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IN NOVEL PENSION MOVE, FORD TO OFFER LUMP SUMS TO EX-WORKERS / PAGE 4

inBrief

D&O rates firming for public companies

Directors and officers liability rates for public companies firmed in the first quarter, says Marsh Inc. in a special report. The primary limit rate, which is the price per $1 million of limit, increased an average of 1.5%, although the median rate is flat. The report said that in comparison, 2011 rates for primary limits decreased on average 4.3%, with a median decrease of 3.8%.

Cyber protection bill passes in House

The House of Representatives passed the Cyber Information Sharing & Protection Act in a bipartisan 248-168 vote last

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SPOTLIGHT

DISPUTE RESOLUTION MANAGEMENT

Consider litigation alternatives; how to overcome insurers' denial of claims; do cost-benefit analysis before filing a lawsuit; case studies. **PAGE 9**

RISK MANAGEMENT

Bribery scandal highlights risks

Alleged corruption at Wal-Mart unit exposes parent

By MIKE TSIKOUDAKIS

Multinational organizations operating in countries where bribing officials can be a condition of doing business face heightened enforcement of anti-corruption laws by U.S. agencies, but strong compliance and training programs can go some way toward mitigating the risks.

Establishing protocols for internal investigations, rewording contracts to require compliance with the U.S. Foreign Corrupt Practices Act by third-party vendors and regular audits can help, but there is no fail-safe plan that will stop some employees from violating the FCPA, experts say.

And if the safeguards fail, the consequences can be serious.

Faced with corruption and bribery allegations at its Mexican unit, Wal-Mart Stores Inc. was hit with a shareholder lawsuit as shares fell 4.7% last week. In addition, the Bentonville, Ark.-based retailing giant may face fines under the FCPA.

The FCPA, a federal law with criminal and civil penalties jointly enforced by the Department of Justice and the Securities and Exchange Commission, punishes foreign bribery, inaccurate financial records and inadequate controls.

"There's nothing a company can do to ensure 100% compliance," said Mike Koehler, assistant professor of business law at Butler University's College of Business in Indianapolis.

"A company can face legal exposure literally based upon the actions of one of its employees, notwithstanding the fact that the company may have pre-existing FCPA compliance policies and procedures in place," he said.

A major concern for companies is the reliance on third-party contractors, agents or any other independent employee acting on behalf of the organization in a foreign country, said Greg Husisian, Washington-based of counsel at Foley & Lardner L.L.P.

"Those people are risk points, especially if they're dealing with state-owned entities or with foreign officials," Mr. Husisian said. "You could be very well-intentioned

See **WAL-MART** page 17

WORKERS COMPENSATION

Comp drug testing raises costs, questions

By ROBERTO CENICEROS

Amid increasing nationwide demand for drug testing to ensure workers compensation claimants comply with prescribed narcotic regimens and don't misuse their medications, questions are surfacing about the testing industry's business practices

See **LABS** page 18

RISK MANAGEMENT

Rules of engagement: How social media alters reputation risk

By RODD ZOLKOS

The flip side of social media's value in advancing a company's brand is that the speed with which messages—mistaken or deliberately fraudulent—spread through social media can quickly put organizations' reputations at considerable risk.

This is an issue that companies such as Factory Mutual Insurance Co., which does business as FM Global, Domino's Pizza Inc. and FedEx Corp. have faced in recent years to turn around negative perceptions.

To address such an exposure, companies need to engage with social media, monitor the media for troublesome messages and, when trouble does arise, respond swiftly, deliberately and via the same social media channels, experts say.

"Companies have to monitor, they have to listen, and social media is all about engagement. It's also about transparency," said Amy Howell, CEO of Howell Marketing Strategies in Memphis, Tenn.

"We certainly believe there's a lot of value in monitoring the 'chatter,' if you will, that occurs on social media," said Shawn Ram, managing director and national technology practice leader at Aon P.L.C.'s Aon Risk Solutions unit in San Francisco.

"We believe social media should begin to enter business continuity plans. Basically, planning for a social media-related event," Mr. Ram said. "It's common to plan for

See **REPUTATION** page 17

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www.BusinessInsurance.com/BITop10

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2. Lead plaintiff in NFL concussion suits dies in apparent suicide
3. Obama administration criticizes CISPA, president urged to veto
4. Liberty Mutual first-quarter net income up 26% from year ago
5. Bermuda insurers, reinsurers report increased income
6. New York workers comp costs rise despite reforms: Report
7. Florida becomes newest state to allow formation of captives
8. DOL stepping up oversight of 401(k) plan administrators
9. Okla. House defeats alternative workers compensation bill
10. Hartford sells off individual annuity operations

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WHITE PAPER: Flood risk exposures are rising. Find out more. *www.BusinessInsurance.com/whitepapers*

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EMPLOYMENT PRACTICES

EEOC alters background check stance

Most recent guidance leaves some questions on state-law interplay

By JUDY GREENWALD

WASHINGTON—Employers may feel they are between a rock and a hard place over how they use arrest and conviction records in employment decisions after the U.S. Equal Employment Opportunity Commission issued updated enforcement guidance on the issue last week.

That is because the EEOC guidelines are unclear as to what employers should do in cases where they conflict with state law, observers say.

However, the guidance (see box), which was approved by the commission in a 4-1 vote, will be a useful guide to the EEOC's pronouncements on the issue of criminal background checks, they say.

"The new guidance clarifies and updates the EEOC's longstanding policy concerning the use of arrest and conviction records in employment, which will assist job seekers, employees, employers and many other agency stakeholders," EEOC Chair Jacqueline A. Berrien said in a statement,

Peter J. Gillespie, of counsel at law firm Fisher & Phillips L.L.P. in Chicago, said the EEOC over the past couple of years has been "strongly encouraging employers to look carefully at a range of common practices that the agency believes could have a disparate impact on minorities," including criminal background checks, as well as refusals to hire the unemployed and the use of credit checks as a screening mechanism.

He said this is part of the EEOC's effort to "shake up" what it views as "the standard industry practices that occur during the hiring process."

The EEOC said its criminal background guidance builds on longstanding guidance documents the agency issued more than 20 years ago.

Commenting on the guidance, Leslie E. Silverman, a partner with law firm Proskauer Rose L.L.P. in Washington and a former EEOC vice chair, said little of the guidance is new "or shattering."

Richard B. Cohen, a partner with law firm Fox Rothschild L.L.P. in New York, said, "The EEOC didn't go as far as it might have gone in using these rules they created." It suggested "that if you have a good-faith system to narrowly tailor your search, you'll probably be OK." This is "not as draconian as it might have been" for employers, Mr. Cohen said.

The Washington-based Lawyers Committee under Civil Rights Law said in a statement that it "will greatly reduce the misuse of criminal history background checks to deny employment to persons of color."

It "strengthens enforcement efforts against employers who are misusing criminal background checks and provides clear guidance to employers on the appropriate use of such background checks."

But there is concern about conflicts with state law. The

See **EEOC** page 18

GUIDANCE

Among the topics the EEOC guidelines discuss are:

- How employers' use of individuals' criminal history in making employment discrimination could violate Title VII of the Civil Rights Act of 1964
- Federal court decisions analyzing Title VI as applied to criminal record exclusions
- The differences between the treatment of arrest and conviction records
- The applicability of disparate treatment and disparate impact analysis under Title VII
- Compliance with other federal laws and regulations that restrict or prohibit employing individuals with certain criminal records
- Best practices for employers.

LIABILITY & LITIGATION

Embattled firm Dewey & LeBoeuf says insurance practice sound

Amid law firm's struggles, competitors taking talent

By MARK A. HOFMANN

NEW YORK—Insurance will remain an important practice for embattled law firm Dewey & LeBoeuf L.L.P. and it will continue serving industry clients despite the exodus of high-profile insurance specialists in recent weeks, the law firm said.

A spokesman for the New York-based law firm, which was formed in 2007 by the merger of Dewey Ballentine L.L.P. and LeBoeuf, Lamb, Greene & MacRae, declined to say how many insurance specialists have left the firm.

But since the beginning of March, defections from Dewey LeBoeuf have been mounting. Six insurance lawyers, including captive industry expert P. Bruce Wright, joined New York-based Sutherland Asbill & Brennan L.L.P., while 12 insurance attorneys joined New York-based Willkie Farr & Gallagher L.L.P.

James R. Woods, co-chair of Dewey LeBoeuf's global insurance industry practice, joined Mayer Brown in New York. In addition, four insurance lawyers, led by John Nonna, chair of Dewey LeBoeuf's insurance and reinsurance dispute resolution practice, joined Patton Boggs L.L.P. in New York in early April.

"Dewey & LeBoeuf retains a strong nucleus of partners, counsel and associates dedicated primarily to our insurance industry clients, offering expert advice on corporate, litigation (including regulatory and compliance) and tax matters," said a Dewey LeBoeuf spokesman in an email. "Going forward, the firm's insurance specialty will remain an important area of focus, drawing on our decades of experience in the industry."

> Dewey & LeBoeuf has seen several high-profile lawyers that specialize in insurance leave over the past several weeks. But insurance will remain "an important area of focus," the law firm says.

Dewey LeBoeuf's website lists more than 30 partners as practicing in the insurance area.

A source familiar with situation who declined to be identified said Dewey LeBoeuf's troubles stemmed from the merger itself, which the source said occurred at the "unfortunate time" just before the economic downturn. Dewey was a firm heavily involved in transactions such as mergers and acquisitions, and such law firms "took a hit" in the recession, said the source.

Meanwhile, disaffected partners got promises of financial guarantees, the source said. The firm also did some high-profile recruiting, with high guaranteed compensation. But profits plummeted to about half of what had been expected in 2011. There was considerably less money to go around, so partners left, said the source, who pointed out that Dewey LeBoeuf is one of several high-profile firms that have faced financial difficulties in recent years.

A legal scholar and practicing attorney who teaches law firm management at Widener University School of Law in Wilmington, Del., said issues of property arise when a law firm breaks up.

"Any time that you have a law firm break up, it's very much like a divorce," said Charles Slanina, adjunct professor at Widener Law and a partner in the Hockessin, Del., office of law firm Finger & Slanina L.L.C.

"You go through property issues," said Mr. Slanina, who has no connection to Dewey LeBoeuf. "The major assets of any law firm are the clients and, of course, attorneys don't own clients. Clients always get to choose who represents them. There's always a lot jockeying about what clients can be persuaded to go or stay."

QUESTIONS & ANSWERS

Peter F. Garvey *is president and CEO of Integro Ltd. in New York. He became president in 2005 and was named CEO three years later. He spoke with Business Insurance Senior Editor Mark A. Hofmann about the state of the property/casualty insurance market and other issues.*

Integro CEO sees limited scope for rate increases

Q: How would you characterize the commercial property/casualty market right now?

Struggling. Certainly the carriers are not getting the results they need to satisfy management and their investors. The return on equity is at an all-time low. There's overcapacity so there's no compelling reason to drive rates up to correct that problem. The global economy seems to be slowly recovering but not enough to raise exposure bases to grow premiums at a rate they're going to need to get them up to and there's no real alternative source of income by way of investments or interest rates. Beyond that, in pockets, in property/casualty where they've had bad loss experience, it alone is not enough to drive the whole market up and to the extent that rates are rising in selected areas, carriers are kind of forced to set up sidecars again to generate fee income for themselves. You would expect, you can't blame them, but it's going to further increase at least temporary capacity to forestall any momentum to improve the rates to satisfy them. If it's improving, it's improving very, very slowly and probably not enough to feel good for the carriers.

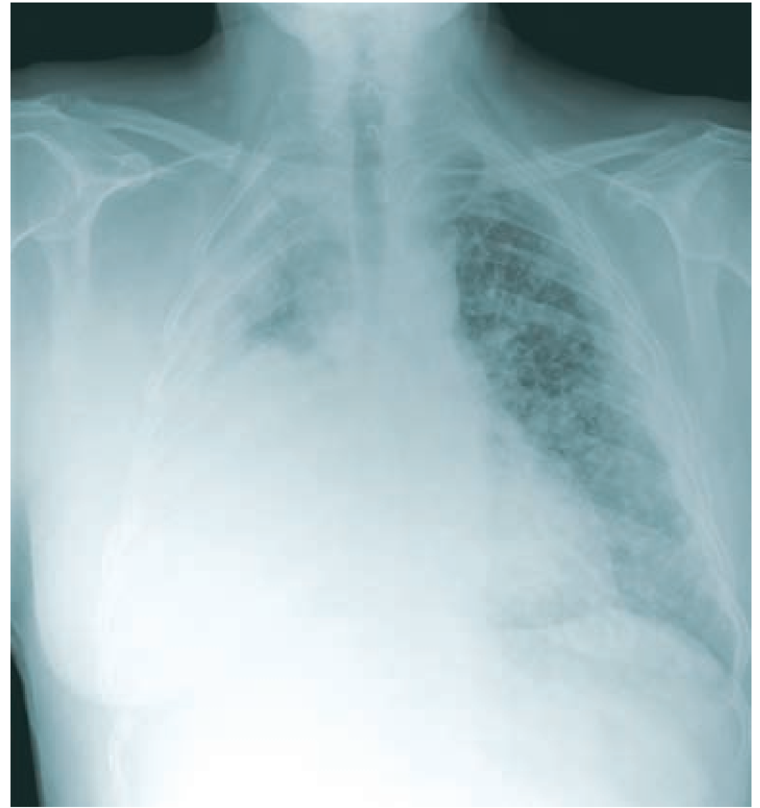
Q: Do you see any signs the market is going to change?

No, I don't. There's been a terrible run of catastrophes and it really

See **GARVEY** page 7

P/C LEGISLATION & REGULATION

Bill would add transparency to asbestos trusts system



Measure in House calls for reports on claims, activities

By MARK A. HOFMANN

WASHINGTON—A measure introduced in the House of Representatives that would require asbestos trusts to make regular quarterly reports about claims and other activities to bankruptcy courts is winning praise from the insurance industry and others.

Supporters of the bill—the Furthering Asbestos Claims Transparency Act of 2012, or H.R. 4369—argue that it is necessary to get compensation to those who are truly sick and to prevent fraud. But opponents say the measure is unnecessary.

The bipartisan measure was introduced this month by Reps. Ben Quayle, R-Ariz.; Jim Matheson, D-Utah; and Dennis Ross, R-Fla.

"This legislation will provide sunshine and transparency to the asbestos trust system," Rep. Quayle said in a statement issued upon the bill's introduction. "The opaque and unsupervised way in which the system operates leaves it wide open to fraud and abuse, which endangers the very existence of asbestos trusts."

"There's increasing concern about the asbestos trusts," said Melissa Shelk, vp of federal affairs at the American Insurance Assn. in Washington. Ms. Shelk noted that more than 50 trusts are in operation, but there is no clearinghouse to determine who is receiving benefits.

The trusts are personal injury

See **ASBESTOS** page 20

RETIREMENT BENEFITS

AP PHOTO

NBCUniversal's 401(k) plan has grown to $340 million since 2011.

NBCUniversal 401(k) sees good ratings

Plan participation more than 96%

By ROBERT STEYER

The 401(k) plan at NBCUniversal Inc., which started from scratch in early 2011, has grown to $340 million by adopting some ideas from its joint-venture parents while adding investment and plan design ingredients of its own.

As a startup serving employees of the joint venture created by General Electric Co. and Comcast Corp., plan executives have had to build participation—now at 96.6%, thanks in part to automatic enrollment—among new hires as well as legacy GE and Comcast employees.

The investment lineup consists of a collective trust target-date

See **NBC** page 20

WELLNESS

New technologies, designs seen boosting wellness

Web, mobile tools helping employers tailor their programs

By MATT DUNNING

NEW YORK—Companies looking to maximize the effectiveness of their employee wellness initiatives must be willing to incorporate new technologies and innovative program designs, a panel of experts said last week at the Northeast Business Group on Health's 2012 Health & Wellness Benefit Conference in New York.

While physicians and insurers await the development of more advanced clinical decision-assistance software (see story, page 21) to improve claim outcomes, employers are turning to Web-based information management and resource platforms, telecommunications and mobile applications to broaden access and tailor their wellness programs to their employees, panelists said.

"Understanding the ways technology can drive engagement, reduce hospital recidivism and ultimately improve health outcomes is key," said Daryl Risinger, a senior vp at Addison, Texas-based Concentra Inc.

Over time, Mr. Risinger said, employers have learned that education-based wellness programs—particularly those utilizing traditional content delivery models—struggle to generate significant participation levels or enhanced health outcomes.

"With wellness, we need an improved methodology for bringing about behavioral changes," Mr. Risinger said, noting that education-based models tend only to attract the "worried well" instead of the more at-risk members of an employee population.

"It's not just about putting the content out there," he said. "If you simply provide education, only the people with a thirst for knowledge will use it."

Among the most popular and simplest strategies to implement to drive employee wellness engagement is the use of smartphone applications, Mr. Risinger said, particularly given the rising ubiquity of smartphones in the consumer market.

"It's where we spend our time," Mr. Risinger said. "We wake up with our smartphone and we go to bed with it. There's a natural fit. It's simply a matter of understanding what the messaging needs to be and how to get to the members."

A more robust model by which companies are putting technology to work in pursuit of more effective employee wellness is the implementation of Web-based interactive resources and medical data management platforms, panelists said. At Hopkinton, Mass.-based EMC Corp., benefits managers worked with network health care providers and third-party providers to design a wellness program centered around individual employees rather than the workforce as a whole.

"Our vision was the accelerated adoption of consumerism by helping employees take responsibility for their health through

See **NEBGH** page 21

RETIREMENT BENEFITS

Ford takes innovative tack to reduce pension risk

By JERRY GEISEL

DEARBORN, Mich.—Ford Motor Co. said Friday it will offer 90,000 U.S. salaried retirees and former employees the option to take their monthly pension benefit as a lump-sum payment, a move that may the first of its kind.

The magnitude of the program, which is part of Ford's long-term strategy to "de-risk" its pension plan, is the largest ever offered "by a U.S. company for ongoing pension plans," the Dearborn, Mich.-based automaker said in a statement last week announcing its first-quarter results.

Typically, lump-sum payments are offered as an option only when an employee terminates employment and is eligible for a pension benefit.

The move probably is the first of its kind, said Jeremy Gold, president of Jeremy Gold Pensions, a New York-based consulting firm.

"I'm not aware of anyone who has done this without terminating or annuitizing their plan," Mr. Gold said.

"Historically, lump-sum distributions, which allow plan participants to exchange receiving periodic annuity payments for a single lump-sum payout, have been offered to participants only upon separation from active employment," benefit consultant Towers Watson & Co. said in a statement.

When individuals take a lump-sum payment rather than monthly payments, Ford would no longer face risks such as paying more if individuals live longer than expected. In addition, Ford no longer would have to pay additional unexpected contributions to its plans in the future if investment returns slump.

"Providing the option of a lump-sum payment to current salaried U.S. retirees and former employees will reduce our pension obligations and balance sheet volatility," Ford Executive Vp and Chief Financial Officer Bob Shanks said in a statement.

Still, there could be a downside to the "de-risking" strategy, pension experts say. By pulling funds out of the plan to pay the lump-sum benefits, Ford would lose potential future investment gains it may have achieved on those assets.

"You eliminate some risk, but employers will forgo opportunity for investment returns on the assets they will have to liquidate

See **FORD** page 19

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States curb ability to shift contractor risk

Anti-indemnity changes cut additional insureds from some CGL policies

By JOANNE WOJCIK

Well-established contractual risk transfer provisions used by construction contractors are being challenged by changes in state laws and additional insured endorsements contained in commercial general liability policies.

Where an accidental loss is connected to the work of a subcontractor, the "belt and suspenders" of indemnity and insurance generally are designed to transfer the risk to a subcontractor, including the defense and indemnification of upstream contractors that may be drawn into a resulting claim or lawsuit.

Though the majority of states have anti-indemnity laws that limit the extent of risk transfer allowed through contractual indemnity provisions contained in construction contracts, upstream contractors in most states still have been able to transfer their risk by being named as additional insureds on their subcontractors' CGL policies.

However, at least three states—California, Louisiana and Texas—recently enacted legislation expanding their anti-indemnity statutes to restrict risk transfer via additional insured coverage. At the same time, the insurance industry has been narrowing additional insured coverage, construction liability experts say.

"Contractual risk transfer is breaking," said Michael Campo, senior vp and construction team leader at Lockton Cos. L.L.C. in Kansas City, Mo. "There is no longer a fail-safe way of passing on the risk of a job to those who may be responsible."

"There are a lot of risks out there that people don't know they're taking," said Joanie Schneider, managing director and national construction placement leader at Marsh USA Inc. in Cleveland.

"I think we're going to see more of this trend to extend the anti-indemnity laws" to encompass additional insured endorsements, said Frank Armstrong, Tampa, Fla.-based senior vp and national director of construction claims at Willis North America.

> **'Contractual risk transfer is breaking. There is no longer a fail-safe way of passing on the risk of a job to those who may be responsible.'**
>
> Michael Campo, Lockton Cos. L.L.C.

For example, "the owner contracts with the general contractor and requires that the general contractor name it as an additional insured (on its CGL policy). Then the general contractor passes it through to the subcontractors, requiring them to name the owner and the general contractor as additional insureds" on their CGL policies, Mr. Armstrong said.

However, some insurers use additional insured endorsements that contain terms that may not comply with contract requirements.

For example, the additional insured coverage may apply only to those parties with which a subcontractor has entered into a direct contract, which may not include the project owner or other parties for whom this added coverage was intended.

"It's something you have to pay attention to. You have to look closely at the wording of these additional insured endorsements," Mr. Armstrong said.

The additional insured endorsement that was adopted by the Insurance Services Office Inc. in 1985 provided broad coverage, granting an additional insured protection for property damage claims resulting from construction defects and third-party-over actions, such as

Continued on next page

AP PHOTO

Firefighters battled the five-alarm Central Synagogue fire in New York in 1998. A wrap-up policy under one insurer could have prevented the protracted litigation that ensued between the contractor and roofing subcontractor on the project.

Wrap-up liability coverage offers additional protection

Contractor-controlled insurance programs, also known as "wrap-ups," can ensure that all companies involved in a construction project have adequate liability protection, even in states with anti-indemnity laws, insurance experts say.

"With a wrap-up, there's a single insurer. You don't have to worry about which insurance applies or how it is shared between contractors," said Tracy Alan Saxe, a policyholder attorney from Saxe Doernberger & Vita P.C. in Hamden, Conn., who spoke during a session on navigating contractual indemnity and additional insured issues held during the recent Risk & Insurance Management Society Inc. conference in Philadelphia. "It's all about risk transfer."

With a wrap-up policy, the owner or general contractor purchases a single commercial general liability policy that extends insurance protection to all contractors involved in a project, said Kevin King, risk manager at Turner Construction Co. in Montvale, N.J., who also spoke during the session.

Turner began using wrap-ups after a 1998 fire claim that involved a historic New York synagogue, he said.

At trial, Turner was found to be more than 50% liable for the fire, which was ignited by a roofing subcontractor and caused $32 million in damage to the 126-year-old Central Synagogue structure, Mr. King said.

By contrast, the roofer was found to be only 20% liable, he said.

Because Turner did not have builder's risk coverage on the project, which is a first-party policy that would have covered the damage claim, it sought coverage under the additional insured endorsements on its subcontractors' CGL policies, Mr. King said.

After 10 years of protracted litigation, Turner finally managed to extract $18 million from its subcontractors' insurers, Mr. King said.

By using wrap-ups, "it prevents finger pointing and having to sue contractors' insurers," he said. "With a wrap-up, you have one carrier, you submit it, and they handle it and they resolve it."

"Wrap-ups solve some of the problems that might be inherent in a nonwrap situation where you are doing contractual risk transfer and additional insured endorsements," said Paul Van Osselaer, a partner at Van Osselaer & Buchanan L.L.P. in Austin, Texas, who also spoke during the session.

—By Joanne Wojcik

CONTINUED FROM PREVIOUS PAGE

when a subcontractor's employee who is injured on the job sues the general contractor for damages beyond what normally would be provided under workers compensation statutes.

Because workers compensation serves as the exclusive remedy for workers injured on the job, they cannot, by law, sue their employers. However, if they become injured on a job site owned by another party, they can sue that party and try to obtain additional damages beyond what are paid under workers comp.

However, later versions of the form are much narrower, eliminating coverage for completed operations and, in turn, construction defects.

For example, the 1997 version of the ISO additional insured form limits coverage to "ongoing operations," while the 2001 version states that coverage does not apply to events that occur after the named insured has completed its work, or the relevant portion of the project has been put to its intended use.

In 2004, in an effort to limit coverage for third-party-over actions, ISO further revised the standard form to provide an additional insured with coverage "only with respect to property damage or personal injury that the named insured also causes," said Randy J. Maniloff, a partner at White & Williams L.L.P. in Philadelphia, who represents insurers in coverage litigation.

Because of these changes, general contractors and subcontractors should carefully review their CGL policies' additional insured endorsements to make sure they match what is required under their construction contracts, said Marsh's Ms. Schneider.

Unfortunately, "most of the time the party getting the additional insured coverage doesn't bother to check what the endorsement actually says," said Mr. Maniloff. "It may be a very limited coverage, more limited than they thought they were getting. You want to say, 'Name me as an additional insured with this kind of coverage,' and then make sure that the subcontractor actually got you that coverage."

"Where the terms of the additional insured coverage are not in compliance with the contract, it creates the risk of breach of contract, which isn't good for either party," said Mr. Armstrong. "In the past, upstream contractors would frequently be satisfied with a certificate of insurance from the subcontractor that says the general contractor is an additional insured. People were comfortable with that until the claim happened, when they learned there were restrictions in the coverage."

"Today, where nonstandard additional insured endorsements are to be used, more upstream parties recognize the risk management practice of securing a copy of the additional insured endorsement, and perhaps other key endorsements, along with the certificate of insurance," he said.

Garvey: Limited scope for rate hikes

CONTINUED FROM PAGE 3

hasn't eroded capacity to a huge extent across the P/C business. Probably RMS 11 has done more to raise rates than the actual catastrophes themselves in property cat, so I don't know that that's really driving it. You'd hate to imagine that catastrophes could be any worse than they've been in the last couple of years, so that's a tough environment.

Again the advent of sidecars has had a smoothing effect on spikes in the market. That's probably going to continue. It's been a good investment vehicle by and large for those who back them and it's a great source of pretty much risk-free fee income for the carriers that sponsor them.

The thing that has to change far and away is we need a stronger economy globally. There was a little bit on the economic adjustment after 2008 between the U.S. and Europe so that carriers and brokers that had large exposure to Europe were focusing there, and that seemed to balance it out for a couple of years but that's shifting the other way. Now, emerging markets might be some sign of hope but that's not a big enough source of revenue for most carriers to satisfy them. I don't really see capacity eroding any time soon.

Q: Where do you see opportunities for a brokerage such as Integro?

We're a relatively new firm so our success in the near term is taking market share. Our growth is coming at the expense of the haves, the people that own the large market shares right now. And in the segments we concentrate in, we are finding out that we compete very favorably with a handful of firms that have the large market shares right now. While they struggle to generate a better profit margin in a low-growth scenario, we can generate high growth profitability simply by winning clients, and it's more than enough to satisfy us for the near-term. Our outlook for the future, we think, is very bright. We just grew in the first quarter by 31% on the revenue line and that's 23% organic growth in a marketplace where large property/casualty business arguably isn't growing more than a couple of points. So while we're small relative to our main competitors, if we can keep that up, we're going to keep ourselves and our investors satisfied, and it will enable us to continue to fund our company to provide the kind of services that satisfy our clients.

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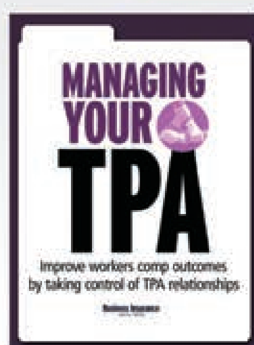

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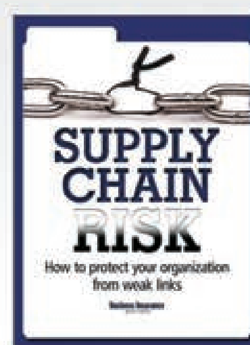

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Opinions

EDITORIAL

Asbestos trust reforms needed

THE SYSTEM of asbestos bankruptcy trusts created by Congress nearly 20 years ago was designed to make sure people injured by exposure to asbestos could be compensated.

But over the years, concerns have arisen that the current system can be gamed. There's a concern that claimants can seek multiple recoveries from different funds, or tap funds and the tort system. That's why we welcome the introduction of the Furthering Asbestos Claims Transparency Act.

As we report on page 4, the act would require asbestos trust funds to make quarterly reports about claims and exposure allegations. The measure also would provide protection for claimants' identities and personal medical information. These are hardly radical ideas, but such disclosures could help deter duplicate claims.

A report issued by the Government Accountability Office last September said that between 2000 and 2011, the number of asbestos personal injury trusts increased from 16 to 60. The trusts' collective assets increased from a little over $4 billion to nearly $37 billion during the same period. That's a significant amount of money.

But one of the major problems is that the 60 trusts operate independently of each other, and there's no central clearinghouse for claims data and other information.

In addition, there's no linkage between the trusts—which represent the assets and liabilities of companies that sought bankruptcy protection because of asbestos claims—and the tort system, where solvent companies must defend asbestos claims.

No one knows how much fraud is involved in the system. But given the amount of money involved, greater transparency strikes us as a worthy—and imperative—goal.

It's a matter of fairness, and not just for those who are paying the claims, be they trusts, insurers or companies that are defending themselves in the tort system.

It's a matter of fairness for the claimants themselves. The purpose of the trusts is to compensate the injured. As we noted, there's an impressive amount of money involved, but it's not unlimited. Curbing even potential double-dipping and other fraudulent acts will help ensure there are adequate funds to compensate the truly ill.

SCHILLERSTROM

LETTERS

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COMMENTARY

If government is at fault, it should pay

If I burned down my neighbor's house, she probably would sue me to recoup her loss. And if someone were to die in the fire, I probably would face criminal charges. But if my neighbor is injured by the government, these normal rules of law don't apply.

Even though the Colorado State Forest Service has been blamed for the destruction of 27 structures and three deaths that occurred after a recent controlled burn went awry, its legal responsibility has been limited under a 1971 governmental immunity statute that caps liability at $150,000 per individual and $600,000 per incident.

JOANNE **WOJCIK**
SENIOR EDITOR

The Lower North Fork Fire started as a controlled burn on March 22, but reignited in 80 mph winds on March 26, spreading across more than 4,000 acres and causing $11.3 million in property damage. Firefighting efforts were hampered by a series of communication mishaps and a delay in ordering evacuations. Many residents did not receive emergency phone calls, including one of the victims.

Sheriff's investigators issued a report that found no criminal violations related to the wildfire, but a separate state government report said the Forest Service violated its own protocols by not monitoring the burn the day before the fire erupted even though the National Weather Service had issued a Red Flag Warning for low humidity and strong winds.

The report also made several recommendations for preventing such catastrophes in the future, including improving weather information and fire-danger rating systems used in fire planning, and strengthening standards for extinguishing controlled burns, especially in populated areas.

Meanwhile, affected homeowners are justifiably angry that the Forest Service chose to set the fire during one of the driest Marches on record. At one point, the fire had forced the evacuation of 900 homes and required more than 700 firefighting personnel, plus numerous aircraft and helicopters to drop fire retardants and water.

I agree with Patrick Mooney, general manager of Intermountain Rural Electric Assn., who said the Legislature should raise the liability cap. The association, one of nine claimants that have filed notices of intent to sue the state, lost 2.5 miles of power distribution lines in the fire and has spent $700,000 to repair them, even before paying mounting overtime compensation for restoring electric service to customers in the affected area.

While tort reforms such as Colorado's Governmental Immunity Act are intended to protect governments from frivolous lawsuits and huge liability claims that could prevent them from providing services, they need to be reviewed and updated to keep pace with inflation. After all, the state and local governments are collecting more in taxes as individuals earn more and homes increase in value. Moreover, capping the state's liability without also ensuring that it will be held accountable for its own negligence gives government too much power.

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ALTERNATE ROUTES BETTER RESULTS

Dispute Resolution Management

SPOTLIGHT

Consider alternatives before litigation

By MATT DUNNING

When policyholders and underwriters find themselves at odds over an insurance matter, attorneys and insurance experts agree that alternative forms of dispute resolution can yield better results for all involved parties than traditional litigation.

Generally faster and almost always cheaper than prosecuting a civil suit, alternative dispute resolution mechanisms often guide companies and their insurers toward settlements acceptable to both sides of complex claims or contractual disagreements (see story, page 10).

However, while avoiding litigation may save on legal costs, it is not always the best route. In particular, policyholders may give up significant advantages they hold over insurers by agreeing to arbitration, and they should think carefully before doing so.

"It's almost always an advantage to go through some form of alternative dispute resolution process before you go to litigation," said Richard Morgan, senior vp of property claims for Zurich North America in Chicago. "It gives

See **RESOLUTION** next page

'It's almost always an advantage to go through some form of alternative dispute resolution process before you go to litigation.'

Richard Morgan,
Zurich North America

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Most disputes boil down to similar issues

Though the specific permutations can be virtually limitless, most insurance disputes between a policyholder and an underwriter can be distilled down to one or more of a few core issues.

Some of the most common causes of commercial insurance disputes—provided by Richard Morgan, senior vp of property claims for Zurich North America in Chicago; Finley Harckham, a shareholder at Anderson Kill and Olick P.C. in New York; and Kevin McCarthy, practice leader for Marsh Risk Consulting's Forensic Accounting and Claim Services in Chicago—are:

COVERAGE LIMITS AND EXCLUSIONS: Conflicting interpretations of contract wording, including scope of insured perils, entities or individuals, per-occurrence and aggregate limits, and other terms and conditions.

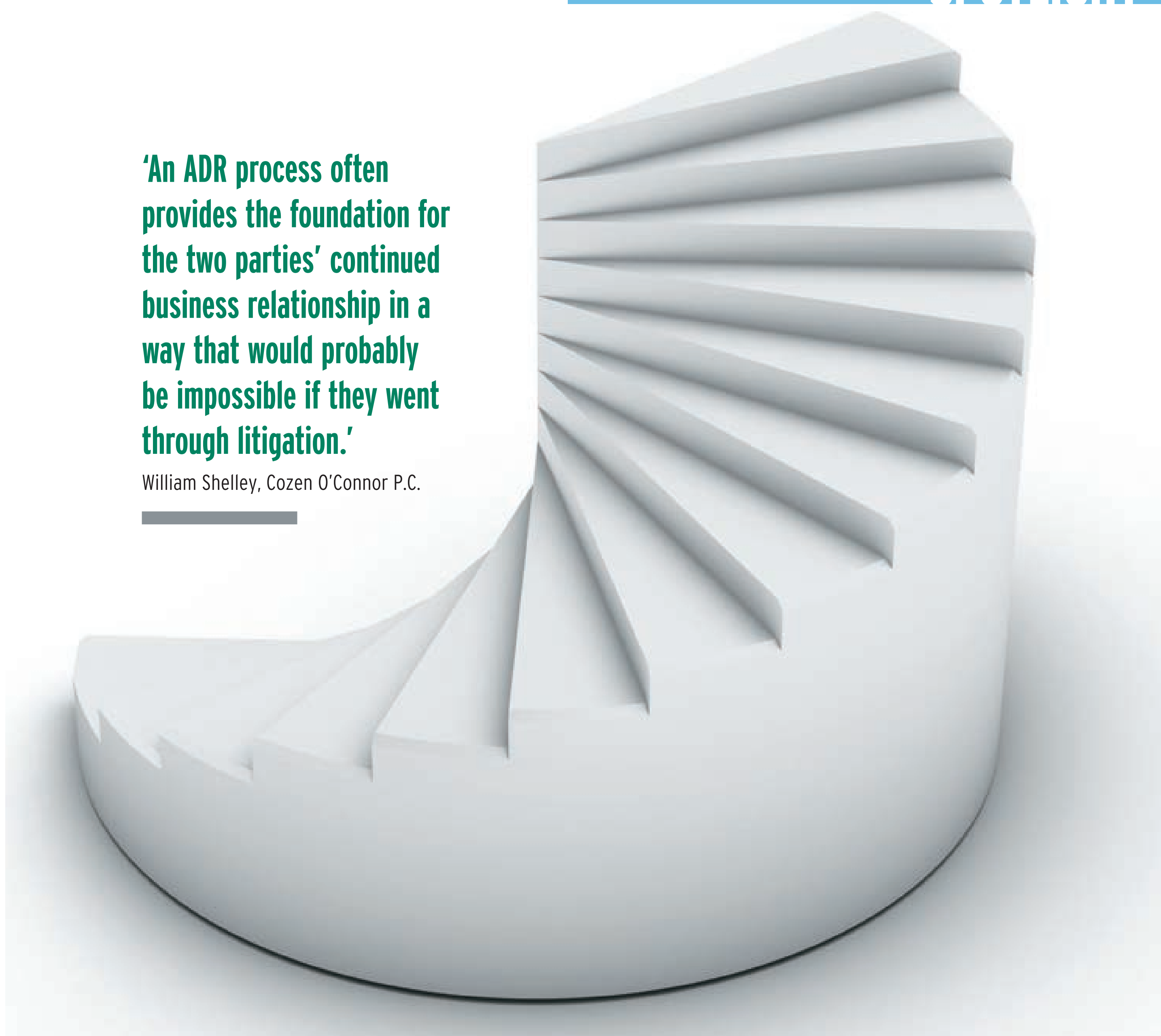
LOSS ASSESSMENTS: Differing valuations for projected or incurred losses. In property cases, this can include assessments of structural damage, repair and remediation costs, and projected profit losses. In liability cases, it can include legal and investigation costs, fines and penalties, and reputational damage.

DUTY TO DEFEND: Disagreements over the insurer's duty to provide legal defense for a policyholder in a lawsuit. Typically, issues arise when a complaint against a policyholder includes covered and noncovered charges.

COMMUNICATION DEFICIENCIES: Poor or infrequent communication between a policyholder and its insurer can lead to an insufficient understanding of the policyholder's risk profile and/or insurance portfolio. Regular communication at multiple stages of an insurance contract's lifespan—from the initial purchase to renewals to any claim adjustments—is vital to avoiding disputes.

UNREASONABLE EXPECTATIONS: Preconceived, hardline positions as to the scope and valuation of a particular claim—and the extent to which the losses are actually covered—not only prolong a claim's processing, they can cause significant and often permanent damage to the business relationship between a policyholder and an underwriter.

—By Matt Dunning



'An ADR process often provides the foundation for the two parties' continued business relationship in a way that would probably be impossible if they went through litigation.'

William Shelley, Cozen O'Connor P.C.

Resolution: Consider alternatives to litigation in claims disputes

CONTINUED FROM PREVIOUS PAGE

the two parties a chance to have a discussion removed from contentious litigation. There's every reason to expect a good outcome for both parties."

By favoring mediation, arbitration and other ADR methods over litigation, both parties can limit the risk of exhausting their financial resources on legal fees, spending years in and out of courtrooms, and jeopardizing their business relationship with the opposing party or the long-term welfare of their organization, experts said.

"The reduction in cost doesn't just apply to the money that was or wasn't spent," said William Shelley, chair of Cozen O'Connor P.C.'s global insurance group in Philadelphia. "There's the distraction of litigation and the drain on some of your people's time to consider. Also, an ADR process often provides the foundation for the two parties' continued business relationship in a way that would probably be impossible if they went through litigation."

Most insurance disputes resolved outside the bounds of civil suits are done so through either mediation or arbitration, depending on the nature of the dispute and the policyholder's insurance contract.

Except where it is ordered by a judge in advance of a suit proceeding to trial, mediation is largely a voluntary exercise said. In most cases, mediation outcomes are treated as nonbinding arrangements. The feuding organizations jointly designate a neutral third party to umpire the proceedings, but any resolution reached must be agreed upon by the policyholder and the underwriter.

PATHS TO SETTLEMENT

Common types of alternative insurance dispute resolution

APPRAISAL: Designed solely to address disagreements over valuation of damaged property and/or repairs.

MEDIATION: Voluntary process in which the policyholder and insurer jointly agree on a third party to evaluate arguments and recommend a nonbinding solution.

ARBITRATION: A more formal process than mediation and typically a contractual requirement; decisions rendered in arbitration cannot be appealed.

Mediation can be requested at any point during a dispute—before or after a civil complaint has been filed—and can vary greatly in terms of its formality. As long as both parties are reasonable and open to negotiation, experts said mediation usually ends in an amicable arrangement.

"It's typically better to go through mediation before you go to arbitration," said Stephen Marcellino, a partner in the New York and White Plains, N.Y., offices of Wilson Elser Moskowitz Edelman & Dicker L.L.P. "Particularly if both parties have any interest in the commercial relationship continuing past the resolution of the conflict. The best way to do that is to reach a conclusion both parties agree to voluntarily."

The most formal form of alternative dispute resolution, arbitration often is mandated by a policyholder's contract with its insurer as a precursor to litigation. Like mediation, one arbitrator or a three-person panel of arbitrators can provide a swift and likely less expensive resolution, particularly in cases of dense contractual disagreements.

By allowing insurers to include an automatic arbitration clause in their policies, companies can remove much of the uncertainty that can manifest during a dispute and begin planning their arguments that much sooner. However, experts warned, policyholders should consider carefully the potential drawbacks of arbitration before agreeing to it as a provision of their insurance contract.

"The threshold consideration companies need to take into account regarding arbitration is that you've got no right to appeal," said Finley Harckham, a shareholder at Anderson Kill and Olick P.C. in New York. Assuming a policyholder can live with the finality of arbitration, he said there are other provisions of standard arbitration mandates they should evaluate before signing.

"They typically require the application of New York state laws to a particular dispute, even if New York has no direct tie to the case," Mr. Finley said, noting that, among other favorable legal conditions for underwriters, New York does not generally allow policyholders to sue their insurers for "bad faith" causes of action.

"The second thing to look for is that a lot of these standard-form clauses take away the advantage that the policyholder has under the law in terms of interpreting ambiguous policy provisions," Mr. Finley said. "Instead, the arbitrator is supposed to interpret the policy in an evenhanded manner in accordance with customs and practices in the industry, without regard to who drafted it. It's a big advantage that the policyholder is giving up."

How to overcome denials of claims

Policy language key to avoiding disputes, successful claims

By RUSS BANHAM

A risk manager files a claim for what he or she considers a loss covered by insurance, but the insurer rejects it.

While the risk manager may consider seeking a court order to require the insurer to pay the disputed claim, there are several steps to take before going to court, experts say.

Claim denials typically arise from differing interpretations of policy wording relating to a financial loss.

"The most strategic item in avoiding a declined claim is to ensure the clarity of the contract language during the insurance policy negotiations," said Neil Harrison, group managing director, risk control, claims and engineering, at Aon Global Risk Consulting's Chicago office. "It is essential that the broker, insurer and insured all have the same interpretation of what the policy covers. I'd say 70% of disputes would be avoided with a shared understanding of contract wording."

As for the other 30%, brokers and attorneys specializing in insurance litigation agree that there are no surefire ways for risk managers to win claim payouts they believe are due their companies. Each dispute resolution mechanism—arbitration, mediation and litigation—has pros and cons.

Nevertheless, there are best practices that begin with a close reading of the policy the minute a claim is denied.

"A risk manager will want to evaluate the merit of the claim rejection by digging into the policy's coverage terms and conditions," said Thomas M. Reiter, a partner at K&L Gates L.L.P., a Pittsburgh-based law firm that represents companies in insurance disputes. "This is your opportunity to negotiate what you think the claim is worth with the insurer, and what you think the law will allow and courts or arbitrators will provide."

'A risk manager will want to evaluate the merit of the claim rejection by digging into the policy's coverage terms and conditions.'

Thomas M. Reiter, K&L Gates L.L.P

Sometimes a claim is denied because the policy requires a claim to be filed within a certain amount of time.

"Most policies will require you to file proof of loss within a certain period, such as within 90

See **DENIAL** next page

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Denial: Policyholders have options for rejected claims

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days after the (loss) occurrence," said Robert W. O'Brien, managing director at Marsh Inc.'s national property claim practice in New York. "Another time-sensitive provision concerns replacement cost. Many policies require, for instance, that to collect on a property claim, the property has to be replaced within a defined period of time. Fortunately, you can ask the insurer for an extension in advance of the deadline."

When claim negotiations fail, a risk manager has some options.

In certain jurisdictions, such as Bermuda, policies often contain clauses directing the next steps.

"Policies written in Bermuda almost always have some kind of (alternate dispute resolution) provision in them—typically arbitration," said Dan Bailey, member of the Columbus, Ohio-based law firm Bailey Cavalieri L.L.C. "Most policies issued by domestic carriers lack these provisions, although sometimes you see it."

Even without an ADR provision, the respective parties can agree to it after a claim is rejected, although determining which course of action is best depends on understanding these resolution mechanisms and their key differences, he said.

"Each of the types of ADR provisions have their advantages and disadvantages to the insured and the insurer, so an insured should carefully consider and understand its options before agreeing to any type," Mr. Bailey said (see related story).

For instance, a decision reached through arbitration typically is binding, whereas a decision reached through mediation is not. The former mechanism ends the dispute and removes litigation as a recourse, while the latter leaves litigation as a possibility.

"Mediation will not resolve a dispute that the parties are unwilling to resolve, although there are professional mediators out there…who are very effective at structuring a resolution," Mr. Reiter said.

Some insurance policies contain mediation and arbitration provisions.

"A mandatory progressive ADR provision might require that the parties first try to resolve the dispute through a meeting, then through mediation and then finally through binding arbitration," he said.

Arbitration is a sophisticated mechanism, involving a host of requirements, restrictions and determinations. In one example Mr. Bailey provided, one Bermuda policy had a three-page arbitration provision. It noted the location of the arbitration proceeding, limitations regarding who can serve as an arbitrator—in this case, someone familiar with the business of insurance—and the selection process to choose a panel of arbitrators.

Typically, each side in a dispute chooses one arbitrator and a neutral third party chooses an arbitrator for the panel. There can be as many as five arbitrators and as few as one, Mr. Reiter noted, although there are no hard and fast rules on the size of the arbitration panel. "All these various permutations can be worked out beforehand," he said.

Most provisions requiring arbitration set a timeline for resolution. "Typically, the deadlines and other rules relating to how the arbitration should proceed are culled from the American Arbitration Assn., which has fairly defined processes," said Paul J. Becker, senior claims consultant in the strategic outcomes practice of broker Willis in Dallas.

Risk managers have at their disposal two other types of ADR to assist claims resolution. One pertains only to those disputes in which the dollar amount of the claim is at issue, in which case the policy can be worded to require a third-party appraisal of the claim value.

The other is what Mr. Becker called an advocacy approach. "Sophisticated brokers have people such as myself who can assist in resolving disputes before they go to mediation, arbitration and litigation," he said.

ADR is not the most common way of resolving disputes. "Most coverage disputes are resolved through a negotiated settlement rather than through litigation or ADR," Mr. Bailey said.

But litigation brings to mind the financial question of when to engage lawyers in the dispute.

This is where observers diverge, with attorneys maintaining that internal and external counsel should become involved once the risk manager has formed an initial impression of the validity of the claim denial, and brokers indicating that lawyers are needed only after discussions have devolved with the insurer.

The size of the claim also figures in this reasoning, with large claims requiring earlier involvement by attorneys and smaller claims not necessarily needing any legal assistance.

As Mr. O'Brien said, "The time to call in an attorney is somewhat fluid."

Pros, cons of dispute resolution methods

By RUSS BANHAM

There are several methods for settling differences, each with its own plusses and minuses.

Take mediation, for instance. While the process generally is quick and inexpensive, the decision isn't binding.

"The fundamental problem with mediation is it is not coercive," said Thomas M. Reiter, partner at Pittsburgh-based global law firm K&L Gates L.L.P.

"You can mediate all you want, but at the end of the day it doesn't guarantee the insured will get its money," he said.

This drawback has a silver lining, however. "The fact that mediation isn't binding means that either party can continue with its side of the dispute in arbitration or litigation," Mr. Reiter added.

Binding arbitration ends the dispute, but it, too, isn't perfect. "One cannot say arbitration is advantageous or disadvantageous," said attorney Dan Bailey, member of the Columbus, Ohio-based law firm Bailey Cavalieri L.L.C.

"On the one hand, it is frequently quicker than litigation because you don't have to wait to get on the docket of the court; you just appoint the arbitrators and do your thing. It is also typically cheaper because you can limit the scope of the discovery so it doesn't drag out like litigation usually does," he said.

Nevertheless, Mr. Bailey acknowledged that "some arbitrations last just as long and are as expensive as litigation," he said. "There's no silver bullet."

The biggest potential downside to arbitration is that once a decision is reached, there is no recourse to revisiting the issue. "You get one shot and that's it," Mr. Bailey added.

While neither attorney recommended litigation as the initial sally in a claim dispute, the primary advantage to the courtroom for the insured is that if a decision is reached with which it disagrees, there is always the opportunity to appeal it to a higher court.

On the downside is the uncertain emotional makeup of a jury. "Unlike professional arbitrators and mediators, juries are made up of lay people who may not understand the issues very well," Mr. Reiter said.

While juries often side with the policyholder in cases against big insurers, there is no guarantee of this outcome, he added. "Many insurers prefer arbitration, and insureds often prefer otherwise," he said. "But, one never knows."

What you should know before suing an insurer

Run the numbers on costs vs. benefits, consider timing

By JUDY GREENWALD

When policyholders decide their only option is to pursue litigation against their insurers in coverage disputes, they should first conduct a cost-benefit analysis to see if it would be worth their while, say policyholder attorneys.

Speed may be critical, say attorneys, who note there can be a "race to the courthouse" as policyholders and insurers rush to file lawsuits in the jurisdictions viewed as most sympathetic to their cause.

At the same time, experts say negotiations should continue even after litigation has been filed. In fact, observers note relatively few coverage cases ever actually reach the trial stage, and settlements often are reached at the last moment before trial.

Experts also say policyholders' frequently voiced concern that they somehow will be excluded from the insurance market if they sue their insurers is unfounded.

Litigation sometimes may be necessary, say observers. "If you're in a spot where simply the insurance company draws the line in the sand and refuses to discuss any further, and the parties are at loggerheads," policyholders may be forced to file suit, said Scott N. Godes, of counsel at Dickstein Shapiro L.L.P. in Washington.

"Policyholders should stand by their rights," said Gary Thompson, a partner with Reed Smith L.L.P. in Washington. "Don't let the insurance company be a bully."

Richard D. Milone, a partner with Kelley Drye & Warren L.L.P. in Washington, said there are three key variables in conducting a cost-benefit analysis: How much the policyholder expects to recover, which "can be a real moving target" because this can depend on the underlying litigation; how much the insurance coverage litigation is going to cost, which takes into account the prospects for a summary judgment; and the case's merits.

Timothy W. Burns, a partner with Perkins Coie L.L.P. in Madison, Wis., said, "I've had million-dollar disputes that it wouldn't make sense to litigate over in court because of the cost of recovery."

Benedict M. Lenhart, a partner with law firm Covington & Burling L.L.P. in Washington,

Continued on next page

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said, "Sometimes, there are issues at stake beyond the immediate case." For instance, there might be a relatively small claim in dispute, but if you are afraid of having to file more of the same type of claim, "you've got to make the precedent that there's coverage."

Another consideration is how litigation could impact underlying litigation, such as in product liability cases, said Steven Gilford, a partner with Proskauer Rose L.L.P. in Chicago. "There may be concern about whether or not it is strategically sensible to be litigating both of those at the same time."

The amount of time involved also should be taken into consideration. "Coverage cases can require significant resources in terms of responding to inquiries and discovery requests," said Mr. Gilford.

"To the extent management is distracted from day-to-day business activities to focus on a dispute, that can lead to more acrimonious litigation" and "certainly is a drain on company resources," said Seth D. Lamden, a partner with Neal Gerber & Eisenberg L.L.P. in Chicago.

Policyholders should develop a clear timeline that lays out "what they are trying to achieve, by what date," said Robert M. Horkovich, a shareholder with Anderson Kill & Olick P.C. in New York.

There is sometimes a rush to the courthouse to try to ensure the most favorable jurisdiction. The law may be favorable for policyholders in one jurisdiction and advantageous to insurers in another, "and frequently it's a race to the courthouse," said Mr. Horkovich.

"Insurance companies sometimes jump the gun and sue their own policyholders first, because they want to get into a jurisdiction where they can manipulate results, or in front of a judge they think is friendly toward insurance companies," Mr. Thompson said.

Mr. Gilford said some courts construe ambiguous policy language in policyholders' favor, some do so only under particular circumstances, some hold policies should be interpreted in light of policyholders' reasonable expectations, and some do not. These issues arise particularly when there is ambiguity or dispute over the policy language that may come into play, he said.

Many times though, said Mr. Lenhart, "there's only one realistic forum."

Finley T. Harckam, a shareholder with Anderson Kill in New York, warned that particularly for first-party property polices, there often are contractual deadlines for filing suit against insurance companies, "and policyholders have to be very mindful of those. They can be as short as one year," he said.

These deadlines can be enforced even if the loss is continuing, for example in a case where a hotel is destroyed and a year later there are still business interruption claims, Mr. Harckam said.

Experts say even if litigation has been filed, it does not necessarily preclude continued negotiation—in fact, filing suit can encourage settlement.

Mr. Gilford said, "One of the things litigation does is allow you to centralize the dispute and deal with information on a centralized basis, and frequently a court will supervise or require a mediation process, so it creates a vehicle to exchange information in an orderly way," which "is often difficult to manage in the absence of litigation."

Observers label as unfounded policyholders' frequently expressed concern that filing litigation will hurt their ability to get insurance.

"My experience has been that insureds frequently bring lawsuits against their insurers to resolve dispute claims and have had no problems finding appropriate insurance," Mr. Lamden said.

The fear is overblown, said Mr. Lenhart. "In my 20 years' experience, I've not seen a policyholder suffer because they decided to pursue a coverage claim in litigation."

Litigation "certainly strains the relationship," but even if it affects your relationship with the claims department, "it shouldn't have an effect on underwriting," said Mr. Gilford.

"Insurers are counting on the fact that policyholders will back down from their heavy-handed positions," said Mr. Thompson. But they "shouldn't be afraid to take on their carriers. That's why they buy the insurance."

LITIGATING AGAINST INSURERS

Advice from experts to consider in pursuing litigation:

- Recognize that sometimes litigation is the only feasible option.
- Conduct a cost-benefit analysis to see whether it is worthwhile based on the potential cost, prospects for success and strength of your case.
- Consider issues at stake beyond the immediate claim, such as future comparable claims.
- Evaluate the impact of coverage litigation on underlying litigation, such as in product liability cases.
- Factor in the amount of time involved, including distraction for management.
- Develop a clear timeline as to what you are trying to achieve, and by what date.
- Keep in mind the possible advantages of filing before the insurer.
- Continue settlement negotiations, even after litigation has been filed.
- Don't worry about litigation's impact on obtaining future coverage.

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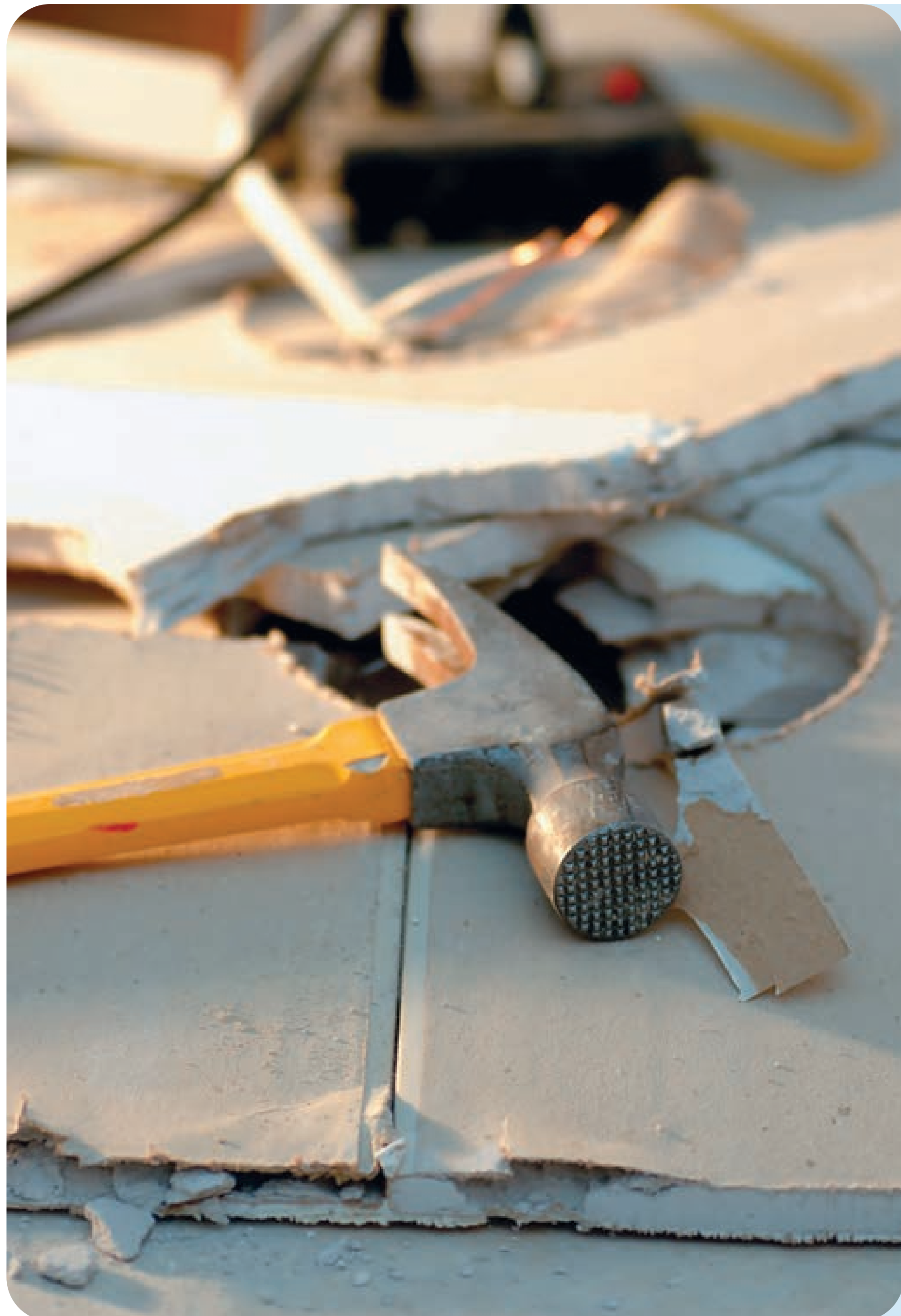

CASE STUDY

Winning race to courthouse proves vital first victory

By JUDY GREENWALD

Policyholders who decide to pursue litigation against their insurers often participate in a "rush to the courthouse" to file before their insurers in the belief this provides them with an advantage.

A September 2010 ruling in litigation involving Chinese drywall in which insurers unsuccessfully moved to have the case moved to a Florida court from one in Louisiana, where policyholders had filed litigation first, illustrates one such policyholder success.

Robert Horkovich, a policyholder attorney and shareholder with Anderson Kill & Olick P.C. in New York, said the ruling in *Chartis Specialty Insurance Co. and Lexington Insurance Co. vs. Robert C. Pate, WCI Communities Inc. and WCI Communities L.L.C.* by the federal district court in Tampa, Fla., was significant because Louisiana does not apply the pollution exclusion outside of traditional environmental contamination, while Florida law does.

According to the ruling, Chartis Specialty and Lexington, units of New York-based Chartis Inc., had sued for declaratory relief as to their duty to defend or indemnify Mr. Pate in his capacity as the trustee of the Chinese Drywall Trust under a liability insurance policy issued by each plaintiff.

The defendant insurers moved to dismiss the "lack of subject matter jurisdiction" and to either dismiss, transfer or stay the action in deference to a previously filed action in the U.S. District Court for the Eastern District of Louisiana in New Orleans.

The "first-filed action" in this case was a lawsuit filed by the policyholders against the insurers that sought a declaratory judgment that each insurer had an obligation to indemnify the trust as to each claim arising from the sale of homes that allegedly contained defective Chinese drywall.

The policyholders also pointed out that the New Orleans judge already had issued discovery orders and scheduled hearings on motions in the case, and charged that the insurers' attempt to have the Florida court hear the case was a "flagrant and belated attempt at forum shopping," according to the Florida ruling.

The insurers argued the first-filed action was "only in its infancy," among other arguments, and that the New Orleans court was an improper forum. It also charged the trustee with forum shopping.

The Florida court agreed to transfer the case to Louisiana, stating in part, "the plaintiffs failed to show a compelling circumstance warranting disregard of the first-filed rule."

Mr. Horkovich said the Louisiana court has stayed the multidistrict litigation in the Chinese drywall cases in favor of mediation among the parties.

CASE STUDY

Litigation pays off in asbestos cases

By JUDY GREENWALD

The asbestos litigation that consumed much policyholder-insurer litigation for decades—and still continues—has resulted in net losses to insurers that are expected eventually to total $65 billion, according to the New York-based Insurance Information Institute Inc.

This reflects, at least in part, policyholder success in litigating the issue of insurer coverage.

There have been dozens of rulings on the issue during the past 30 years or so. One illustrative decision is the 1996 ruling by a three-judge panel of the California state appeals court in San Francisco in *Armstrong World Industries Inc. vs. Aetna Casualty & Surety Co.*, which denied review of a lower court's ruling in policyholders' favor.

The opening paragraph illustrates the intricacy of the issue: "This appeal raises a number of complex questions concerning insurance coverage for claims of asbestos-related bodily injuries and property damage," wrote Justice Robert L. Dossee.

"In the proceedings below, separate declaratory relief actions and related cross-actions involving three asbestos manufacturers—Armstrong World Industries Inc., Fibreboard Corp. and GAF Corp.—and their various insurance carriers were coordinated and tried in six separate phases over a five-year period."

A footnote explains that Phase 1 involved the existence and terms of missing insurance policies; Phase 2 concerned the application of exclusions for asbestosis; Phase 3 involved the trigger and scope of coverage for bodily injury claims, the meaning of the "neither expected nor intended language" contained in some of the policies, and the defense obligations of various insurers under their policies; Phase 4 involved various coverage issues not resolved in Phase 2; Phase 5 concerned coverage for property damage claims; and Phase 6 involved issues of damages, bad faith and contribution claims.

In ruling in the policyholders' favor, the court said, "In summary, we affirm the trial court's decision that all claims in the underlying building cases, whether for releases of asbestos fibers or for the mere presence of (asbestos-containing building material), qualify as claims for 'physical injury to…tangible property' and are covered by the insurance policies."

The appellate court upheld the lower court's ruling in favor of policyholders on several other issues as well, while it remanded one issue related to an excess policy.

UP CLOSE

COMINGS & GOINGS

BRIAN CELIBERTI

NEW JOB TITLE: New York-based executive director and employee benefit services sales leader for New York-based Frank Crystal & Co.

PREVIOUS POSITION: New York-based managing director for Strategic Employee Benefits Services of New York Inc.

GOALS FOR NEW POSITION: Continuing the dramatic growth trend of our employee benefits practice and FCC as a whole.

CHALLENGES FACING INDUSTRY: The never-ending increase in health care costs and potential impact of pending health care reform.

INDUSTRY OUTLOOK: The future is bright for innovative, hard-working, client-centric brokers. Brokers who have successfully assisted their clients through the recent economic and regulatory pressures have fared very well. The challenges won't go away anytime soon, and organizations will increasingly engage talented organizations for solutions.

BEST THING ABOUT A BAD ECONOMY: It provides opportunity. Every organization has been forced to take a closer look at budgetary items and more closely examine their employee benefit and risk management costs. Providing innovative solutions to fiscal challenges has successfully seen FCC though a challenging economy.

COLLEGE MAJOR: Political science, Susquehanna University.

SOMEONE ONCE TOLD ME: To win the race...get ahead and stay ahead.

OUTSIDE THE INDUSTRY, A DREAM JOB: General manager for the Yankees.

HOBBIES: Golf, whatever my children are doing.

MOST PASSIONATE ABOUT: My family.

FAVORITE BOOK: There are many. Two recent favorites are "1776" by David McCullough and "Lone Survivor: The Eyewitness Account of Operation Redwing and the Lost Heroes of SEAL Team 10" by Marcus Luttrell.

FAVORITE MEAL: My mother's spaghetti and meatballs.

ON A SATURDAY AFTERNOON: I am on a ball field watching my kids' games followed by a family dinner.

EMAIL OR PHONE, AND WHY: Email is a great tool, but nothing replaces the phone.

Market Moves

Validus launches catastrophe reinsurer

PEMBROKE, Bermuda—Validus Holdings Ltd. has launched a new Bermuda reinsurer capitalized with $500 million.

The reinsurer, PaCRe Ltd., will underwrite top-layer property/catastrophe reinsurance, a Validus spokesman said.

In a statement announcing the capitalization, Validus said the Bermuda entity was formed to "combine the attractive returns available" from underwriting such reinsurance with a long-term approach to asset management.

PaCRe will begin deploying capacity for the June 1 renewal season, Validus said in the statement.

Validus has invested $50 million in PaCRe's equity. The rest will come from outside parties, the spokesman said. New York-based Paulson & Co. will manage the reinsurer's investment portfolio.

Gallagher acquires Besselman & Little

BATON ROUGE, La.—Arthur J. Gallagher & Co. has acquired Baton Rouge, La.-based employee benefits consultant and insurance broker Besselman & Little Agency L.L.C.

Terms of the transaction were not disclosed.

Founded in 1986, Besselman & Little specializes in group medical, dental, life, retirement and pension plans, as well as disability and long-term care insurance programs.

Besselman & Little's existing staff of 22 employees, including former owner Tom Besselman, will continue to work in their current offices in Baton Rouge and New Orleans, Itasca, Ill.-based Gallagher said in a statement.

"With their team-focused approach to outstanding service, client satisfaction and solid relationships, Besselman & Little is a great example of what we look for in a merger partner," Gallagher President and CEO J. Patrick Gallagher Jr. said in the statement.

TPA TRISTAR acquiring claims management firm

CRANBURY, N.J.—Third-party administrator TRISTAR Risk Management says it is acquiring Cranbury, N.J.-based national property/casualty claims management company Risk Enterprise Management Ltd.

REM's brand will be retired, and the combined company will operate as TRISTAR Risk Management. The combination is expected to generate more than $100 million in annual revenue with nearly 1,000 employees in 44 offices providing services nationwide, TRISTAR said.

Terms of the deal, which was effective April 11, were not disclosed.

Long Beach, Calif.-based TRISTAR said neither company will close offices. It also said a "significant corporate office presence" will be maintained in Cranbury.

"We are approaching the combination of the two companies as a merger to leverage the complementary strengths of both organizations," Tom Veale, TRISTAR's founder and president, said in a statement.

Privately held TRISTAR, with annual revenue of $65 million, said it has more than 600 employees in 22 branch offices across 10 states.

"The merger will create a leading national property/casualty TPA with significant scale, an extensive geographic footprint, deep analytical and (information technology) resources and a diversified claims management offering," TRISTAR said in the statement.

Aon to buy ABN AMRO brokerage operations

AMSTERDAM—London-based Aon P.L.C. said its Rotterdam-based Aon Groep Nederland B.V. subsidiary will acquire the commercial insurance intermediary operations of ABN AMRO Bank N.V.

Amsterdam-based ABN AMRO's insurance activities include a risk consultant and insurance brokerage for small, midsize and large commercial enterprises. In total, 78 employees will transfer to Aon Risk Solutions, the global risk management business of Aon, the companies said in a statement.

"This acquisition brings together two premier organizations and reinforces Aon's strong commitment to the Netherlands," Aon Risk Solutions Chairman and CEO Steve McGill said in a statement. "Combining the best talent between the two firms enhances our ability to deliver world-class solutions to our clients."

Financial terms of the transaction were not disclosed.

Comings&Goings

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Perspectives

Despite predictions that the next big liability exposure would come from activities that allegedly led to global warming, there have been few cases directly related to climate change. And where suits have been filed, most courts have found them "nonjusticiable" or political in nature, say attorneys Lawrence D. Mason and John A. Lee of Segal McCambridge Singer & Mahoney Ltd.

Climate change lawsuits gaining little traction

Mr. Mason

Mr. Lee

Thus far, the response to climate change lawsuits has been a fairly consistent judicial chorus of, 'You've come to the wrong place.'

By Lawrence D. Mason and John A. Lee

Many in the insurance industry recall the Y2K scare and the flood of litigation it was expected to unleash.

More recently, some were predicting that the lawsuits the insurance industry avoided when Y2K fizzled would materialize in response to global climate change claims. "Global Warming: Here Come the Lawyers," warned Businessweek in late 2006, proclaiming, "It's the next wave of litigation—after tobacco, guns, and junk food. Why Detroit, Big Oil, and utilities should worry."

Enough time has passed now since that initial alarm was raised to allow us to look back and gauge to what extent the predicted wave of cases has materialized and to measure any impact it might have made.

While some questions remain unsettled about the effects of global warming and the efficacy of curtailing it by changing human behaviors, few scientists dissent from the idea that the burning of fossil fuels, which releases greenhouse gases such as carbon dioxide and methane, has had an observable impact on Earth's atmosphere and oceans. People skeptical of our political institutions' ability to address this impact recently have begun to turn to the courts for relief.

So far, the targets of this litigation have been limited to fossil-fuel burning industries and the insurance companies who defend and indemnify them.

To date, only a few cases directly related to climate change have been filed. Of these, *American Electric Power Co. Inc. et al. vs. Connecticut et al., California vs. General Motors Corp., Comer vs. Murphy Oil USA Inc.* and *Native Village of Kivalina vs. ExxonMobil Corp.* are the most significant.

Interestingly, most of these courts have proven reluctant to deal with the underlying issues in the cases, dismissing them as "nonjusticiable" or political in nature, more properly dealt with by the other branches of government.

In *American Electric Power*, eight states, New York City and three nonprofit land trusts sued five major power companies, claiming their carbon dioxide emissions harmed the environment. As relief, they sought an emissions cap, one that would be tightened progressively in following years. The lower court dismissed the case as political, but the plaintiffs appealed to the U.S. Supreme Court, which upheld the dismissal of the underlying suit because regulation of power plants' carbon-dioxide emissions is under the purview of the appropriate federal agencies and not a subject for private suit.

In *California*, the state sued various automakers under public nuisance law, saying their products' emissions contributed to the public nuisance of global warming. Again, the lower court dismissed the case as centering on political questions. California appealed the ruling but then withdrew the appeal.

In *Comer*, property owners along the Mississippi Gulf Coast sued several oil companies, claiming that their activities had led to global warming, which had worsened the severity of Hurricane Katrina. Once again, the lower court deemed the case political in nature and dismissed it. After some more legal maneuvering, including a reversal of the initial federal court decision, the case ultimately returned to the Southern District of Mississippi federal district court. It dismissed the action because the alleged injuries were not fairly traceable to the defendants, the lawsuit was displaced by the Clean Air Act, and the complaint was premised on political questions.

The pattern that clearly emerged in these earlier cases continued in the *Kivalina* case. Kivalina is an Inupiat island community in the Arctic waters just off the Alaskan coast. Residents sued ExxonMobil and other energy firms, claiming the companies' activities were contributing to global warming, which damaged the sea ice that protects the island's coast from storms. Shoreline erosion, the suit claimed, ultimately would force the population to relocate.

Once again, the judge dismissed the issue as political, ruling that "Plaintiffs are in effect asking this Court to make a political judgment that the two dozen Defendants named in this action should be the only ones to bear the cost of contributing to global warming." The court also addressed another issue—the fact that while the plaintiffs admitted they were unable to directly trace their alleged injury to any particular defendant, they claimed the defendants "contributed" to their injuries. The judge rejected this argument, reasoning that because there is no federal standard limiting the discharge of greenhouse gases, "it is entirely irrelevant whether any defendant 'contributed' to the harm because a discharge, standing alone, is insufficient to establish injury."

This case is awaiting an appellate decision.

Insurance coverage

At publication time, *Kivalina* was the only underlying climate change case that has given rise to a coverage action.

One of the defendants in *Kivalina* was AES Corp., a Virginia-based energy company. AES turned to its insurer, Steadfast Insurance Co., seeking defense and indemnification. Steadfast provided a defense under a reservation of rights and filed a declaratory judgment action seeking a determination of no coverage based on the grounds that the suit didn't allege "property damage" caused by an "occurrence," as the policy contemplated it; any injury happened before the policy was in place; and the pollution exclusion in the policy precluded coverage.

The Virginia Supreme Court ultimately affirmed a lower court ruling that AES was not entitled to coverage under the Steadfast policies. In reaching its decision, the court focused on the fact that AES' emissions of greenhouse gases were intentional, arguably negligent, and generally known to be contributory to global warming. The court didn't address the pollution exclusion issue.

In a surprising twist, however, the Virginia Supreme Court on Jan. 17 agreed to set aside its ruling and granted AES' petition for a rehearing. According to AES, the Virginia Supreme Court's *Kivalina* ruling departed from precedent and basic principles of insurance law by replacing an intentional act standard with an ordinary negligence standard when considering whether there was an occurrence providing coverage, and if allowed to stand, "will eliminate (CGL) insurance coverage in most cases."

On April 20, the Virginia Supreme Court upheld its prior ruling, finding there was no coverage because the underlying complaint alleged damages that were the "natural and probably consequence" of AES's intentional actions. Consequently, the court noted that the complaint did not allege a fortuitous accident or event.

Thus far, the response to climate change lawsuits has been a fairly consistent judicial chorus of, "You've come to the wrong place." Insurers have not been exposed to protracted litigation or been required to pay indemnification costs, and the one coverage case was a win for the industry. Nevertheless, the claims picture remains uncertain for insurers and insureds alike as scientific understanding grows, the regulatory framework continues to evolve, and plaintiffs attorneys inevitably bring additional climate change cases based on different legal theories.

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Wal-Mart: Firms need corruption safeguards

CONTINUED FROM PAGE 1

going into this, trying to do the right thing, and you're being undermined by your agent," he said.

Nearly half of the enforcement actions come from allegations stemming from third-party intermediaries that expose U.S. companies to FCPA violations, Mr. Husisian said.

Since 2008, FCPA enforcement trends show that the size of the penalties is increasing, and many of the largest settlements occurred in 2010 and 2011, experts say.

According to a Marsh Inc. report, the Department of Justice in 2010 imposed a record $1.2 billion in criminal fines for FCPA-related cases, and the SEC received about $530 million in disgorgement, civil penalties and pre-judgment interest. The combined recovery is more than twice the $890 million recovered in 2008, Marsh said.

Enforcement trends show high-risk geographies and industries for FCPA activity, which include oil and gas, mining, infrastructure, telecommunications and technology industries in countries such as China, Indonesia, Iraq, Nigeria and Mexico, experts say.

"All this is intended to have a deterring effect so that companies don't say, 'This is just the way you have to do business in these countries,' " Mr. Husisian said.

In the case of Wal-Mart, which is under investigation over allegations that Wal-Mart de Mexico paid $24 million in bribes to foreign officials, potential settlements with U.S. authorities reportedly involve several hundreds of millions, or even billions, of dollars of penalties. Wal-Mart did not return calls seeking comment.

With the increased FCPA enforcement, companies' compliance with the regulation is a top priority for senior-level executives, who are concerned with other implications of FCPA violations such as loss of business and reputational harm, said Joe C. Underwood, principal at Albert Risk Management Consultants Inc. in Needham, Mass.

"It's not just the penalties," he said. "They could lose very lucrative contracts if they were found in violation of the FCPA. They can have reputational injury. There could be stock value drops. These are difficult to measure, but they are substantial."

Machua Millett, Boston-based senior vp in Marsh's FINPRO practice, said most multinational companies seek to comply with FCPA regulations with robust compliance and legal departments.

"But there comes a point at which it becomes impossible to control every single employee and every single third-party agent that you interact with and hire," he said.

"In response to that more aggressive focus on this issue, companies are doing everything they can to ensure that they're in compliance with the law," said Bryan Quigley, Washington-based senior vp and spokesman for the U.S. Chamber of Commerce's Institute for Legal Reform.

Mr. Quigley said companies are pushing for clarity and guidance in terms of how authorities are pursuing FCPA issues.

While experts note that changes to the FCPA are unlikely, the Chamber of Commerce has proposed guidelines for enforcement clarity to help organizations comply (see related story).

To mitigate FCPA violations, multinational companies should first institute reasonable internal controls and develop a formal compliance program, which would include training and obtaining written agreements if, for example, a foreign official is to receive payment that he or she will not have a role in awarding a contract, Mr. Underwood said.

"Because of the ambiguity regarding who constitutes a foreign official, I would err on the side of caution and make it a broad assessment," he said.

Multinational companies also should utilize independent FCPA experts and advisers when building and structuring their compliance program, such as legal and financial consultants, and decide whether to launch an internal investigation and self-report to the Department of Justice in the event of a violation, said Marsh's Mr. Millett.

Organizations also need strong contractual provisions for third-party vendors and consultants to quickly cut someone off if an FCPA violation occurs, Mr. Husisian said. "The only way to combat that is to make sure you have the right agent, make sure the agent is trained and realizes the risk, and that you're checking up on the agent through audits," he said.

Once contracts and compliance standards are in place, companies need to monitor, supervise and periodically audit those agents, Butler University's Mr. Koehler said, also noting that FCPA compliance should be applied holistically and not be the sole responsibility of the legal department.

An organization's finance, audit, logistic, risk management and human resource departments need to have "a pair of FCPA goggles," Mr. Koehler said. "They don't need to be experts, but they need to know enough to spot issues."

U.S. Chamber calls for FCPA clarifications

The U.S. Chamber of Commerce's Institute for Legal Reform recently proposed five amendments to the U.S. Foreign Corrupt Practices Act to help multinational organizations comply with regulations.

Bryan Quigley, Washington-based senior vp and spokesman at the Chamber of Commerce's Institute for Legal Reform, said the bottom-line effort is not to eliminate the FCPA but to strengthen the law through clarity.

"Companies that do business abroad very much want to comply with the FCPA and, if there are places where there are genuine issues of clarity, we think it is common sense that the rules of the road are clarified so that (companies) can make sure they're in compliance," Mr. Quigley said, noting that unclear enforcement of the statutes and rules of the FCPA may have a chilling effect on businesses considering operating abroad.

In February, the Chamber of Commerce and more than 30 businesses and organizations sent a letter to the Department of Justice and the U.S. Securities and Exchange Commission identifying five areas that FCPA guidance should address.

"At this point we're waiting to see what the guidance is coming out of the Department of Justice," Mr. Quigley said. "Exactly when it's going to come, we're not sure. I would anticipate sometime hopefully around the middle of the year."

The five proposed reforms to the FCPA are:

- Adding a compliance defense;
- Limiting a company's liability for the prior actions of a company it has acquired;
- Adding a "willfulness" requirement for corporate criminal liability;
- Limiting a company's liability for acts of a subsidiary; and
- Defining a "foreign official" under the statute.

—By Mike Tsikoudakis

Reputation: Use social media in responding to crises

CONTINUED FROM PAGE 1

these kinds of circumstances around natural catastrophes, right? Social media needs to come into that fray now."

"We do crisis management plans for our clients and part of that is social media," said Ms. Howell, noting that those plans cover aspects such as who will respond to a reputational crisis and what steps will be taken.

"It's all got to be ready to go instantly," said Ms. Howell. "Companies have to have a plan in place to deal with it, and then they have to deal with it. And they can't wait."

Last fall, Johnston, R.I.-based FM Global faced its own social media reputation threat during derivatives brokerage MF Global Holdings Ltd.'s financial collapse. The insurer first became concerned about the reputational issue in October 2011 as speculation grew about MF Global.

FM Global Chairman and CEO Shivan S. Subramaniam "at the time was experiencing concern that there might be name confusion and that FM Global's name might be associated with some of the things that were being said about MF Global," said Steven Zenofsky, assistant vp and manager of public relations at FM Global.

When MF Global announced its bankruptcy, "what we started noticing as a public relations team was the more stories were being written about MF Global, the more mistakes were being made unintentionally," said Mr. Zenofsky, who was involved in the insurer's response effort.

The reputation risk accelerated in December when, during a U.S. House Agriculture Committee hearing on the MF Global collapse, Rep. Frank Lucas, R-Okla., the committee chairman, mistakenly—and repeatedly—referred to the failed company as FM Global.

"The public relations team started responding to errors that were occurring in blogs or in the Twittersphere," Mr. Zenofsky said. "Before long, FM Global was one of the top 10 trending topics on Twitter."

FM Global's team reached out through social media to anyone mistakenly associating their brand name with the financial firm's collapse. "We did it with a sense of humanness," Mr. Zenofsky said. "Because if they're unintentionally making an error, you don't want to bash them."

Ann Arbor, Mich.-based Domino's Pizza faced a social media reputation threat with a less innocent origin in April 2009 when two employees of a Conover, N.C., Domino's created a video of one of them engaging in various unsanitary acts with food items they claimed were being sent out to customers. They posted the video to YouTube, the video went viral, and Domino's suddenly faced a serious reputational risk.

Ultimately, Domino's responded with a YouTube video of its own featuring now-CEO J. Patrick Doyle explaining the incident as a hoax and offering the company's response.

"Now, three years later after the scars have sort of gone away, I wish we would have done our CEO's video one day earlier," said Tim McIntyre, vp, communications at Domino's. "Or I wish we could have been more public with what we were doing behind the scenes."

The incident occurred on Easter Sunday. "The video was posted at 4 in the afternoon and we knew about it 45 minutes later," Mr. McIntyre said. But, he said, before the company could respond it had to find the people responsible and determine whether the video was real or a hoax. The following day, having accomplished those things, the company began crafting its social media response.

On Tuesday, "We temporarily turned one of our employee's Twitter accounts into a Domino's Twitter account," he said. "We decided we couldn't go the traditional route to handle a social media crisis," Mr. McIntyre said. "It was a social media crisis, so we had to use the social media."

When they posted Mr. Doyle's video on Wednesday, Domino's deliberately mirrored the keywords and tags used in the original video so their response video would come up alongside the offensive video in any searches. "We kind of ruined it for them," Mr. McIntyre said.

Ms. Howell offered another example with Memphis-based FedEx Corp.'s response in December when a YouTube video of a delivery man tossing a new computer monitor over a fence went viral as another example of a company responding quickly. FedEx quickly posted its own video acknowledging the event, taking responsibility and apologizing to the customer, and communicated its response on Twitter.

"They've been criticized for the quality of that video but it was more important that they got the video out there," the consultant said.

In each case, the companies involved used the social medium in which the threat was developing as a cornerstone of their response.

"FedEx did not issue a press release. They did not put anything on the wire. They responded in social media," Ms. Howell noted. She said, however, her preference is to "blend all media. It's being proactive and covering all your bases."

FM Global's Mr. Zenofsky said, "It's interesting now if you look at the outcome. We really were able to preserve our digital footprint," Mr. Zenofsky said. For example, the top result in a Google search of "FM Global bankruptcy" is a story about the insurer's efforts to correct the misidentification.

"These things can live forever in search if you don't move quickly to correct them," Mr. Zenofsky said.

"People are going to YouTube to look at these videos," said Aon Risk Solutions' Mr. Ram. "You want your response to be right next to that video."

Labs: Tests raise costs, questions

CONTINUED FROM PAGE 1

and ethics.

The recent questions raised by workers comp experts about the urine and blood testing laboratories are ones that employers seeking their services also should be asking, observers say.

Drug-testing companies provide their services through medical providers, including those treating workers compensation patients who are prescribed narcotics because of the nature of work-related injuries, sources said.

But the Oakland-based California Workers' Compensation Institute is expected to release results as early as this week from a study seeking to answer whether skyrocketing demand for drug testing is a new workers compensation system "cost driver," said Alex Swedlow, CWCI's executive vp-research.

"The level of utilization and costs (of drug testing) have been increasing at a viral-like rate," Mr. Swedlow said. "The preliminary numbers that we are seeing validate that the number of tests and dollars spent on these tests are growing at a very, very significant rate."

Meanwhile, the workers comp system lacks protocols for the testing of narcotics, Mr. Swedlow said. "There is no guideline, no acceptable standard, no rationale for when and how and what to test for," he said.

But drug-testing companies and other testing advocates say prescription-compliance monitoring helps assure that patients in and out of the work compensation system consume addictive pain medications as prescribed for them rather than divert them into the black market.

Testing also helps discourage drug misuse or abuse, such as doctor shopping for multiple prescriptions, and is a "best practice" to ensure patients' well-being, they say.

"Monitoring these medications through urine drug testing is part of the clinical guidelines recommended by the American College of Occupational and Environmental Medicine and Official Disability Guidelines," among other organizations that develop practice guidelines, said Dr. Harry Leider, chief medical officer for Baltimore, Md.-based Ameritox Ltd., a drug-testing company. Ameritox offers a program to help identify workers comp claimants who should be candidates for the testing, Dr. Leider said.

Interest in claimant drug-testing services among insurers, third-party administrators, managed care companies and self-insured employers has grown within the past two years as they seek to determine which claimants might benefit from the testing, said Jennifer Kaburick, director of workers comp product management for St. Louis-based Express Scripts Inc.

"We see (that) discussed more frequently," Ms. Kaburick said. "Our clients discuss it with us as a tactic they are using to help control and manage the use of narcotics. It's an opportunity for them to validate that either the person is taking the medication at dosages that are being prescribed or they are not."

Payers can then use that information in discussions with claimants' doctors, Ms. Kaburick said.

Interest in testing injured workers for drug-regimen compliance has followed in the wake of U.S. government reports released in the past year about skyrocketing pain-medication use and abuse among the nation's population.

Ironically, while those reports focus on prescription use among the general population, narcotics have been commonly prescribed for injured workers for years because workplace accidents often cause painful injuries, Ms. Kaburick said.

Some payers also have grown interested in prescription-compliance monitoring because narcotics account for a substantial portion of workers comp medical expenses, sources said.

Simultaneously, more companies are entering the drug-testing field, and more drug-testing labs

are seeking to service the workers comp industry.

"They have certainly marched into comp and said, 'Our services are needed here and underutilized and how can we grow our business through the comp channel?'" said Ron Skrocki, vp of product management and development for GENEX Services Inc., a Wayne, Pa.-based case-management company.

But some major testing laboratories are themselves raising questions about industry practices in lawsuits against one another. Ameritox Ltd. and San Diego-based Millennium Laboratories Inc., for example, are enmeshed in lawsuits against each other over issues such as their use of science, ethics questions, and business practices used to attract doctors' business.

Some labs have provided doctors with revenue for patient referrals, while others have coached doctors on how to increase their revenue with schemes such as "up-coding" billing practices, sources said.

Such practices have led GENEX to question several lab companies about their business models, ethics, and strategies for attracting new business, said Mr. Skrocki. The vetting has been part of GENEX's search for potential business partners. "We want (partners with) a clean and defensible and fully transparent business model," Mr. Skrocki said

GENEX also has questioned labs about their workers compensation expertise, their service quality, their technological abilities and their scientific approaches.

"That has been interesting for us, to assess what they say they have against what they (actually) have," Mr. Skrocki said.

Employers seeking the services of drug-testing labs will want to raise similar questions, he said.

"Any of that is something you need to make sure of if you are looking at any of these companies," Mr. Skrocki said.

EEOC: Most recent guidance introduces questions

CONTINUED FROM PAGE 3

Alexandria, Va.-based Society for Human Resource Management said in a statement that while it "is pleased that the guidance does not appear to impose a one-size-fits-all set of rules on employers," it "remains concerned with the potential conflict between this federal guidance and state laws that require criminal background checks in some industries and for some positions."

Others say they also are concerned about the issue. Michael W. Fox, a shareholder with law firm Ogletree Deakins Nash Smoak & Stewart P.C. in Austin, Texas, said if the state and federal laws conflict as to when criminal background checks are permitted, "you're going to have to decide which one is right, and any time employers are put in the position of having to make a technical legal judgment" it is "very problematic" and places a burden on the employer.

> 'I would agree with SHRM that the EEOC guidance is not very clear…and could create some conflict.'
> Michael A. Warner Jr., Franczek Radelet P.C.

"That's what really causes employers to have heartburn, and worse," he said.

"I can see how employers will feel burdened and confused by this, because it is confusing," Mr. Cohen said.

Michael A. Warner Jr., a partner with law firm Franczek Radelet P.C. in Chicago, said: "I would agree with SHRM that the EEOC guidance is not very clear…and could create some conflict."

However, Fisher & Phillips' Mr. Gillespie said, "If the employer considers the nature of the conviction and the timing of it, I don't think it necessarily creates a conflict between the state law and the EEOC's guidance."

Responding to a query on the issue, an EEOC spokeswoman quoted Title VII of the Civil Rights Act of 1964 in an e-mailed response, stating the federal law "pre-empts state and local laws or regulations if they 'purport to require or permit the doing of any act which would be an unlawful employment practice' under Title VII."

The ruling also has wider implications, said Mr. Fox, who pointed to statistics on the disproportionate incarceration rate of blacks.

According to U.S. Department of Justice data released last week, blacks accounted for 38% of the jail population as of June 30, 2011. They represented 12.6% of the total U.S. population in 2010, according to the U.S. Census Bureau.

"Employers are going to have to end up being sort of the intermediary that bears a lot of the risk as society works out a big issue," said Mr. Fox. "Maybe that's just a fact of life, but it doesn't make life any more pleasant for employers."

Ford: Automaker takes innovative tack to reduce risk from pension plans

CONTINUED FROM PAGE 4

to pay lump sums. There is a definite tradeoff," said Larry Sher, a partner with benefit consultant October Three L.L.C. in Morristown, N.J.

Employers will evaluate those trade-offs as they evaluate Ford's move, pension experts say. "What companies do will depend on individual company circumstances," Mr. Sher said.

"It could stimulate copycats (among other corporate pension plans) so I would think we might see a fair amount of this particularly from companies whose pension plans are liquid enough or whose capability to fund their plan is not under great stress so you might see a lot of this," Mr. Gold said.

At year-end 2011, Ford's U.S. pension plans—including plans covering salaried and union employees and retirees—had a funded ratio of 80.7%, with $39.41 billion in assets and $48.82 billion in liabilities. That compares with a funded ratio of 85.8% at year-end 2010, when the U.S. plans had $39.96 billion in assets and $46.65 in billion in liabilities.

Ford said the lump-sum payouts will start this year and will be funded from existing pension plan assets.

Rob Kozlowski, a reporter for Pensions & Investments, a sister publication of Business Insurance, contributed to this story.

AP PHOTO

At year-end 2011, Ford's U.S. pension plans—including plans covering salaried and union employees and retirees—had a funded ratio of 80.7%

IRS pledges guidance on reform law

By JERRY GEISEL

WASHINGTON—The Internal Revenue Service will develop rules to give employers several ways to prove that their health care plans provide "minimum value" to enrollees.

Under the Patient Protection and Affordable Care Act, plans must have a minimum value to escape financial penalties. To meet the minimum value test, a plan must cover 60% of the "total allowed costs of benefits provided under the plan," according to the PPACA.

The IRS said it will develop a variety of design-based safe harbors in the form of checklists to provide "a single straightforward way" for employers to determine if their plans meet the minimum value threshold "without the need to perform any calculations" or use an actuary.

The IRS said it will develop a "minimum value calculator" in which employers would enter information about plan benefits, coverage of services and cost sharing to determine if the plan provides minimum value. It also said for plans with "nonstandard features" that would preclude the use of a minimum-value calculator without adjustments that an employer could seek "appropriate certification" from an actuary that the plan provides minimum value in accordance with recognized actuarial standards and other conditions the IRS would provide in future guidance.

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CURRENT PROGRAM SCHEDULE:

SUNDAY, JUNE 17
Welcome Reception: Sugar Loaf Mountain

MONDAY, JUNE 18
Opening Ceremony
Global Leadership Panel
Special Address: **Impact of the Social, Economic and Environmental Crisis on Insurance**
Luncheon
Special Address: **Insurance Industry Relevance to G-20 Priorities – 2012 and Beyond**
Executive Panel: **Strategies for Global Growth**
Discussion Session
Awards Gala Cocktail Reception and Dinner

TUESDAY, JUNE 19
Keynote Address from the United Nations: Official launch of the UNEP FI Principles for Sustainable Insurance
Plenary Session: **Principles for Sustainable Insurance**
Luncheon
Shin Research Program: **Insurance Solutions for Developing Countries**
Special Address: **Life Insurance Industry's Response to the Great East Japan Earthquake**
Discussion Session

WEDNESDAY, JUNE 20
Special Address: **Insurance Industry in China: Development, Regulation and Outlook**
Global Reinsurance Leadership Panel
Special Address: **Strategic Approach Towards Sustainable Insurance: Consumer Trust and Social Responsibility**
Luncheon
Industry Focus: **Mobile Mania: Effective Distribution Channels for Emerging Markets**
Industry Focus: **Key Risk Issues in Emerging Markets: A Rating Agency Perspective**
Closing Reception

GUEST PROGRAM:

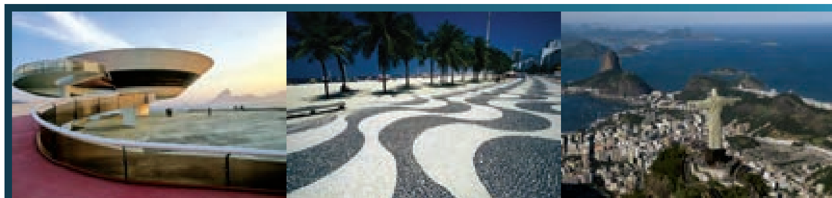
SUNDAY, JUNE 17
Welcome Reception: *atop Sugar Loaf Mountain, with unsurpassed views of Rio*

MONDAY, JUNE 18
Iconic Rio: *visit the most iconic symbol of Rio, Christ the Redeemer, followed by lunch and a highlights tour of historical Rio*

TUESDAY, JUNE 19 OPTIONAL TOUR
Tijuca Rain Forest Jeep Tour and Picnic: *tour the world's largest urban forest, home to hundreds of unique species of plants and wildlife*

WEDNESDAY, JUNE 20
The Smile City: *explore Niteroi, on Guanabara Bay, featuring vast works by Brazilian architect Oscar Niemeyer and the historical Fortaleza Santa Cruz de Barra*

Closing Reception: *enjoy an evening of Brazilian dining, entertainment and hospitality graciously hosted by CNseg*



Due to extremely high demand for accommodations in Rio during the time of the Seminar, we advise you to register as soon as possible.

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NBC: 401(k) offering sees good ratings

CONTINUED FROM PAGE 4

fund series run by Vanguard Group Inc. and 16 mutual funds, 12 actively managed and four passively managed.

New employees are automatically enrolled into the target-date fund series at a 3.5% default rate. The auto enrollment takes place 30 days after hiring. The deferral rate automatically escalates 1 percentage point a year to a maximum of 6.5%.

In aggregate, NBCUniversal's annual 401(k) plan contribution for a new employee is between 5.5% and 8.5% of pay. Here's how it works:

- The employer match is 100% up to 3.5% of pay.
- NBCUniversal also provides a contribution of 1% of an employee's pay regardless of the employee's contribution.
- New hires are eligible for an annual flexible retirement account contribution that depends on the company's financial performance. It has a graded vesting schedule reaching 100% after six years. This payment—a minimum of 1% and a maximum of 4%—is made regardless of an employee's contribution to the 401(k) plan.

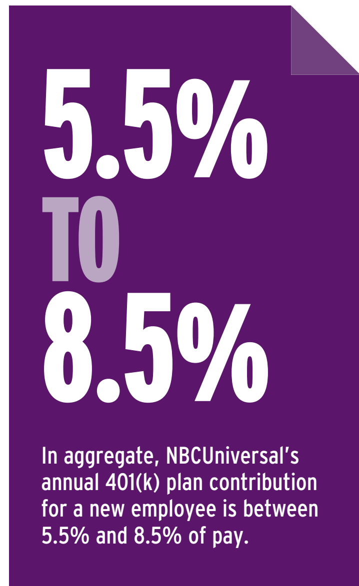
More to come

Meanwhile, as the asset base has grown, executives have begun exercising the plan's muscle in reducing expense ratios, moving to institutional share classes and reviewing some of the original investments.

"We're not standing pat," said Jaime Erickson, director of retirement benefits for NBCUniversal, New York. "We're trying to make sure we're in the cheapest share class possible. To get into the institutional share classes, you need a certain level of assets."

Among the plan's 16 core mutual funds, 10 are lower-priced institutional shares, and more are on the way. On July 1, the plan will switch to institutional shares for two funds—the large blend Spartan 500 Index Fund run by Fidelity Investments and Vanguard's Prime Money Market fund. Expense ratios will be cut to four basis points from six and to nine points from 20, respectively.

Also on July 1, the plan will offer lower-fee Admiral shares for Vanguard's FTSE All-World ex-U.S. Index Fund, reducing the expense ratio to eight basis points from 35.



These aren't the only money-saving efforts by NBCUniversal. In December 2011, the plan switched to a different class for the Vanguard target-date fund series, reducing the expense ratio to nine basis points from 17.

In February, NBCUniversal cut the expense ratios on two Fidelity Spartan funds by switching to Advantage class shares. The Spartan Extended Market Index Fund's expense ratio was reduced to seven basis points from 10 basis points, while the expense ratio for the Spartan 500 Index Fund was trimmed to six basis points from seven basis points.

July 1 also marks the introduction of a 2060 fund to the Vanguard target-date series. The series accounts for 57% of the plan's total assets.

Ms. Erickson said NBCUniversal chose Vanguard, Malvern, Pa., for the target-date series for its low cost and because Vanguard manages the target-date series for Comcast's 401(k) plan.

Boston-based Fidelity was chosen as record keeper for the NBCUniversal plan because Fidelity already is record keeper for both the $17.3 billion GE plan and the $3.21 billion Comcast plan, Ms. Erickson said. "We wanted to leverage that relationship," she said.

The original investment lineup and plan design were created with advice from Aon Hewitt, Lincolnshire, Ill. The current investment consultant, Tower Watson & Co., was chosen in December following an RFP in which Aon Hewitt was invited to bid.

"We're looking at the lineup to see if there is a need to cover all distinct 16 asset classes," Ms. Erickson said. "We are looking at some of the funds where there may be performance issues, or where we decide we may not need to have that specific fund in our lineup."

Popular options

Ten money managers provide the 16 mutual funds for the core lineup. The most popular have 5% of plan assets each—the BlackRock (BLK) Equity Dividend fund, a large-cap value fund; Fidelity Contrafund, large-cap growth; and PIMCO Total Return Fund. All are institutionally priced and actively managed.

Other actively managed institutional funds are the PIMCO Low Duration Fund; hybrids PIMCO All Asset and BlackRock Global Allocation funds; large domestic blend Neuberger & Berman Socially Responsive Fund; the large domestic blend Hartford Capital Appreciation Fund; the small-cap growth Royce Value Plus Fund; and the Columbia Small Cap Value Fund. The share class price for the actively managed Thornburg International Value Fund is the second lowest among this fund's several classes.

The four passively managed funds are: State Street Global Advisors Bond Index Non-Lending Series Fund; the two Fidelity Spartan funds; and the Vanguard FTSE All-World ex-U.S. Index Fund.

NBCUniversal doesn't offer a self-directed brokerage account in part because it's not offered by either the Comcast plan or the GE plan, said Ms. Erickson. She said she hasn't received requests from participants for the brokerage option.

The NBCUniversal plan now has 16,504 participants. The average participant balance is $20,579; participants invest in an average of 2.3 funds.

When the NBCUniversal plan took effect in January 2011, legacy employees of GE—including those working for NBC—could keep their balances at GE, roll them over into the NBCUniversal plan or a conduit individual retirement account, or take a lump-sum distribution. Legacy Comcast employees didn't join the NBCUniversal plan until a year later. They could leave their retirement money in the Comcast 401(k) plan or transfer it to the NBCUniversal plan.

Robert Steyer is a reporter for Pensions & Investments, a sister publication of Business Insurance.

Asbestos: Trusts system transparency

CONTINUED FROM PAGE 4

settlement funds created through the bankruptcy process, said Harold Kim, executive vp at the U.S. Chamber Institute for Legal Reform in Washington. The 60 trusts represent the assets and liabilities of the major asbestos defendants driven into bankruptcy. Mr. Kim said the trusts had accumulated more than $36 billion in assets as of last year.

"One of the more significant problems is the fact these trusts do not link payments across themselves," he said. "They're all very separate and independent," with no centralized way to determine the legitimacy or veracity of a claim, he said.

In addition, there's no linkage between the bankruptcy trusts and the tort system, where current solvent defendants are sued, he said. Thus, there's no transparency about what they are filing and saying in the two systems, and there is no "orderly way for defendants in the tort system" to access filings in the trusts, said Mr. Kim.

Meanwhile, solvent defendants in the tort system are facing increased liabilities, he said.

Ms. Shelk said the proposed legislation is important for several reasons. "We don't know who is getting payments out of any trust," she said. "There's no public information out there. You don't know if people are being paid out of multiple trusts for the same injury."

"The issue is to bring transparency on who is getting paid, what they're getting paid, and what the allegations are they're making to get the money," she said."The trusts need to be there for people who are really sick."

"The bill would help ferret out fraud in asbestos litigation by giving defendants a tool to verify that claimants are providing reliable and consistent exposure history information on bankruptcy trust claim forms and in civil litigation," said Mark A. Behrens, a partner in the Washington office of Kansas City. Mo.-based law firm Shook Hardy & Bacon L.L.P. "This would help future claimants by preventing trust and defendant assets from being drained by false or exaggerated claims."

Mr. Behrens said the "modest and targeted" bill is designed to "address a major issue in asbestos litigation today: the need for greater transparency between the trust and tort systems."

Ms. Shelk said that while there have been some efforts at the state level to bring more transparency to the trusts' operation, the House bill "is the first step in moving the legislation at the federal level."

But there is disagreement over whether the system needs reform.

"I don't think there is any problem," said Charles S. Siegel, a partner in the Dallas law firm Waters & Kraus L.L.P.

"The acid test of whether there is a problem is the results of trials," said Mr. Kraus, who has represented plaintiffs in asbestos liability cases. "The theory behind these bills is that somehow tort defendants are being denied evidence of other exposures to products made by the bankrupt companies. I don't agree at all with the premise of these bills that tort defendants cannot get the discovery they need."

"This bill shields asbestos manufacturers and insurers from accountability by delaying justice for Americans suffering from asbestos-related diseases," Gary M. Paul, president of the American Assn. for Justice, said in an email. "Congress should instead focus on protecting victims of asbestos exposure and looking into why this deadly product is still in use in the U.S."

But the bill's chances in the current Congress appear slim. "Until after the elections, any legislation that has well-funded opposition is going to have difficulty gaining momentum even though it is totally fair and much needed," said a Capital Hill veteran.

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NEBGH: Wellness initiatives

CONTINUED FROM PAGE 4

targeted and meaningful health management programs," said Delia Vetter, EMC's senior director of benefits and programs. "What we needed to do was create a connected health care infrastructure, create a less redundant and more efficient health care delivery system and accelerate the adoption of health care technologies."

Within EMC's branded HealthLink wellness concept, each participating employee's medical utilization and costs incurred, biometric screening data, health risk assessment findings and wellness participation results are combined to generate a personal health record accessible online or via smartphone through the HealthLink portal.

"That information provides a greater transparency for the true cost of health care," said Ms. Vetter, who was the *Business Insurance* 2011 Benefit Manager of the Year.

With that breadth of information, Ms. Vetter said, employees and their dependents can track their performance on fitness goals and other wellness initiatives, and receive targeted reference guides, health advisories, physician recommendations and other guidance based on recent diagnoses or treatments.

Marrying those separate data fields in one consolidated system also provides a significant and direct benefit to the employer, Ms. Vetter said. Through a customized data dashboard, EMC is able to track financial indicators including total and per-capita health care spending, plan-specific enrollment and paid claims totals, and member out-of-pocket costs. Those metrics then can be compared against utilization data such as hospital visits, diagnoses, prescriptions and treatments received, as well as wellness performance statistics.

The results, Ms. Vetter said, speak for themselves. Since implementing the HealthLink system in 2004, EMC estimates it has saved more than $223 million in health care expenditures and lowered the percent increase of its health care costs to 4.6% in 2010, well under the national average of 7%.

"And that's without any cost shifting," Ms. Vetter said. "We have not had any plan design changes since 2004."

However companies decide to integrate technology into their existing wellness plans or launch a new tech-friendly program, panelists warned that implementation must be gradual and that a successful program must maintain the employees and their dependents as its central focus.

With appropriate attention and sensitivity to common employee concerns—incentives, ease of use, support from senior management, communication, privacy and types of services offered—panelists said employers are in the best possible position to drive workers and their families toward healthier lifestyles.

"Beyond the fact that a majority of Americans get their health care coverage from their employer, look at where they spend their time," Mr. Risinger said. "A third of their time is spent in the workplace. You as an employer have a much greater chance of influencing their behavior than any other activity in their daily lives."

WellPoint banks on Watson for intuitive health support

NEW YORK—Without providing much in the way of specific dates or benchmarks, WellPoint Inc. Chief Information Officer Andrew J. Lang last week gave attendees of the Northeast Business Group on Health's 2012 conference and exposition in New York an update on the health insurer's progress in integrating the IBM Inc. Watson supercomputer with its patient databases.

Ultimately, WellPoint hopes to use Watson's intuitive software to support health care providers in making medical and clinical decisions with evidence-based diagnostics and treatment recommendations.

Mr. Lang told conference attendees that Watson is being woven into WellPoint's clinical and medical review processes across a range of medical disciplines, including oncology and outpatient care.

"The reason for that is that the work is all internal to WellPoint," Mr. Lang said. "We can control it and work on it without outside interactions, and it was a great area for us to hammer through some challenges and build this great partnership with IBM on Watson and some of its surrounding systems."

Named for Thomas J. Watson, IBM's founder, Watson's computing system mimics a human's ability to answer questions posed in natural language—accounting for meaning and context as well as factual information—with speed, accuracy and confidence.

Watson's capacity to quickly process massive amounts of data and use those calculations to evaluate a patient's circumstances—including medical history, genetics, biometric fluctuations and other factors—could assist physicians and nurses in arriving at more accurate diagnoses and effective treatment options, Mr. Lang said.

By integrating Watson into WellPoint's clinical and medical archives, the company will provide the computer with the empirical data it needs to begin evaluating and assisting in active cases, Mr. Lang said.

"That's what we're working on right now within the WellPoint walls, and you'll start to see that grow and expand outside WellPoint and into provider offices," he said, though he was not specific as to when providers and consumers might expect to see the technology in the marketplace.

"I don't have firm dates on it yet, but it is in process right now," Mr. Lang said. "It's a relatively near-term activity."

—By Matt Dunning

inBrief

CONTINUED FROM PAGE 1

week. Advocates say the bill will make it more difficult for economic cyber spies to steal American business plans and research. The bill, however, is opposed by the Obama administration, which said the president's advisers would urge him to veto it should it pass Congress.

M&A lawsuits increase: Report

Lawsuits filed for acquisitions of U.S. companies valued at or over $500 million increased twofold, Cornerstone Research said in a report. The number of M&A lawsuits valued at over $500 million for deals announced in 2008 and 2009 were 201 and 250, respectively. That compares with 557 and 502 lawsuits of M&A deals valued at or over $500 million in 2010 and 2011, respectively. Of acquisition deals valued at or over $100 million dollars, 789 lawsuits were filed in 2010 and 740 in 2011.

New leadership team in place at GRC

Property loss control consultant Global Risk Consultants Corp. has named James J. Marsh as its new CEO and Christopher Heaton is its new president. Mr. Marsh previously was deputy CEO. He succeeds William F. Ramonas, who retired. Mr. Heaton was a principal at Global Risk Consultants prior to his appointment. He replaces Glenn Giles, who also retired. Messrs. Marsh and Heaton will be based in Global Risk's corporate office in Clark, N.J.

Discrimination law protects transgendered workers

Federal discrimination law protects individuals who are discriminated against because they are transgendered, said the Equal Employment Opportunity Commission. In *Mia Macy vs. Eric Holder*, Ms. Macy said she was offered a position at a crime laboratory operated by the Bureau of Alcohol, Tobacco, Firearms and Explosives in January 2011 while still presenting as a man. But after she informed the lab in March 2011 that she was in the process of transitioning from a male to a female, she said she was told the position had been cut. She was subsequently told the job had been offered to someone else. As part of a complicated regulatory process, Ms. Macy was told that her gender identity discrimination claim could not be adjudicated before the EEOC, and she filed an appeal. In its ruling, the EEOC held that her complaint of discrimination "based on gender identify, change of sex, and/or gender status is cognizable under Title VII" of the Civil Rights Act of 1964, and her complaint was remanded to the agency for further processing.

Florida to allow captive formations

Florida Gov. Rick Scott signed into law a measure allowing the formation of captive insurance companies in the state. The measure allows the formation of single-parent captives, special-purpose captives, industrial insurance captives and captive reinsurance companies.

Hardy shareholders OK acquisition by CNA

Shareholders of Hardy Underwriting Bermuda Ltd. have voted to approve a proposed acquisition by CNA Financial Corp. The $227 million purchase, which CNA said will further its specialty lines focus and give it access to the Lloyd's of London marketplace, was first announced in March. Hardy will maintain its own brand and its existing leadership team, CNA said.

Noted

With civil unrest and the continued effects of the global economic crisis contributing to 37 countries being downgraded in the **Aon 2012 Terrorism & Political Violence Map**, businesses should make sure they address business continuity exposures, according to Aon Risk Solutions....J. Powell Brown, president and CEO of **Brown & Brown Inc.**, has resumed his duties after a temporary leave of absence for health reasons....**Beecher Carlson Holdings Inc.** has surpassed $100 million in revenue for the first time for any 12-month period, the broker announced. It projects revenue to reach $100.9 million for the 12 months ending April 30.

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AUTO AUTOS: WILL INSURERS OFFER COVER?

How close are we as consumers to whizzing around in fully automated cars? Only the auto insurers know for sure.

Mountain View, Calif.-based Google Inc. has approached several major car insurance underwriters to gauge the coverage implications making of its driverless car technology available to the commercial market, according to a news report.

"They see the opportunities for this technology being really positive," Anthony Levandowski, the product manager for Google's self-driving car, said in a keynote address Wednesday at the Society of Automotive Engineers World Congress in Detroit, according to the report. "From their point of view, this technology is not going to be released until it's safe."

Mr. Levandowski did not reveal which insurers had been approached. According to reports, discussion between Google project leaders and underwriters focused on, among other things, the challenges of applying separate rates and liability standards for policyholders based on whether they manually operate their car or engage the automated navigation.

In March, Google announced that it logged more than 200,000 miles of automated driving without accidents.

CONTRIBUTING: Matt Dunning, Judy Greenwald, Sheena Harrison, Mike Tsikoudakis

End Page

U.K. firm turns red after pink slip-up

A London insurance company's unit last week emailed pink slips to its entire staff before retracting the statement.

Aviva Investors, the fund management unit of London-based Aviva P.L.C., mistakenly emailed departing instructions to 1,300 employees that were intended for only one employee, according to new reports.

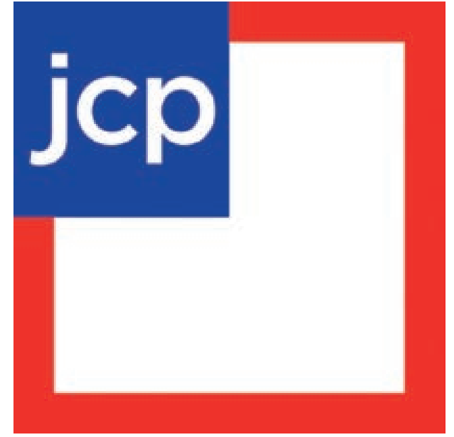
Aviva's human resource department 25 minutes later retracted the email and soon afterwards sent another email apologizing for the error, company spokesman Paul Lockstone said in news reports.

"It was intended that this email should have gone to one single person," Mr. Lockstone said in a media report. "Unfortunately, as a result of a clerical error, it was sent to all of the Investors staff worldwide."

The offending email is part of the company's standard process when people depart from the organization, which covers how to return company equipment and confidentiality rules.

"People were pretty quickly aware of the fact that this was a mistake," Mr. Lockstone said. "I don't believe any of our staff would have seen it really as anything other than the mistake that it was."

The rude awakening on employees was not unfounded. According to news statements, Aviva Investors said in January that it would be shedding 160 jobs, nearly 12% of its workforce worldwide.



J.C. PENNEY, DISPLAY FIRM SQUARE OFF

J.C. Penney Corp. Inc. is being accused of unfairness by a New York retail display company that was hired to create signs with the retailer's "Fair and Square" logo.

Hudson & Broad Inc. accuses Plano, Texas-based J.C. Penney of misappropriation of trade secrets, breach of contract and unjust enrichment in a lawsuit filed Tuesday in U.S. District Court in Manhattan.

In the complaint, Hudson & Broad said J.C. Penney hired the company to create store signs that would include the retailer's new square logo and change color each month. Hudson & Broad said it created an "illuminated square" display that would use remote-controlled LED lights to shift hues.

Hudson & Broad created and installed illuminated square displays for J.C. Penney's headquarters and a store in the Manhattan Mall, according to the complaint. The company said J.C. Penney discussed ordering hundreds more displays for other stores but ultimately used another manufacturer for the work.

Hudson & Broad is seeking at least $52 million in punitive and compensatory damages for what it says was "disgraceful abuse of a vendor by senior executives at J.C. Penney."

EX-WORKER'S SUIT NOT MUSIC TO COMPANY'S EARS

A worker and his former boss are trading charges about profane language and sunflower seeds in a dispute.

According to a news report, Miaoguang Jin, a former worker for a national facilities maintenance firm, SMS Assist L.L.C., is suing his erstwhile employer, claiming his boss put a naughty word on his computer. But the former boss said he had several problems with the worker, including his habit of eating sunflower seeds, and his taste in music.

Mr. Jin charges the indignities he suffered during his six months at Chicago-based SMS Assist, include his boss, Jianqing Zhao, the firm's chief information officer, gaining access to his computer to draw a big "f-- you" on his screen, and then inviting the office to have a look and a laugh.

Mr. Jin, a native of China, charged also that while a $75,000-a-year project manager, Mr. Zhao mocked his English. Other claims in the lawsuit, which names the firm, Mr. Zhao and Mr. Zhao's wife, who is an SMS Assist employee, as defendants, include that he worked more than 500 hours of overtime at the firm, and was shown the door when he refused a request to work part time. Mr. Jin is seeking $37,000 to $75,000 in damages.

Mr. Zhao denies the charges. "I hired him and first of all he didn't perform his job and he took a nap during work all the time," Mr. Zhao said. "And he ate sunflower seeds all the time in the office, and he'd listen to non-work-related music all the time." Mr. Zhao did not offer an explanation as to what he considered to be work-related music.

SMS said in a statement, "We cannot comment on the specifics of the lawsuit at this time, since we have not had an opportunity to fully review the claims. However we can tell you that SMS Assist is committed to treating its employees fairly and has demonstrated a strong culture of respect, integrity and humility."

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