



FEDERAL RULE TARGETS DRIVER HEALTH / PAGE 4

EMPLOYERS FREEZE PENSIONS, SUSPEND 401(K) MATCHES DUE TO POOR ECONOMY / PAGE 3

HIGH COURT SAYS FEDERAL LAW DOESN'T PRE-EMPT STATE LAW IN TOBACCO CASE / PAGE 3

In Brief

Rating agencies downgrade XL units

Standard & Poor's Corp. last week downgraded the financial strength rating on XL Capital Ltd.'s core units to A from A+ with a negative outlook. S&P said its downgrade was due largely to the insurer's "perceived franchise issues stemming from a string of material earnings and capital charges." Moody's Investor Services downgraded XL units to A2 from A1. Meanwhile, Allianz Global Corporate & Specialty said that it no longer will front long-tail business for XL as a result of the downgrades.

AIG sells securities to Fed-backed vehicle

American International Group Inc.'s life insurance units sold a pool of about \$39.3 billion in

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SPOTLIGHT

YEAR IN REVIEW EMPLOYEE BENEFITS

BI looks back on the top stories and newsmakers in employee benefits over the past year, including the expected change in health care policy direction with the election of Barack Obama as president; pension-funding relief; and San Francisco's health care mandate.

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COMING NEXT WEEK:

The seventh annual Market Sourcebook provides extensive rankings on risk and benefits management vendors from BI's 2008 directories.

Judge shows leniency in Gen Re case

Two-year sentence for former CEO lower than guidelines

By COLLEEN MCCARTHY

HARTFORD, Conn.—The relatively light sentence imposed on former General Re Corp. Chief Executive Officer Ronald E. Ferguson for his conviction in a sham reinsurance deal may bode well for the remaining defendants, legal experts say.

U.S. District Judge Christopher Droney last week imposed a two-year prison term, a \$200,000 fine and two years of supervised release



Ex-Gen Re CEO Ronald E. Ferguson arrives in court last week, where he was sentenced to two years in prison.

in sentencing the first of five former Gen Re and American International Group Inc. executives convicted in

February in the case.

The judge last month determined that AIG shareholders lost more than \$500 million in the phony reinsurance deal—a figure that, under recommended sentencing guidelines, could have resulted in a sentence of life in prison.

However, the judge said he considered Mr. Ferguson's "character" as well as his long history of community service and volunteerism in imposing a sentence far below federal guidelines.

Judge Droney said he received more than 400 letters on behalf of Mr. Ferguson, saying he had "never seen such an outpouring of support" and that the letters "painted a

picture of an extraordinarily good man."

Describing the case as a "tragedy," Judge Droney added, "We will never know why such a good man did such a bad thing."

Victory for defense

Legal experts say the two-year sentence is a victory for Mr. Ferguson and his defense team, while still sending the message of deterrence prosecutors had sought.

For Mr. Ferguson, "it's a very favorable sentence, and about as much of a departure as the defense could have hoped for," said Peter

See **FERGUSON** page 20

Medicare mandate raises liability worries

Employers fear claim reporting rule may cause litigation

By ROBERTO CENICEROS

A government effort to ensure that Medicare does not pay expenses for which casualty insurers and self-insured employers are primarily responsible could hamper the settlement of liability claims, observers warn.

The government's effort, which includes a mandate to report information to Medicare, also could increase litigation, said Roy Franco, director for risk management strategies at Pleasanton, Calif.-based Safeway Inc.

And it comes as risk managers are likely to face more liability claims filed by Medicare beneficiaries because of an aging population.

Medicare compliance issues affect 15% of Safeway's open liability claims, Mr. Franco said.

Mr. Franco also serves as steering committee co-chair for a recently formed Medicare Advocacy Recovery Coalition, which met last week with the Centers for Medicare & Medicaid Services.

The U.S. administrative agency is eager to help resolve some of the potential problems that policyholders, insurers, self-insureds, attorneys, third-party administrators and others in the liability industry could face as CMS implements the claims data reporting mandate that goes into effect on July 1, 2009, Mr. Franco said.

Precisely what payers will have to do to be in compliance still is under development, Mr. Franco said.

But legislation may become necessary and its makeup would

See **MEDICARE** page 22



Pirates aboard a small boat—a common method of attack on shipping traffic in the Gulf of Aden—head for the shore in Somalia in October after leaving a merchant vessel.

REUTERS

Some ships arm guards as pirate attacks rise

By ZACK PHILLIPS

Most ship owners and their underwriters are resisting arming their ships and crews to combat a wave of piracy off the coast of Africa, but some say that armed security aboard ships is increasing and becoming more common.

As of last week, Somali pirates had attacked 108 ships in the Gulf of Aden in 2008 and hijacked 42 of them, according to the London-based International Maritime Bureau's Piracy Reporting Center. More than a dozen vessels were still being held, including the Saudi oil tanker MV Sirius Star that was hijacked in a high-profile attack in mid-November.

The United Nations passed a res-

olution Dec. 16 authorizing countries to take "all necessary measures appropriate in Somalia" to arrest or stop pirates.

The most basic risk management tactic that shippers can use is avoiding piracy hot spots. In the case of ships heading through the Gulf of Aden to the Suez Canal and Europe, that means sailing around the southern tip of Africa, which can take up to two extra weeks and add associated costs.

So far, Copenhagen-based A.P. Moller-Maersk A/S and Norwegian shipping group Odfjell SE have chosen this option. In the case of the Sirius, which was hijacked 450 miles off the southeast coast of

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 BI offers additional coverage from the National Business Group on Health's 22nd National Conference on Health, Productivity and Human Capital, held Dec. 8-10 in San Diego. Go to www.BusinessInsurance.com/extra.

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Companies blame pension freezes on economy

Motorola, GenCorp freeze DB plans, suspend 401(k) match

By JERRY GEISEL

Two major U.S. employers say they will freeze their defined benefit pension plans and suspend 401(k) plan matching contributions, the latest sign of how the ailing economy is battering companies and their employees.

Schaumburg, Ill.-based global communications equipment and service provider Motorola Inc. and Sacramento, Calif.-based defense and aerospace company GenCorp Inc. last week said they will freeze their pension plans and suspend their 401(k) contributions to cut

costs. Motorola's latest step expands an earlier freeze of its defined benefit plan for new employees.

Motorola and GenCorp's actions are, in one way, part of a growing trend. More than 25% of the 624 companies on the Fortune 1000 list with defined benefit plans had frozen at least one of their defined benefit plans, Watson Wyatt Worldwide reported earlier this year. That was nearly four times as many as 2004, when the corporate drive to freeze defined benefit plans started gathering steam.

Those freezes, though, nearly always were combined with increased 401(k) contributions, such as a larger company match

and/or an automatic company contribution. Through beefing up the 401(k) plan, companies sought to partially offset the loss of retirement income resulting from freezing their defined benefit plans.

But benefit experts say it is unusual for employers to freeze their defined benefit plans and suspend their 401(k) matches, with one exception being organizations in bankruptcy.

Now, though, with the economy in a recession and corporations unsure whether things will get worse, once nearly unheard of benefit plan changes are being considered.

"Everything is on the table," said Chantel Sheaks, a principal in the

Washington office of Buck Consultants L.L.C.

"It is obvious that these are difficult times and employers are evaluating" many options, said Matt Smith, a senior vp in the Seattle office of Aon Consulting.

For Motorola, its move to freeze its defined benefit plan, which will take effect on March 1, 2009, comes at a time of deteriorating financial results. It reported a third-quarter loss of \$397 million on revenue of \$7.5 billion. During the comparable period in 2007, the company reported net income of \$60 million on revenue of \$8.8 billion.

Financial results at GenCorp, which said its defined benefit plan freeze will take effect on Feb. 1, 2009, also have fallen. In the latest

25%

OF Fortune 1000 companies with defined benefit plans have frozen at least one of them.

See PENSIONS page 20

Insurer's defense denial sparks strategy debate

Court should decide available coverage, critics argue

By DAVE LENCKUS

SAN FRANCISCO—A defense cost coverage battle between a former executive facing criminal prosecution and an excess insurer was ended at least temporarily last week when the defendant's former employer agreed to pay his attorneys.

But the situation raises questions among legal experts about how insurers should handle defense coverage disputes.

Criminal defense attorneys at Kasowitz, Benson, Torres & Friedman L.L.P. in San Francisco had asserted in a complaint filed Dec. 4 in U.S. District Court in San Francisco that the excess insurer's denial of defense coverage—even after the primary insurer and two other excess insurers had responded—would leave the defendant without defense funds by mid-December.

The attorneys suggested they might have to suspend their work for Dr. W. Scott Harkonen, former chief executive officer of Brisbane, Calif.-based biopharmaceutical company InterMune Inc. as a result.

The excess insurer, Arch Specialty Insurance Co., a subsidiary of Bermuda-based Arch Capital Group Ltd., asserted it is not required to fund Dr. Harkonen's defense cost for a few months even if it doesn't deny his claim.

Dr. Harkonen headed InterMune from 2000 until 2003, when he and the company began facing charges from investors, consumers and health insurers that the drug Actimune had been improperly marketed and labeled for unapproved uses. Many of those cases still are pending.

In addition, federal authorities launched a criminal investigation into the charges. Dr. Harkonen was indicted in March, and he faces a June 2009 trial.

InterMune faced similar charges and agreed in 2006 to settle the case for \$36.9 million.

Although three lower layer insurers on InterMune's directors and officers liability program already had agreed to cover \$20 million of defense costs for Dr. Harkonen, Arch informed InterMune's broker in a Nov. 19 letter that it would not extend its \$5 million of limits, according to Dr. Harkonen's complaint.

National Union Fire Insurance Co. of Pittsburgh, Pa., a subsidiary of New York-based American International Group Inc., wrote \$10 million of primary limits above a \$2 million self-insured retention. Underwriters at Lloyd's of London and Continental Casualty Co., a subsidiary of Chicago-based CNA Financial Corp., wrote the next two excess layers of \$5 million each. The coverage period ran for a year beginning in March 2003, according to court documents.

Arch contends that Dr. Harkonen lied in a warranty, included in his D&O liability insurance application, when he claimed no knowledge of any circumstances that could generate claims, Dr. Harkonen's complaint asserts.

But in its court filings, Arch stated it had no proof that the underlying limits had been tendered. It also said the primary policy's terms give Arch until mid-March 2009 to review defense costs and advance its policy limits. Arch also said the primary policy requires that all coverage disputes be settled by binding arbitration.

The defense coverage dispute was shelved last week, however, when

See DEFENSE page 18



GETTY IMAGES

The U.S. Supreme Court heard a case involving 'light' cigarettes that centered on whether a federal law on advertising pre-empted a state fraud law.

State fraud law survives pre-emption challenge

Supreme Court ruling in 'light' cigarette case may have wider effect

By MARK A. HOFMANN

WASHINGTON—Legal experts are divided over whether a U.S. Supreme Court decision involving cigarette advertising could reach beyond tobacco.

At issue in the case decided last week—*Altria Group Inc. et al. vs. Good et al.*—was whether a federal law that regulates cigarette advertising pre-empted state anti-fraud statutes. The high court held 5-4 that it does not.

The case centered on the alleged promotion of "light" cigarettes as allegedly less harmful than regular cigarettes under the Federal Cigarette Labeling and Advertising Act. The act holds that no "requirement or prohibition based on smoking and health shall be imposed under state law with respect to the advertising or promo-

tion of any cigarettes the packages of which are labeled in conformity" with the law.

A group of Maine residents sued Richmond, Va.-based Altria, the parent company of Philip Morris USA, alleging that the cigarette maker violated the Maine Unfair Trade Practices Act by fraudulently advertising that light cigarettes delivered less tar and nicotine than regular cigarettes. A U.S. District Court granted summary judgment for Altria, holding that the federal law trumped the state statute. But a three-judge panel of the 1st U.S. Circuit Court of Appeals in Boston overturned that decision in August 2007.

Altria appealed to the Supreme Court, which sided with the Maine consumers. The majority noted that while the text of an express pre-emption clause in a federal statute may be read more than one way, courts usually "accept the reading that disfavors pre-emption." The court also said that Federal Trade

See ALTRIA page 20

Massachusetts nears universal health insurance coverage

Landmark reforms help cover 97.4% of state residents

By JERRY GEISEL

BOSTON—More than two years after Massachusetts passed groundbreaking legislation to move the state closer to universal health insurance coverage, the Bay State has achieved that milestone, according to a survey released last week.

Some 97.4% of Massachusetts residents now have health insurance, by far the highest coverage rate of any state.

In 2007, according to the U.S. Census Bureau, just under 95% of the state's residents had coverage.

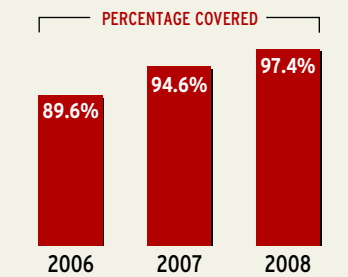
State officials hailed the findings, which are based on a survey conducted between June and August by the Urban Institute, a Washington-based research organization.

"Massachusetts has succeeded in covering the uninsured at an amazing rate. Massachusetts now has both the lowest rate of (uninsured residents) in the country and a rate that is less than half of the next-lowest state.... This is a remarkable achievement," Secretary of Health and Human Services Dr. JudyAnn Bigby said in a statement.

In 2007, Hawaii had the second-lowest uninsured rate with 7.5% of the population lacking health insurance, according to the Census Bureau.

ON THE RISE

Massachusetts residents who have health insurance coverage



Sources: Massachusetts Division of Health Care Finance and Policy, U.S. Census Bureau

Several provisions in Massachusetts' 2006 reform law have

been key in increasing coverage, experts say, including state premium subsidies for the low-income uninsured, imposing financial penalties of more than \$900 a year on those who are not covered under a health plan and a \$295-per-employee assessment on employers who do not offer coverage.

Coverage tied to income

The report found that of those with health insurance coverage, 68% received coverage from employers, while 17% obtained coverage from public or other programs, while 15% of the insured population—chiefly those age 65 and older—had coverage through Medicare.

Even though Massachusetts sub-

sidizes health insurance premium for eligible low-income uninsured residents, insurance coverage was directly related to income, according to the survey.

For example, 5.4% of residents with incomes less than 150% of the federal poverty level were uninsured, while 5.1% of those with annual incomes between 150% and 299% of the federal poverty level were uninsured.

By contrast, just 1.9% of those with incomes between 300% and 499% of the federal poverty level were uninsured, while 0.3% of those with incomes at least 500% of the federal poverty level lacked coverage.

The survey is based on responses from 4,910 households in Massachusetts.



A rule recently issued by the Federal Motor Carrier Safety Administration is intended to streamline the process by which states determine whether drivers are healthy enough to operate commercial vehicles.

Federal rule targets medically unfit drivers

Critics say effort may simplify process but won't curb fraud

By JEFF CASALE

WASHINGTON—Supporters of a rule issued by the Federal Motor Carrier Safety Administration designed to keep medically unfit drivers off the road say it is a step in the right direction, but others say the rule does little to prevent drivers from committing medical certificate fraud.

The rule, finalized earlier this month, merges the commercial driver's license and the driver's medical examination certificate into a single electronic record. The idea was to streamline the process by which states determine whether drivers are healthy enough to operate commercial vehicles, but critics

say that the improvement is "marginal" and that much work needs to be done to keep drivers from committing fraud by self-certifying themselves as medically fit.

The rule is in response to a federal report released in June by the Government Accountability Office that found 563,000 commercial drivers licenses had been issued to drivers who are eligible for full disability benefits. Of those, 85% still are active despite medical conditions including vision, hearing and seizure disorders.

The GAO study, which was conducted from May 2007 through June 2008, found commercial drivers with serious medical conditions can meet the U.S. Department of Transportation medical fitness requirements and thus obtain and hold a CDL.

"They've made a marginal

See **DRIVERS** page 19

Wellness may help productivity as layoffs add to strain: Experts

Healthy employees better able to cope with added work

By JOANNE WOJCIK

SAN DIEGO—With layoffs forcing many U.S. companies to do more with less, now is an opportune time for employers to provide their remaining employees with wellness and health promotion tools that will enhance their productivity, benefits experts say.

But to win top management support for such investments during a down economy, benefit managers must provide

proof that there is a link between employee health and corporate performance, a management expert says.

Fortunately, data-driven benchmarking tools have been developed to make building a business case for wellness and health promotion a less daunting task, a health benefits expert says.

"Right now the challenges seem endless," said Helen Darling, president of the National Business Group on Health, at the opening of Washington-based NBGH's 22nd National Conference on Health, Productivity and Human Capital, which was held Dec. 8-10 in San Diego.

On the contrary, "there's never been a more opportune time to make the changes that are necessary," she said. "When everything's going OK, CEOs don't want to change. But we are in a different place."

Because of the economic challenges facing corporate America, "we have to make the employees that are left more efficient," she said. Moreover, "everybody's going to have to work longer because they can't afford to retire."

Unfortunately, employee health and productivity are not high on the list of priorities for most chief executive officers,

See **LAYOFFS** page 6

Integrated EAP, disability plan helps employer reduce costs

By JOANNE WOJCIK

SAN DIEGO—Combining the services of an employee assistance program with a disability management program can shorten the duration of medical disability claims, one employer has found.

The integrated program is a form of "behavioral risk management," an emerging area of workforce risk management and health care cost containment designed to better understand the underlying behavioral aspects of claims, produc-

tivity and employee relations issues, said Marcia Carruthers, president and chief executive officer of the Disability Management Employer Coalition, a nonprofit based in San Diego.

"We use psychology to get a take on what may be happening below the surface," she said during a session on behavioral risk management at the 22nd National Conference on Health, Productivity and Human Capital held Dec. 8-10 in San Diego.

She estimated that psychiatric conditions, which often

occur in conjunction with medical disability, may be costing U.S. employers an estimated \$344 billion annually in lost productivity and medical costs.

"Pretty much everybody with a disability has a psychosocial issue that needs to be addressed," Ms. Carruthers said.

Realizing this, Southern California Edison, a unit of Edison International based in Rosemead, Calif., embarked on an experiment in which it integrated its disability manage-

See **DISABILITY** page 6

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Layoffs: Wellness enhances productivity

CONTINUED FROM PAGE 4

according to the institute's keynote speaker, Robert Rosen, chairman and CEO of Healthy Cos. International, an Arlington, Va.-based business consulting company and the author of "Just Enough Anxiety: The Hidden Driver of Business Success."

Outlining the typical CEO's four top agendas, Mr. Rosen said that even though "the human agenda" may ultimately have the greatest impact on a company's performance, most CEOs focus on the other three: marketplace, finance and operations.

"Right now, the human agenda is a second-class citizen," he said.

But the human agenda—expressed through corporate values, culture, health and leadership—is what gives a company a distinct competitive advantage, Mr. Rosen said.

"In the best-performing companies, the human agenda is on top," he said. "Great companies that understand the human side of their business outperform their competitors" on virtually every financial measure because they realize the impact organizational culture can have on employee health and productivity, he noted, citing as examples Milwaukee-based Harley-Davidson Motor Co.; the Mayo Clinic in Rochester, Minn.; and Midland, Mich.-based Dow Chemical Co.

Mr. Rosen urged human resource and benefit managers to supply their CEOs with the evidence that

552 attend NBGH gathering; Philadelphia venue in 2009

SAN DIEGO—A total of 552 health benefits executives and industry experts attended the 22nd National Conference on Health, Productivity and Human Capital sponsored by the Washington-based National Business Group on Health.

The Dec. 8-10 conference in San Diego, which had the theme From Science to Solutions, included three days of educational seminars on topics such as onsite clinics, health risk

appraisals, racial and ethnic disparities, the cost of premature births, tobacco cessation and weight-control strategies, and behavioral risk management.

Next year's conference, which will have the theme of Optimizing Productivity: Leading with a Culture of Health, will be held Oct. 13-15, 2009, in Philadelphia.

For further information, visit www.businessgrouphealth.org.

—By Joanne Wojcik

'In the best-performing companies, the human agenda is on top.'

Robert Rosen,
Healthy Cos. International

shows how health and performance are inextricably linked so they can win their support.

That evidence can be obtained by using EMPAQ, a tool developed by NBGH to measure the link between health and productivity in organizations, according to Dr. Pam Hymel, medical director and senior

director of integrated health at Cisco Systems Inc., who also spoke at the NBGH institute.

EMPAQ, an acronym for Employer Measures of Productivity, Absence and Quality, is a set of standardized metrics and benchmarking tools employers can use to evaluate the effectiveness of their health and productivity management programs, she said.

It does this by measuring the impact of employee assistance programs, absences related to short- and long-term disability, workers compensation and the Family and Medical Leave Act as well as group health programs that include behavioral health and pharmacy benefits, according to Ms. Hymel.

Disability: Integration helps employer cut costs

CONTINUED FROM PAGE 4

ment program with its EAP. The result was more employees returned to work within the time they were expected to, and those who came back were less likely to go out on disability again, according to Deborah Jacobs, disability manager at SCE, who also spoke during the session.

Historically, 30% of those who returned to work went back on disability, she said. Post-integration, that proportion fell to less than 1%, she said.

Of the 540 disability cases referred to the program to date, "only two went off work again, and one of them went to part-time, so they were not really off work," Ms. Jacobs said.

Perhaps the most surprising outcome of the experiment was the discovery that many of the barriers that had been preventing employees from returning to work post-disability had nothing to do with their medical conditions, she said. Rather, they involved such things as dependent care issues or personality conflicts with supervisors.

"A number had legal and financial issues, which I expect will increase with the economy," Ms. Jacobs said. "It's amazing what's going on in people's lives. It's like a soap opera."

Advocates, not antagonists

At the start of the program, which was initiated as a pilot and was implemented companywide on Jan. 1, disability examiners were renamed "job coaches" to demonstrate to SCE's highly unionized workforce that they would be serving as advocates working on behalf of the disabled employees rather than antagonistic claims administrators representing the employer.

After being trained by the EAP's

behavioral health counselors to identify certain triggers, these job coaches directed disability claimants they thought needed intervention to the EAP.

"They had a standard script," Ms. Jacobs said. "First, they'd identify any issues, get them to talk and refer them to other Southern California Edison resources such as the EAP or work/life programs. They'd call their supervisor, too, to find out their concerns."

Later, after the employee had returned to work, the coach would call them again, following up a week later with yet another phone call.

While most of the disability cases could be handled easily, some were labeled "Level 2 cases" and

required a higher level of intervention, oftentimes with the coaches going to the worksite to talk to co-workers. EAP counselors occasionally were enlisted to help supervisors improve their managerial skills, which resulted in improved relations with returning employees, making them less likely to go on disability again.

The program encourages the coach/examiners to look beyond the definition of disability and regard the injured employee holistically, Mr. Jacobs said. For employees, the program changed their perspective so they focused on their strengths, capabilities and accomplishments rather than on the limitations of their illnesses or injuries, she said.

Ms. Jacobs said she is evaluating the program's costs to come up with a return on investment figure that will include productivity enhancements as a result of reduced disability-related absences.

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Provider guide focuses on behavioral health, EAPs

SAN DIEGO—The National Business Group on Health has published a new guide to help employers select behavioral health and employee assistance program providers.

"An Employer's Guide to Employee Assistance Programs," which the NBGH released at its 22nd National Conference on Health, Productivity and Human Capital that was held Dec. 8-10 in San Diego, was developed after developers of a 2005 NBGH guide on behavioral health services uncovered a lack of coordination and integration between employer-sponsored health plans and EAPs.

In response, the NBGH formed a work group in 2007 to

develop recommendations to improve coordination and integration as well as to examine other best practices and evidence-based approaches to the design and delivery of effective and efficient EAPs.

The goal of the EAP work group was to create a strategic program definition, solidify a set of core program elements, and identify critical metrics for managing and evaluating EAPs, said Paul Heck, manager, global employee assistance and work/life services at DuPont Co., during a session at the NBGH conference.

The EAP guide can be found at the NBGH's Web site at www.businessgrouphealth.org.

—By Joanne Wojcik

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Business Insurance OPINIONS

Ferguson sentencing sends clear message

WHY DID SUCH a good man do such a bad thing?

That was a question U.S. District Court Judge Christopher Droney asked last week when he sentenced former General Re Corp. Chief Executive Officer Ronald Ferguson to two years in prison for his role in a phony reinsurance deal involving Gen Re and American International Group Inc.

No doubt many in and outside of the insurance community have been pondering the same question.

Certainly, there are many theories to explain the actions of Mr. Ferguson and the other convicted executives in participating in a criminal fraud, perhaps pressure from a big client or a perception that no one would be harmed by the deal.

But in the end those are just theories and it is possible that Mr. Ferguson himself can't explain why he allowed the phony deal to go forward.

In fact, the motivations of the convicted executives really don't matter. What is more important is that their fraudulent actions were exposed and they were found guilty with one executive receiving an appropriate prison sentence and, we are sure, appropriate sentences soon coming for the other individuals involved in the phony deal.

We hope that more than justice will be served. We hope the episode serves as a powerful and sobering reminder to top corporate executives of the responsibility that comes with their positions.

Yes, they have a responsibility to generate profits. But they also have a responsibility to abide by the nation's securities laws. Obviously, Mr. Ferguson brushed aside that basic requirement and will pay for that omission by serving time in a federal penitentiary.

We hope the publicity surrounding this case and the consequences for those involved will reduce the likelihood of such fraudulent action at other corporations.

We hope that more than justice will be served.

Leave it to professionals to fight pirate menace

SOME MATTERS ARE best left to the professionals. We believe that should be the case where combatting piracy is concerned.

As we report on page 1, there's an ongoing debate in shipping and insurance circles over the wisdom of putting armed security on ships traveling the pirate-infested waters of Africa.

There are reasonable arguments on both sides of the issue. Advocates of arming merchant ships say nonlethal responses buy time at best and that navies simply aren't up to the task of patrolling more than 1 million square miles of sea. Opponents respond having guns aboard can lead to unintended consequences, such as the inadvertent killing of innocent civilians and the possibility that a confrontation with pirates will escalate far beyond what anyone imagined. And in some cases, having firearms aboard a ship simply is illegal.

This is a case where we believe the opponents have the stronger case. Piracy is an international problem that can't be dealt with on an ad hoc basis using uncoordinated private security measures. We're under no illusions that ending the curse of modern piracy will be quick or easy. The new piracy has been allowed to fester by the international community for far too long. But it is the international community, through the navies of its individual member states, that must respond. This is a job for the professionals.

Piracy is an international issue. The new pirates make no distinction among national flags when they strike. Only a coordinated international response relying on official military power can resolve that issue in a satisfactory manner.



What a year this has been,
two thousand and eight,
with bankruptcies and floods
it sure wasn't great.

The storms did their damage
though losses weren't small,
'twas the stock market crash
that ruined it all.

Now this holiday time,
so tinged with our fright,
hangs heavy over us
and threatens our sight.

Lest we weigh this season
in baubles and bling:
what counts is the warmth that
this time of year brings.

Hold close all your loved ones
(there's no greater cheer)
Happy Holidays and
a joyous New Year!

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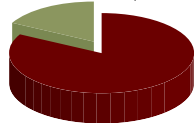
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THIS WEEK'S RESULTS

Q Are C-suite executives increasing scrutiny of insurers their companies use?

No 17% Yes 83%



NEXT WEEK'S QUESTION

Q: How do you view the sentence for Ronald Ferguson?

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YEAR IN REVIEW - EMPLOYEE BENEFITS



Top employee benefits stories of 2008

1. Barack Obama's election as president promises new health care policy direction.
2. Congress approves pension plan funding relief.
3. Federal appeals court upholds San Francisco's health care spending law.
4. Federal law gives parity to mental health care benefits.
5. Law beefs up Family and Medical Leave Act coverage for military families.
6. Massachusetts eases health care coverage rules.
7. Increases in health care plan costs level out.
8. Supreme Court increases exposure of defined contribution plan fiduciaries.
9. Law allows employees called to military duty to cash in flexible spending accounts.
10. House of Representatives launches surprise assault on health savings accounts.

Financial crisis puts focus on pension funding, plan design

Consumer-driven health plans gain more ground in 2008 as do health-related productivity, wellness initiatives

By KRISTIN GUNDERSON HUNT

While employee benefit managers spent the earlier part of 2008 focused on trying to contain health care plan costs and improving the health of their workforces, their concerns quickly shifted to retirement benefits as a result of the economic downturn, experts said.

The fall of the equities markets and that impact on companies' pension plan funding concerned benefit managers, even those working at companies whose plans at the start of 2008 were fully funded or overfunded, experts said.

"It was a trend for benefit managers to be very focused on the changes in funding that were presented by the changes in the marketplace performance in the third and fourth quarters of the year," said Chris McSwain, director of global benefits for Whirlpool Corp. in Benton Harbor, Mich.

The funding levels of many corporate plans plummeted during the last few months of the year, which will force many companies to significantly boost future contributions, said Chantel Sheaks, a principal with Buck Consultants L.L.C. in

Washington.

She said many companies that didn't expect to make contributions because of the healthy funding levels they enjoyed at the start of 2008 with their pension plans, now face the prospect of making hefty contributions.

Ms. Sheaks said companies are concerned about coming up with the money needed to satisfy funding requirements. She said they worry layoffs might be imminent to cover the amount of money owed to the plans.

At Nationwide Mutual Insurance Co. in Columbus, Ohio, however, funding the defined benefit pension plan wasn't as much of a worry as it was for other companies because Nationwide has been managing investments to ensure a lower equity exposure, helping to mitigate risk, said Jack Towarnicky, the company's associate vp-benefits planning.

"While we have had some investment losses, we did not have as much equity exposure as what the headlines are showing for some of the other corporate plans in America," he said.

Chris Cannova, director of compensation and benefits for the Arch-

diocese of Chicago, said he too was less worried about the organization's defined benefit plan because it was frozen in June 2007. Additionally, the structure of its pension assets had been moving away from equities toward bonds to protect against volatility in the market, he said.

He said the freeze was spurred by the potential impact the financial markets could have on the plan's funded status and the extreme volatility the organization faced. By freezing the plan, he said the liability level was established and won't further increase.

Reacting to the funding concerns, Congress approved legislation easing pension funding rules for 2008-2010. (see story, page 10.)

Given its concern about the financial markets, the Archdiocese of Chicago shifted its focus more to its 403(b) savings plan, making automatic, age-related contributions to so-called target-date funds. Freezing the defined benefit plan and boosting benefits in the 403(b) plan was a shift that allowed the archdiocese to budget retirement plan costs more accurately, Mr. Cannova said.

"It was a shift in mindset to get

folks engaged and understanding and interested in their own retirement," he said. "It brought to the forefront this voluntary retirement plan as the primary retirement plan for our employees."

Mr. Cannova said the major focus of the organization's retirement plans in 2008 was offering automatic enrollment for the 403(b) plan and implementing target-date retirement investment options.

The Archdiocese of Chicago was not alone. Ms. Sheaks and Mr. Towarnicky said the number of employers offering automatic enrollment for their defined contribution plans significantly increased in 2008.

Despite all the focus on retirement benefits, concerns about health care weren't entirely lost in benefits departments in 2008. Employee benefit consultants and managers said they continued to see a rise in employers adopting and pushing consumer-driven health plans.

As of Jan. 1, 2008, more than 6.1 million people were covered by health savings account-eligible insurance plans, a 35% increase from 2007, according to a survey by the Washington-based America's Health Insurance Plans.

Mr. Towarnicky said CDHPs are no longer uncommon—a change from just four years ago. He said that in 2009, approximately 35% to 40% of Nationwide's employees with health coverage will be enrolled in a plan that qualifies for a health savings account.

"It's like any other change," he said. "It takes awhile to work its way through the diversity that is the corporate benefits community. (CDHPs) are part of the fabric of voluntary employee benefit plans now."

Thomas Grass, a Los Angeles-based managing consultant for Southern California with Watson Wyatt Worldwide, said employers are turning to CDHPs with the hope of containing health care costs by encouraging employees to be more proactive with their health care.

"Consumer-directed health plans include more heavy involvement with employees," he said. "Employees need to become more involved with their health care. It just can't be the case anymore that employees don't care about their health care and don't care about their health."

Continued on next page

President-elect makes reforming health care a top priority

Health care reform will go in a new direction with the election of Barack Obama as president.

1 Significantly expanding coverage has not been a priority during the eight years of the Bush administration. In fact, President Bush vetoed a bill passed by Congress in 2008 that would have expanded eligibility in a program providing coverage to lower-income uninsured children.

In contrast, health care reform will be a key priority of the president-elect and former Illinois senator. Indeed, the Democrat demonstrated the importance he attaches to the issue by creating a White House office of health reform earlier this month and naming former Senate Majority Leader Tom Daschle to head that office. The president-elect also nominated Mr. Daschle to be secretary of the Department of Health and Human Services.

Long before that move, which was widely applauded in the busi-

ness and health care communities, President-elect Obama demonstrated his interest and commitment to changing the country's health care system.

On the campaign trail, he frequently stated his support of greatly reducing the number of people who have no health insurance, a group now estimated at 45 million. While not going in to detail, the president-elect outlined a plan much like the 2006 Massachusetts law that has drastically reduced the number of workers without health insurance. Like the Massachusetts model, Pres-

ident-elect Obama would require employers to pay a fee if they don't offer coverage to employees, while lower-income individuals would receive federal subsidies to help them pay health insurance premiums.

Whether the next president will be able to develop a broad consensus to pass health reform legislation is another matter. But experts say his Senate experience has taught him a crucial lesson that increases the odds of winning passage of health care legislation: his willingness to work with Republicans to

hammer out a bipartisan agreement.

Still, even with a president committed to health care reform and one who will enjoy Democratic majorities in both branches of Congress, speedy passage of legislation is far from a sure thing.

With Congress' top priority next year certain to be how to boost the slumping U.S. economy, consideration of health reform legislation might come later, not sooner, during the Obama administration.

—By Jerry Geisel

Employers applaud last-minute reprieve on pension funding

Cliffhanger is an apt way to describe this month's passage of pension funding relief legislation.

2 On the last day of the post-election session of Congress, a measure to remove a provision in a 2006 law that significantly tightened pension funding rules won final congressional passage.

The equities markets crash, which sent the funding levels of

pension plans plummeting, triggered the move. Business groups welcomed the relief, although it was short of what they had been seeking.

As of the end of last month, most corporate plans were between 75% and 85% funded, actuaries said. By contrast, plans typically were slightly overfunded at the end of 2007.

With the 2006 Pension Protection Act requiring employers to rapidly shore up their depleted plans, businesses faced a huge financial burden. While U.S. employers contributed an estimated

\$50 billion to the pension plans in 2008, funding requirements in 2009 would have been an estimated \$138 billion absent the funding relief provided by the legislation, according to Watson Wyatt Worldwide.

With the slumping economy, tight credit markets and increased plan contributions, lobbying groups warned that employers might have to lay off even more workers and exacerbate the nation's economic problems.

Congress responded modestly to those pleas for relief. Part of the leg-

islation it passed in the closing day of the 110th Congress eliminated a PPA provision that required employers to dramatically accelerate plan contributions if they missed certain funding targets.

If the target were missed in any year, employers then were required to fund toward a 100% target.

However, under the legislation—the Worker, Retiree and Employer Recovery Act of 2008—that requirement would be removed for 2008, 2009 and 2010. So if an employer missed the 92% funding target for 2008, its funding target under the

legislation would be 94% in 2009 rather than 100%.

The relief, which President Bush is expected to sign into law, will be especially important to employers that may have missed the funding target by only a percentage point or two and, in the absence of relief, would have had to increase their funding the following year.

Still, business groups say the legislation is only a first step and they will be back in 2009 to lobby Congress for even greater funding relief.

—By Jerry Geisel

City's health cover mandate concerns employers nationwide

Employers lost a battle in their challenge of a San Francisco health care spending mandate that went into effect in 2008, but the war is far from over.

3 In a decision that employers nationwide have closely followed due to its potential effect on the design, cost and administration of corporate health care plans, a unanimous three-judge panel of the 9th U.S. Circuit Court of Appeals ruled that the law does not conflict with the Employ-

ee Retirement Income Security Act, which pre-empts state and local laws and rules that relate to employee benefit plans.

In its decision, the panel noted that the 2006 ordinance does not require employers to adopt an ERISA plan or any other health care plan and does not require "any employer to provide specific benefits through an existing ERISA plan or other health plan."

The decision was not surprising. A ruling earlier in 2008 by the same three-judge panel that allowed San Francisco to implement its law pending a final resolution foreshadowed the later decision.

In the earlier ruling, Judge William Fletcher wrote that San Francisco had a "strong likelihood" of prevailing in its argument that ERISA does not pre-empt the spending ordinance.

While employers may not have been surprised, they warned that the ruling could have devastating effects if allowed to stand. Employers said such a ruling could open the floodgates to hundreds, if not thousands, of other cities and states passing their own benefit mandates. Opponents also said multistate employers would have an enormous burden just trying to track the varying requirements, let alone find

a way to pay for them.

The San Francisco law requires employers to make health care expenditures of at least \$1.76 per hour for every eligible employee working at least 10 hours a week. Permitted expenditures include payment of group health insurance premiums, contributions to health spending accounts and health reimbursement arrangements, or to reimbursement accounts that San Francisco administers.

The law also imposes numerous reporting requirements on employers.

The outcome of the next round in the litigation also is highly pre-

dictable. The San Francisco restaurant trade group that challenged the law has asked the full 9th Circuit to review the three-member panel's decision. Such a review is unlikely given that the panel was unanimous, legal experts say.

The next step then would be the restaurant owners seeking review by the U.S. Supreme Court.

Given the national importance of the issue and that another appeals court ruled differently in rejecting a somewhat similar Maryland health care spending law, the odds favor a review by the high court, ERISA experts say.

—By Jerry Geisel

Benefits: Tough economy shifts attention to retirement savings

CONTINUED FROM PREVIOUS PAGE

Ms. Sheaks said employers have realized they can't just offer a high-deductible plan and expect everyone to join. Instead, they must engage employees, explain the plans and their advantages, and even open health savings accounts for employees and put in some seed money to start out. Otherwise, she said, employees might view the plans negatively.

"In today's economic climate, if you change the benefit structure, even if it might eventually be better

for them, (employees) are looking at it as a cut," Ms. Sheaks said.

Mr. Towarnicky said the increased interest in CDHPs correlates with the expanding breadth and depth of wellness and prevention programs sponsored by employers. He said employers have ramped up their efforts to increase the productivity of their workforces by encouraging lifestyle changes, such as quitting smoking, losing weight or adhering to prescribed medicine regimens that can avoid more serious medical conditions in the future.

Mr. McSwain said the productivi-

ty lost because of poor health is a major problem and he's seen a bigger push to measure productivity more accurately.

"It's a very true and fair cost that has, historically, not been given a lot of attention," he said. "More and more employers are interested in trying to build their business cases for their investment in health around the measurement of productivity lost due to poor health."

Mr. Cannova said while the Archdiocese of Chicago did not implement a wellness program in 2008, he has begun taking preliminary

actions to target particular diseases affecting employees and the organization for 2009. The organization hopes to encourage people to be healthier and proactive when it comes to their health.

Despite the economic downturn, Ms. Sheaks said she doesn't think employers will abandon wellness programs. However, being able to prove the return on investment has become that much more critical. She said to contain costs, employers are re-evaluating the incentives they offer, moving away from offering cash for actions such as taking a

health risk assessment and instead offering things such as time off or gift cards.

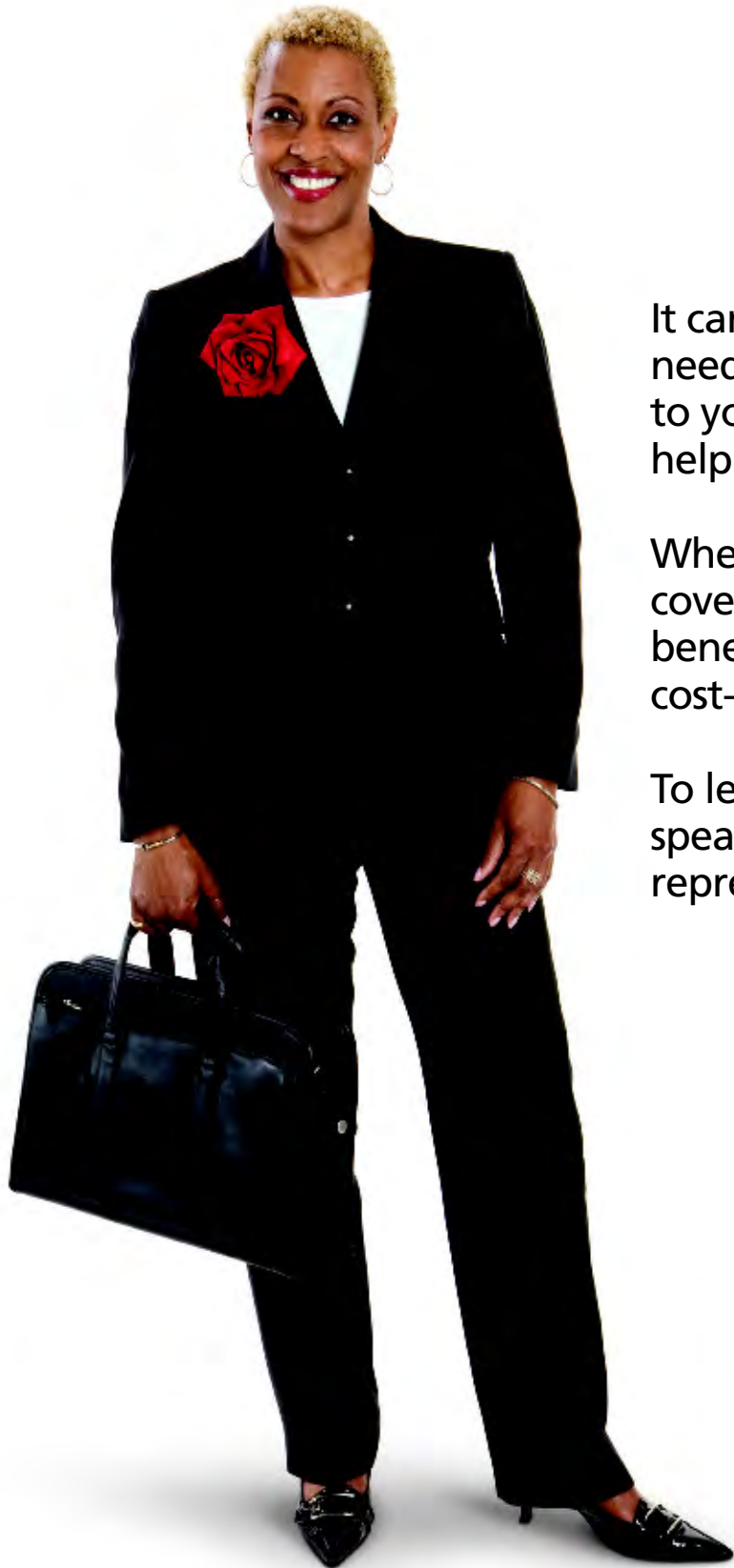
While health care might have taken a back seat to retirement benefits toward the end of 2008 because of the rocky economy, benefits managers say it is critical they stay on top of developments in both areas.

"We have a broad-based perspective on benefits and we keep all of those things on our radar all the time," Mr. McSwain said. "We're constantly evaluating each of the elements of a comprehensive benefits program."

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Mental health parity finally becomes law

Thanks to congressional action at the end of the regular session, most U.S. employers will have to upgrade their health care coverage for mental disorders.

Ending a legislative journey that began nearly two years ago, Congress approved a bill to require group plans to provide the same coverage for mental disorders as they do for other medical conditions. The implementation date generally is Jan. 1, 2010.

The new law ends such widespread discriminatory plan designs as imposing a cap on the number of annual visits to mental health therapists, with no comparable limit of treatment for other medical conditions.

The bill's odyssey began long before the 110th Congress began in January 2007. Prior to that, Senate supporters of parity for mental health care benefits, including Sen. Edward Kennedy, D-Mass., who chairs the Health, Education, Labor & Pensions Committee, reached out to the business community for its help in devising legislation that employers would not oppose.

That olive branch proved to be a successful approach.

Business groups such as the

American Benefits Council and National Retail Federation supported the parity bill that Sen. Kennedy introduced.

In turn, noticeably absent from the legislation was a provision that would have required group plans to cover any condition included in the psychiatric industry's compendium of mental disorders. That requirement, which had been included in parity legislation introduced in the House, drew strong business opposition.

A big breakthrough came in May when, during negotiations to iron out differences between the two bills, House negotiators agreed to accept the Senate bill.

Still, it wasn't until the very last day of the regular congressional session that the legislation won final approval. In an unusual arrangement, the parity legislation was joined with a measure to bail out the financial services industry, one that President George W. Bush signed immediately.

Business groups say they hope that the way the parity bill was fashioned—with different interest groups working together to find a common ground—can be a model for legislators when they tackle the more ambitious effort of developing comprehensive health care reform legislation in the future.

—By Jerry Geisel

Military families gain from FMLA expansion

Congress eased the burden of military service on employees and their families in 2008 by expanding Family and Medical Leave Act coverage for family members of employees called to active military duty.

Federal legislators tucked the provisions into a broader Department of Defense spending bill that they passed and President Bush signed in January to expand the FMLA in two key ways.

Under the first expansion, employees are allowed to take up to 12 weeks of unpaid leave when a spouse, child or parent is on active duty in the armed forces or is called to active duty. Such leave can be for any "exigency," which Labor Department regulations defined broadly.

Under the second expansion, employees who are the spouses, children, parents or next of kin of a member of the U.S. military can take up to 26 weeks of leave under the FMLA to care for their relative who was injured or became ill dur-

ing active military duty.

Final Labor Department regulations cleared up many questions that employers had raised about the new law, the first revision since 1993 when the original Family and Medical Leave Act was approved.

Under the final regulations, an employee is entitled to a maximum of 26 weeks of leave during a 12-month period. For example, if a working parent took 26 weeks of leave to care for a child injured while on active duty, the parent could not take another 26-week leave during the same 12-month period if a second child were injured during the same 12-month period.

How much the FMLA expansion will affect employers will vary significantly. The greatest effect will be on those employers with large numbers of employees who are called to active military duty, such as airlines and defense contractors.

Even though relatively small numbers of employees will be affected by the FMLA expansion, the availability of the benefits will be very important for those individuals and their families, experts say.

—By Jerry Geisel

Top 10 newsmakers of 2008 in the field of employee benefits

The spotlight shone during 2008 on New York **Attorney General Andrew Cuomo** when he revealed that his office was investigating Ingenix Inc., an Eden Prairie, Minn.-based subsidiary of



Mr. Cuomo

UnitedHealth Group Inc., and several health insurers over their reimbursement practices. Mr. Cuomo's investigation centered around Ingenix's Prevailing Healthcare Charges System, which most of the nation's health insurers and third-party administrators use to calculate reimbursements for out-of-network health care providers based on usual and customary or reasonable and customary charges.

Although no lawsuits were filed, the attorney general alleged that consumers were forced to pay higher-than-necessary out-of-pocket medical expenses because the reimbursement rates for out-of-network providers were set too low.

Mr. Cuomo, the elder son of former New York Gov. Mario Cuomo, was elected as New York attorney general when Eliot Spitzer won election to the governor's mansion.

In a major ruling affecting employers, the 9th U.S. Circuit Court of Appeals decided in 2008 that San Francisco's health care spending law does not violate the Employee Retirement Income Security Act.



Judge Fletcher

ERISA is the 1974 federal law that pre-empts state and local laws and rules that relate to employee benefit plans. Writing for the unanimous three-member appeals court panel, **Judge William Fletcher** said ERISA pre-emption doesn't come into play as the 2006 ordinance does not require employers to adopt an ERISA plan or any other health care plan and does not require "any employer to provide specific benefits through an existing ERISA plan or other health plan."

Under the San Francisco ordinance that went into effect in January 2008, employers in the city must make health care contributions to avoid fines.

Expenditures can include payment of group health insurance premiums, contributions to health savings accounts and health reimbursement arrangements, or

payments to a special San Francisco fund or reimbursement accounts that San Francisco administers. It also imposes numerous reporting rules on employers.

Business groups worry that if the decision is allowed to stand, it would pave the way for numerous other cities and states to enact their own health care spending mandates, resulting in a maze of new requirements on employers.

Some benefit experts predict the ruling could serve as the catalyst for eventual Supreme Court review of such play-or-pay type health insurance mandates on employers, which would resolve the issue once and for all.

Seriously ill college students no longer will face the prospect of losing their insurance coverage thanks to the efforts of **Rep. Paul Hodes**, D-N.H.

Rep. Hodes has been leading the charge to expand employer coverage for ill college students for the past two years. On Oct. 9, President Bush signed into law H.R. 2851, which allows students to continue coverage under their parents' health insurance plans even if they can't

maintain status as full-time students.

The legislation, sponsored by Rep. Hodes, provides coverage for up to 12 months after the student takes a leave of absence and is based on a 2006 New Hampshire law known as "Michelle's Law." That law was named after Michelle Morse, a Manchester, N.H., college student who continued her studies while battling colon cancer so she could maintain health insurance coverage. Ms. Morse died in 2005.

The federal measure applies to both insured and self-insured plans and takes effect Jan. 1, 2010. The American Cancer Society estimates that it could help the estimated 2,400 college students diagnosed with cancer each year.

For **Sen. Edward Kennedy**, D-Mass., 2008 brought both triumphs and challenges.

The chairman of the Senate Health, Education, Labor and Pensions Committee realized a longtime objective when, on the very last day of the regular session, Congress gave final approval to legislation to require group health care plans to provide the same coverage for mental disorders as other medical conditions.

Sen. Kennedy played a key role in developing and winning support for the legislation. As he noted when the parity bill passed, the change eliminated decades of



Sen. Kennedy

widespread discrimination in coverage of mental disorders.

"It will now be the law of the land that people with such illnesses deserve the same access to affordable coverage as those with physical illnesses," he said.

President Bush added to the triumph by signing the bill into law.

But there also was tragedy. In May, after suffering a seizure, Sen. Kennedy was diagnosed with a malignant brain tumor. In June, he underwent surgery to remove the tumor.

Just two months after the surgery, in a brief address at the Democratic National Convention in Denver, Sen. Kennedy touched on one of the great passions of his 46-year career in the U.S. Senate; the need to expand health insurance coverage.

Now, he told the convention, there is "new hope that we will break the old gridlock and guarantee that every American—North, South, East and West, young, old—will have decent, quality health care as a fundamental right and not a privilege."

Sen. Kennedy's own prognosis was uncertain, but he pledged to help lead the drive for enactment of universal coverage legislation as long he remains in the Senate.

Why aren't mainstream health care plans already offered by employers good enough to be considered qualified coverage so employees can avoid a hefty assessment imposed by Massachusetts' health care reform law?



Mr. Kingsdale

That was a question posed by employers and benefit consultants in 2008 to Massachusetts regulators as the Jan. 1, 2009, deadline for imposing the penalties neared.

Such assessments can be more than \$900 a year for individuals not enrolled in plans offering so-called minimum creditable coverage. In 2008, the penalties applied only to state residents not

Continued on next page

YEAR IN REVIEW - EMPLOYEE BENEFITS

CONTINUED FROM PREVIOUS PAGE

enrolled in a health plan.

In the end, **Jon Kingsdale**, the executive director of the Commonwealth Health Insurance Connector Authority, the agency in charge of implementing key portions of the Massachusetts law, agreed that more flexibility was needed and that plans should be judged on the full range of benefits offered, not merely on a rigid set of requirements.

"An employer might set a \$2,100 deductible but have fairly generous coverage after that. We wanted to recognize the value of the entire package," Mr. Kingsdale said.

"The intent of the law's individual mandate is to make sure Massachusetts residents have real insurance. It's not to penalize people who are enrolled in plans that provide decent health coverage," he said.

A final rule the Connector board approved in October incorporated that philosophy. Health care plans that don't meet the strict minimum creditable coverage standards, such as having a deductible that is too high, still would be considered in compliance if their relative value is equivalent to so-called bronze-level plans that are sold through the Connector.

Bronze-level plans generally provide the lowest level of benefits offered through the Connector.

That added flexibility increases the likelihood that most employer plans will be deemed to offer creditable coverage under state law.

Rep. George Miller, D-Calif., failed in his 2008 effort to win passage of legislation to require employers to offer 401(k) plan participants at least one low-cost index fund as well as to disclose more information about plan costs.

However, the chairman of the House Education and Labor Committee isn't giving up on that and other 401(k) plan issues.

Rep. Miller said in November that he wants more disclosure of what he described as "excessive fees" paid by 401(k)

plan enrollees and that enrollees should have access to low-cost index funds.

In a statement of principals he said he intends to push for enactment during the next congressional session, Rep. Miller wants to require employers to offer automatic enrollment in their 401(k) plans. He said that change would boost participation substantially.

And to increase the likelihood that employees' 401(k) plan accounts haven't been depleted before retirement, Rep. Miller wants account balances to automatically roll over into

a new retirement plan when employees change jobs.

The last time a U.S. president tried to win passage of comprehensive health care reform legislation, the result was a major defeat for the Clinton administration.

At the time, that failed effort was widely attributed to the secrecy in which the reform plan was developed and the unwillingness of then-President Bill Clinton and then-First Lady Hillary Clinton, who led the drafting of the proposal, to try to develop bipartisan support for the

measure.

President-elect Barack Obama clearly will have a different strategy.



Mr. Obama

This month, he named former Senate Majority Leader Tom Daschle to lead the White House health care reform effort. Mr. Daschle's many years of experience on Capitol Hill is a decided contrast to Hillary Clinton, who had virtually none when she came to

Washington in 1993.

Understanding that bipartisanship is crucial if health care reform is to have any chance of passage, the next U.S. president said Mr. Daschle is someone "who knows how to reach across the aisle."

During the campaign, the Illinois Democrat voiced his support for a plan in which employers would either offer coverage or be hit with an assessment, while the government would subsidize health insurance premiums of the lower-income uninsured.

Such an approach has worked well in Massachusetts, where the uninsured rate has fallen

dramatically since enactment of a groundbreaking reform measure in 2006.

But whether such an approach can be passed, much less successfully implemented, at the national level will be one of President-elect Obama's biggest domestic challenges.

Gov. Arnold Schwarzenegger's concerted push for health care reform in California petered out early in 2008 when a measure he had championed with the help of

Continued on next page

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Rep. Miller



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CNA

YEAR IN REVIEW - EMPLOYEE BENEFITS

Assembly Speaker Fabian Nunez, D-Los Angeles, succumbed to the state's economic troubles.

Citing the state's huge budget deficit and concern about the cost of subsidizing health insurance premiums for millions of low-income uninsured state residents, an 11-member Senate Health Committee killed the governor's measure at the beginning of the legislative session.

The measure would have required employers either to provide health care coverage to their workers or pay a tax to the state, which would have provided coverage on their behalf.

The bill, which passed the Assembly in December 2007, also

included an individual mandate that would have required all state residents to obtain health insurance.

Aside from its huge price tag of \$14 billion, another aspect of the legislation that made it untenable to lawmakers was its failure to address rising health care costs, critics said.

The 9th U.S. Circuit Court of Appeals ruled in August that cash balance pension plans are not age discriminatory, a ruling that may have been the proverbial nail in the coffin on the age discrimination issue.

Writing for the three-member appeals court panel, **Judge N. Randy Smith** rejected arguments by the plaintiffs' bar that the plans discriminated against older retirees because the same benefit earned by younger employees is worth more when expressed as a retirement

annuity.

The reason, Judge Smith wrote, that a younger employee's benefit is worth more is the result of time.

"Although a younger worker's total accrued benefit at retirement age will be greater under the cash balance formula than an older worker's if both started at the same time, the difference is due to the time value of money rather than age discrimination," he wrote.

With five appeals courts—including the 9th Circuit, which is widely considered to have an anti-business slant—all ruling the same, litigation over the cash balance plan age discrimination issue and the possibility that employers could have to shell out huge

damages almost certainly came to an end in 2008, legal experts say.

Rep. Pete Stark, D-Calif., has never been one to hold back concerning his views on health savings accounts.

The chairman of the House Ways and Means health subcommittee and a key co-sponsor of the landmark 1986 COBRA health care continuation law described HSAs in 2006 as a "multibillion dollar tax break for healthy, wealthy people."

In 2008, he said HSAs are simply a way to shift costs to enrollees and not an effective means to

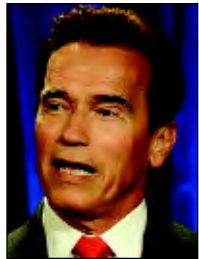
control costs.

But Rep. Stark did more than criticize HSAs. He was one of the key backers of 2008 legislation that would have required HSA trustees, who are chiefly banks, to substantiate whether distributions from the accounts were used to reimburse enrollees for medical expenses.

Critics maintained that such a change would have boosted administrative costs and led some banks to withdraw from the HSA market.

While the House of Representatives approved the measure, the Senate took no action, perhaps because it knew President George W. Bush would have vetoed the bill.

But with President-elect Barack Obama less favorably disposed to HSAs than President Bush, Rep. Stark's chances of winning congressional approval for the HSA proposal will be much greater.



Mr. Schwarzenegger

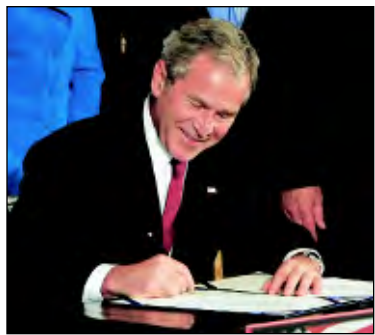


Judge Smith



Rep. Stark

A look back at major employee benefits events in 2008



AP PHOTO

JANUARY

■ President Bush signs legislation expanding the Family and Medical Leave Act for military families, the first expansion since FMLA was passed in 1993. The measure allows employees to take up to 12 weeks of unpaid leave when a spouse, child or parent is on active military duty or is called to active duty for any "exigency." In addition, employees who are the spouses, children, parents or next of kin could take up to 26 weeks of FMLA leave to care for a service member injured while on active duty.

FEBRUARY

■ Legislation that would have had California subsidize health insurance premiums of millions of low-income, uninsured residents

and imposed penalties on employers not offering health care coverage dies in a Senate committee amid concerns about its cost while the state budget deficit is huge and growing.

■ The U.S. Supreme Court rules that defined contribution plan participants can sue fiduciaries, such as employers, for individual account losses. The decision resolves uncertainty due to conflicting previous federal court decisions.

MARCH

■ The U.S. Supreme Court declines to review and thus lets stand a final 2007 rule by the Equal Employment Opportunity Commission that exempts retiree health care plans from age discrimination law. The EEOC rule allows employers to provide a two-tier system of health coverage in which younger retirees can receive richer benefits than Medicare-eligible retirees without fear of being sued for age discrimination.

APRIL

■ The House of Representatives approves legislation that would effectively boost the cost of administering health savings accounts by requiring HSA trustees,

typically banks, to substantiate that distributions are for health care-related expenses. The Senate, though, later declines to act on the bill.

■ Employees in New Jersey could take up to six weeks of paid leave per year after the birth or adoption of a child or to care for a seriously ill relative under newly approved legislation. While on leave, employees receive payments from a state fund to replace up to two weeks of their salary, up to a maximum of \$524 a week. The benefit is funded entirely through employee payroll deductions, the size of which are based on employee salary. Gov. Jon Corzine later signs the bill into law.

MAY

■ Enrollment in high-deductible health insurance plans linked to health savings accounts continues to surge, according to a survey by America's Health Insurance Plans. AHIP said the survey found that 6.1 million people were enrolled in HSA-linked plans as of Jan. 1, a 35% increase over Jan. 1, 2007. Enrollment increased in all markets, with the biggest percentage increase—70%—in the small-employer market.

JUNE

■ A so-called "grab-bag" of Internal Revenue Service guidance resolves dozens of questions employers raised about health savings accounts. Among other things, the guidance clarifies that employees do not lose HSA eligibility if they receive low- or no-cost services from onsite corporate medical clinics so long as the clinics do not provide extensive medical services.

■ President Bush signs legislation to allow reservists called up for at least six months of active duty to take their health care flexible spending account balances as a taxable cash distribution. The FSA provision is included in a broader bill dealing with a variety of issues facing members of the military. The measure also exempts reservists called to active duty from the 10% penalty tax on preretirement distributions from 401(k) plans.

AUGUST

■ A fifth appeals court rules that the design of cash balance pension plans do not discriminate against older employees, which experts say almost certainly puts an end to the controversy. Joining four other appeals courts that handed down similar decisions previously, the 9th U.S. Circuit Court of Appeals

rules that while the same benefit—expressed as a retirement age annuity—is worth more to a younger employee than an older employee, that difference is the result of the time value of money, not discrimination based on age. The case involved a cash balance plan sponsored by Southern California Gas Co., a subsidiary of Sempra Energy.

■ The number of U.S. residents without health insurance dipped in 2007 as the growth in government-based programs more than offset a decline in employment-based coverage, the U.S. Census Bureau says. In 2007, 45.7 million U.S. residents lacked health insurance, down from 47 million in 2006. Those with coverage through government-based programs, such as Medicaid, climbed to 27.8 million in 2007, up from 27 million in 2006, while employment-based coverage declined to 59.3 million in 2007 from 59.7 million the previous year.

SEPTEMBER

■ Seriously ill college students could continue coverage under their parents' health insurance

Continued on next page



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YEAR IN REVIEW - EMPLOYEE BENEFITS

CONTINUED FROM PREVIOUS PAGE

plans even if they can't maintain status as full-time students under legislation given final congressional approval. With President Bush's signature in October, students can maintain coverage under their parents' health plan up to a year after taking a leave of absence from school.

OCTOBER

■ Ending years of debate, Congress approves mental health care benefits parity legislation. The measure, included as part of a massive financial services bailout bill signed into law by President Bush, requires employers to offer the same coverage for mental disorders as for medical problems. The law generally goes into effect on Jan. 1, 2010.

■ In a unanimous decision, the 9th U.S. Circuit Court of Appeals rules that the Employee Retirement Income Security Act does not preempt a 2006 San Francisco law requiring employers to spend a certain amount of money on health care per employee. The court said the law neither requires employers to adopt a health care plan nor mandates what benefits a health plan offers. Business groups worry that unless the decision is overturned, it could lead other cities and states to impose new and expensive requirements on employers. The San Francisco law requires large employers to spend about \$3,600 a year for each full-time employee, which they can do through such options as paying employee health insurance premiums or contributing to a city fund.

■ Under a new rule approved by state regulators, Massachusetts companies with more than 50 employees must provide health care coverage to at least 25% of employees and pay at least 33% of the premium for individual coverage to prove they are making a "meaningful" health care

coverage contribution and avoid an annual \$295 per employee assessment. The rule revamps an existing regulation that said employers are exempt from the assessment—mandated by the state's 2006 health care reform law—if they satisfy either requirement. That either/or requirement continues to apply to employers with up to 50 employees, while employers with fewer than 11 employees continue to be exempt.

Business groups welcome new Massachusetts "creditable coverage" rules that significantly decrease the likelihood that employees in employer-provided

plans will be hit with special assessments. The final rules retain earlier requirements that employees must be in plans offering a broad range of medical services to avoid a state assessment that can exceed \$900 a year. But in a major change, employees could be enrolled in plans that don't exactly meet minimum creditable coverage requirements and be exempt from the assessment if the plans are equal to so-called bronze-level plans sold through the state agency implementing key portions of the health care reform law.

NOVEMBER

Health care costs in 2008 continue

rising at the same level—just above 6%—as they did the prior three years, according to a Mercer L.L.C. survey. The continuing cost rise is leading more employers to hike employee payments, such as plan deductibles, and offer lower-cost consumer-driven plans.

DECEMBER

■ Responding to the dire financial straits of the Big Three Detroit automakers, the United Auto Workers union says it will give the companies more time to pay into special retiree health care trusts. The trusts were a key part of a 2007 contract in which the automakers were allowed—starting in 2010—to

walk away from their retiree health care obligations in exchange for contributions to the trusts that are substantially less than the value of those obligations.

■ Partially responding to business lobbying, Congress approves legislation that modestly eases pension funding rules included in the 2006 Pension Protection Act. Among other things, legislators removed a PPA transitional provision that had required employers to start to fully fund their plans if they miss certain funding targets in 2008, 2009 and 2010. But employer groups say they will press for greater relief during the next session.

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YEAR IN REVIEW - EMPLOYEE BENEFITS

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UNITED STATES BANKRUPTCY COURT • SOUTHERN DISTRICT OF NEW YORK

In re Petition of Thomas Klaus Freudenstein, as foreign representative of GLOBAL GENERAL AND REINSURANCE COMPANY LIMITED and GLOBALE RÜCKVERSICHERUNGS-AG Debtor in a Foreign Proceeding. x
 In a Case Under Chapter 15 of the Bankruptcy Code Case No. 08-14939 (Jointly Administered) x

NOTICE OF FILING AND HEARING ON PETITIONS UNDER CHAPTER 15 OF THE UNITED STATES BANKRUPTCY CODE

PLEASE TAKE NOTICE that on December 10, 2008, Thomas Klaus Freudenstein (the "Petitioner"), the duly authorized foreign representative, as defined in section 101(24) of title 11 of the United States Code (the "Bankruptcy Code"), of GLOBAL General and Reinsurance Company Limited ("GLOBAL General") and GLOBALE Rückversicherungs-AG ("GLOBALE," together with GLOBAL General, the "Scheme Companies"), commenced cases (the "Chapter 15 Cases") by filing Petitions (the "Petitions"), pursuant to Chapter 15 of the Bankruptcy Code, with the United States Bankruptcy Court for the Southern District of New York (the "Court").

PLEASE TAKE FURTHER NOTICE that the Petitioner seeks, among other things, entry of an order giving full force and effect in the United States to the Schemes of Arrangement (collectively, the "Schemes") proposed by each of the Scheme Companies and sanctioned, pursuant to Part 26 of the Companies Act 2006 of Great Britain, by the High Court of Justice of England and Wales, a permanent injunction and related relief.

PLEASE TAKE FURTHER NOTICE that with respect to GLOBALE General, the Petitioner is requesting recognition of a foreign main proceeding, as well as a permanent injunction and related relief.

PLEASE TAKE FURTHER NOTICE that with respect to GLOBALE, the Petitioner is requesting recognition of a foreign nonmain proceeding, as well as a permanent injunction and related relief.

PLEASE TAKE FURTHER NOTICE that by Order dated December 11, 2008, the Chapter 15 Cases are being jointly administered for procedural purposes only and all pleadings filed in the Chapter 15 Cases should bear the above-referenced caption.

PLEASE TAKE FURTHER NOTICE that in addition to the Petitions, the Petitioner filed, among other things: (i) the list required to be filed with each of the Scheme Companies' Petitions pursuant to Rule 1007(a)(4) of the Federal Rules of Bankruptcy Procedure (the "Bankruptcy Rules"); (ii) the Statement of Foreign Representative required to be filed with each of the Scheme Companies' Petitions pursuant to section 1515 of the Bankruptcy Code; (iii) the Verified Petition under Chapter 15 of the Bankruptcy Code for Recognition of Foreign Proceedings, for a Permanent Injunction and Related Relief; (iv) the Memorandum of Law in Support of Petitions Under Chapter 15 of the Bankruptcy Code for Recognition of Foreign Proceedings, for a Permanent Injunction and Related Relief; and (v) the Declaration of Juliette Stevens, English Counsel (collectively, the "Supporting Documents").

PLEASE TAKE FURTHER NOTICE that pursuant to the Order Limiting Notice, Scheduling Hearing and Specifying the Form and Manner of Service of Notice, dated December 11, 2008 the Court has scheduled a hearing (the "Hearing") for January 21, 2009 at 10:00 a.m., or such other time as counsel may be heard, before the Honorable Robert D. Drain in Room 610 of the Bankruptcy Court, One Bowling Green, New York, New York, to consider the Petitions and the relief requested by the Petitioner.

PLEASE TAKE FURTHER NOTICE that any party in interest wishing to submit a response or objection to the Petitions or the relief requested by the Petitioner must do so pursuant to the Bankruptcy Code and the Local and Bankruptcy Rules, including, without limitation, Bankruptcy Rule 1011, in writing and setting forth the basis therefore, which response or objection must be filed with the Office of the Clerk of the Court, Room 534, One Bowling Green, New York, New York 10004-1408, and served on Chadbourne & Parke LLP, 30 Rockefeller Plaza, New York, NY 10112 (Attn: Howard Seife, Esq.) so as to be received by them all no later than 4:00 p.m. (EDT), January 16, 2009.

PLEASE TAKE FURTHER NOTICE that the response or objection to be filed with the Office of the Clerk of the Court must be filed: (i) electronically by registered users of the Court's electronic case filing system in accordance with General Order M-242 of the Bankruptcy Court for the Southern District of New York, a copy of which may be viewed on the Court's website, www.nysb.uscourts.gov; and (ii) by all other parties in interest on a 3.5 inch disc, with hard copy provided to the Chambers of the Honorable Robert D. Drain, at the address specified above.

PLEASE TAKE FURTHER NOTICE that all parties-in-interest opposed to the Petitions or the Petitioner's request for relief must appear at the Hearing at the time and place set forth above.

PLEASE TAKE FURTHER NOTICE that the Hearing may be adjourned from time to time without further notice other than an announcement in open court at the Hearing or the adjourned date or dates of the Hearing and filing of a notice on the Court's electronic docket of the Chapter 15 cases; and

PLEASE TAKE FURTHER NOTICE that if no response or objection is timely filed and served as provided above, the Court may grant the recognition and relief requested by the Petitions without further notice. Copies of the Petitions and the Supporting Documents will be made available upon request at the office of the Petitioner's United States Counsel at the address below:

CHADBOURNE & PARKE LLP • Attorneys for the Petitioner • 30 Rockefeller Plaza • New York, New York 10112 (212) 408-5100 • Attn: Howard Seife, Esq. and Francisco Vazquez, Esq.

IN THE HIGH COURT OF JUSTICE
 CHANCERY DIVISION
 COMPANIES COURT
 No. 5963 of 2008, No. 5962 of 2008
NOTICE OF SANCTION OF SOLVENT SCHEME OF ARRANGEMENT
 IN THE MATTER OF
GLOBAL GENERAL AND REINSURANCE COMPANY LIMITED
 (former names The Christiania Reinsurance Company Limited, United Reinsurers Limited, Gerling Global Reinsurance Company Limited and Gerling Global General and Reinsurance Company Limited)
 AND IN THE MATTER OF THE COMPANIES ACT 2006 OF GREAT BRITAIN
 IN THE MATTER OF
GLOBALE RÜCKVERSICHERUNGS-AG
 (former names Gerling-Konzern Globale Versicherungs-Aktiengesellschaft, Gerling-Konzern Globale Rückversicherungs-Aktiengesellschaft and Gerling Globale Rückversicherungs-Aktiengesellschaft)
 AND IN THE MATTER OF THE COMPANIES ACT 2006 OF GREAT BRITAIN

NOTICE IS HEREBY GIVEN that, by an Order dated 25 November 2008 made in the High Court of Justice in England and Wales, Chancery Division, Companies Court, in the matter of GLOBAL General and Reinsurance Company Limited ("GLOBAL General") and by an Order dated 10 December 2008 made in the High Court of Justice in England and Wales, Chancery Division, Companies Court, in the matter of GLOBALE Rückversicherungs-AG ("GLOBALE") (together the "Companies"), the solvent scheme of arrangement (the "Scheme") to be made between each of the Companies and their respective Scheme Creditors (as defined in the Scheme) pursuant to Part 26 of the Companies Act 2006 which was voted on and approved by the Scheme Creditors during the meetings held on 10 October 2008 (in respect of GLOBAL General) and 17 October 2008 (in respect of GLOBALE), was sanctioned. A copy of the Order sanctioning the Scheme in respect of each Company was filed with the Registrar of Companies on 10 December 2008, and the Scheme became effective on that date (the "Effective Date").

Scheme Creditors are required to submit completed Claim Forms together with the supporting evidence required by the Scheme in respect of their Claims (as defined in the Scheme) by midday London time on 8 June 2009 (the "Final Claims Submission Deadline").

Completed Claim Forms in respect of the GLOBAL General Scheme should be returned to GLOBAL General and Reinsurance Services Limited, (marked for the attention of Anne Williams), 50 Fenchurch Street, London, EC3M 3JY or by fax to +44 (0) 20 7173 3301 or by email to enquiries.pre@9scheme@globalre.com.

Completed Claims Forms in respect of the GLOBALE Scheme should be returned to GLOBALE Rückversicherungs-AG, (marked for the attention of Mr Holger Fiedler), Im Mediapark 4b, 50670 Köln, Germany, or to GLOBAL General's Scheme Manager at the address above. Alternatively, Claim Forms can be sent by fax to +49 221 2889 405 or by email to solvent.scheme@globalre.com.

In the event that a Scheme Creditor fails to complete and submit a Claim Form to the relevant Company at or before the Final Claims Submission Deadline, the Claims of that Scheme Creditor against the Company will be deemed to have been satisfied in full and that Scheme Creditor will not be entitled to receive any payment in respect of such Claims.

Notice of the Effective Date and the Final Claims Submission Deadline has been sent to all known Scheme Creditors for whom the Companies have contact details which it does not believe are incorrect. Any person who believes himself or herself to be a Scheme Creditor of GLOBAL General who has not received notice of the Effective Date should contact Anne Williams at GLOBAL General and Reinsurance Services Limited at the address above or by telephone on +44(0) 20 7173 3328 or by email to enquiries.pre@9scheme@globalre.com. Any person who believes himself or herself to be a Scheme Creditor of GLOBALE who has not received notice of the Effective Date should contact Mr Holger Fiedler at GLOBALE Rückversicherungs-AG at the address above or by telephone on +49 221 2889 177 or by email to solvent.scheme@globalre.com.

Any Scheme Creditor who is unclear about or has any questions regarding this Notice, or the action he is required to take, should contact the relevant Company using the details set out below:

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 GLOBAL General and Reinsurance Services Limited, 50 Fenchurch Street, London EC3M 3JY, United Kingdom.
 Tel: +44 (0) 20 7173 3328 Fax: +44 (0) 20 7173 3301
 Email: enquiries.pre@9scheme@globalre.com
 Website: www.globalre.com/schemes

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For details on listing your company, contact Monique at 212-210-0129 or mmurray@businessinsurance.com

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Defense: Denial sparks debate on strategy

CONTINUED FROM PAGE 3

InterMune agreed to cover the next \$5 million of Dr. Harkonen's defense costs.

InterMune's tab in picking up Dr. Harkonen's defense costs would be limited to \$5 million for now. That's because there is at least one more excess insurer in the company's D&O program, and it sits above Arch, a source said. InterMune did not return calls.

Some policyholder attorneys assert that courts in several high-profile coverage cases have made clear that insurers should not deny defense coverage without first seeking court approval.

Courts hearing coverage disputes involving Tyco International Ltd., HealthSouth Corp. and Adelpia Communications Corp.—all of which faced massive securities fraud charges—ruled that insurers should

seek court approval before trying to either rescind a policy or deny a defense for a specific claim, attorneys said.

A few courts have rejected that idea, "but the strong majority goes the other way," said policyholder attorney Bernard P. Bell, a partner at Jones Day in Washington.

An insurer that denies a defense without court approval creates a bad-faith exposure for itself, which could result in costly damages, noted policyholder attorney William G. Passannante, a partner with Anderson Kill & Olick P.C. in New York.

"In claims involving life and liberty, you shouldn't be able to only send a letter" to deny coverage, Mr. Passannante asserted.

Insurer attorney Arthur J. Washington, a partner in New York at Mendes & Mount L.L.P., does not dispute the findings in the Tyco,

HealthSouth and Adelpia cases.

"But, overall, there's not a great deal of judicial guidance on this," Mr. Washington said. "It's all developing."

He noted, for example, that the Mississippi Supreme Court has ruled that insurers do not have to first seek court approval to deny a defense.

He added that if a claim is "excluded in its entirety" or if a policyholder has somehow voided its policy, "it seems unreasonable for an insurer to have to outlay millions of dollars in defense costs until they can get a court to rule" on the issue.

Broker Karen Kutger, a vp in Philadelphia with Professional Risk Solutions, said insurers with "weak" proof to justify denying a defense usually will act unilaterally, because that approach is cheaper than seeking court approval.

Market Moves

Faber & Dumas to gain 3 new divisions

LONDON—Broker Willis Group Holdings Ltd. is adding three more divisions to its new Faber & Dumas (Agencies) Ltd. operation, the firm announced last month.

Three of Willis' London-based specialty businesses—kidnap & ransom broker Special Contingency Risks Ltd.; Hughes-Gibb, a bloodstock insurance specialist; and Fine Art, Jewellery & Specie—will operate under the Faber & Dumas umbrella along with London-based Glencairn Group Ltd., the former specialty wholesale broker of Hilb Rogal & Hobbs Co. Willis created Faber & Dumas in October after acquiring HRH. The new additions make Faber & Dumas one of the largest London-based wholesale brokers, Willis said in a statement.

Lockton merges offices to form Northeast team

NEW YORK—Kansas City, Mo.-based broker Lockton Cos. L.L.C. has merged its Manhattan and Connecticut offices into a single team for the Northeast.

The new division will include a total of 70 personnel in a Farmington, Conn., and Manhattan office.

Asked whether the move would include layoffs, a spokesman said the company doesn't have "specifics on that at this point."

Donegal purchases Sheboygan Falls Mutual

SHEBOYGAN FALLS, Wis.—Marietta, Pa.-based Donegal Group Inc. has purchased Sheboygan Falls Mutual Insurance Co., the firm announced recently.

The property/casualty insurance

holding company bought all of Sheboygan's outstanding capital stock for \$12 million, including \$8.5 million to support future premium growth.

Sheboygan writes commercial package policies, fire, general liability, workers compensation, and other commercial and personal lines in Wisconsin. It had an estimated \$8 million in earned premiums in 2008.

Donegal said in a statement that the acquisition is part of a plan to expand into specific geographic areas and into the Midwest. Its subsidiaries sell insurance in 19 states.

Hanover completes acquisition of AIX Holdings

WINDSOR, Conn.—Worcester, Mass.-based Hanover Insurance Group Inc. has completed the previously announced acquisition of specialty property/casualty insurer AIX Holdings Inc.

Windsor, Conn.-based AIX uses alternative risk transfer techniques to underwrite general liability, workers compensation and property insurance for various underserved markets, Hanover said in a statement.

Hanover is a holding company for a group of property/casualty insurers.

Brown & Brown completes two deals

PORTLAND, Ore.—Insurance intermediary Brown & Brown Inc. has purchased Stewart & Tunno Insurance Agency Inc. in Portland, Ore.

Stewart & Tunno writes property/casualty insurance with about \$1.8 million in annual revenue, according to a statement from Brown & Brown. The firm's leaders and staff will combine with the existing Brown & Brown office in Portland. Brown & Brown offers insurance, reinsurance, risk management, third-party administration and managed health care.

Separately, subsidiary Brown & Brown of Indiana Inc. acquired the assets of Brownsburg, Ind.-based employee benefits consultant R.E. Sutton & Associates L.L.C.

R.E. Sutton specializes in helping school districts, libraries and other public entities with their employee benefit programs. The firm generates annual revenues of about \$1.5 million, according to a statement from Brown & Brown.

Its staff will continue to operate under the R.E. Sutton name as a separate, specialty unit within Brown & Brown, the statement said.

Mercer to manage Nissan pension plan

TOKYO—Car manufacturer Nissan Motor Co. Ltd. has appointed New York-based Mercer L.L.C. as global retirement consultant.

Mercer, a subsidiary of Marsh & McLennan Cos. Inc., will help the manufacturer manage the global governance structure for its pension plan, according to a statement from the consultant firm.

A 2006 Mercer survey found that nearly all multinational corporations in the West had some global governance structure for their pension programs, but the practice still is uncommon in Japan, where local pension plan managers have full responsibility to manage the plan, according to the statement.

Ironshore purchases Marine Re assets

TORONTO—Hamilton, Bermuda-based Ironshore Inc. has purchased the assets of maritime underwriter Marine Re Inc. The management and staff will be retained, according to a statement from Ironshore.

Marine Re writes all kinds of marine reinsurance, specializing in hull and cargo for commercial and pleasure craft. In 2008, it generated \$35 million in gross premium income.

TO SUBMIT ITEMS

BI's Market Moves column reports on activities by insurance industry companies and related entities. Please send Market Moves news to: Zack Phillips, zphillips@businessinsurance.com.

UP Comings & Goings CLOSE



JOSEPH FERRARO

NEW JOB TITLE: Senior vp, business process outsourcing client services at Cambridge Solutions Ltd. in Cambridge, Mass.

PREVIOUS POSITION: Independent consultant

CHALLENGES FACING THE INDUSTRY:

The outsourcing wave started in earnest probably 15 to 20 years ago, and there was a mad dash to outsource as much work offshore as possible to drive cost savings. Then the pendulum swung the other way. There was some concern about quality. Some companies including Dell brought some work back onshore based on those quality concerns. I think some of the management practices that have been in place in the U.S. for a long time were lacking overseas. They have now been remedied. Given that, plus the state of the economy, companies are looking again to drive significant savings in their business. (As an outsourcer), labor markets are always a challenge. Certainly in the India labor market there has been escalation with market prices (and) basic wages. Attrition has been an issue traditionally. We

have to constantly monitor those things by providing competitive wages and career opportunities.

FIRST EXPERIENCE IN THE INDUSTRY JOB MARKET:

My first job at AT&T, I actually ran a 1,000-person customer service center in San Antonio, which was a very unique experience. You truly learned about your own management style and how to manage people.

IF YOU COULD MAKE ONE CHANGE IN THE INDUSTRY:

I think there is a stigma with taking work offshore, but I think it provides a valuable service within the economy and allows companies to take advantage of offering products and services to customers at a competitive rate. There was a big backlash when people thought Martha Stewart and others were associated with brands and clothing lines that were manufactured in low-cost, low-labor-wage locales...the perception of taking jobs offshore that people might otherwise want to do here in the U.S. Given the overall cost of living in India, I would argue U.S. folks wouldn't want those positions...given what we would be able to offer them in terms of pay.

Comings & Goings

ONLINE

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- Barney & Barney L.L.C.
- Gallagher Healthcare

REINSURANCE:

- White Mountains Re Ltd.

OTHER PROVIDERS:

- Health Fitness Corp.

Drivers: Medical fitness

CONTINUED FROM PAGE 4

improvement to only some of the existing problems they have with medical certification," said Dave Snyder, vp and general counsel with the American Insurance Assn. "Our basic approach is that it's important that drivers be in good medical condition and it's particularly important when they've got 80,000 pounds of vehicle they're in charge of."

Christie Cullinan, director of workplace safety for the American Trucking Assn., agrees that there still are "some wrinkles" in the new rule and that drivers and motor carriers have until Jan. 30, 2010, to comply with the rule. She added one major improvement to be made is setting up a notification system for motor carriers that allows them to see if their driver has been downgraded or disqualified or if their CDL or medical certificate has expired.

Gerald Donaldson, senior research director for Advocates for Highway & Auto Safety, a nonprofit in Washington, says drivers are committing medical certificate fraud and that some state departments of motor vehicles are not verifying the medical certificates to ensure they are legitimate.

The Department of Transportation requires commercial drivers to undergo a medical physical exam at least every two years. Drivers with known health problems, such as hypertension and adult onset diabetes, may be required to have an examination every year or every six

months depending on the physician's recommendation.

Michael Megehee, a chiropractor and member of TeamCME nationwide physician network for motor carriers, said that hypertension, adult onset diabetes and sleep apnea are the top three ailments commercial drivers suffer from and are carefully evaluated when considering disqualifying a driver.

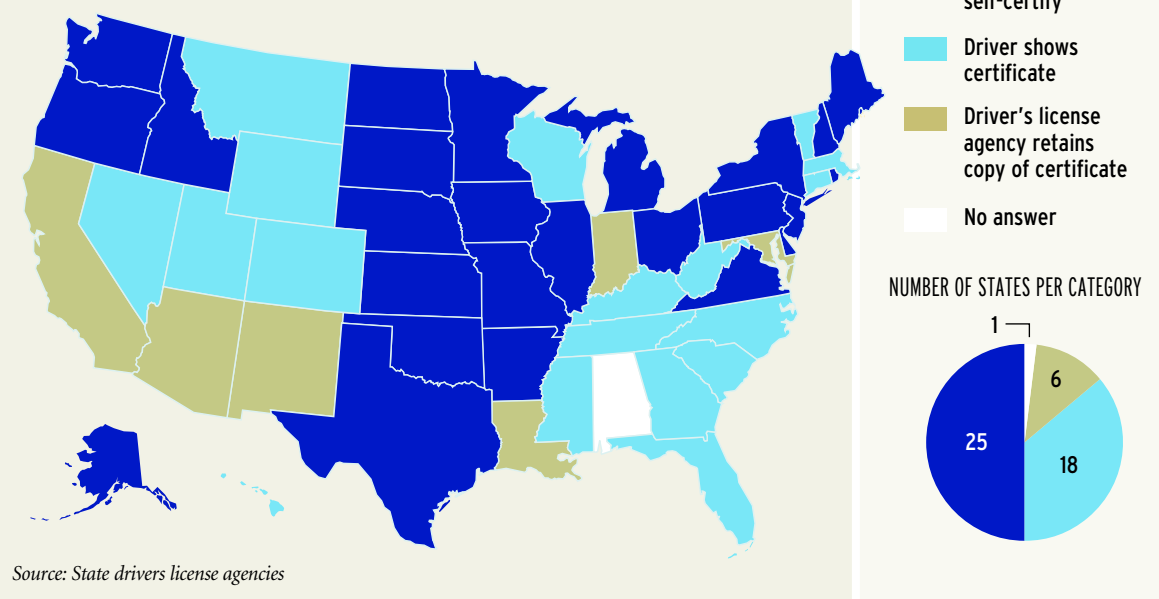
"What is going on out there now is an epidemic of drivers using any form of a medical certificate they want to because (the form) isn't standardized by the FMCSA," Mr. Donaldson said. "They are filling out the medical certificates fraudulently, providing false examiner names and false identification numbers and giving them to the state DMVs."

Mr. Donaldson, as well as the GAO report, found there only are a handful of states that will go one step further and verify that driver's submitted medical certificate is valid. To see if a driver's medical certificate is valid, the state DMV can request the "long form" of the driver's exam certificate that was submitted by the physician who performed the exam by Department of Transportation standards, which sometimes leads to another problem: the physician isn't familiar with the standards.

With the fear of losing their job, drivers sometimes "doctor shop" in an attempt to seek out a physician that isn't familiar with the standards, the examination process, or the driver's medical history. In oth-

CERTIFICATION LAWS VARY FROM STATE TO STATE

Methods used by states to verify commercial drivers license medical certification



er cases, drivers may want to use their own family doctor as they might be more sympathetic if the driver's livelihood is threatened.

"Drivers sometimes want to go to their personal physician because they have a personal relationship with them and they will explain to their doctor that if they don't get this certification that they won't be able to drive," said Andy Walker, vp-risk management with Oklahoma City-based Oklahoma Tank Lines-United Petroleum Transports, "and the doctor, who may not be aware of DOT standards, will go ahead and sign off on the certificate without a physical."

To combat this, Mr. Walker said most large motor carriers like his will have a company physician. For motor carriers without that luxury, the FMCSA is proposing to provide another safeguard in setting up a national registry of certified medical examiners, which would create certification standards, including training and testing programs and national registry examiners who are qualified to conduct examinations of interstate truck and bus drivers.

"The number of exams has gone up and the number of drivers has gone up, so you need more physicians that are capable of performing the exams," Mr. Megehee said.

A national medical registry of approved DOT physicians can reduce the number of errors made by examiners, Mr. Megehee said, adding that training is needed to ensure that all examiners were familiar with Department of Transportation standards and the type of examination that needed to be performed.

In a letter to the FMCSA commenting on the need for a national registry, Mr. Megehee wrote: "Allowing a driver with a disqualifying medical condition to continue to drive can have a devastating effect, but it also can be devastating to a family whose livelihood is lost when a driver is disqualified erroneously."

Pirates: Attacks trigger debate on arms

CONTINUED FROM PAGE 1

Kenya on its way south, taking the long route still was not enough.

Ships also can speed up to evade attackers and use water hoses to repel pirates attempting to scale its hull. Some ships have deployed a noise machine called a long-range acoustic device, which shoots a painful wall of sound at its target.

But putting firearms aboard a ship, even in the hands of trained professional security services, is a threshold most ship owners are hesitant to cross, observers say.

"In general and historically, ship owners have been reluctant to have

weapons on ship," said Rich DeSimone, president of the New York-based Ocean Marine division of Travelers Cos. Inc.

"The potential issues it could create are greater than what it might prevent," he said.

Depending on the ship's flag, its destination port and the relevant maritime law, firearms may be illegal aboard ships. Even if firearms are legal, guns can add exposure by increasing the likelihood of cargo being damaged and the crew being hurt or killed in a firefight, insurers and industry representatives say. Somali pirates generally have returned hijacked ships and crew uninjured in exchange for a ransom payment.

Even some security consultants discourage using firearms.

"Getting armed guards is a massive risk; it could escalate a situation dramatically," said Jereon Meijer, the national practice leader for crisis consulting in North America at London-based Control Risks Group Ltd. "What if you shoot a pirate and they get on board? What is the consequence then?"

Mr. Meijer also pointed to the legal and reputational risk of an incident such as the Nov. 18 exchange of fire between pirates and the Indian war ship INS Tabar. The INS Tabar returned fire, igniting an explosion on the vessel that turned out to be a Thai fishing trawler that the pirates had just

hijacked. The pirates escaped on speedboats, but 14 fishermen, who apparently were still aboard, were missing, according to media reports.

"Are you willing to take the risk that your armed security guards open fire on innocent passers-by, (or get into a fire fight) with armed pirates that ultimately get on board and exact revenge?" Mr. Meijer asked.

Blackwater Worldwide, the Moyock, N.C.-based security firm known for its work on behalf of U.S. government officials in Iraq, reportedly has held meetings with shippers and insurers about the piracy problem and suggested using a ship it owns to provide armed escorts through the Gulf of Aden. Five of its security guards were indicted last week on murder charges related to the slaying of unarmed civilians in Iraq.

Hiring armed security is expensive.

Tom Brown, managing director of Seacurus Ltd., a Gateshead, England-based insurance intermediary, estimated that hiring armed security costs about \$100,000 per transit.

"To do it right would be cost prohibitive given the number of ships that pass through the Gulf of Aden," said Derek Rogers, managing director of the kidnap and ransom team at Hamilton, Bermuda-based Hiscox Ltd.

About 16,000 ships transit the Gulf of Aden a year, observers say.

Still, observers say there are some ship owners who are hiring armed security services for ships traveling through the Gulf of Aden.

"Some of the ship owners I know are considering it," Mr. Brown said. "Some have done it."

Defenders of arming ships say it's easy for distant observers to describe the risks and call for more action from world navies, but the size of the Gulf of Aden's piracy hotbed—more than 1 million square miles—means that naval forces can't realistically patrol the entire area, so ship owners have to do something.

"There's some risk attached. At the same time, I think owners have a responsibility if they are going to send a ship through a (piracy hot spot) to protect their crew," said Johnny M. Kulukundis, director of research at Greenwich, Conn.-based ship insurance broker and marine consultant Charles R. Weber Co. Inc. and a board member of the Connecticut Maritime Assn.

Mr. Kulukundis also pointed to the case of the MV Biscaglia, a Liberian-flagged container vessel hijacked last week despite the efforts of two unarmed, private security officers on board, who used water cannons and LRADs, among other efforts.

"Nonlethal (devices)—all they can do is buy time," said Charles Kuneff, a senior partner at the Muse Professional Group, a Ukraine-based security firm offering anti-piracy services to ships in the Gulf of Aden.

Mr. Kuneff would not disclose how many clients his firm is work-

ing with but said they are mostly smaller shipping companies and private yachts. He said the number is "multiplying like rats" and it is only a matter of time before reluctant larger shippers hire security for ships.

According to an e-mail solicitation, Muse's security agents board ships at sea before they enter troubled areas and disembark after they have made it to safer waters. Mr. Kuneff would not discuss specific tactics but said arms do provide an effective deterrent.

"(Pirates) see us. They say, 'OK, I'm not going to go to that boat. There's another boat 5 kilometers away. I'll go to that boat,'" he said.

Insurers and brokers say most hull and cargo underwriters, as well as the protection and indemnity clubs that cover injuries to crew members, would not view firearms on ships favorably. The one exception, they said, might be kidnap and ransom insurers, who might provide a discounted premium—or write a policy they otherwise would not have—for a ship that has hired armed security.

Still, it appears insurance policies generally do not prohibit the use of firearms aboard ships.

"There's nothing (in marine insurance policies) right now to the best of my knowledge that excludes you from arming yourself," said E. Anthony Cowie, an Armonk, New York-based senior vp at Swiss Reinsurance Co. and a hub head for marine. "Maybe that's a question underwriters need to be asking themselves."

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Ferguson: Judge shows leniency in sentencing of former Gen Re chief

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Henning, a professor at Wayne State University Law School in Detroit. He said a sentence of seven to 10 years in prison would not have been surprising.

The judge's stance signals "a move away from the mathematical calculations" of sentencing, said Ellen Podgor, an associate dean and professor at Stetson University College of Law in Gulfport, Fla. "The judge chose to look beyond the offense and, instead, looked at the offender."

Mr. Ferguson and four others were convicted in February on charges of conspiracy, securities and mail fraud and making false statements to the U.S. Securities and Exchange Commission.

Prosecutors alleged the defendants engineered a sham loss portfolio reinsurance transaction that helped AIG inflate its loss reserves by \$500 million in 2000 and 2001. The deal, aimed at countering stock analysts' concerns about AIG reserve levels, transferred no risk to AIG and included an unwritten side agreement that AIG would refund Gen Re's \$10 million premium and pay it a \$5 million fee, the government charged.

After weeks of briefings and oral arguments, Judge Droney last month found that three days of AIG stock price drops in 2005 could be linked to disclosures about AIG's bogus loss portfolio deal with Gen Re. He said the declines resulted in shareholder losses up to \$597 million.

Prosecutors had argued for "substantial" jail time to deter other executives who "may go down a similar path."

AWAITING SENTENCING



ELIZABETH MONRAD, former Gen Re chief financial officer, is scheduled to be sentenced on Feb. 10, 2009.



CHRISTOPHER P. GARAND, former Gen Re senior vp in charge of U.S. finite underwriting, has not had sentencing date set.



To read full coverage of the trial over a sham reinsurance deal between Gen Re and AIG and see court papers related to the case go to www.BusinessInsurance.com



ROBERT GRAHAM, former Gen Re senior vp and legal counsel, has not had sentencing date set.



CHRISTIAN M. MILTON, AIG's former vp for reinsurance, is scheduled to be sentenced Jan. 27, 2009.

Before the sentence was read, Assistant U.S. Attorney Eric Glover said, "There isn't a more serious white-collar crime than manipulating the earnings of a public company," adding that Mr. Ferguson's conduct contributed to the erosion of the public's trust in the financial system.

Defense attorneys argued, and Judge Droney agreed, that unlike many corporate CEOs convicted of white-collar crimes, Mr. Ferguson neither sought nor achieved any personal financial gain. However, the judge rejected the defense argument that Mr. Ferguson had only a peripheral role in the scheme.

"He knew he was involved in a sham transaction and had many opportunities to stop it, but did not," Judge Droney said.

Michael Horowitz, Mr. Ferguson's attorney and a Washington-based

partner with Cadwalader, Wicker-sham & Taft L.L.P., asked for leniency, citing Mr. Ferguson's age and his plans to become an ordained minister.

Defendant 'crushed'

"My life is in shambles. I come before you as a man who's been crushed by what has happened over the past four years," Mr. Ferguson told the judge prior to sentencing. He asked for "clemency" to finish his seminary education and "live my purpose to serve others."

Mr. Ferguson's colleagues, friends and his wife, Carol, also addressed the judge and portrayed him as an honorable, spiritual man who has led a life devoted to helping others.

While the leniency appeals and overwhelming support of his "quality of character" clearly affected Judge Droney's decision, "it

remains to be seen if these are really good reasons for giving him a lighter sentence," Mr. Henning said.

"This is a sentence that would not have happened 10 years ago," Ms. Podgor said. As a result of several rulings by the U.S. Supreme Court, federal sentencing guidelines no longer are mandatory and federal judges seem more inclined to impose a penalty more proportionate to the crime, she said.

In addition, the judge's drastic departure from sentencing guidelines may help the remaining defendants "to the extent they take a similar approach in their pleas for leniency," Mr. Henning said. "I doubt the judge would give disparate sentences."

The remaining defendants—Elizabeth Monrad, former Gen Re chief financial officer; Christopher P.

Garand, former Gen Re senior vp in charge of U.S. finite underwriting; Robert Graham, former Gen Re senior vp and legal counsel; and Christian M. Milton, AIG's former vp for reinsurance—last month filed requests with the Hartford, Conn., federal court seeking lenient sentences far below federal guidelines.

Mr. Milton is scheduled to be sentenced Jan. 27, 2009. Ms. Monrad is scheduled to be sentenced on Feb. 10, 2009. Sentencing dates for the other two executives had not been set.

Meanwhile, Mr. Ferguson is free on \$1 million bond while he appeals his conviction. While he was ordered to report to federal prison on Feb. 18, 2009, his attorney said he will ask the court to allow Mr. Ferguson to remain free while his appeal is pending.

Altria: Court rules against pre-emption

CONTINUED FROM PAGE 3

Commission decisions regarding statements of tar and nicotine content in cigarettes do not implicitly pre-empt state deceptive trade practices laws such as the Maine statute.

The court's decision could encourage plaintiffs to file consumer fraud complaints in cases that might otherwise be product liability actions, said Glenn Lammi, chief counsel-legal studies division at the Washington Legal Foundation, which had filed a brief in support of Altria.

"Depending on how lower courts interpret and apply it in other situations, it could have a broader impact beyond tobacco," in terms of federal pre-emption, said Mr. Lammi. "The underlying facts of the case involve situations where the federal government was involved as a regulator. It permitted these claims by the tobacco company that cigarettes were 'light' and then the companies get sued for the fact that smokers smoke harder."

"You're definitely seeing a trend—and I think it will increase—that cases that were traditionally brought as product liability cases will be brought as consumer fraud

cases," Mr. Lammi said.

But the president of the Chicago-based Defense Research Institute said he doubted the decision would have a great effect on many types of litigation.

"I think it's unlikely to have an impact beyond perhaps drug cases and maybe some chemical cases," said Marc Williams, who also is a partner in the Huntington, W. Va., office of law firm Huddleston Bolen L.L.P. "Absent some sort of federal regulation of labeling, it isn't likely

to be an indicator of trend."

A Maine official said the pre-emption issue depends on the language of a particular statute.

"I figure it's really tied into what the exact language Congress had in the Cigarette Labeling Act and the Federal Trade Commission Act," said Linda Conti, assistant attorney general for Maine in Augusta. "So this analysis goes back to what does the federal statute at issue in any pre-emption analysis" say, she said. The state filed a brief supporting its residents.

There could be "different language in every act of Congress," said Ms. Conti. "You'd have to look at each one of them on a case-by-case basis. I'm really not sure that this is going to turn back the tide of pre-emption."

"The fact of the matter is that pre-emption really depends on the statute involved in the particular case," said Robin Conrad, executive vp of the Washington-based National Chamber Litigation Center, which handles litigation for the U.S. Chamber of Commerce and filed a brief in support of Altria. "In general, what was particularly troubling is what seemed to be a step backwards with regard to the so-called presumption against pre-emption."

Ms. Conrad added, though, that "you can't tell" whether the decision will lead to a flood of litigation.

Still, "in recent decisions, the court had seemed to add much-needed clarity to the doctrine of federal pre-emption and, unfortunately, this decision has just further muddied the waters," she said.

Altria Group Inc. et al. vs. Stephanie Good et al.; U.S. Supreme Court No. 07-562; Dec. 15, 2008.

Pensions: Cuts temporary

CONTINUED FROM PAGE 3

three-month reporting period, it reported a loss of \$2.7 million on revenue of \$172.5 million. During the comparable year-earlier period, GenCorp reported net income of \$15.6 million on revenue of \$198.5 million.

Top Motorola executives described the retirement plan changes, along with other cost-cutting moves, as necessary as the economy has deteriorated.

"The sustained downturn in the global economy requires that we take these difficult but necessary steps," Greg Brown and Sanjay Jha, Motorola's co-chief executive officers, said in a statement. "While serving our customers remains a top priority, we are equally focused on our cost structure, and we will continue to implement appropriate measures to conserve cash and reduce expenses," the statement said.

"This was a difficult decision to make," a GenCorp spokeswoman said. She noted that GenCorp had been matching employees' salary deferrals with company stock, which, in turn, was diluting the value of the stock. Matching deferrals

with cash would have deprived the company of money it needed to meet other requirements, she said.

Given the tough economic climate in which employees' top concern is holding onto their jobs, employees have been relatively understanding of benefit cuts, such as suspension of 401(k) plan matches, consultants say.

"Obviously, these are difficult times," said Buck Consultants' Ms. Sheaks.

But experts say as soon as the economy begins to improve, they expect companies to resume their 401(k) plan matches.

"If you don't offer a match and you are in a competitive industry, you are going to have trouble recruiting new employees" and retaining existing workers, Ms. Sheaks said.

"These are not permanent steps. Realistically, the economy will improve and there will be a competitive marketplace" and companies will need to attract employees, said Alan Glickstein, a senior consultant in the Dallas office of Watson Wyatt.

"We want to remain a competitive employer," the GenCorp spokeswoman said.

READ documents from this case online at B/I's Knowledge Center www.BusinessInsurance.com

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News In Brief

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residential mortgage-backed securities to a special purpose vehicle backed by the Federal Reserve Bank of New York, the insurer said. The sale to Maiden Lane II L.L.C. was for an initial purchase price of \$19.8 billion. The Federal Reserve Bank of New York loaned Maiden Lane the resources to make the payment to AIG under terms of an agreement announced last month. The initial term of the loan is six years. It is secured by the \$39.3 billion face value of the mortgage-backed securities and carries an interest rate of 1% over the London inter-bank offered rate.

Toxic tort ruling upheld on appeal

Liability insurers have no duty to defend or indemnify a policyholder's toxic tort personal injury claim if the initial manifestation of the underlying disease predates their policies, a state appellate court ruled. In making its decision in *Polarome International Inc. vs. Greenwich Insurance Co. and Zurich Insurance Co.*, a three-judge panel of the Superior Court of New Jersey Appellate Division applied the "continuous trigger" theory for determining the occurrence of a bodily injury and ruled that the trigger ends at the time of initial manifestation of the disease. Under the continuous trigger theory, bodily injury occurs during each phase of environmental contamination: exposure, further progression of injury after exposure and manifestation of disease.

Court backs manufacturers in asbestos cases

Manufacturers cannot be held liable for failing to warn about the dangers of asbestos used to insulate their products but not sold or supplied by the manufacturers, Washington's Supreme Court ruled. In *Simonetta vs. Viad Corp.*, the state high court addressed the issue of whether a manufacturer can be held liable for failing to warn of the hazards of another manufacturer's product. It found that Viad had no duty to warn and cannot be held strictly liable. The case stemmed from a claim that Joseph A. Simonetta's lung cancer resulted from exposure to asbestos while he was in the U.S. Navy. During the late 1950s, he performed maintenance on a ship water evaporator that was insulated with asbestos, court records show. Viad was a successor to a company that manufactured the evaporator, but the insulation was manufactured by another company and installed later.

Catastrophes, financial crisis hit insurer results

Natural catastrophes, the soft market, the recession and the financial crisis all took bites out of

U.S. property/casualty insurers' financial results in the first nine months of 2008. Nine-month 2008 results announced by the Insurance Services Office Inc., the Insurance Information Institute and the Property Casualty Insurers Assn. of America show that insurers suffered a combined \$19.9 billion net underwriting loss compared with an \$18.4 billion net underwriting gain in the same period in 2007. The insurers' combined ratio worsened to 105.6% vs. 93.8% in 2007.

Cambridge wins wage and hour case

Third-party administrator Cambridge Integrated Services Group Inc. successfully defended a \$40 million wage and hour suit brought by a class of more than 1,000 current and former claims adjusters in California, who had alleged they were misclassified as exempt and therefore deprived of overtime pay. After an 11-day bench trial, a Los Angeles state court judge ruled that the job description of a Cambridge claims adjuster met the criteria of an exempt position for which overtime pay would not be required. Aon Corp., which sold Cambridge in 2004, also was named in the suit.

AIG shareholder lawsuit settled

A Delaware judge last week approved a \$115 million settlement in a shareholder lawsuit against former executives of American International Group Inc. The settlement stemmed from a lawsuit over commissions the insurer paid to C.V. Starr & Co. The suit focused on the Teachers Retirement System of Louisiana, which accused AIG executives of paying Starr for doing work that AIG could have done and receiving unjustified compensation.

RIMS names board officers

Joseph Restoule was named president of the Risk & Insurance Management Society Inc. board of directors for the 2009 term, the organization said last week. Mr. Restoule, risk manager at NOVA Chemicals Corp., has been on the New York-based RIMS board since 2001. Terry Fleming, director of the division of risk management at Montgomery County, Md., will serve as vp. Additionally, John Phelps, director of business risk solutions at Blue Cross & Blue Shield of Florida Inc., will serve as treasurer. Scott Clark, risk and benefits officer at Miami-Dade County Public Schools, will be secretary. Robert Cartwright Jr., loss prevention manager at Bridgestone Retail Operations L.L.C., and Frederick Savage, director of risk management at Chevron Corp., were named board members.

Florida urged to raise comp rates 18.6%

NCCI Holdings Inc. sought an 18.6% workers compensation rate hike over two years during a hearing before Florida's Office of Insurance Regulation. The request resulted from a projected impact of Florida Supreme Court decision expected to boost workers comp costs.

Medicare: New mandate may hinder settling claims

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depend on CMS' ability to address payer concerns, said Katie A. Fox, manager of a Medicare secondary payer compliance unit of Franklin, Tenn.-based MedInsights Inc.

MedInsights is a managed care subsidiary of GAB Robins North America Inc. Ms. Fox also is a steering committee co-chair for MARC, which has periodic meetings planned to provide CMS with input on the mandate.

The reporting mandate was contained in the Medicare, Medicaid and SCHIP Extension Act of 2007 that President Bush signed a year ago. Among other measures, it aims to help Medicare collect medical expense reimbursements.

The law is part of a congressional attempt to ensure the government saves money in cases where Medicare is supposed to be a secondary payer for its beneficiaries, after health plans, liability insurers and self-insured employers pay their primary share of claims.

Data that payers are to provide will enable Medicare to review all liability and workers compensation settlements, judgments and awards owed to Medicare beneficiaries.

The reporting mandate potentially poses several problems for settling liability claims, but many employers remain unaware of it, Mr. Franco said.

One potential problem for payers stems from a requirement that anyone paying a general liability claim must report the activity to Medicare if the claimant is a Medicare beneficiary.

Verifying that a liability claimant also is a Medicare beneficiary would require obtaining their Social Security number, Mr. Franco said.

Managing liability claims already can be an adversarial undertaking, Mr. Franco added. Asking for a Social Security number could cause additional friction that would undermine an established risk management practice of settling some claims quickly and amicably before attorneys are called.

"For the claims examiner to ask as (one of) their first questions, 'what is your Social Security number?' tends to, unfortunately, push the claim in a direction we don't necessarily want to push at that time," Mr. Franco said.

One hope is that CMS will provide a work-around or help payers collect Social Security numbers, birth dates and other necessary information from Medicare beneficiaries, said Marcia Nigro, assistant vp and complex claim consultant in Philadelphia for Sedgwick Claims Management Services Inc.

"Elderly people are told by many organizations, 'You never give your Social Security number out,'" Ms. Nigro said. "It's going to be hard to crack that nut. That is one of the major issues we are all going to have."

Sedgwick also is a MARC participant.

Another concern is that Medicare does not recognize state laws appor-

tioning liability among claimants and defendants who share fault, Ms. Fox said.

Medicare wants 100% reimbursement from claims payers regardless of contributory negligence laws in some states, Ms. Fox said, and one MARC goal is to encourage Medicare to follow states' contributory negligence laws.

While group health and workers comp payers must report information under the new Medicare mandate, doing so for general liability claims is likely to present additional complications, several sources said.

Under group health plans and workers comp systems, payers typically pay a claim immediately, before Medicare pays. But because general liability claims regularly require determining fault, which can be a time-consuming process, Medicare is more likely to pay first and then require reimbursement, sources said.

Yet Medicare cannot provide payers with a final dollar amount they are responsible for until all necessary medical treatment has been provided. That could leave payers that want to settle a claim quickly

'You have to get the reporting piece of it right because the penalties are pretty steep.'

Darrell Brown, Sedgwick Claims Management Services Inc.

not knowing how much they may have to reimburse to Medicare, Mr. Franco said.

Additionally, to cover its medical payouts, Medicare could require reimbursements totaling the entire amount an insurer or self-insurer would otherwise provide to a beneficiary.

Mr. Franco said that could mean claimants would not receive money because it all would go to pay Medicare instead. Those claimants would be less likely to settle and, instead, pursue litigation in hopes of obtaining dollars for themselves, he said.

"Ultimately, it could be a significant cost driver," Ms. Fox said.

Apart from claims-settlement issues, self-insured employers should assure all of their contracted third-party administrators are positioned to provide Medicare with required information, said Darrell Brown, workers comp practice lead for Sedgwick in Long Beach, Calif.

"Employers are concerned because the penalty for failure to report is \$1,000 per day per claim," Mr. Brown said. "You have to get the reporting piece of it right because the penalties are pretty steep."

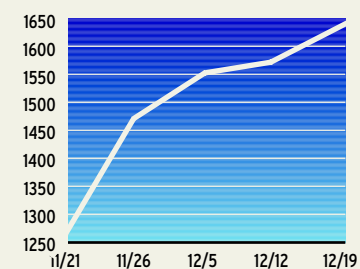
So far, though, the government has focused more on smoothing the reporting mandate's implementation than on penalizing payers, Mr. Franco said. But if the process is proving complex for sophisticated payers, beneficiaries are even more likely to be caught in the middle, he added.

Stock Index

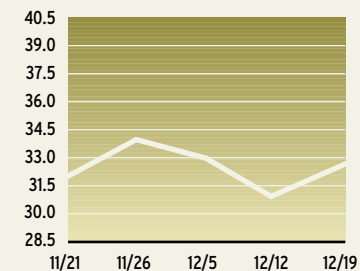
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Up-to-the-minute data for all 82 companies that comprise the BI Stock Index can be found at www.IndustryFocus.com.

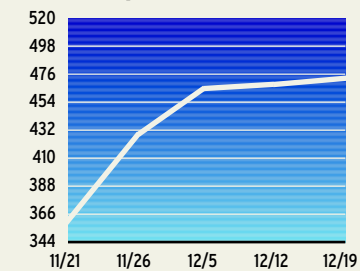
BI STOCK INDEX



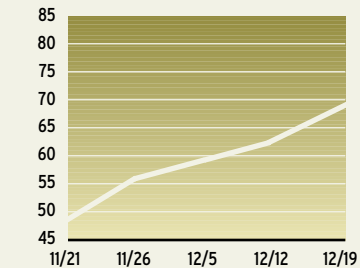
BI BROKERS INDEX



BI INSURER/REINSURERS INDEX



BI MANAGED CARE ORGANIZATIONS INDEX



Percentage change of BI Stock Index vs. key indicators

BI STOCK INDEX	1644.21	▲ 5.79%
DOW JONES	8579.11	▼ -0.59%
S&P 500	887.88	▲ 0.93%

LARGEST GAINS

XL Capital Ltd.	49.25%
Aetna Inc.	28.32%
PMA Capital Corp.	26.70%
MetLife Inc.	24.95%
United Fire & Casualty	24.09%

LARGEST LOSSES

MBIA Inc.	-22.36%
AIG	-11.11%
Baldwin & Lyons Inc.	-9.08%
Citigroup Inc.	-8.83%
Unitrin Inc.	-6.22%

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



JOANNE FORCHAS/ZUMA PRESS

Actress Jessica Lange sold her Victorian home in Stillwater, Minn., for \$1.83 million. The original asking price for the property was \$3.3 million.

Reinsurer CEO gets good deal on stars' former home

Actress Jessica Lange and playwright/actor Sam Shepard often have their names in lights, but they're rarely associated with mysteries.

Yet the recent sale of their Stillwater, Minn., home for nearly \$1.83 million set up a mysterious situation.

Although the selling price was made public, the identity of the buyer was not disclosed.

But according to published reports, the Washington County, Minn., assessor's office since has identified the buyers as Patrick and Jane Thiele.

If the name seems familiar, it should be. Mr. Thiele is a former top executive at St. Paul Cos.—now Travelers Cos. Inc.—and currently is chief executive officer of Bermuda-based PartnerRe Ltd.

But even the star power of Ms. Lange and Mr. Shepard dimmed amid the gloom of a depressed housing market.

Ms. Lange, a Minnesota native, paid \$415,000 for the onetime bed and breakfast when she bought it in 1994. When the property that includes an 1892 Victorian house, guesthouse and pool first was listed, the asking price was \$3.3 million. Subsequently, the Stillwater property was pulled off the market and offered anew this summer for less than \$2 million—much closer to the actual price paid by the Thieles.

Ms. Lange

REUTERS

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Business Insurance END PAGE

Contributing: Jeff Casale, Mark A. Hofmann, Sally Roberts

Town can always find Jesus thanks to GPS

People looking for baby Jesus around this time of year usually find him—and then some take him.

Nativity scenes often are where the babe can be seen nestled in a manger bed with Mary and Joseph looking over him, along with several barnyard animals and the three wise men. But with his popularity comes demand, and throughout the years, many folks have taken such a liking to the Nativity figures that they snatch them up and take them home.

On Dec. 16, the Philadelphia Inquirer reported that a statue of the baby Jesus, which was bolted to a display, was swiped

from the Nativity scene in front of Independence Hall. On Dec. 12, CBS 3 in Springfield, Mass., reported that the black sheep outside the manger in front of Easthampton Congressional Church was stolen for the second time since 1999, with the baby Jesus figure being stolen in 2004 and a large camel in 2006.

The thefts have gotten to be too much for Wellington, Fla. The town's community center saw its statue of the baby Jesus lifted last year. Little did the thief know, the figure was equipped with a GPS unit, which allowed police to track down the thief and make an arrest.

"They took the family Jesus," resident Gloria Herrera told the Associated Press. "How can anybody do that?"

With a hidden tracking device, it might become a little bit harder to do so.



A minotaur in a china shop finds insurance all the rage

"In ancient times, there lived a dreadful beast descended from a divine bovine." So starts a new computer video game about a minotaur that owns its own fine china shop.

The problem is that the minotaur is anything but a graceful, calm beast and often breaks the china offered for sale, causing the minotaur to become enraged.

Thankfully, the video game creature has "rage insurance," which reimburses him for the china he breaks while flying off the handle. The more china he breaks, the more insurance he collects.



FLASHBANG STUDIOS

The minotaur (top) from "Minotaur China Shop" uses a rage insurance meter (bottom) to acquire reimbursement for broken merchandise.

And committing insurance fraud is one of the secrets to earning more profit in "Minotaur China Shop."

While old-fashioned customer service also earns the minotaur some money, it's not nearly as fun as tearing the whole china shop apart and collecting on the claims.

The game, which can be found at <http://blurst.com/minotaur-china-shop/play>, was developed by Tempe, Ariz.-based Flashbang Studios L.L.C.

Too much funny business going on with National Lampoon stock?

National Lampoon has been synonymous with funny business for almost four decades.

From the fabled magazine to "Animal House" and the "Vacation" movie series, National Lampoon has generated many a laugh and guffaw.

But National Lampoon isn't just funny business; it's a publicly traded business as well.

That was more than evident last week when Laurie Magrid, the acting U.S. attorney for the Eastern District of Pennsylvania in Philadelphia, said that National

Lampoon Chief Executive Officer Daniel Laikin had been indicted on charges of conspiring to artificially inflate the company's stock and securities fraud.

In a news release, the U.S. attorney's office said Mr. Laikin conspired with a consultant to pay others to artificially inflate the price of the stock. The conspirators allegedly paid a Rochester, N.Y.-based stock promoter about \$40,000 to make purchases "with the objective of driving up the share price" from about \$2 to \$5.

The promoter allegedly made

purchases "over the course of a number of days and used various accounts to give the false impression of a steady demand for the stock," according to the release.

These are serious charges for a company involved in the business of humor.

No word yet on how the Lampoon will respond to what is now a legal—not laughing—matter, especially because prosecutors say there was an individual involved in the scheme who was secretly cooperating with law enforcement.



Daniel Laikin, CEO of National Lampoon Inc., was indicted on charges of conspiracy and fraud.



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