.

At the same time, insurers are taking a closer look at claims to make sure they are legitimate and to weed out those that are fraudulent, sources say.

"Any source of money you can find," said Luca Franzi, board member at Milan, Italy-based broker RVA Rasini Viganò S.p.A. That is the attitude many policyholders have taken as they work to survive in perilous financial times.

That means legitimate claims are pursued, no matter how small, and illegal claims increasingly are being filed by policyholders desperate for cash, sources say.

"It is far easier to commit insurance fraud than to get funds by legitimate means in the current economic situation," said Bobby Gracey, vp-counterfraud solutions at Crawford & Co. in London.

Reliable fraud statistics are hard to come by because the crime often is not caught or reported. But experts agree that the economic crisis is fertile ground for fraudulent claims to grow (see story, page 14).

As for legitimate claims, some market sources say they are seeing an increase as the recession has taken hold. Others note that it will take time to fully know how the downturn will affect claims.

"This has all happened very quickly. Up until 12 months ago, we were in a boom trading environment and then, very suddenly, the financial crisis began to take hold," said Sarah Baker, London-based director-corporate and major incident team, at Crawford & Co.

"I think that it is a bit early to say whether we are seeing any changes in the volume or magnitude of claims," Ms. Baker said. "It may be another six to nine months before the situation can be properly assessed."

Among the types of claims the financial downturn is expected to foster, D&O is far and away the most obvious, market sources say.

**'As costs rise, (companies) are cutting back on maintenance, and claims are increasing.'**

Luca Franzi, RVA Rasini Vigano S.p.A.

As financial services companies have sunk, their boards are taking the blame for bad business moves.

"I don't think we are seeing an increase in D&O claims yet, but there has been an increase in the number of circumstances that could give rise to claims," said John Batch, London-based senior vp in Marsh Inc.'s financial and professional practice.

He said D&O policyholders can lodge a "circumstance," or notification that an incident has occurred that might eventually lead to a claim. "We have seen an uptick in the number of those circumstances filed."

Others say a spike in professional liability claims already has begun.

"Shareholders want someone to be responsible if a bank collapses or a financial institution reports terrible earnings," and as a result, D&O claims are increasing, said David Siesko, principal at Siesko Partners L.L.C., a claims consultant in New York. "When someone does something wrong, people want someone held responsible," he said.

Mr. Franzi said professional liability claims are close to erupting. "We will see a big increase in D&O claims. I know the insurance market is waiting for D&O claims," he said.

There is no doubt that legal action related to the financial crisis is rising, according to Mr. Batch.

He said figures from NERA Economic Consulting, a Marsh unit in Washington, show that securities class action lawsuits in the United States have jumped since the subprime crisis triggered the global financial chaos.

There was a 37% increase in such cases in 2008, with 267 filings, NERA figures show. "That's the

Continued on next page

## Insurance fraud on the rise as result of global recession

By MICHAEL BRADFORD

**LONDON**—Insurance fraud is flourishing during tough times as some cash-strapped businesses succumb to the temptation to cheat their insurers.

"The global recession is the No. 1 driver," said Bobby Gracey, vp of counterfraud solutions at Crawford & Co. in London. "We are seeing it across all business lines, from insurers directing more work to our fraud unit and from our adjusters who are seeing more fraud in their case handling."

**'The global recession is the No. 1 driver. We are seeing (insurance fraud) across all business lines...'**

Bobby Gracey, Crawford & Co.

Reliable numbers about insurance fraud are hard to come by, experts say.

"In reality, I suspect the level of fraud is probably much higher than reported," said John Cassey, London-based head of the fraud and litigation division at consulting and audit firm Protiviti Inc.

Fraud committed internally at businesses rarely is reported to authorities or insurers, said Alan Williams, manager of Protiviti's fraud and litigation division in London.

But there are some numbers that may indicate fraud is showing up more frequently in claims during the global financial downturn.

For instance, fire losses on businesses and homes in the United Kingdom rose 16% in 2008 to a record £1.3 billion ($1.87 billion), according to statistics from the Assn. of British Insurers in London. Commercial losses were £865 million ($1.24 billion) of the total, a 15% rise from 2007.

"We know that arson tends to increase during an economic downturn," Nick Starling, ABI's director of general insurance and health, said in a statement. "Insurers are reporting a rise in large-scale fires that are increasingly putting lives at risk. We believe that arson and fraud are contributing factors."

"There has been a substantial increase in arson claims," particularly among commercial rental properties. Such claims for rental homes also are starting to appear in greater numbers, Mr. Gracey said.

Fraud may show up in a claim even if a fire was not intentionally set, as policyholders sometimes exaggerate the business interruption or property loss, Mr. Cassey said.

Businesses also rely on other ways inflate claims, sources say.

Fraud among small- to medium-size businesses has increased because many of those operations have cash-flow problems, and some are filing fictitious claims for theft of stock and cash, Mr. Gracey said.

In some ways, the recession has helped expose fraud, Mr. Williams said.

Staff cutbacks can uncover fraud that has been going on for some time, he said. "One of the consequences of the recession is that sometimes a disaffected worker becomes a whistle-blower," he said.

CONTINUED FROM PREVIOUS PAGE

largest figure since 2002," said Mr. Batch.

And some struggling policyholders are filing more property claims.

Some Italian companies cannot afford to take proper care of property and equipment, said Mr. Franzi. "As costs rise, they are cutting back on maintenance, and claims are increasing," he said.

And all claims are likely to get a thorough examination these days, sources point out.

Insurers and policyholders are taking tougher stances on coverage, said Mr. Siesko, an attitude not so prevalent when his company was formed a few years ago.

"Three years ago, insurers were willing to do more for the policyholder than they are now," Mr. Siesko said. "Now, it's more of a return to basics on the policyholder and carrier sides. If coverage provides for X, that is what the carriers will deliver. They will not do any more because of relationship-building or other considerations."

## LARGEST PROPERTY/CASUALTY TPAS

*TPAs that specialize in property/casualty claims administration*

| Company | 2008 revenues from self-insured clients |
|---|---|
| Gallagher Bassett Services Inc. | $411,200,000 |
| Broadspire Services Inc., a Crawford Co. | $253,514,697 |
| ESIS Inc. | $202,660,000 |
| Specialty Risk Services L.L.C. | $162,000,000 |
| Cannon Cochran Management Services Inc. dba CCMSI | $67,000,000 |
| Avizent | $63,500,000 |
| York Insurance Services Group Inc. | $58,000,000 |
| Helmsman Management Services L.L.C. | $47,098,495 |
| Berkley Risk Administrators Co. L.L.C. | $45,000,000 |
| GAB Robins Group of Cos. | $41,000,000 |

*Source: BI survey*

That's not a bad practice, Mr. Siesko said. "A policy should pay what a policy owes, not an extra 10% to enhance business relationships."

**'It is very difficult for a policyholder to perfect a fraudulent claim because everyone looks at large claims in an insurance company.'**

David Siesko, Siesko Partners L.L.C.

And policyholders are fighting for payments, he said. In today's climate, every dollar is fought for harder than might be the case if finances were not so shaky, Mr. Siesko said, and "we are seeing much more litigation than a willingness to negotiate."

Insurer scrutiny means it is difficult for policyholders to get away with fraud, according to Mr. Gracey.

"Most (insurers) have effective anti-fraud policies," he said. "They have metrics in place to identify claims fraud."

Large commercial claims are particularly hard to sneak by, said Mr. Siesko. "It is very difficult for a policyholder to perfect a fraudulent claim because everyone looks at large claims in an insurance company," he said.

As claims increase while businesses continue to suffer in the downturn, insurers are likely to feel some heat to speed up payments, said Ms. Baker.

"In the claims arena, there is likely to be pressure on insurers to make quicker decisions on policy liability," she said. That could be difficult, Ms. Baker noted, because "there are procedures and inquiries that have to be carried out before any decision on policy liability can be taken."

But as soon as their liability is established, most insurers make funds available to policyholders, Ms. Baker pointed out. "But in a recessionary trading climate, this is likely to be requested quicker and perhaps more regularly than usual," she said.

The lag between the time a claim is filed and payment is received can be a particular hardship at a time when the company is struggling financially, which means those with ready funds are in the best shape to wait on claims payments, said Ms. Baker.

"I'm not saying that those that don't have access to cash won't survive," she said, "but these are the types of businesses that are likely to need a swift decision on liability so that interim funding can be put in place quickly. This will assist them in continuing to operate, post-loss."

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**Publishing: March 23**
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**RIMS Conference & Orlando Preview**
**Publishing: March 30**
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**BMS: Health Care Cost Control**
**Publishing: April 6**
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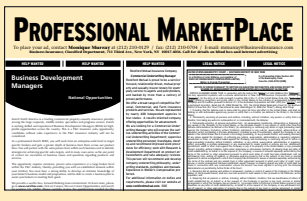


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# UP Comings & Goings CLOSE

## BRUCE MacDOUGALL

**NEW JOB TITLE:** Senior vp for Boston-based William Gallagher Associates Insurance Brokers Inc.

**PREVIOUS POSITION:** Executive vp at Wakefield, Mass.-based Mazonson L.L.C.

**GOALS FOR NEW POSITION:** I'd like to make a concerted effort to have some marketing and new business in three of our marketplaces: Boston, New York area and Washington area.

**CHALLENGES FACING THE INDUSTRY:** The classic (challenge) is figuring out how to continue to generate revenue in the face of the continued development and capabilities of alternative risk strategies—captives and retentions—as more and more business continues to flow to some kind of what we call self-insurance. That's been sort of a 20-year trend. Another challenge is working and being effective with the insurance carriers inside of a shrinking world. By that I mean the number of carriers continues to shrink, and a number of those call into question the financial quality of insurance. That's causing significant concerns on the part of consumers and brokers.

**FIRST EXPERIENCE IN THE INDUSTRY JOB MARKET:** I started at Mazonson over 24 years ago. All my insurance experience was from there. It was in a number of different areas. When I started, we were small, doing about $400,000 in revenue, which would have been about $3 million in premium. The sophistication of the product line wasn't nearly as sophisticated as it is today. There weren't nearly as many coverages as we have today. Privacy coverage, for example, didn't exist. The continued complexity of our legal system forces us to create new products.

**WHAT I WOULD CHANGE IN THE INDUSTRY:** I would say national licensing. I think that is the one, clear thing that would make an improvement. That would allow us to work across state lines more efficiently.

**ADVICE:** Insurance is a marathon. In a marathon you don't sprint all-out. You have to sustain a pace to make it through. The nature of the (insurance) business is you never make a quick hit. You make slow, steady progress. If you've been in the business only three years and you haven't met your goals, don't worry about it. It takes 10 years.

## Comings & Goings ONLINE

**VISIT** ***www.businessinsurance.com/ComingsandGoings*** for a full list of this week's personnel moves and promotions. Check our Web site daily for additional postings and sign up for the weekly e-mail.

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*Business Insurance* would like to report on senior-level changes at commercial insurance companies and service providers. Please send news and photos of recently promoted, hired or appointed senior-level executives to:

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### POSTING THIS WEEK

**BROKERS:**
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Karen Clark & Co.
Mayer Brown L.L.P.

# Products & Services

## Valiant offers D&O policy for public companies

**NEW YORK**—Valiant Insurance Group Inc., a wholly owned subsidiary of Ariel Holdings Ltd., has introduced a primary directors and officers policy for public companies with $1 billion or less in revenues.

The Safeguard management liability policy provides coverage for individuals and the entity and has several features built into the form to respond to increasing risks, the company said.

The policy offers a broad definition of claims that trigger coverage for an insured person who is at risk of being named in a lawsuit.

The representations clause includes full severability for insureds for the dishonesty exclusion and personal profit exclusion.

Limits are available up to $10 million. For more information, contact Lori Marino, senior vp-management liability, at 212-444-4019 or *lori.marino@valiantinsurance.com*.

## Baseline Management introduces cat models

**SUMMIT, N.J.**—Baseline Management Co. Inc. has introduced a set of catastrophe models for the U.S. insurance industry which can be accessed through the company's Web-based platform.

The Baseline U.S. Hurricane Model and U.S. Earthquake Model features search tools that enable users to access exposure and loss data in detail, and the program displays results through maps, satellite imaging and other analytical graphics, according to the Summit, N.J.-based natural catastrophe risk management firm.

The hurricane model was developed with Albuquerque, N.M.-based Applied Research Associates Inc. and integrates hazard and vulnerability components from the engineering and research firm's HURLOSS U.S. Hurricane Model, according to the company.

The earthquake model takes advantage of San Francisco-based URS Corp.'s expertise in the area of building codes and earthquake vulnerabilities, the company said. It also models site-specific building damage using URS's Code-Oriented Damage Assessment methodology, the company said.

Both models can be integrated with Baseline's suite of analytical products and accessed online without installing software.

For more information, contact Michael Minter, senior vp-client services at 203-524-2781 or *mminter@basemgt.com*.

## Darwin offers professional liability coverage

**FARMINGTON, Conn.**—Darwin Professional Underwriters, a member company of Allied World Assurance Holdings Ltd., has begun offering professional liability coverage for small to midsize law firms in the United States.

The admitted, standard market lawyers professional liability coverage is available to firms with fewer than 25 attorneys and annual revenues of $50,000 or more. Coverage features include several retention options including zero and aggregate retentions. In addition, the policy offers a broad definition of legal services including title agent, notary public and author or publisher of legal research articles. The broad definition of claim includes civil proceedings, administrative proceedings and requests to waive the statute of limitations, the company said. The policy offers limits up to $5 million and access to the product is available through partnerships with state coordinators.

Policyholders also will have access to Darwin's risk management programs including e-mail alerts, a risk management hot line and loss control audits, the company said.

Professional liability coverage for small to midsize law firms also is available on a surplus lines basis, with limits up to $10 million.

For more information, contact Nicole Haggerty, senior vp and directors and officers practice lead, at 860-284-1968 or *nhaggerty@darwinpro.com*.

## VSP Vision Care launches online wellness program

**RANCHO CORDOVA, Calif.**—VSP Vision Care has launched a free online wellness program to help members adopt a healthy lifestyle and control health care costs, the company said.

The GetFit program is available to VSP members and clients as well as other visitors to the company's Eyecare Discovery Center section of *www.vsp.com*.

The online program features a variety of tools and resources including an interactive diet and nutrition catalog, a calorie calculator, exercise logs and other health and fitness information. In addition, benefit managers can access a specially tailored program that can be implemented in their workplace, the company said. For more information, contact Paula Farmer, market manager, at 916-858-7545 or *paulfa@vsp.com*.

### TO SUBMIT ITEMS

***BI*'s Products & Services column reports on new product offerings. Please send Product & Services news to Colleen McCarthy, 711 Third Ave., New York, N.Y. 10017 or e-mail *cmccarthy@businessinsurance.com*.**

# **D&O:** Bankruptcies, class actions add to rising rates

CONTINUED FROM PAGE 4

at Travelers Bond & Financial Products in Hartford, Conn. "We never put the genie back in the bottle from a coverage standpoint."

Several factors are driving the market-hardening trend.

Rising corporate bankruptcies, the prospect of undiscovered major fraud cases, an accompanying rise in securities class actions and other lawsuits, and increased investigations by the Obama administration's Securities and Exchange Commission likely will continue the recent trend of more and costlier D&O claims, observers and experts said. In addition, struggling stock prices mean insurers can't rely on investment income to subsidize unprofitable underwriting.

"There's definitely starting to be a differentiation of risk," said Michael Karmilowicz, vp at Hartford Financial Products in New York. "Certain accounts are getting increases. For larger business, you're definitely seeing a flattening out of the pricing."

Still, several observers said they expect the overall D&O market to harden gradually.

"We won't have that radical change that we've had in other hard markets," Mr. Kuhn said. "Hopefully, it's going to be more of a gradual hardening of the market and not the heavy swing of the pendulum going back and forth."

Underwriters said some firms with tight budgets may drop D&O coverage.

"For a private company, they're discretionary coverages," said James P. Bronner, a Warren, N.J.-based chief underwriter officer and senior vp at Chubb Specialty Insurance. "They have to buy an auto policy. They have to buy a property contract. They need to buy a general liability and workers comp policy, but they don't have to buy D&O. And it's unfortunate, but we do run the risk of seeing that dynamic where, because of the underlying economic fundamentals facing these firms, they're going to have to make those decisions (whether to maintain D&O coverage)."

The market has not yet seen a significant flight of capacity, but capacity is expected to contract as losses get costlier and the environment becomes more unfavorable for underwriters, Mr. Bronner said.

"Unfortunately, carriers tend to look at results in the rear-view mirror…as opposed to forecasting how the environment is going to play out going forward," Mr. Bronner said.

"I think a lot of (D&O) carriers are certainly asking the question—maybe not answering it, but asking the question—about the longevity and viability of (underwriting) the financial services sector," Mr. Bronner said.

## 1,200 attend PLUS' D&O Symposium

**NEW YORK**—About 1,200 people attended the Professional Liability Underwriting Society's D&O Symposium in New York on Feb. 25-26.

The event included sessions on securities litigation, bankruptcies, the D&O claims process and coverage for companies with international operations.

Next year's symposium will take place Feb. 3-4 in New York.

## Make sure D&O cover can withstand 'storm'

**NEW YORK**—Risk managers need to ensure that their directors and officers liability insurance policies are adequate now, because a rash of bankruptcies and stepped-up enforcement by the Securities and Exchange Commission will test those policies in 2009, underwriters and attorneys say.

"The storm is coming," Randall W. Bodner, a partner and head of the securities litigation practice at Boston-based Ropes & Gray L.L.P., told attendees at the Professional Liability Underwriting Society's D&O Symposium in New York on Feb. 25-26. "It's not even fully here and you better make sure your coverage is in the right place."

After an estimated 41,200 bankruptcies in 2008, credit insurance firm Paris-based Euler Hermes forecasts 62,000 bankruptcies in 2009. Mr. Bodner said the full extent of bankruptcies has not even begun to show.

"For brokers out there or people who are risk managers advising the company, now is the time to make sure your D&O policies are stress-tested for bankruptcy," he said. "If you wait until the company is approaching…insolvency, then you've waited until the first moment it's too late to do anything. Because you're either going to pay extortionist fees…to get the coverage or you're not going to get it."

A rise in bankruptcies, especially large public bankruptcies, tends to mean a rise in securities class action lawsuits. More than three-quarters of large public companies filing for bankruptcy in 2007 and 2008 also were named in securities class action suits, according to New York-based Advisen Ltd. Such lawsuits often generate large D&O claims.

Lawyers said that in today's environment, D&O policies can be exhausted when they're hit with several related actions at the same time. In addition to securities litigation, employees can sue under the Employee Retirement Income Security Act if the company loses its retirement savings, and shareholders can bring a derivative suit against a third party, often directors and officers, for damaging the company.

"You get hit with a derivatives suit and a class action and an ERISA suit and you've got five different defense firms. And suddenly it isn't just the class action; it's all of this wrapped up together that hits one policy," said Denise Amantea, senior vp at San Francisco-based consulting firm Woodruff Sawyer & Co. and a former securities defense attorney.

Observers at the conference said they expected the SEC to conduct more frequent and more thorough investigations under the Obama administration, which will exacerbate the escalating cost of mounting a legal defense. Unlike civil litigation, where limits on the discovery phase or a motion to dismiss can reduce the amount of legal work, companies facing inquiries by the SEC essentially must do whatever the regulator asks, attorneys at the conference said. Searching through e-mails and other electronic data is especially important in government investigations, Mr. Bodner said, and especially expensive.

"Electronic discovery has just changed the landscape and I think probably you could track the costs of defense in D&O" with electronic discovery, he said. "I've had three hedge funds that…the document production and copying costs—and I know this will surprise people—have blown through $20 (million) to $25 million in coverage for those policies, just in an SEC investigation. This is not typical, but this is what can happen."

The SEC "can impose incredibly onerous and expensive…obligations to your company," he said.

It's not clear that many of these costs are even covered by a typical D&O policy. Some companies may want SEC investigations specifically included in their D&O coverage, while other parties, such as outside directors, may not want the cost incurred by the corporation responding to an SEC investigation to erode their own D&O coverage. And it varies by policy whether the D&O cover extends to informal SEC investigations, the agency's initial inquiries before an investigation is launched or inquiries in which the company is not a target. But all those cases necessitate a significant amount of legal work, attorneys say.

"The millions in attorneys fees that are piling up is staggering long before there is a trigger of coverage, given the standard coverage in the policy, which requires a formal proceeding or subpoena," Ms. Amantea said.

Ms. Amantea and others said D&O insurers sometimes credit a policyholder for legal expenses to mitigate a problem that could have become more expensive later, even if the expenses were incurred before a trigger of coverage.

*—By Zack Phillips*

# **Security:** Worries increase about threat of insider-aided data breaches

CONTINUED FROM PAGE 4

Lapidus said.

A study that Ponemon Institute L.L.C. released last month found that more than 88% of all data breaches involved insider negligence, while the remaining 12% were the result of a malicious act. The study also found that the cost of data breaches to companies rose in 2008 to an average $202 per record compromised, up 2.5% from 2007 and 11% from 2006.

According to Traverse City, Mich.-based Ponemon, "the investment required to prevent a data breach is dwarfed by the resulting costs of a breach." While the external hacker is something companies have learned to better defend, the internal data breach threat is growing.

Insiders gain access to the data through lax controls and monitoring of network systems, a direct effect of cutbacks in security software and information technology support staff, Mr. Brill and other cyber risk analysts say.

"The ability to stop an insider who has access is not really practical," said Mike Rothman, senior vp of strategy with Acton, Mass.-based IT consultant eIQnetworks Inc. "The tools have been put in place to monitor (systems), but I think that IT workers have such a long list of activities to do on a daily basis…you can overlook the monitoring when you have other tangible projects that people are waiting for action on."

Software programs capable of sweeping systems for irregular data flows are available, Mr. Rothman said. It is becoming more "critical" to run automated network scans as companies cut back on data security staffing, he said.

But the attacks are becoming more complicated and intelligent, cyber risk specialists say.

Alex Horan, director of product management for Boston-based Core Security Technologies, said hackers are using "more talented" malware—or malicious software—than in the past and that the attacks have gone beyond the viral e-mail or embedded link to what appear to be safe software downloads.

In a data breach at Princeton, N.J.-based Heartland Payment Systems Inc., investigators uncovered the breach in January but found that malware had been installed more than a year earlier, according to statements by Heartland executives.

The malware was specifically designed to take certain information and was relatively undetectable. Heartland executives said they did not know how the malware was installed or how much data was taken from the payroll processing operation.

"It's an attacker knowing the organization and the type of data it holds," Mr. Horan said. "(The hacker) is not sending out a billion e-mails hoping that someone will click on the e-mail. It's now a more targeted approach."

Mr. Brill agreed, adding that malware is becoming more specialized and, in most cases, is undetectable by the software that fights malware as it is something software companies have not seen before and cannot defend against.

Network security, especially for organizations that use a third party to manage databases, is becoming more important to companies, said Mark Steinhoff, New York-based a principal in Deloitte & Touche L.L.P.'s security and privacy practice. Deloitte recently surveyed global top 100 financial institutions, banks and insurers and found that 36% of the respondents were more concerned with internal breaches, while 35% of all respondents were concerned with internal and external breach threats.

"When you look at what organizations are most concerned about, it's both the internal and external threat," Mr. Steinhoff said. "The insider threat is getting more attention, but the tools to protect against it are still evolving."

The recent attention surrounding data breaches is puzzling to Kevin P. Kalinich, Chicago-based co-national managing director of Aon Corp.'s financial services group for professional risks. "There have always been data breaches," but recent developments in state and federal laws that require data breaches be made public have generated more attention and the incorrect belief that data breaches are rising, he said.

Mr. Kalinich said studies have shown that "people feel less guilty about taking electronic data" than hard copy files and data breaches may, indeed, increase.

"Organizations have to be aware of economic turmoil and specifically its effects on their employees," advised Tracey Vispoli, vp and manager for the financial fidelity and cyber solutions unit at Warren, N.J.-based Chubb Group of Insurance Cos.

"I think people need to be more worried about (internal data breaches) than in the past. The trends are changing and essentially you have a workforce that is more disgruntled and more upset than in years past, and I think that is something that will be a looming issue in the years ahead," she said.

# Devices: Pre-emption opponents work to overturn court ruling

CONTINUED FROM PAGE 4

with state and local requirements concerning medical devices "shall be construed to modify or otherwise affect any action for damages or the liability under the law of any state."

Supporters say changed political circumstances favor their cause.

"The odds are better this year because there's a different administration," said Allison Zieve, senior attorney at Public Citizen in Washington. She said the Bush administration reversed a longtime federal view that federal device laws did not pre-empt damage claims under state law.

But times have changed. Both houses of Congress have larger Democratic majorities and, Ms. Zieve pointed out, then-Sen. Barack Obama, D-Ill., "was a co-sponsor of the act when it was introduced in the Senate last July."

"Consumers' ability to hold manufacturers accountable for injuries caused by their products is important because it is the sole means consumers have of getting compensation for their injuries," Ms. Zieve said. "The existence of state tort law provides a powerful incentive for companies to make their products as safe as they can be and to improve their products as soon as they become aware that the design or labeling is inadequate."

**'We feel that those FDA experts are in a better position to determine the safety and efficacy of a device than a lay jury.'**

Mark Leahey
Medical Device Manufacturers Assn.

The president of a group of medical device makers said there is no blanket pre-emption for such devices, which undergo exhaustive scrutiny.

Products that go through the FDA's premarket approval process undergo clinical trials and generate "an extraordinary amount of data that is exhaustively reviewed by scientists and others," said Mark Leahey, president and chief executive officer of the Medical Device Manufacturers Assn. in Washington. "We feel that those FDA experts are in a better position to determine the safety and efficacy of a device than a lay jury," he said.

"It's looking to trump the highest court in the land, who ruled that federal law trumps state law in medical device cases," said Anthony Wisniewski, executive director-health care policy for the U.S. Chamber of Commerce in Washington. "This is a direct shot over the bow of *Riegel vs. Medtronic*."

Mr. Wisniewski said if the measure became law, there could be 50 different state standards. "There needs to be one FDA and one FDA only. They are the gold standard in approving medical devices," he said. "Congress should be focusing a lot more on trying to promote medical innovation in this country."

## Judge throws out suit against Marsh Inc.

By SALLY ROBERTS

**WEST PALM BEACH, Fla.**—A federal district court judge has dismissed a breach-of-contract lawsuit against Marsh Inc. brought by a Florida client that said the broker failed to obtain the correct windstorm coverage.

Tiara Condominium Assn. Inc. said it thought it had purchased windstorm coverage from Citizens Property Insurance Corp. through Marsh with a per-occurrence limit of about $50 million, but after suffering damages from Hurricanes Frances and Jeanne in 2004, Citizens said it was responsible for only one aggregate limit. Tiara sued Citizens and the two settled the litigation for $89 million—about $10 million less than Tiara would have been entitled to under its own interpretation of its insurance policy, court papers say.

Tiara then sued Marsh in 2007, alleging the broker breached its contract by failing to procure the correct per-occurrence insurance policy.

Earlier this month, a judge for the U.S. District Court for the Southern District of Florida granted Marsh's motion for summary judgment ruling that the insurance policy in question contained a per-occurrence limit, as Tiara had directed and as a result, Marsh did not breach its duty of care regarding its conduct or its representation to Tiara or its fiduciary duty as Tiara's insurance broker.

## ADVERTISER INDEX

**Issue of March 16**

# Gulf: Risk managers renewing earlier as capacity tightens, prices rise

CONTINUED FROM PAGE 1

reduce Gulf of Mexico market capacity—by 30%, according to Willis' forecast—and several insurers, including Lloyd's specialist insurer Advent Capital (Holdings) P.L.C., already have said they plan to reduce capacity or leave that market altogether.

As capacity shrinks, some risk managers are moving up their renewals, some are seeking extensions on their existing policies and some are starting negotiations earlier, brokers and underwriters say. This is especially true for companies with a gap in their windstorm program because an insurer is reducing its capacity or dropping Gulf of Mexico business, said Axel Brohm, the Zurich-based head of energy and power for Swiss Reinsurance Co.

"They come early to gauge what can they have; what will it cost; what will it entail?" Mr. Brohm said. "Then they can discuss with their own internal decision-makers, like the board of directors."

### *Retentions also increase*

Such decisions are perhaps more complicated this year for energy companies, especially in the Gulf of Mexico, where insurers are asking for dramatic increases in pricing and retention levels. Willis' March 3 energy market review said one large Lloyd's syndicate is approaching 2009 renewals with the conviction that it must double its premium income and quadruple the level of risk retained by the buyer compared with last year.

Insurers say this is necessary because of the paucity of investment income to subsidize underwriting and because of heavy losses in 2008. Of $7 billion in damage from Hurricane Ike, about $3 billion was absorbed by insurers, compared with about $900 million in global premium income last year for the Gulf of Mexico market, according to Willis' report.

"We believe strongly that the situation in Gulf of Mexico windstorm cannot be purely dealt with (through) an increase in premium," Watkins Syndicate's Mr. Hoare said. "We have to restructure the product (so) the event of a windstorm loss in 2009 will not have the same impact as 2008. We have to move the entire product higher up so it responds more to a 'Super Ike.' It would still respond to an Ike event, just not to the same extent."

### *Some may self-insure*

The Willis report says under retention levels insurers are seeking, a small exploration and production company owning a single, $70 million platform could end up absorbing 75% of the risk, after higher deductibles and reduced limits, despite higher premiums.

"I think if the average retention last year was, let's call it 2% of exposed asset value, we're now going to see it in the 4% to 5% range of exposed asset value," said Michael Garrison, senior vp at New York-based Starr Technical Risks Agency Inc., a unit of C.V. Starr & Co. Inc.

Swiss Re's Mr. Brohm and others say some energy companies may refuse to buy cover at the price and terms insurers are offering, and self-insure or adopt other alternative means of transferring the risk.

Mr. Hoare said he suspects one or two large energy companies will self-insure some or all of their assets this year, although he said the indications so far are that the companies will be buying some cover. "They may be buying less or may be buying (cover for) selective assets, but they are buying some form of wind cover in the Gulf of Mexico," he said. "People are making sure every dollar of premium is used to insure their key assets."

Brokers and underwriters say shareholders, capital providers and the terms of a company's debt may restrict its ability to eschew insurance. On the other hand, Willis' report points out that 25% of upstream energy insurers' global premium comes from the Gulf of Mexico, so insurers may find it difficult to walk away if they cannot get the desired terms.

Willis' report says this might be an advantage for insurance buyers who shop later in the year because insurers may be less resolute in seeking higher rates and retentions if they feel pressure to secure premiums to help pay for reinsurance. Large marine and energy insurance programs without Gulf of Mexico exposure were seeing an average of 10% price increases at Jan. 1 reinsurance renewals, according to the Willis report.

Excluding the Gulf of Mexico, worldwide capacity in the energy insurance market actually has increased 5% over 2008. But Willis' Mr. Garner said that figure likely reflects last summer's soaring asset values, which attracted new capacity. Because of a time lag, that does not reflect the subsequent liquidity crisis and Hurricane Ike, which eroded insurers' asset values and capital. He said he expects capacity in the global energy market to decline next year.

TOP 10 INSURED LOSSES

*Windstorms produced nine of the 10 costliest insured losses from 1999-2008, in billions of dollars*

| EVENT | INSURED LOSS | YEAR |
|---|---|---|
| Hurricane Katrina | $68.52 | 2005 |
| Sept. 11 attacks | 23.65 | 2001 |
| Hurricane Ike | 15.00 | 2008 |
| Hurricane Ivan | 14.12 | 2004 |
| Hurricane Wilma | 13.34 | 2005 |
| Hurricane Rita | 10.70 | 2005 |
| Hurricane Charley | 8.84 | 2004 |
| Winter Storm Lothar | 7.22 | 1999 |
| Winter Storm Kyrill | 6.10 | 2007 |
| Hurricane Frances | 5.65 | 2004 |

*Source: Energy Market Review 2009 from Swiss Reinsurance Co., Munich Reinsurance Co., Willis Group Holdings Ltd.*

# Stringfellow: Ruling focuses on sudden, accidental pollution clauses

CONTINUED FROM PAGE 1

fornia Supreme Court also held that when applying a sudden and accidental pollution coverage clause, the relevant event is the release of pollutants from the site, not the discharge of pollutants onto the site.

While the high court's holding is significant in that it reverses lower court rulings in the state, the number of pollution cases involving CGL policies that cover sudden and accidental pollution have dwindled since the absolute pollution exclusion was introduced in 1986, attorneys say.

### *Case dates back to 1956*

The coverage litigation stems from the state's operation of the Stringfellow hazardous waste site for 16 years, beginning in 1956. The state closed the site to new deposits in 1972 after the discovery of groundwater contamination.

In 1998, a federal judge determined that the state of California was 100% liable for environmental damage the site caused, because the state had negligently designed and operated the site. Environmental contamination occurred when pollutants leaked into groundwater, when heavy rains washed waste into the environment and when a deteriorating dam wall at the site forced the state to release 1 million gallons of contaminants to prevent the dam from collapsing.



Between 1972 and 1978, the state purchased comprehensive general liability coverage from 24 insurers. The policies contained pollution exclusions, with exceptions for sudden and accidental pollution incidents.

Last week's decision involved four of the state's excess CGL insurers: Allstate Insurance Co., Century Indemnity Co., Columbia Casualty Co. and Westport Insurance Corp.

The insurers denied coverage, citing their policies' pollution exclusions. A trial court initially granted them summary judgment.

In upholding the appeals court reversal, the state Supreme Court ruled, among other things, that the state's inability to delineate covered and excluded damages does not preclude coverage.

"If the insured proves that multiple acts or events have concurred causing a single injury or an indivisible amount of property damage…the insured's inability to allocate the damages by cause does not excuse the insurer from its duty to indemnify," the court wrote in its unanimous decision.

It is up to the insurer to present evidence that the damages are divisible and that "only a limited portion of them resulted from covered events," the court said.

The high court also upheld the appeals court in determining the relevant sudden and accidental event that triggers coverage.

The insurers argued that the initial disposals of the waste into the unlined ponds were the relevant discharge and were neither sudden nor accidental. The high court, however, ruled that because the basis for the state's liability was the escape of pollutants into the environment from contaminated ponds on the site, the release of the wastes after they had been deposited was the "relevant discharge."

Policyholder attorneys welcomed the ruling.

"Any policyholder in California or any policyholder whose policy is governed by California law that is interested in trying to tap coverage for environmental cleanup costs really has reason to hope that they will be able to get coverage," said Robert M. Horkovich, an attorney with Anderson Kill & Olick P.C., who represented California in the case.

Prior to the ruling, "if a policyholder couldn't prove the precise amount of covered damages, it got nothing" in terms of insurance, said David B. Goodwin, a policyholder attorney at Covington & Burling L.L.P. in San Francisco. The issue "comes up all the time" in insurance recovery cases and the ruling will go "way beyond the pollution context" to other liability claims as well, such as directors and officers liability and errors and omissions liability cases, he said.

"When all is said and done, the legacy of this case will be the burden of proof and allocation," said Randy Maniloff, an insurer attorney with White & Williams L.L.P. in Philadelphia. "The sudden and accidental pollution exclusion is a dodo bird of a coverage issue—it is on the road to extinction," he said. "But the burden of proof aspect will be around for a long time and will be important in all types of cases—whether they involve pollution or otherwise," he said.

Laura A. Foggan, an insurer attorney with Wiley Rein L.L.P., however, remains cautious about the decision's overall impact describing the decision as being "grounded in its own facts."

The court's holdings "are crafted to the facts of what took place, the selection of the site, the intent to confine at the site and these… unusual rainfall events. All of those facts aren't likely to carry over generally. So we don't know how big of an opinion this really is."

STRINGFELLOW, BY THE NUMBERS:

**34 MILLION:** Approximate gallons of toxic chemicals dumped at the site from 1956 through 1972

**20:** Inches of rain that fell in March 1969, causing ponds to overflow and sending polluted water down a canyon

**1972:** Year groundwater contamination was discovered

**100:** Percentage of California's liability for environmental damage from its negligent operation of the site

**$700 MILLION:** Expected cost to remediate the site

**24:** Number of insurers from which the state purchased comprehensive general liability coverage between 1972 and 1978

**19:** Number of insurers from which California has recovered to date

**$121 MILLION:** Value of insurance California has recovered to date

# **Retention:** Keep old records

CONTINUED FROM PAGE 1

"I think it's a big problem for most companies," said Curtis D. Porterfield, a partner with Howrey L.L.P. in Los Angeles. "The biggest problem I see with corporate insureds is that they don't hang on to their policies, or they don't keep them organized. The risk management department is pretty much occupied with trying to place their coverage, and they're not necessarily maintaining that big picture of their insurance portfolio."

In a perfect world, insurance policies would be kept "forever, undoubtedly," said Jerrold Oshinsky, a partner with Gilbert Oshinsky L.L.P. in Washington. "The prudent thing to do would be to never dispose of a policy. Best practices would be to treat your insurance articles as valuable assets and not subject to any document destruction program."

Robert N. Lane, chief legal counsel and senior vp at Willis (Bermuda) Ltd., agreed that best practices would dictate a document retention policy that keeps insurance policies indefinitely. However, he also noted that for businesses that choose not to keep every policy, some are more disposable than others.

"If you cancel (a claims-reported policy) and you've never put any notice of claims under that policy, then you don't have access after the policy expires," Mr. Lane said. "It's our recommendation that clients maintain copies of their policies no matter what, but there are varying levels" of importance.

The decision to keep policies indefinitely is easy to make; actually retaining them in an accessible way can be more difficult. On top of the direct threats to insurance records—fires, floods and movers, for example—complex corporate histories can make it difficult to sort out what policies still are of value.

"There are so many mergers and acquisitions; it's very rare in today's world that the descendent company has been in the same corporate structure from the beginning," said Jill Berkeley, a Chicago-based partner with Howrey and co-chair of the firm's national insurance recovery group. That flurry of mergers and acquisitions can scatter a businesses' insurance record.

The growth of electronic media has made policy retention a bit easier, even amid corporate turmoil.

"People would be crazy not to have electronic documents today," Ms. Berkeley said. "It's not always a substitute—just because it's in electronic form doesn't mean you won't lose it—but so many things can happen to paper, at some point, the electronic copy may be the only copy you have."

As electronic storage has become the norm, more businesses have used it to secure policies. "We retain all of our insurance policies indefinitely and for approximately the past eight years have been making copies of policies and storing them on our (risk management information system) database," said W. David Little, senior vp, risk management, with Hilton Hotels Corp. in Beverly Hills, Calif.

A further advantage of electronic documents is ease of sorting, indexing and searching—a necessary function, given the complexity of many insurance portfolios.

"There's not always the right assumption about what policy you're looking for," Ms. Berkeley said. "If you have a claim that could be covered by a (commercial general liability) policy or a professional liability policy, for example, you have to know which policy you have to make notice on first. If you give notice to the CGL carrier and it doesn't get around to reserving its rights right away, and you wait for them before giving notice to the other insurers, you could find yourself in a late notice situation."

Phillip Lucas, director of global product management with Aon eSolutions Group in Marietta, Ga., advises making that kind of database functionality a deliberate part of electronic document storage. "When you've put the electronic copy in, you're still not necessarily in a situation where you can sort and find information," Mr. Lucas said. "Another step is to get it into a database structure that you can search. What hazards are covered, what are the limits?"

Ultimately, most experts agree that while there is no such thing as a one-size-fits-all document retention program, maintaining a thorough corporate insurance history is a significant but worthwhile commitment of time and resources.

"I just think people have to be proactive in terms of collecting data and understanding how their past insurance coverage worked," Mr. Oshinsky said. "I would be inclined to suggest to a client that they start tracking down their historical coverages if they think there are gaps."

# Ways to track down an old insurance policy

**By NICK WHITFIELD**

If a business cannot locate its original insurance policy documents, there still are options to win a policy dispute.

Courts place the burden of proving a policy's existence on the policyholder, meaning a would-be claimant has to produce prima facie evidence of a policy. Obviously, the policy itself is ideal, but several other forms of evidence can be used to meet that burden.

"Every jurisdiction has its own rules about how you prove up documents, but it's a preponderance-of-evidence standard," said Jill Berkeley, a Chicago-based partner with Howrey L.L.P. and co-chair of the firm's national insurance recovery practice.

"I'm sure they exist, but I can't think of a single case, in 30 years of my experience, where we didn't find some evidence of coverage," said Jerrold Oshinsky, a partner with Gilbert Oshinsky L.L.P. in Washington.

There are several places to begin a search, either for long-lost policy documents or for secondary evidence to establish a policy's existence, placement and terms.

"First off, I do a historical analysis of all the people who have had that (insurance buying) position and start interviewing them," Mr. Oshinsky said. "One client of mine called a retired risk manager, and he had a box sitting in his house with all of their old policies. You just never know."

Brokers, who generally retain copies of the policies they place, are another potential source of missing documentation. Brokers, however, are not required to keep policies indefinitely.

"We, as brokers, may maintain documents longer for one client than for another, per agreements with the client," said Robert N. Lane, senior counsel and executive vp with Willis (Bermuda) Ltd.

Even if the policy itself cannot be found, the policyholder's burden can sometimes be pieced together through a variety of secondary evidence.

Accounting records often include payments to insurers, which can establish which carrier issued the policy, when the policy was in effect and, in some cases, a policy number. "If a check has one of a carrier's policy numbers on it, that can shift the burden back to the carrier," said Curtis D. Porterfield, a partner with Howrey in Los Angeles.

Records of other claims activity from the relevant period also can offer a clue as to what carrier handled a company's risks at the time. "Find out if your company has ever been sued," said Mr. Oshinsky. "Find out who the lawyers were, and who paid their bills. That might give you the name of the carrier."

Workers compensation records also can be valuable. Because they generally are maintained by the state, these records have the added advantage of not being subject to the vagaries of corporate recordkeeping.

"There's a good chance that whoever was carrying your workers comp coverage in the '60s, for example, was also your liability carrier," Mr. Oshinsky said.

Another potential source of policy information is the London insurance market. Many London brokers have detailed recordkeeping practices, Mr. Oshinsky said, and still might have records that no longer can be found in the United States.

Once a policy's placement is known, the next step is to establish the policy's terms.

For standard-form general liability policies, a policyholder may only need to prove what carrier issued the policy, its limits and the policy period, Mr. Porterfield said. Depending on the circumstances of the case, that may be enough to place a burden on the carrier to prove the policy in effect included any exemption that was not part of the standard form.

There is a small industry of insurance archaeologists—professionals who make a living piecing together fractured insurance histories.

"You can look to an archaeological firm to recreate what happened and what the policy said, and there are good firms out there that do that," Mr. Lane said, "but it's expensive."

"There's always a fairly decent chance," said Michele G. Piero, executive vp of Insurance Archaeology Group, a New York-based insurance archaeology firm. "A lot of it depends, obviously, on the record-keeping practices of the company, but there are outside sources, too. If a company doesn't have records, but they're in a business where they've always had a lot of claims, for example, then they might have a good paper trail anyway."

## FINDING THAT POLICY

*Alternative sources to establish historical insurance coverage:*

- Other departments in-house. The accounting department still might have ledgers detailing premium payments on the policy in question. The corporate records department may have insurance policies stored alongside other valuable corporate documents.
- Past claims and lawsuits that may have invoked the same policy.
- Workers compensation claims from the same period. In some cases, the carrier that handled workers compensation cases at the time also may have handled liability claims.
- If a company worked with a government agency or a railroad during the period in question, those entities might have required and retained proof of insurance.
- The London insurance market. If a company purchased excess coverage in the London market, records may exist there that no longer exist in the United States.
- Standard policy forms from the same carrier in the same period. If it can be established that a policy was in effect at the time, the carrier might then have a burden to prove that the coverage was somehow different from the standard form.
- Excess policies from the same period may disclose the underlying coverage.
- Reinsurance carriers sometimes have records that policyholders and base insurance carriers have lost. Getting those records, however, may require formal discovery.

# **Mandate:** Appeals court declines to review San Fran health care law

CONTINUED FROM PAGE 3

Kevin Westlye, executive director of the Golden Gate Restaurant Assn., says the group intends to seek a Supreme Court review of the case.

Legal experts say it is likely the Supreme Court will take up the case because the ruling has created a split at the appeals court level—in 2006, the 4th U.S. Circuit Court of Appeals ruled that a Maryland health care spending law was preempted by ERISA.

In addition, experts say, a Supreme Court review is likely given the huge impact the San Francisco ruling would have on corporate benefit plans.

"Given that there is a conflict in the courts and that this clearly is a case of national importance, one would think that the Supreme Court will take it up," said Kathryn Wilber, senior counsel-health policy, with the American Benefits Council in Washington.

It is the potential of a proliferation of similar laws that most concerns national employers. It would be incredibly difficult for employers to track, let alone administer, what could become a maze of spending laws, experts say.

"If ERISA pre-emption means anything, it should be that employers shouldn't have to analyze and comply with benefit laws that could pop up in every nook and cranny of the country," said Andy Anderson, of counsel with Morgan, Lewis & Bockius L.L.P. in Chicago.

For employers that meet the $1.85 per hour spending mandate, the only direct impact is the ordinance's reporting requirements.

But many employers don't meet the spending requirement. Few employers provide health care coverage to employees working as little as eight hours a week—the trigger for the mandate.

In addition, the law generally requires a spending contribution even for those employees who have rejected coverage from their employers in favor of being covered under a spouse's group health care plan.

Employers not meeting the spending requirements have taken a variety of approaches. Some have found that the easiest action is just to pay the required contribution to San Francisco, said Rich Stover, a principal with Buck Consultants L.L.C. in Secaucus, N.J.

Other employers have established health reimbursement arrangements for affected employees. With that approach, employers have assurance that their contributions are being used to pay for their own employees' health care expenses rather than going to a city fund, Mr. Anderson said.

# News In Brief

CONTINUED FROM PAGE 1

increase of 15%, according to the commission. The EEOC said while all major categories of filings increased, charges based on age and retaliation saw the largest annual increases, and allegations based on race, sex and retaliation continued as the most frequently filed charges. The EEOC said the surge may be because of multiple factors including economic conditions, increased diversity and demographic shifts in the workforce, employees' greater awareness of the law, the EEOC's focus on systemic litigation and changes to its procedures used to accept complaints.

## Feds keeping watch on AIG spending: Bernanke

The federal government is keeping a close eye on American International Group Inc.'s expenditures, Federal Reserve Board Chairman Ben Bernanke said in a letter last week to Sen. John Kerry, D-Mass. Responding to a letter sent by Sen. Kerry in October, Mr. Bernanke wrote: "We routinely make our views known on key issues...We have also pressed the company to ensure that robust corporate governance surrounds all compensation claims....We believe it is in the taxpayers' interest for AIG to provide reasonable, market-based compensation with a view toward attracting and training qualified staff in order to maintain the value of the businesses that AIG is seeking to sell in order to repay the federal financial assistance it has received."

## Pension funding levels plunge in 2008: Report

A Watson Wyatt Worldwide analysis of financial statements filed by sponsors of the 100 largest pension plans found that the plans, on average, were 75% funded at the end of 2008, a big drop from 2007 when the plans were 103% funded on average. While 80% of plan sponsors had pension programs at the end of 2007 that were more than 90% funded, only 14% of sponsors reported that their plans were more than 90% funded by the end of 2008. In all, the plans had a $217 billion deficit at the end of 2008. That marked a huge change from the end of 2007, when the plans had a surplus of $86 billion, according to the analysis.

## Brit plans move to Netherlands

Brit Insurance Holdings P.L.C. said last week it will relocate its group holding company to the Netherlands. Brit Insurance's relocation will help the company grow, the insurer said, citing the Netherlands' European Union membership and strong financial services sector.

## Bill would ease union formation

Democrats in the U.S. House and Senate introduced legislation last week that would make it easier for employees to form unions. The Employee Free Choice Act, H.R. 1409, would substantially change existing law by allowing workers to organize when a majority sign cards opting to unionize. Currently, employers can insist on secret ballots overseen by the National Labor Relations Board before they recognize a union.

## S&P upgrades SCOR to A

Standard & Poor's Corp. has upgraded the financial strength rating of Paris-based reinsurer SCOR S.E. and its core subsidiaries to A from A-. S&P added that its outlook on SCOR is stable and that the upgrade reflects a positive trend in SCOR's nonlife underwriting performance and reduced risk profile. "The ratings also reflect our view of SCOR's strong competitive position, strong capitalization, strong liquidity and invested asset quality, and commitment to building a strong enterprise risk management program," Mark Coleman, S&P credit analyst, said in a statement.

## Noted

A Vermont federal judge has sentenced Kenneth MacKay, a former senior vp of **Willis Group Holdings Ltd.**'s Vermont-based captive management operations, to nearly six years in prison for stealing more than $5 million from Willis and its clients....**Assurant Employee Benefits**, a provider of life, disability and dental group employee benefits, has named John S. Roberts as president and CEO, effective March 15. Mr. Roberts had held the posts on an interim basis since July 2007....Small captive insurance companies set up in **Montana** and subject to the state's $5,000 minimum premium tax would have the assessment prorated during the year the captive was licensed under legislation that received final approval last week.

# Libel: Employers 'entitled to protection'

CONTINUED FROM PAGE 3

In last week's amicus brief, media organizations argued that allowing the ruling to stand "will increase the length, cost and risk of litigation for libel defendants," could have a chilling effect on journalistic freedom and "will work a significant and unfortunate change in modern libel law." The brief seeks either a rehearing by the full appeals court or transferring the case to the Massachusetts Supreme Judicial Court, the state's highest court.

In a footnote, the appeals court ruling says the Massachusetts law does not apply to "matters of public concern." But "the question is really, who is going to decide?" whether an issue is one of public concern, said Robert A. Bertsche, an attorney with Prince, Lobel, Glovsky & Tye L.L.P. in Boston, who filed the brief on behalf of media organizations that include the New York Times and Washington Post. "A person who feels disparaged by something in the press can sue" and set up a situation where a jury is "exercising editorial judgment," he said.

"That the case arises in the employment context does not take it outside the realm of the First Amendment," says the media organizations' brief. "Whether the employer's speech is deemed to be of public or merely private concern, it remains entitled to constitutional protection, and the government has an interest in shielding it from infringement."

"It is fundamental under the freedom of speech guaranteed by the First Amendment that true statements of fact are absolutely protected from defamation liability," said Charles S. Sims, an attorney with Proskauer Rose L.L.P. in New York.

The decision is "bizarre" in its failure to address the constitutional issue, said Jonathan D. Hart, an attorney with Dow Lohnes P.L.L.C. in Washington. "It is out of step with the last 45 years of libel decisions in the United States. My hope is that this is just an aberration that will be short-lived" and overturned.



"When courts visit a dusty old corner (of state law), it's the court's job to clean it up and not give it new life," said Mr. Feigelson. "The clear trend in modern law is that a true statement can't be libelous."

States that have laws similar to Massachusetts are Arkansas, Delaware, Florida, Illinois, Nebraska, Nevada, Rhode Island, South Dakota, West Virginia and Wyoming and all the laws are quite old, Mr. Feigelson said.

As for employers, the ruling "certainly creates a great deal of uncertainty" about how statements made by companies about employees will be treated under the law, said David Heller, senior staff attorney at the Media Law Resource Center Inc. in New York, one of the amicus brief parties.

It leaves employers "in an absolute conundrum if even truthful statements can give rise to defamation liability" and could become a part of the increased litigation expected as part of this economic downturn, said Bruce E.H. Johnson, an attorney with Davis Wright Tremaine L.L.P. in Seattle.

"The risk is that on very, very thin evidence of bad intent on the part of the employer…you have to take these cases to juries, and that's generally a dangerous place for an employer to be in the case against an individual employee," Mr. Feigelson said.

Wendy Sibbison, Mr. Noonan's Greenfield, Mass.-based attorney, said "the flap" raised by the case "is way out of proportion to the very small significance of the 1st Circuit opinion. This case involves a private individual suing a private company for defamation on an issue of private concern. It does not implicate the First Amendment," she said.

"Moreover, the 1st Circuit is discussing a rather unusual statute, which has been in Massachusetts for over 100 years, with no known impact on the media. It's been sitting there bothering no one and chilling no one," said Ms. Sibbison, an appellate litigation specialist.

A Staples attorney had no comment.

*Alan S. Noonan vs. Staples Inc.; 1st U.S. Circuit Court of Appeals No. 07-2159; Feb. 13, 2009.*

# Private equity-backed purchases fall

## *S&P: Economies of scale driving buyouts of brokers*

By JEFF CASALE

The private equity-funded acquisitions of brokerages of recent years are coming to a halt, which is opening the door to deals by global insurance brokers, according to a report by Standard & Poor's Corp.

In its report, S&P said private equity cash flows are drying up due to the economic downturn, which is dampening brokers' ability to execute leveraged buyouts like they did in 2007 when private equity firms funded the acquisitions of USI Holdings Corp., Hub International Ltd. and Crump Group Inc. Instead, S&P said global insurance brokers such as Aon Corp., Marsh & McLennan Cos. Inc. and Willis Group Holdings Ltd. now are in a financial position to acquire smaller brokerages.

"The era of private equity-leveraged buyouts in the insurance broker sector is overdue to a fundamental shift in debt market and broker industry fundamentals," S&P wrote, adding that private equity acquisitions are predicated on cheap debt and strong cash flow. "As such, we expect that future acquisitions will be predicated on larger brokers acquiring smaller brokers with the goal of enhanced economies of scale," S&P said.

Global brokerages have had to deal with the "competitive disadvantage" of forgoing contingent commissions, which S&P said limited them in being able to pursue acquisitions as they were forced to find other ways of replacing the lost revenue.

However, in May 2008, the New York attorney general amended the agreement with Aon, Marsh and Willis to allow the brokerages to accept contingent commissions on acquired business for up to three years. This development "has significantly narrowed the competitive gap for the global broker" in regard to their appetite for acquisitions, S&P said.

*For S&P RatingsDirect members, the report, "Big Insurance Brokers Step Up While Private Equity Steps Out of he Acquisition Game," is available at www.ratingsdirect.com. Nonmembers can e-mail research_request@standardandpoors.com.*

# Missing Xbox leads to $1M lawsuit filing

What's a missing Xbox worth? Would you believe $1 million?

According to *cincinnati.com*, Yale University junior Jesse Maiman had packed an Xbox in his checked baggage on a December flight from New Haven, Conn., to Cincinnati/Northern Kentucky International Airport. But when he picked up his bag, he noticed it was light. A look inside showed the game console and associated gear were gone.

Mr. Maiman said his complaints to US Airways resulted in "weeks" of runaround and he decided to sue. In a lawsuit filed earlier this month in Hamilton County, Ohio, court, Mr. Maiman is seeking $1,700 for the loss of the device.

He also is seeking "noneconomic distress" damages of at least $25,000 but "in the maximum amount allowable by law or, in the alternative, in the sum of $1 million."

A US Airways spokeswoman told Gannett Co. Inc.-owned Web site via e-mail that the airline was unaware of the suit, but didn't seem overly concerned. "Regardless of the figure in the complaint, there are federal loss limits applicable to all airlines on their liability for lost luggage and belongings, which are currently set at $3,300 per bag," the spokeswoman said.

"Our publicly available baggage policies specifically exclude liability for electronics checked in luggage," the spokeswoman said.

That could no doubt add to Mr. Maiman's distress, noneconomic and otherwise.

# Business Insurance END PAGE

## Test your insurance IQ

What you don't know can hurt you.

Judging from the results of a recent survey commissioned by the National Assn. of Insurance Commissioners, most U.S. residents don't know all that much about insurance.

In fact, 1,000 adults surveyed recently posted the paltry average of four correct on a 10-question quiz that was "designed to test the nation's insurance IQ," according to the Kansas City, Mo.-based association. The NAIC noted in a statement that the 40% rate amounts to "a solid 'F' by most educational grading standards."

What didn't most people know? Only 41% knew that automobile insurance doesn't automatically cover a rental car. Only 19% realized that the requirement for private mortgage insurance on a newly purchased home depends on the size of the down payment and lender; almost 30% thought the coverage was required by law.

In addition, only 49% knew that those who lose their job and choose COBRA health care continuation coverage must pay the entire premium.

But before taking the test, almost 60% of the respondents claimed to be "very confident" overall about their insurance decisionmaking ability, while only 15% expressed any insecurity about that ability, according to the NAIC.

Those interested in testing their Insurance IQ can do so by going to the association's *www.insureuonline.org*.

If you fail, don't despair—the book "Insurance for Dummies" has been available for some time.

*Contributing: Jeff Casale; Mark A. Hofmann; Matt Scroggins*

PA PHOTOS

**Gennaro Pelliccia, master taster for Costa Coffee, has £10 million in insurance for his taste buds. A famous former coffeehouse in London wrote the policy.**

# Coffee taster's tongue insured

A matter of taste has led U.K.-based Costa Coffee to the organization that brewed up coverage of unconventional risks at a London coffeehouse.

The London-based company said it's taken out a £10 million ($14.2 million) policy on what it described in a statement as "arguably the world's most valuable tongue" belonging to Gennaro Pelliccia, its Italian master of coffee.

Costa Coffee last week said it placed the coverage through Lloyd's of London broker Glencairn Ltd. based on a survey that showed its cappuccino beat well-known competitors by a better than 3-1 margin in taste tests.

Mr. Pelliccia personally samples every batch of raw coffee beans before they're roasted and sent to stores, the company said.

"In my profession, my taste buds and sensory skills are crucial," Mr. Pelliccia said. "My taste buds allow me to distinguish any defects, which enables me to protect and guarantee Costa's unique Mocha Italia blend."

The insurance covers a "vital element of the business," the company said.

The taste tester has company in getting such coverage, the London Telegraph reported. In 1993, British food critic Egon Ronay took out a £250,000 ($353,775) insurance policy on his taste buds.

While Mr. Pelliccia's policy certainly trumps Mr. Ronay's, it is significantly less than longtime soccer player David Beckham's reported £40 million ($56.6 million) policy on his legs.

# Is Windy City turning into Insurance City?

Aon Corp. might be bigger than Willis Group Holdings Ltd., but in Aon's hometown of Chicago, Willis now has the more impressive digs.

Willis last week said it plans to move its Chicago-area offices to the city's iconic Sears Tower, which will be renamed Willis Tower.

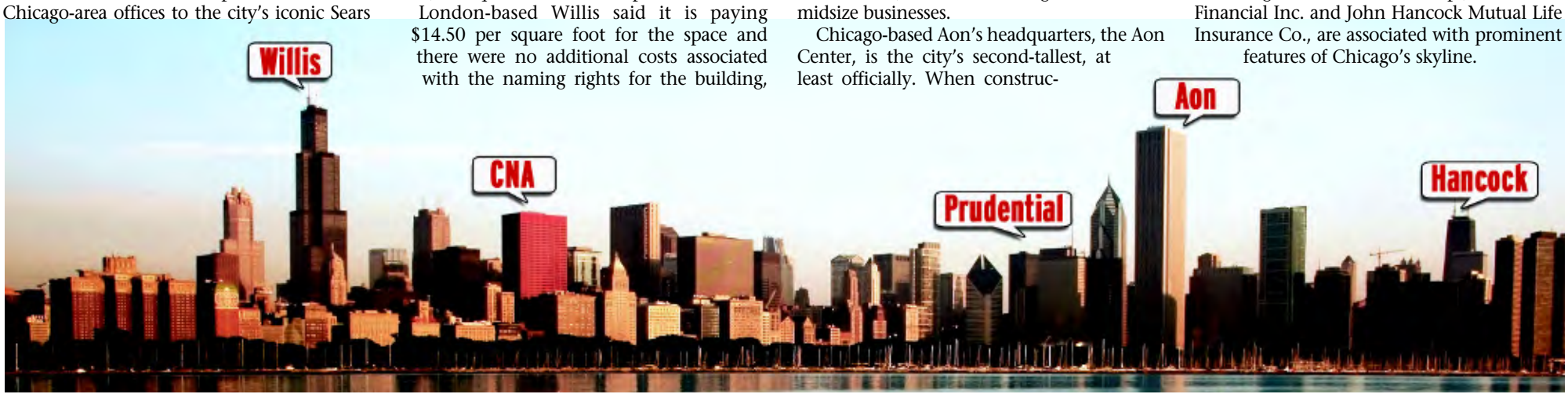
Willis plans to consolidate five offices and move about 500 associates into the tower by the end of the summer, occupying more than 140,000 square feet on multiple floors.

London-based Willis said it is paying $14.50 per square foot for the space and there were no additional costs associated with the naming rights for the building, which is the tallest in the Western Hemisphere.

Willis said Chicago will be the Midwest headquarters of Willis HRH as well as Willis Commercial, its unit focusing on small- to midsize businesses.

Chicago-based Aon's headquarters, the Aon Center, is the city's second-tallest, at least officially. When construction is complete, the Trump International Hotel & Tower will move into the city's No. 2 spot.

Other insurance industry companies, including CNA Financial Corp., Prudential Financial Inc. and John Hancock Mutual Life Insurance Co., are associated with prominent features of Chicago's skyline.



# Meet AIU Holdings, Inc.

We are pleased to introduce AIU Holdings, a newly formed, global property casualty insurance organization that is an industry leader from day one. This extraordinary organization will include companies with:

- 90 years of underwriting experience
- 500+ products and services
- 40+ million customers
- exceptional claims and litigation management abilities
- operations in 130 countries and jurisdictions
- *Excellent* financial strength ratings from the principal ratings agencies
- $43 billion in equity at December 31, 2008

The insurance companies of AIU Holdings will give you access to a global network of unparalleled financial strength, underwriting, and claims capabilities… a network that is evermore committed to managing your risk.

AIU Holdings, Inc.

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