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Business Insurance

April 2, 2007

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In Brief

Pa. Blues, Highmark plan merger

Pittsburgh-based Highmark Inc. and Philadelphia-based Independence Blue Cross announced last week that they will merge to create the largest health insurer in Pennsylvania, providing health care coverage to about 8 million people. Formal filings for state and federal regulatory approvals will begin this month.

Flagstone IPO raises $175.5M

Bermuda-based Flagstone Reinsurance Holdings Ltd. raised $175.5 million in its initial public offering of stock, giving the company an initial market capitalization of about $1.1 billion. The reinsurer intends to use the new capital to increase its underwriting capacity. In the offering last week, 13 million

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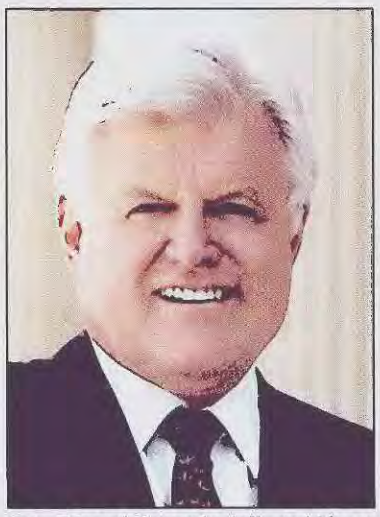
SECTOR BRIEFING

AEROSPACE

Aviation rates continue to fall as capacity increases; efforts to limit ground liability losses from terror attacks move ahead; despite losses airlines still shun costly coverage for weather-related losses. **PAGE 11**



Sen. Edward Kennedy, left, and his son, Rep. Patrick Kennedy, have introduced similar mental health parity bills in the Senate and the House, but Rep. Kennedy's bill includes elements strongly opposed by employers.

Rival bills may derail mental parity effort

Employer groups oppose measure in House

By JERRY GEISEL

WASHINGTON—Different approaches taken in House and Senate versions of federal mental health care benefits parity legislation could erode the broad support the parity drive initially enjoyed.

When a Senate panel in February overwhelmingly approved legislation to expand a federal mental health care benefits parity law, the path to congressional approval seemed clear.

For the first time since the drive began several years ago to expand the 1996 parity law, federal legislators brought in employer and insurer groups to try to build support for a compromise bill.

That effort was successful, with several business groups that had staunchly opposed prior measures—including the American Benefits Council and the National Retail Federation—lining up to support and help shape the measure proposed by Senate Health, Education, Labor and Pensions Committee Chairman Edward Kennedy, D-Mass.

But the path to final approval no longer is as clear. Standing in the way is a new House bill, which on a key point takes a very different approach than the Senate measure.

That difference: the House bill, introduced last month by Sen. Patrick Kennedy, D-R.I., would require group plans to cover any diagnosis listed in the psychiatric community's compendium of mental health disorders on the same basis as any other medical condition. By contrast, the Senate bill leaves it to employers to decide which mental health disorders they will cover, though that coverage would have to be equal to coverage for other medical conditions.

Employer groups say that difference alone renders the House bill unacceptable and pledge to fight against its passage.

See **PARITY** page 26

Liberty Mutual to face charges

Judge denies motion to drop allegations of fraud, bid rigging

By RUPAL PAREKH

NEW YORK—Units of Liberty Mutual Group Inc. will face charges of fraud and bid rigging related to brokerage compensation practices, after a trial court judge last week said New York officials' civil suit against the Liberty Mutual operations could proceed.

The State Supreme Court judge's ruling came in response to Liberty Mutual's motion for a dismissal of the charges, which were leveled in a May 2006 civil suit by then-New York State Attorney General Eliot Spitzer.

In his suit, Mr. Spitzer charged that the Boston-based insurer engaged in bid rigging, steering, reinsurance tying and other improper business practices as part of a massive scheme with New York-based Marsh & McLennan Cos. Inc. Marsh in 2005 paid $850 million in client restitution to settle Mr. Spitzer's 2004 suit against the brokerage, which charged that Marsh rigged bids and steered clients to maximize the contingent commissions it received from Liberty Mutual and several other insurers.

The amended complaint against Liberty Mutual further charges the company with inducing producers to breach their fiduciary duty to clients.

In his ruling last week, Judge Bernard J. Fried said the case will

See **LIBERTY** page 25

Using best treatments to shape plan design

Some employers focus on effectiveness in setting coverage

By JOANNE WOJCIK

Two studies released last week questioning the use of stents in some patients with heart disease have attracted the attention of employers and medical academics working on ways to use medical efficacy to influence the design of benefit plans.

Researchers say more than 1 million stent procedures are performed each year, which health care experts say cost U.S. employers billions of dollars annually.

The studies involving stents—mesh tubes inserted into blocked blood vessels to prop them open—were released at the annual meeting of the American College of Cardiology in New Orleans. The first study, presented by Dr. William Boden of Buffalo General Hospital, found that stents provided no extra benefits compared with drugs alone for patients with stable heart disease. The second study, by a team of researchers at the Mayo Clinic, found patients were more likely to get drug-eluting stents—those coated with medication to help prevent arteries from blocking again—if they have private, third-party health insurance.

While early evidence-based health care plan models focused primarily on drug interventions, they are expected to evolve to not only allow plan sponsors to dictate which medical services will be covered, but also which plan participants will receive those services on a free or discounted basis.

Although self-insured employers

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How can you reduce medical costs in workers' compensation?

Ask Aon.

With the medical component of workers' compensation soaring, many organizations see no end in sight. However, there are strategies that have proven effective in the group health arena that could also have a dramatic effect on the medical and pharmacy components of workers' comp. Visit **www.aon.com/ask** to learn more about cost-containment strategies that can help your workers' comp program.

– **Heidi Mader**, *assistant vice president in Aon Consulting's health and welfare practice*

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On the Web

SECTOR BRIEFING

Flying the risky skies: All clear ahead?

Business Insurance's Sector Briefing reports address risk management issues that face key global industry sectors. This week's issue features the Aerospace Sector Briefing, which gives an in-depth look at trends in aviation insurance. Articles that begin on page 11 are also available at *www.BusinessInsurance.com/sectorbriefings.*

BENEFIT MANAGER OF THE YEAR®

Nominate your favorite benefit manager for '07

Business Insurance seeks nominations for the its 2007 Benefit Manager of the Year® award to recognize excellence and innovation in benefits management. The winner will be profiled in a future issue of the magazine. To nominate a candidate by June 1, download a nomination form at *www.BusinessInsurance.com/BMOY* or request a form from *BI* Editor Regis Coccia at *rcoccia@businessinsurance.com.*

ONLINE EXECUTIVE FORUM tm

CDHP webinar archived, ready for listening

Business Insurance's March webinar, "Mapping Consumer-Driven Health Care: Strategies to Drive Enrollment and Employee Understanding," is archived and ready to listen to at your convenience. Register to hear the online forum featuring CDHP experts at *www.BusinessInsurance.com/webinars.*

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Ernst & Young settles charges in finite probe

AIG, PNC previously reached settlements with the SEC

By JUDY GREENWALD

WASHINGTON—Accounting firm Ernst & Young L.L.P. has agreed to pay $1.6 million in fines in a settlement with the Securities and Exchange Commission in connection with a structured financial product that was developed by American International Group Inc. and used by Pittsburgh-based PNC Financial Services Group Inc. in 2001.

AIG, PNC and others using the product previously reached settlements on the issue with the SEC. "This is the end of the line for us," said Scott Friestad, an associate director in the SEC's enforcement division.

E&Y, which neither admitted nor denied wrongdoing, was sanctioned "for conduct arising out of the firm's violations of auditor independence standards," according to the SEC.

"The events at issue took place more than five years ago, and we are pleased to put this matter behind us," the New York-based accounting firm said in a statement. "The SEC's order recognizes that 'E&Y has significantly revised its independence policies and procedures' since these events occurred.'"

According to SEC documents, a unit of New York-based AIG developed a product in 2001 called a Contributed Guaranteed Alternative Investment Trust Security and marketed it to several public companies, including PNC. For a fee, AIG offered to establish a special-purpose entity to which a company would transfer troubled or other potentially volatile assets.

AIG said that under generally accepted accounting principles, the special-purpose entity did not have to be consolidated into a company's financial statements, enabling it to avoid income statement charges resulting from declines in the transferred assets. But, according to the SEC, the SPE should have been consolidated into the financial statements according to GAAP.

Michael S. Joseph, then a partner in E&Y's national office, helped develop the product for AIG and advised PNC on its accounting treatment, according to the SEC.

PNC used the product to transfer $762 million of loan and venture capital assets from its balance sheet in three transactions, the SEC said.

In 2002, PNC consented to a cease-and-desist order issued by the SEC. That same year, PNC also agreed to pay $30 million to settle a class action lawsuit brought by investors in connection with the transactions.

In addition, PNC paid a $115 million penalty in 2003 to the U.S. Department of Justice, including a $25 million fine and $90 million for a restitution fund. PNC also restated its 2001 results.

In 2004, AIG agreed to pay $126 million in penalties and disgorgement to the Justice Department and the SEC to settle charges over transactions involving PNC as well as Plainfield, Ind.-based mobile telephone distributor Brightpoint Inc.

The payment reflected an $80 million penalty to the Justice Department over the PNC and Brightpoint transactions and a $46 million payment to an SEC disgorgement fund related to the PNC deals. AIG admitted no wrongdoing under the settlement.

In addition, the SEC filed cease-and-desist orders last December against Mr. Joseph and Thomas Grabe, the former head of PNC's accounting policy department, concerning violations of securities laws.

OIL increases limits, adds coverage sectors

Moves follow departure of several members

By RUPAL PAREKH

HAMILTON, Bermuda—Changes to Oil Insurance Ltd.'s structure—including a hike in aggregate limits to $750 million—could help stabilize the embattled energy insurance mutual, but whether it will retain its membership remains to be seen.

Shareholder members of OIL—the largest of three mutual insurers collectively known as the OIL Group of Cos.—approved two new initiatives at its annual general meeting in Bermuda last month.

The first amends OIL's rating and premium plan to include two additional business sectors, onshore and offshore Atlantic Named Windstorms, effective June 1. Existing sectors include non-ANWS onshore and offshore risks, chemical, mining, utilities and others.

The second initiative will allow OIL to incorporate a "top up pool" mechanism for extra aggregation limits for ANWS events that exceed OIL's aggregation limit per event, which could either mutualize the risk among members or, possibly, purchase additional limits from the reinsurance market.

OIL's board of directors also voted to increase the mutual's aggregation limit for all risks to $750 million from $500 million effective June 1.

The moves came as part of an ongoing process undertaken by OIL to review how it will cover Gulf of Mexico windstorm risks in the wake of heavy storm losses sustained in 2005. As of January, OIL shareholders reported total losses of $2.09 billion from Hurricane Katrina and $1.47 billion from Hurricane Rita.

A previous aggregation limit of $1 billion was halved in 2006 to protect OIL's solvency margin, but the combination of a quiet 2006 storm season and a $600 million preference-share issue last year have helped the insurer get back to "a pretty good spot," said George Hutchings, senior vp and chief operating officer at OIL.

Robert Stauffer, OIL's president and chief executive officer, noted he was "very pleased with the outcome of the meeting" this year. The results of the shareholder vote are "a clear indication that the membership supports further differentiation of Atlantic Named Windstorm risk within the mutual pool," he said in a statement.

Still, it remains uncertain whether initiatives taken by the mutual's management are enough to retain all 74 current members, some energy insurance experts say.

Pushing limits back up to $750 million "is something that will help

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EXITING OIL

The following nine shareholder members left the OIL structure effective Jan. 1. Collectively, the nine exiting companies had gross assets representing 12% of the weighted gross assets insured by OIL immediately before their withdrawal.

American Electric Power
Atmos Energy Corp.
Duke Energy Corp.
Kinder Morgan Inc.
Koch Industries Inc.
Kuwait Petroleum Corp.
NiSource Inc.
Praxair Inc.
Royal Dutch/Shell Group

Source: OIL Group of Cos.

JOHN BOYKIN

The Occupational Safety and Health Act does not require that sideboom pipe-laying tractors have rollover cages, but that does not protect tractor makers from product liability lawsuits.

Federal safety rules don't pre-empt state law

Lack of guidelines is no defense shield, appeals court says

By DAVE LENCKUS

PHILADELPHIA—Manufacturers of equipment used in the workplace are not shielded from product liability claims in state court even if federal safety regulations do not set out how the equipment must safeguard users, a federal appeals court ruled.

In what attorneys say is a precedent-setting decision, a 3rd U.S. Circuit Court of Appeals panel in Philadelphia ruled that federal safety law in most cases does not pre-empt state tort law claims against equipment manufacturers.

The March 26 ruling overturned a federal district court decision in the case, which involved a product liability suit stemming from a tractor rollover that killed the equipment's operator.

In its ruling, the 3rd Circuit panel noted that the New Jersey Supreme Court had ruled in an unrelated case that the federal Occupational Safety and Health Act did pre-empt a product liability lawsuit that, like the current case, had been filed in New Jersey state court. But the 3rd Circuit panel determined that the earlier case involved an unusual type of situation that did not apply in the tractor rollover case.

"If the (appeals) court had ruled the other way, it would have been shocking to me," said employer attorney Julie Pacaro of Cozen O'Connor P.C. in Philadelphia.

Some federal statutes, such as the interstate commerce law, are intended to "occupy the field" they cover and, therefore, pre-empt related state laws, Ms. Pacaro said.

That was not Congress' intention when it enacted OSH Act, she said. Instead, the act is protective in nature, because it is designed to prevent injuries, she said. But after a workplace accident, it does not replace workers' rights that state

See **OSHA** page 26

REUTERS

Melanie Lidle, left, the widow of former New York Yankees pitcher Cory Lidle, above, is suing MetLife for denying AD&D benefits after Mr. Lidle's death.

MetLife sued over benefits for death of pitcher Lidle

By GLORIA GONZALEZ

LOS ANGELES—The widow of New York Yankees pitcher Cory Lidle has sued MetLife Inc. for more than $1 million for failing to pay benefits from an accidental death and dismemberment insurance policy.

Mr. Lidle and his flight instructor were killed when their plane crashed into a New York building last October.

Major League Baseball purchased a policy from New York-based MetLife in 2004 that provided life insurance and AD&D benefits for its players. Melanie Lidle was paid $450,000 in life insurance benefits from that policy, but the insurer has refused to pay $1.05 million in AD&D benefits, according to the lawsuit, which was filed in the Superior Court of California in Los Angeles.

The plane Mr. Lidle and his instructor were flying has dual controls, meaning either individual may have been flying at the time of the crash. MetLife will likely argue that Mr. Lidle was piloting the plane, which would trigger an exclusion in the policy that invalidates coverage if the insured was acting as a pilot, crew member, flight student or in a capacity other than a passenger, according to the lawsuit. Ms. Lidle, though, contends her husband was simply a passenger on the plane. The complaint asks the court for a declaration that Ms. Lidle and the couple's son, Christopher, are entitled to the full proceeds of the policy and for damages of $1.05 million and the costs of the lawsuit.

A MetLife spokesman declined to comment.

Under MLB's benefits program, Ms. Lidle will receive a widow's benefit, consisting of 95% of a $175,000 pension benefit available to MLB players. Mr. Lidle was just shy of the 10 years required for full vesting under the pension plan. In addition, a $200 monthly dependent benefit will be paid to the family on behalf of Christopher until he reaches adulthood.

California commissioner orders SCIF audit

Poizner also calls for changes at state-run workers comp fund in wake of executive firings

By SALLY ROBERTS

SACRAMENTO, Calif.—California Insurance Commissioner Steve Poizner has ordered an audit of the State Compensation Insurance Fund, citing "serious questions" about its corporate governance and management, and demanded that SCIF make structural and operational changes.

The move came amid a brewing scandal at the state's largest workers compensation insurer that led to the recent firing of SCIF President James C. Tudor and Vp Renee Koren, which SCIF attributed to results of an internal review (*BI*, March 26).

At a state Senate Banking, Finance and Insurance Committee hearing last week, Jeanne Cain, SCIF board chair, told legislators that the board's ongoing internal investigation will not be complete for another 90 days.

Mr. Poizner

The investigation centers in part on millions of dollars in administrative fees SCIF paid to two of its former board members who resigned last fall amid conflict of interest concerns raised by California Gov. Arnold Schwarzenegger's office.

Mr. Poizner said last week he will conduct his own audit of SCIF.

"This audit will be an independent, thorough, top-to-bottom examination of SCIF to include a review of matter relating to the recent dismissals, as well as all aspects of the organization and its governance," he said in a statement.

The insurance commissioner also issued strong structural and operational change directives to SCIF, giving it 14 days to respond or face formal regulatory action that could include a public hearing.

Mr. Poizner directed SCIF to address the fol-

See SCIF page 22

Fidelity to revamp retiree programs, terminate DB plan

By JERRY GEISEL

BOSTON—Mutual fund giant Fidelity Investments is overhauling its retiree savings program, setting up new retiree health care accounts to fill a gap in its benefit plans, while beefing up its 401(k) plan and terminating its defined benefit pension plan.

Boston-based Fidelity is setting up health reimbursement arrangements under which Fidelity will provide employees with a $3,000 annual credit. Employees can draw upon the accounts after turning age 55 to pay for retiree health care expenses, such as insurance premiums, on a tax-free basis. Employees will vest in the credits after 10 years of service.

A Fidelity spokeswoman said the company began to consider adding a retiree health care benefits program after employee surveys found that more than 70% of employees said they didn't know how they would pay for retiree health care expenses.

Retiree health care expenses are a "looming challenge" for employees and "we are restructuring our plans to meet that need," the spokeswoman said.

Benefit experts say the retiree HRA approach being taken by Fidelity is an appealing middle ground for employers, avoiding the extremes of providing no coverage or providing a traditional plan, whose future costs are difficult to measure and ultimately may be unaffordable.

"It is applying a defined contribution approach to retiree medical benefits. It is a way of controlling your costs and knowing what to expect in terms of expense," said Nancy Gerrie, a partner with McDermott, Will & Emery L.L.P. in Chicago.

Aside from adding a retiree HRA benefit, Fidelity is improving its 401(k) plan match, with the company matching 100% of employees' deferrals, up to 7% of pay. Fidelity now fully matches deferrals up to the first 5% of pay.

Fidelity also is terminating, effective June 1, its defined benefit plan, which has more than 32,000 participants. Participants will have a choice of taking their accrued benefits as an annuity or taking the accrued benefit as a lump sum, and, if they so choose, and transfer the benefit to their profit-sharing plan.

Unlike many other companies that are phasing out or terminating their defined benefit plans, the Fidelity plan is not the cornerstone of its retirement savings program. The biggest component is its profit-sharing plan, to which Fidelity in recent years has contributed an amount equal to 10% of employees' salaries annually, the spokeswoman said.

MAJOR MANAGED CARE ORGANIZATIONS: FULL YEAR 2006 RESULTS

Ranked by net income. Dollar figures in millions.

Company	Net income 2006	% Increase (Decrease)	Revenues 2006	% Increase (Decrease)
UnitedHealth Group	$4,159.0	35.0%	$71,542.0	54.0%
WellPoint Inc.*	3,094.9	25.6	56,953.0	27.9
Aetna Inc.	1,700.0	8.0	25,100.0	12.0
Kaiser Permanente	1,300.0	23.0	34,400.0	9.6
CIGNA Corp.	1,155.0	(25.0)	16,547.0	(1.2)
Coventry Health Care Inc.	560.0	12.0	7,733.7	17.0
Humana Inc.	487.4	64.3	21,416.5	48.5
Health Net Inc.	329.3	30.0	12,908.3	8.0

** Does not include 2005 earnings from WellChoice Inc., which was acquired by WellPoint in December 2005.*
Source: Company reports

Stable costs drive gains at managed care firms

Disciplined pricing expected to continue through 2007

By GLORIA GONZALEZ

Managed care companies had a profitable 2006 as health care costs hovered in a predictable range, allowing them to engage in disciplined pricing practices.

Commercial health care cost and premium increases settled mainly in the range of 6% to 8% last year. Although the range was lower than increases of 7% to 9% reported in 2005, health care costs continued rising faster than general inflation last year and analysts predict a slight uptick in cost trends this year.

Most of the major managed care companies reported higher full-year profits, recovering from profit slumps in the first half of 2006 that were related to the implementation of the Medicare prescription drug benefit. The exception was Philadelphia-based CIGNA Corp., which reported lower profits in 2006 than in 2005, which included income from discontinued operations and the sale of certain businesses.

"All the others are doing well, earnings wise," said Sally Rosen, a senior financial analyst with Oldwick, N.J.-based A.M. Best Co. Inc.

Louisville, Ky.-based Humana Inc. posted the largest percentage rise in profits due to substantial growth in its governmental sector (see chart).

Medical cost increases remained in a stable range, which allowed insurers to price their products appropriately. WellPoint Inc., for example, said its 2006 medical trend rose less than 8% and the Indianapolis-based insurer expects it will remain relatively flat in 2007 at just less than 8%.

"The marketplace remains competitive, but we see generally rational pricing, which allows us to achieve targeted margins," said David Colby, chief financial officer for WellPoint, during the company's fourth-quarter earnings conference call. "We remain very disciplined in our underwriting approach and will not sacrifice margin for market share."

Insurers are pricing their products at or slightly above their medical costs. "Pricing seems to be disciplined," said Stephen Zaharuk, vp and senior analyst for Moody's Investors Service Inc. in New York. "It's competitive, but restrained."

Although managed care companies have done a good job of developing products, such as consumer-driven health plans to keep premi-

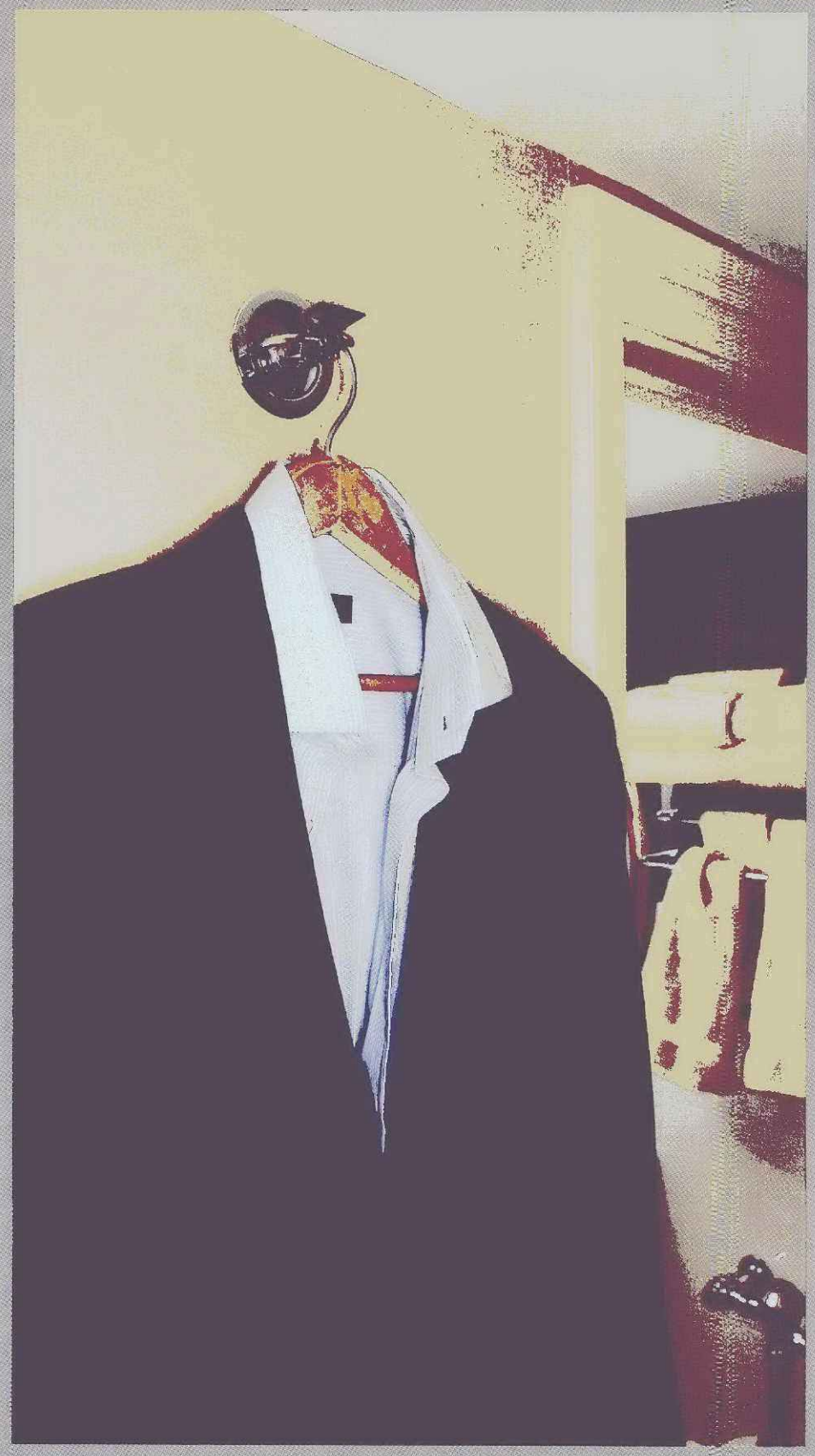
See MANAGED CARE page 23

200,000 REASONS

A SPRINKLER HEAD DOES NOT

DOUBLE AS A COAT RACK.

WAUSAU PACKAGE AT WORK. Recently, we received some interesting property claims. Hotel guests, trying to expand their closet space, enlisted the help of sidewall sprinkler heads, using them as makeshift coat racks. The weight of the clothing damaged the fusible element of the sprinklers, setting them off and causing more than $200,000 in water damage. When our loss prevention experts located the source of the problem, they quickly advised clients to place a warning sign next to sidewall sprinklers to prevent similar damage. Simple, but effective. That kind of industry knowledge and attention to detail can be found throughout Wausau, in any of our areas of expertise – from hospitality to construction. And with Wausau Package, you can leverage that expertise to get comprehensive coverage tailored to the specific needs of your business. It's all part of Wausau TotalValue℠ and our commitment PRICE≠COST. to lowering your total cost of risk. A commitment backed by the financial strength of Liberty Mutual. To learn more, contact your Wausau Signature Agency representative or your appointed Wausau producer.



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Reinsurers report strong results, but prices expected to fall in 2007

Low losses last year means more capacity for buyers this year

By JUDY GREENWALD

WASHINGTON—U.S. reinsurers' results are expected to remain strong this year, although softening rates and an anticipated increase in catastrophes will make 2007 less of a banner year than 2006, say observers.

One unknown factor is the impact on the overall market of Florida legislation, which adds up to $17 billion in state-backed capacity for property catastrophe reinsurance buyers (*BI*, Jan. 29).

The 23 U.S. reinsurers surveyed by the Washington-based Reinsurance Assn. of America posted a 94.9% combined ratio for 2006, a dramatic improvement from the 129.4% reported by a comparable group in 2005.

Based on net premiums written, the top 20 U.S. reinsurers reported a 94.6% combined ratio for 2006 vs. 118.6%, which was based on a weighted average, by the same group in the year-earlier period.

Reinsurers "had a phenomenal year last year," said Adam Klauber, director of equity research for Cochran Caronia Waller, a Chicago-based insurance industry investment banking firm. "Everything really aligned for the industry."

An important factor boosting results was the absence of major U.S. catastrophes last year, say observers. Hurricanes were priced into the rates, but "that never happened," said Diane Cocgan-Pushner, a portfolio manager with Philo Smith & Co., a Stamford, Conn.-based investment banking firm.

While the weather was good to reinsurers, "there was more to the story than that," including favorable reserve development for most companies and good underwriting cash flow, said Cliff Gallant, an analyst with Keefe, Bruyette & Woods Inc. in New York. "They hit on all cylinders in 2006."

In terms of nonproperty lines, however, John Gwynn, managing director at Memphis, Tenn.-based investment banking firm Morgan Keegan & Co. Inc., said most reinsurers "reported a down drift in their premium accounts," which was partially a function of price competition, "but probably more importantly, a function of increased retentions by primary companies as they got more comfortable with the profitability of the underlying business."

Catastrophes, lower prices and the possible impact of the Florida reinsurance legislation are factors that will affect 2007 results, say observers.

Reinsurers did so well last year that there is a lot more capital in the sector now, "so it's tougher to

See **REINSURERS** page 23

Commentary

Play by the numbers with fantasy insurance

Paul Winston is on vacation. This commentary was originally published in March 2003.

PAUL WINSTON

Associate Publisher and Editorial Director
Paul Winston's commentary appears monthly. E-mail: pwinston@businessinsurance.com

If your office is anything like mine, the month of March means one thing: March Madness.

This year, not even the sober reality of the war in Iraq could dissuade the faithful from trying to divine the fortunes of the 64 teams in the NCAA men's college basketball tournament. According to a column in USA Today, even U.S. troops in the Middle East were hastily completing their brackets and following the tournament in the midst of the conflict.

And the march to the Final Four is not the only time when office betting on sports occurs. With April comes the start of rotisserie baseball leagues. August brings fantasy football—college and pro—contests.

Although betting money on office pools is illegal in many states, few if any district attorneys are prosecuting (probably because they are in their own office pools). That said, many management pundits have decried the diversion of workplace human resources from productive tasks to following the fortunes of fantasy teams on the office clock. I think it's a harmless distraction that tackles no more time away from the tasks at hand than the usual mindless Internet surfing taking place during working hours. I can assure you that as long as the boss' picks are still in the Final Four, he or she is not worrying that the rank-and-file are wasting time on pools.

This obsession got me to thinking. Why not a fantasy insurance competition?

Observing this obsession with competing against coworkers with virtual sports teams and players, and the apparent effort by online services to find new sources of competition, got me to thinking. Why not a fantasy insurance competition?

Insurance is perfectly suited to such a contest. It's a numbers-based field, with any number of benchmarks for determining winners and losers. It's an industry already familiar with the use of Monte Carlo simulations. And the entire business is founded on the concept of gambling. By that, I mean that insurers in the course of business gamble that their calculation of premiums will offset expected losses. And policyholders routinely gamble that the amount of coverage they buy will cover the size and frequency of losses they incur.

There are many organizations well suited to organizing fantasy betting on various insurance outcomes. Consider A.M. Best Co. Inc., which gathers reams of data annually. Or the Insurance Information Institute, which organizes a Groundhog Day forecast of insurer results among analysts. Creating an III March Madness competition would be a natural.

The possibilities are endless for betting in the insurance arena.

For those who favor the simple style of an office baby pool, people could enter their picks for insurance premium volume, policyholder surplus, net income or loss and combined ratio.

For people who favor the bracket style of a tournament pool, you could pick the 32 largest insurers, seed them based on factors like profitability, and then have them go head to head based on quarterly results. A No. 1 seed such as AIG, for example, might be matched up in the first round against an 8th-seeded insurer team like Ohio Casualty.

Another elimination-style contest, though admittedly one that could drag out over a few years, could involve picking insurers that will survive the pressures of consolidation. Pick the companies that will survive M&A attempts and win. Alternatively, start with a pool of reinsurers, or maybe new companies created in the fourth quarter of 2001, and pick which will still be standing a year or two from now.

For those interested in more exotic or unusual friendly wagering, bet on the outcome of such things as asbestos liability reform legislation in the U.S. Congress.

If any of the above stir your passion for competition and your craving for a new source of office competition after the NCAA tournament is over, let me know and I'll see what I can do.

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Business Insurance OPINIONS

House bill would doom mental health parity law

DO ADVOCATES OF mental health care benefits parity in the House want enactment of legislation this session?

If they do, then they would be wise to drop their support of a bill in the House in favor of a measure approved by a Senate panel.

There are several troubling provisions in the House measure, but one makes it unacceptable—requiring equitable coverage of any diagnosis listed in the psychiatric community's manual of mental health disorders.

That goes far beyond parity. Since when is the listing of a condition a mandate for coverage? Should employers be required to provide the same coverage for every dental problem that they offer for treatment of medical problems?

> *Since when is the listing of a condition a mandate for coverage?*

With employers footing the bill, they should have the right to decide what should be covered in their benefit plans.

We think the approach on mental health care benefits parity taken by the Senate's Heath, Education, Labor and Pension Committee is reasonable. If an employer provides coverage for mental health disorders, that coverage should be equal to that provided for other medical conditions.

The House measure surely will win approval in that chamber, but final passage is another matter. Given the work Senate legislators have put into their bill, we can't see them endorsing the House approach.

That will mean stalemate. With that likely result, we ask House legislators and their supporters: Do you want an issue, or do you want enactment of legislation that improves coverage of mental disorders?

We think the answer should be obvious.

Public cat fund popular, but far from a good idea

AN IDEA THAT'S gaining popularity on Capitol Hill and elsewhere is that government ought to get into the business of insuring catastrophe-exposed property by establishing public natural catastrophe funds.

The reasons for the idea's popularity are quite understandable. After all, nobody—homeowner or business—wants to get slammed with the higher insurance rates the private market will demand to cover an increasingly expensive exposure. But simply because there are good reasons behind an idea's popularity does not make it a good idea.

In fact, subsidizing property insurance at artificially low rates through government-backed catastrophe funds strikes us as a bad idea indeed. Political reality can be expected to trump actuarial reality, and pressure will always be exerted to hold rates down, thus encouraging more building and greater exposure. When the catastrophe occurs, the taxpayers are left holding the bag.

Government policy would be far better directed toward reducing vulnerability to hurricanes than by pursuing politically popular yet economically unsound—and potentially quite expensive—measures that could very well make a bad problem even worse.

Letters

Stop the mind-numbing endorsements

TO THE EDITOR: It's time the insurance industry started using the technology we all have available to us. It's time to stop the mind-numbing, prolific use of endorsements on insurance policies.

I have in front of me a 12-page professional liability policy form. Attached to the contract are 32 pages of endorsements. There is barely a paragraph in the base policy that is not affected by the endorsements. How is this helping insurance buyers? How is this bolstering the industry's image? How does this lend to clear and unambiguous coverage understanding? Quality? Customer service? The above mentioned policy has three endorsements that change the same original paragraph.

Why can't an underwriter select from various coverage sections to construct the policy? How about a simple word processor! This is not difficult and not complicated. Insurance policies should be a straightforward construction of terms and conditions, not a mishmash of amendments and endorsements. This is not 1950.

What other industry would force upon their customers such gobbledygook? No bank would issue a mortgage with 30 pages of amendments. How about a car rental agreement

See **LETTERS** page 20

Write us

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Online Poll at www.businessinsurance.com

Should employee benefit plans pay for contraceptives?

NEXT WEEK'S POLL: *Should government entities play a role in providing natural catastrophe coverage?*

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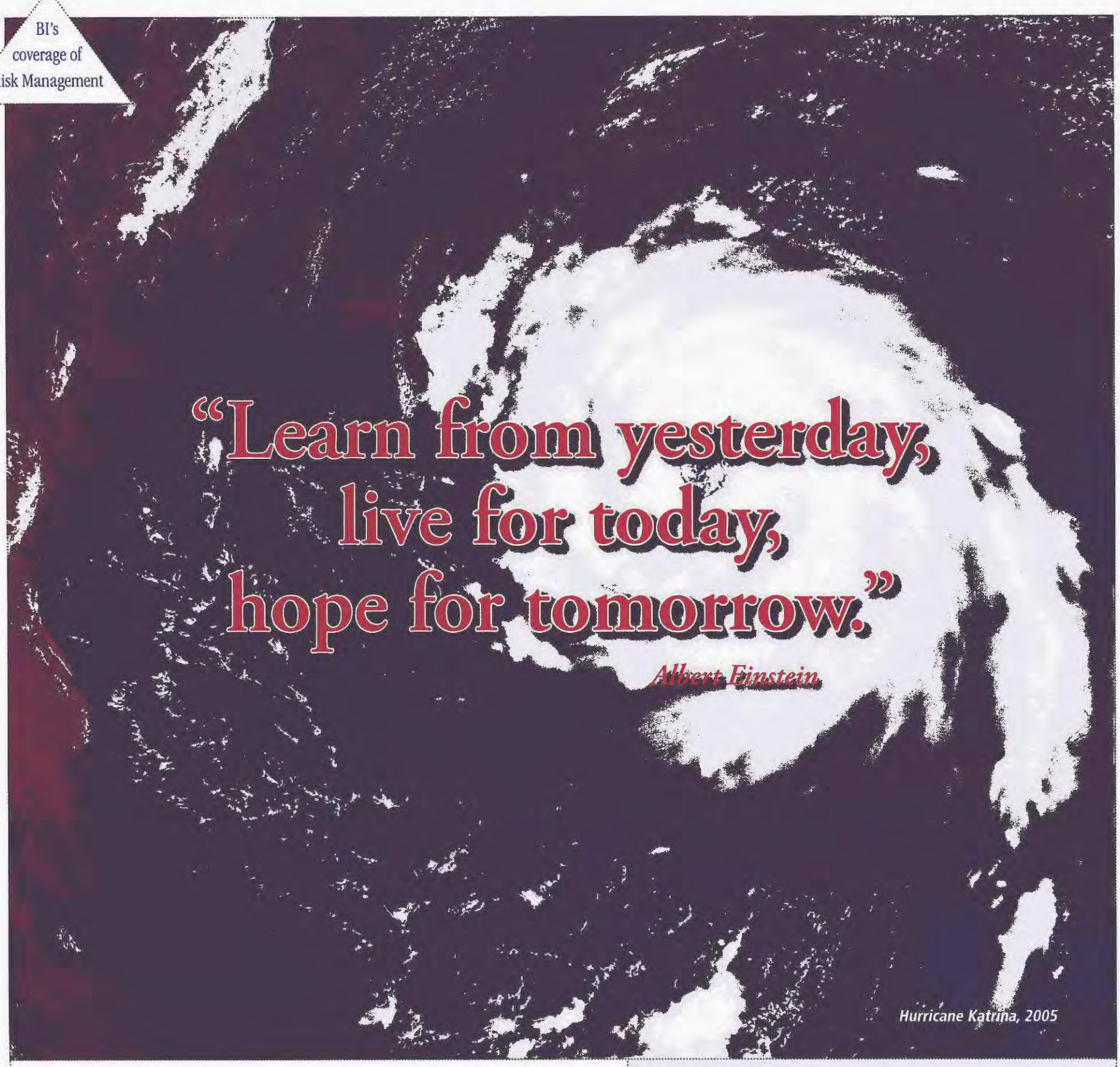

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AIRLINES SEE CLEAR SKIES AHEAD

SECTOR BRIEFING

AEROSPACE

Aviation insurance rates fall as capacity rises

By STACY SHAPIRO

Airline insurance premiums will continue their slow descent this year as a result of increased capacity and an excellent loss record.

But not everyone wants to compete with prices falling and at least one major aviation underwriter, Global Aerospace Underwriting Managers Ltd., says it will withhold some of its capacity until the market hardens again.

During 2006, worldwide airline hull and liability insurance premiums, excluding excess hull war, decreased by 17% on average, with many airlines in the last quarter receiving 20% to 25% premium reductions, brokers say. The airline accident rate was the second-best ever, with hull and liability losses from jetliners totaling about $1.4 billion.

Premium reductions of between 20% and 25% have continued during the first quarter of 2007 and several major airlines, such as Virgin Atlantic Airways Ltd. and British Airways P.L.C., are about to renew.

"While premium levels seem low at first glance, historical analysis suggests that there is scope for further declines on 2007/8 policies," said Aon Corp.'s recently published "Airline Insurance Market Review 2006."

"The simple reason for this is that while the average lead premium in the airline insurance market has fallen at a breathtaking rate over the last quarter," said Doug Peterson, Aon's aviation global practice leader, "it potentially still has some way to go before it reaches the bottom when capacity in the airline insurance markets, the contribution of the excess third-party war coverage, technological and safety improvements and the renewal cycle...are taken into account."

Based on these premium prices, the average insurance cost per passenger in 2006 was 73 cents, compared with 98 cents in 2005, Aon noted.

Only a major catastrophe could upset this scenario, most brokers, underwriters and airline risk managers say. However, the safety record of the airline industry is improving all the time, with new audits and safety systems being implemented regularly, so claims may remain low.

But airline hull and liability insurance is just one part of the aviation insurance market. Aircraft manufacturers, airports and air traffic controllers also buy insurance and the market for them is somewhat different.

For example, airports are experiencing smaller reductions up to 10% during this year's renewals, according to Marsh Aerospace's "Aviation Review 2006," and air traffic controllers also are renewing with close to 5% premium reductions.

"The airport and ATC provider portfolio has suffered from lack of capacity and therefore has not been able to enjoy the level of reductions obtained by airlines," the Marsh report said.

According to Marsh, the market actually

See AEROSPACE next page

Inside

TOTAL HULL AND LIABILITY PREMIUMS & CLAIMS

In billions of U.S. dollars

Source: Aon Corp.

Aerospace: Rates decline as competition increases

CONTINUED FROM PREVIOUS PAGE

has been tight for aircraft manufacturers' product liability insurance, and underwriters will continue to maintain the current premium levels this year.

Last year, underwriters applied an average premium increase of 4% to aircraft manufacturers' programs, and the total premiums paid in the sector was just over $1 billion. The increase reflected underwriters' concerns about deterioration on losses during prior years, which led to a $1.69 billion increase in loss reserves over the past 48 months. "Even though 2006 looks likely to be a profitable (year for underwriters), we will not know the true profitability of the book until 2009," the Marsh report said.

Airline insurance, however, is still the most talked-about sector of the aviation insurance market, totaling just under $2 billion in total premiums in 2006.

The state of the aviation insurance market is still one of the most important issues for airline risk managers. Ralf Oelssner, director of corporate insurance for Lufthansa AG, sums up airline risk managers' current priorities as:

- Available capacity for airline insurance programs.
- A "respectable" price, given the lack of major airline claims.
- Claims payments.

'We're entering a more competitive landscape... where premiums have been reducing since 2002.'

Stephen Riley
Global Aerospace Underwriting

Indeed, there has been a huge increase in capacity in the past year, up by over 200% by some estimates, which has led to a very competitive marketplace. Although there was a "short sharp" increase in prices following the terrorist attacks of Sept. 11, 2001, profitability and competition returned quickly, said Stephen Riley, executive director of Global Aerospace Underwriting Managers Ltd. in London. "But over the last 12 months, we have seen that accelerate with new capacity coming into the market."

The most significant development in the market has been the introduction of almost a dozen new aviation underwriters in the past year, according to Marsh.

"There are at least 70 people who have moved in the last year or so in the aviation insurance industry in London and the United States," said Mr. Riley. "So it's a time of fairly significant change, and some of it seems to be for opportunist reasons...and some of it for strategic reasons," he said.

"So we're all entering a more competitive landscape and that is most visible from a pricing point of view in the airline insurance market, where premiums have been reducing since 2002, though the rate of average reduction accelerated last year," Mr. Riley said.

As a result of the premium reductions, Global Aerospace has reduced its airline business capacity to a maximum of 12.5% of an airline's insurance program, down from 17.5%, he said. "We're not in the business to write insurance which we think is likely to produce a loss."

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Flight cancelations largely uninsured as airlines dismiss costly coverage

Groundings linked to weather, terrorism take billions off profits

By STACY SHAPIRO

Each year, airlines across the globe lose tens of millions of dollars from cancellations and delays caused by weather and other forced groundings. Despite this, few airlines buy insurance to cover these losses.

Although insurers do offer coverage for weather losses, the cost is prohibitive, risk managers and observers say.

Some brokers say they are working on programs that would be more attractive to airlines. And alternative markets, such as weather derivatives, also are options for airline risk managers, but coverage for weather-related interruptions to operations remains largely an uncovered exposure for airlines.

REUTERS PHOTOS

Several airlines in the United States and Europe saw revenues decrease last year as a result of flight cancelations due to snow storms in Denver (above right) and terrorism threats in London (above).

The lack of coverage purchased does not reflect a lack of financial losses resulting from interruptions to airlines normal operations.

For example, cancellations and delays caused by air traffic control cost an estimated $5.9 billion in direct operating costs for U.S. airlines in 2005, according to the U.S. Air Transport Assn. in a report issued late last year.

Airline balance sheets in the recent months also reflect these kinds of losses.

For example, severe service disruptions as a result of the Feb. 14 ice storm in New York cost JetBlue Airways Corp. $20 million to $30 million, according to stock analysts. JetBlue had to revise its first-quarter and full-year 2007 projections downward as a result of the disruption (see related story).

United Airlines also saw its fourth-quarter 2006 passenger revenues hit by three severe winter snowstorms in Chicago and Denver, the company's two largest hubs.

During December, United and United Express canceled some 3,900 flights systemwide due to the storms, reducing passenger revenues by $40 million, according to parent UAL Corp.'s 2006 results.

Weather, though, played only a small part in losses at British Airways P.L.C. A bigger factor was disruption from a security scare last August that cost the company much more. According to the airline's second-quarter results ending Sept. 30, 2006, the airline lost £100 million ($195 million) from the security crackdown at U.K. airports in August after British police thwarted an alleged massive terrorist attack on several trans-Atlantic flights.

In addition, the airline faced increased costs related to the ongoing crackdown on passenger security at U.K. airports in its third quarter, as well as weather-related losses when it canceled 800 flights in the pre-Christmas peak period because of fog. This cost the airline £40 million ($78 million) for the third quarter ending Dec. 31, 2006.

Insurance to cover these types of costs is available, but few airlines buy it.

"I have not heard of anyone taking the cover," said Ralf Oelssner, director of insurance for Lufthansa A.G. in Frankfurt, Germany.

However, airlines are protected in their existing insurance programs for claims associated with the "loss of use" of an aircraft that is damaged or destroyed, Mr. Oelssner said.

Insurance for weather-related losses "is available, but it's very expensive because the losses are high," said Carol Gates, director of industry risk management and insurance at the International Air Transport Assn. in Montreal. "Some airlines purchase some coverage, but it's very expensive."

One of IATA's future aims is to "benchmark" the cost of the operational interruptions and examine total losses, she said. Total losses could include time when aircraft are damaged on the ground and when additional costs come into play such as aircraft downtime, leasing new aircraft, rerouting, employee costs and so on.

Brokers at Chicago-based Aon Corp. have put together weather risk management insurance products that will cover airlines for interruptions caused by weather, said Steve Doyle, manager of aviation and global practice at Aon Ltd. "We are trying to help the airlines...and are working with our clients to offer custom-made products," said Mr. Doyle. He would not disclose any details about the products.

One type of financial mitigation tool that is used by other industries, weather derivatives, is not widely used by airlines.

Ms. Gates of IATA and Mr. Oelssner both said they have not heard of any airline using weather derivatives to mitigate cancellation and delay costs.

"Airlines have their hands full as the rising cost of fuel has superseded everything," said Ms. Gates. Airlines do hedge to offset their rising fuel costs.

"I've yet to hear that an airline has bought a weather derivative," said Robert Holmes, director and meteorologist for Overland Park, Kan.-based Guaranteed Weather L.L.C., a weather risk management company. Guaranteed Weather's partners are Ramsey Quantitative Systems Inc., Mitsui Sumitomo Insurance Co. and Hannover Re. "A five day snowstorm in Denver doesn't seem to be enough to make airlines or airports scream or shout."

But weather derivatives could be a useful tool for airlines, he said.

For example, an airline could try to protect itself from weather-related losses by hedging against the amount of snowfall at, say, Chicago's O'Hare International Airport, said Mr. Holmes.

Depending on the derivative, the airline might earn $1 million for every inch that falls above the average of, say, 36 inches per year, and possibly lose $1 million for every inch below 36 inches that falls during the year, he said. But if the airline had to pay out, then the likelihood is that there would be fewer cancellations and less cost because there was less snow, he said.

AP PHOTO

JetBlue, which had to cancel more than 1,000 flights following a February ice storm, quickly issued a Customer Bill of Rights that promises to compensate passengers for cancellations or delays.

Travel disruptions spawn compensation programs

JetBlue Airways Corp. canceled more than 1,000 flights in a six-day period following a Northeast U.S. ice storm on Valentine's Day, but its subsequent handling of the troubles has been described as a textbook case of effective crisis management, experts say.

Following the storm that left some of its passengers stranded aboard aircraft for up to 10 hours, JetBlue admitted fault, offered compensation and announced steps that it would take to correct the problems.

The airline also announced a Customer Bill of Rights that seems to have spurred proposed federal air passenger rights legislation that was introduced in the U.S. House of Representatives in early March. The European Union has had such a law in force since early 2005.

"We've learned some huge lessons from this experience," said JetBlue Chief Executive Officer David Neil during a Feb. 22 investor conference. "We have operated this airline in very difficult weather conditions for the last seven years and this isn't the first storm we've ever seen. It was a collision of a lot of events that came together that exposed some of the weaknesses in our operation, particularly in our recovery side. If there is any good news to come out of this, then (it is that) we have already started implementing new operations to make sure this never happens again."

JetBlue's response to a subsequent winter storm on March 16 was markedly different—it warned customers of cancellations and waived change fees and air fare differences to allow rescheduling before the storm hit.

Meanwhile, JetBlue has been praised for introducing its Customer Bill of Rights that was made retroactive to Feb. 14. The code promises notifications of delays, cancellations and diversions, and compensation up to a full refund for cancellations and delays.

U.S. consumers have called for a federal passenger bill of rights for some time. Indeed, legislation was introduced March 1 in the House by U.S. Rep. Mike Thompson, D.-Calif. The Airline Passenger Bill of Rights Act of 2007, which does not provide details of compensation, has been passed to a House subcommittee.

In Europe, rules stipulating passenger rights have already been introduced. The European Union introduced "air passenger rights" in a regulation that went into effect Feb. 17, 2005.

The E.U. regulation (Directive 261/2004) established common rules on compensation and assistance to passengers in the event of denied boarding, cancellation or a long flight delay. E.U.-based airlines must compensate each passenger on a European flight for denied boarding or cancellation. The amount of compensation varies between €250 ($330) and €400 ($528) depending on the distance of the flight. Airlines must compensate passengers for cancellations unless the airline can prove "extraordinary circumstances."

European airlines under this E.U. regulation also must show "reasonable care" to passengers in the case of delays or cancellations. This includes offering "free of charge" meals and refreshments, two telephone calls or the equivalent, and hotel accommodation when a stay of one or more nights becomes necessary. The air carrier also is obliged to pay particular attention to the needs of people with reduced mobility as well as unaccompanied children.

—By Stacy Shapiro

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AMERICAN EXPRESS

Consensus grows on liability limits for some terrorism losses

International group proposes liability caps for ground damage

By STACY SHAPIRO

Moves are afoot to cap airline third-party liabilities for ground losses following terrorist attacks using aircraft as weapons.

The proposed changes would amend international agreements on ground losses that were implemented 49 years before the Sept. 11, 2001, terrorist attacks in the United States.

The draft wording has been in the works for years, though the United States has not been involved in the discussions.

A meeting of the "special group" of the International Civil Aviation Organization, which is working on the changes, is planned for June to finalize a draft for a revised convention on ground damage caused by aircraft.

The original 1952 Rome Convention on Damage Caused by Foreign Aircraft to Third Parties on the Surface, which went into effect in 1958, was designed to address ground damages that were caused by an aircraft accident.

The convention relates to ground damages caused by foreign aircraft, and limits the liabilities of those responsible for any damage. The convention also deals with a host of related matters such as apportionment of claims, financial security requirements, jurisdiction and enforcement of judgments.

A protocol to amend the convention to increase those liability limits was adopted and signed by ICAO in Montreal in 1978. The convention did not deal with ground damage caused by acts of terrorism and ICAO's special group has proposed a new convention rather than amendments to the old convention in order to deal with the issue.

According to ICAO, neither the Rome convention nor the protocol have received wide acceptance, largely because the liability limits are viewed as inadequate. The convention had been ratified by 45 governments, and the protocol had been ratified by only four governments and was not in force. The United States did not ratify either document.

Limits set by aircraft size

Strict liability limitations fall in several categories in the Rome Convention and vary depending on the size of the aircraft. However, liability per person for loss of life or personal injury has been limited to 500,000 gold francs ($40,000) per person, which was amended to 125,000 special drawing rights ($158,125) per person in the failed 1978 protocol.

Moves to amend the convention were in the works before the 2001 attacks, but the attacks brought additional urgency to the revision.

Should the group finalize a draft convention in June, ICAO would call a diplomatic conference next year to consider the draft. Only then could it be sent to all 189 member countries for ratification.

The proposed draft "has teeth, but it also has a cost," said Carol Gates, director of risk management for the International Air Transport Assn. in Montreal.

The draft proposes an "unbreakable cap on the liability of the operator to victims" of between $1.1 million for light aircraft and up to $1 billion for the largest aircraft, according to a summary prepared by Sean Gates, senior partner at London law firm Gates and Partners.

Additional compensation above this limit would be provided by a special fund that would be financed through a special tax on passengers and cargo that would be collected by airlines. Over time, the fund is expected to accumulate about $3 billion, according to the IATA's Ms. Gates. Airlines would collect this tax and pass it on to the fund.

Compensation above the fund's limits would be provided for by agreement between governments rather than specified in the draft convention, said Gates and Partners' Mr. Gates, who also is legal adviser to International Union of Aviation Insurers.

Not all ICAO members, however, agree with the need to draft a new convention dealing ground damages from terrorism.

The United States, for example, has not been involved in the draft proposals, although it could still send representatives to the June meeting if it so chooses. U.S. airlines are protected from terrorist exposures by the Federal Aviation Administration Aviation Insurance Program that provides unlimited war risk coverage for hull loss and passenger, crew, and third-party liabilities. The FAA's war risk insurance program, which has been provided to U.S. airlines since 2001, is up for renewal on Aug. 31, but observers expect it to be renewed.

Harold Caplan, a retired aviation trial lawyer who practiced in England, is strongly opposed to changes in the Rome Convention dealing with terrorism. He believes that these losses would be caused by the actions of terrorists and not airlines, therefore, airlines should not be held liable for any damages without any defenses.

"The special group assumes that this should, for the first time, be deliberately a feature of aviation law in a terrorism context," said Mr. Caplan.

Expanded war risk exclusions held at bay by soft market

A soft aviation insurance market has meant that new war risk clauses intended to limit liability coverage for "weapons of mass destruction" have yet to see the light of day.

In August 2006, the London-based Aviation Insurance Clauses Group adopted new aviation war exclusion and write-back clauses for aviation liability insurance policies after many months of consideration.

The clauses are intended to restrict the potential accumulation of liability claims arising out of terrorist attacks on aircraft that use "weapons of mass destruction" such as nuclear devices, radioactive contamination, and biological/chemical and electromagnetic pulse weapons.

Specifically, the clauses:

- Exclude atomic, nuclear fission and fusion risks.
- Offer coverage in three sublimits for WMD risks.
- Only offer WMD write-back cover for passenger injury or death while on an aircraft and not while in an airport.

Of the clauses published, Lloyd's of London and London-market company underwriters favored the clause AVN48C, which excludes all cover for hostile use of WMDs and two other clauses, AVN52H and AVN52J, that offer limited extended coverage endorsement for some WMD risks, excluding nuclear risks.

The other clauses that were published were supported by Marsh Ltd., the Assn. of European Airlines and the International Air Transport Assn. One of the clauses, AVN48D, offers limited WMD coverage for all but nuclear devices or materials and the others, AVN52K and AVN52L, offer similar extended coverage endorsements for all WMD risks excluding nuclear.

Aviation underwriters have been concerned about the "considerable threat" from the use of WMDs by terrorist organizations, particularly while aircraft are on the ground at airports, said Stephen Riley, executive director of Global Aerospace Underwriting Managers Ltd. in London. Underwriters have been particularly concerned about the "accumulation" of risk at airports where many passengers and aircraft could be affected at the same time.

So far, none of these war risk clauses for liability policies has been used. Brokers say inclusion of the clauses has been stymied by the soft market for aviation risks.

Mr. Riley, however, has another interpretation: "It's taken a long time to develop the wordings and we can't just introduce them overnight," he said. Underwriters would rather introduce the clauses "by agreement" with their clients, he said.

—By Stacy Shapiro

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Market Moves

Max Re Capital Ltd. seeks to change monikers

HAMILTON, Bermuda–Max Re Capital Ltd. is seeking shareholder approval to change its name to Max Capital Group Ltd. It also wants to rename its Bermuda-based operating company, now Max Re Ltd., as Max Bermuda Ltd.

In a statement, Max Re said the changes–set for a vote at its May 4 annual meeting–are intended to show its evolution from purely reinsurance offerings at its founding in 1999 to today's mix of reinsurance and specialty products.

Markel to purchase social services book

GLEN ALLEN, Va.–Markel Insurance Co. said it has agreed to purchased the $24 million social services book of business from Black/White & Associates Insurance Brokers of Alameda, Calif.

Markel, a Glen Allen, Va.-based niche market commercial lines insurer and subsidiary of Markel Corp., said the acquisition is part of its strategy to take its social services business nationwide.

"It will be business as usual for our agents and customers," Euclid G.H. Black, founding partner, chairman and chief executive officer of Black/White, said in a statement.

Underwriting association opens Capitol Hill office

WASHINGTON–The Assn. for Advanced Life Underwriting has opened a Capitol Hill office from which its key legislative and public affairs staff members now operate.

The office is at 101 Constitution Ave. N.W., Suite 703 E., Washington D.C., 20001.

The AALU, a professional trade association founded in 1957 that now represents 2,000 U.S. life and health insurance agents and financial advisers, will maintain its headquarters at Falls Church, Va.

Woodruff-Sawyer acquires Northwest Benefit Planning

PORTLAND, Ore.–Woodruff-Sawyer & Co. has acquired Northwest Benefit Planning, which will move its operations and staff to Woodruff's existing Portland, Ore., offices.

"We already share several clients, which makes a great fit even better," Bill Paulbitski, founder and president of Northwest Benefit Planning, said in a statement.

The entire staff of Northwest Benefit Planning–a 20-year-old provider of employee benefits, management liability and property/casualty insurance–will join the Portland operations of Woodruff-Sawyer–an 87-year-old insurance brokerage based in San Francisco–the privately held companies said. The purchase price was not disclosed.

FERMA completes office move

BRUSSELS, Belgium–The Federation of European Risk Management Assns. has moved to a new office in Brussels, Belgium.

The new address is Avenue Louis Gribaumont, 1 B/4, 1150, Brussels, Belgium.

The phone number is 011-322-761-9432 and the fax is 011-322-771-8720.

Squaremouth rolls out health comparison site

ST. PETE BEACH, Fla.–Insurance agency Squaremouth Inc. has added health insurance to the products it offers as well as a Web-based quote and comparison engine at *www.squaremouth.com/health-insurance*.

The system, which builds on the insurer's already existing travel insurance offerings, provides health insurance quotes from major insurers in all 50 states, the St. Pete Beach, Fla.-based company said in a statement.

Standard Insurance celebrates 100 years

PORTLAND, Ore.–Standard Insurance Co. has celebrated 100 years of being in business by providing more than 10,500 hours of public service activities to 164 nonprofits across the United States, the Portland, Ore., financial services company said.

"It is important not only that we give of our own time, but that we encourage and teach volunteerism so that our communities remain healthy and vibrant for the next 100 years," said Eric E. Parsons, chairman, president and chief executive officer of Standard Insurance and StanCorp Financial Group Inc., in a statement. What now is Standard Insurance Co. was founded in 1906.

TO SUBMIT ITEMS

BI's new Market Moves column reports on activities by insurance industry companies and related entities. Personnel changes appear in Comings & Goings, while Products & Services reports on new product offerings. Please send Market Moves news to: Charmain Benton, *Business Insurance*, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; *cbenton@businessinsurance.com*. P&S and C&G items should be sent to Joe Walker at *jwalker@businessinsurance.com*.

Cash balance plans not biased against older workers: Court

Discrimination issue remains unresolved with rulings pending

By JERRY GEISEL

DENVER—El Paso Corp.'s cash balance pension plan does not discriminate against the Texas natural gas and pipeline company's older employees, a federal judge has ruled.

Looking at the numerous rulings on the age discrimination issue, Judge Walker D. Miller of the U.S. District Court for the District of Colorado noted that in the majority of rulings, the term "benefit accrual" has been interpreted by courts to refer to the benefit credits employers provide to employees. As long as an employer gives at least the same credits to older employees as younger employees, there is no age discrimination.

In a minority of rulings, Judge Miller wrote, courts have found the plans to be age discriminatory because the same benefit provided to a younger employee and to a older employee will generate a bigger retirement annuity for the younger employee because the younger employee's credits will have more time to earn interest.

Judge Miller said he was persuaded by the majority interpretation, noting that the minority interpretation results in what he described as an "untenable discrepancy."

Under the minority view, "it would be permissible for a younger employee in a defined contribution plan to benefit from the time value of money, while making it illegal for a younger employee in cash balance plan to do the same."

'On the basic age discrimination issue, things are looking very promising.'

Christopher Rillo, Groom Law Group

Judge Miller's ruling comes in the wake of a ruling this month by a federal judge in Illinois that dismissed cash balance plan age discrimination charges against Boeing Co. The majority of courts that have ruled on the issue have rejected age discrimination allegations.

"On the basic age discrimination issue, things are looking very promising. The trend for plaintiffs has not been very encouraging," said Christopher Rillo, a principal with the Groom Law Group in Washington, which represented both Boeing and El Paso.

Still, the age discrimination issue is far from resolved, with several appeals courts expected to rule on the issue over the next year or so. The two appellate courts that have ruled on the issue—the 7th U.S. Circuit Court of Appeals in a widely publicized case involving IBM Corp., and the 3rd U.S. Circuit Court of Appeals in a case involving PNC Financial Services Group Inc.—both found that the design of cash balance plans does not discriminate against older employees.

Employers now sponsor about 1,200 to 1,500 cash balance plans, which are so named because benefits are expressed as a cash lump sum. Congress, as part of major pension funding reform legislation it passed last year, shielded new cash balance plans from age discrimination suits, but left it to the courts to resolve the issue for plans already established.

Letters

CONTINUED FROM PAGE 8

with 12 pages of changes and amendments?

Put policy forms into one single document that we can all read in an organized fashion. Make these forms easier to understand and follow. When the endorsements are almost three times as long as the policy, it's time for a new approach.

I've been in the insurance business for 27 years. I have earned my CIC, CPCU and ARM designations. I have studied insurance my whole career. Yet, I struggle to follow what the insurer is trying to do in many of these over-endorsed insurance contracts. How is the owner of a small manufacturing company supposed to understand 12 pages of policy and 32 pages of endorsements? It is almost like we are intentionally making this more complex.

We certainly have the technology to build a policy that has one set of conditions, one set of definitions and an understandable listing of exclusions. Computers, digital storage and the Internet all can make this so much simpler and even understandable.

Scott Simmonds
Insurance Consultants of Maine Inc.
Saco, Maine

International NEWS

Czech, Slovak buyers see rates plummet

E.U. membership brings more competition

By RICHARD MILLER

BRATISLAVA, Slovakia—Insurance buyers in the Czech and Slovak republics have seen rates for large industrial risks fall dramatically in the past few years—a trend that experts say may have hit bottom already.

Since 2004, when both countries joined the European Union, rates on corporate lines have fallen by an average of 20% year-over-year, according to local insurers and brokers in each market.

REUTERS

Flooding in the Czech Republic in 2002 led to rate increases that year, but prices have fallen since.

The low prices obviously benefit corporate buyers, but there can be a downside when a loss occurs, noted one expert. With brokers and insurers earning much less from such low premiums, neither may be eager to do more than is "absolutely necessary" when it comes to the enforcement and payment of claims, the source said.

From another perspective, being able to secure "more coverage for a better price" means buyers may "start thinking of buying coverage (they) never bought before," said Boris Kostov, general manager at Pojiš'ovna AIG Slovakia A.S. in Bratislava.

While experts point out that rates have been softening across Europe, some said the decrease has been more pronounced in the Czech and Slovak republics. "It would be right to say that in one or two of the areas we operate in, the declines are ahead of some neighboring nations," said Michael Kleiter-Bingel, the Vienna-based managing director for Austria/CEE at XL Insurance Co. Ltd.

Rates are being kept low by competition in the local market and a long-term positive loss ratio, said Mr. Kleiter-Bingel. "However, with the economy doing well, we are seeing larger sums being insured and more frequent demands for higher casualty limits," he added.

Losses from the major floods that struck the Czech Republic in 2002 led to a 25% hike in rates for natural perils coverage, said a spokesman for Ceská Pojiš'ovna A.S. in Prague.

In 2004, individual insurers tried to stabilize rates, but then prices began to fall markedly across the market—by 15% in 2005 and 20% to 25% in 2006, the spokesman said. The rate decline was most pronounced in property insurance, though the decline affected all corporate lines, he added.

The entrance of the two countries into the European Union in 2004 opened the insurance markets to foreign players, leading to huge competition, experts said. In the Czech Republic, the significant investment in industry and infrastructure also has an impact on rates, said Paul Moritz, head of commercial and industrial lines at UNIQA Group Austria, based in Vienna.

"Whenever a market becomes more major, like our Western markets, then pressure on premium rates, especially in property business, increases," he said.

In Slovakia, the corporate market is small, but there are between 10 to 15 insurers focused on the business, which has led to "very aggressive competition," said Milan Fleischhacker, a member of the management board at Generali Pojiš'ovna A.S. in Bratislava.

Lloyd's earnings soar on low cats

Despite a stellar 2006, chairman warns 2007 may not be as profitable

By LOUISE ESOLA

LONDON—The calm after the storm helped Lloyd's of London post a marketwide pretax profit of £3.66 billion ($7.16 billion) for 2006, the year after Lloyd's went into the red as a result of a string of hurricanes in the United States.

In 2005, the Lloyd's market reported a pretax loss of £103 million ($176.8 million), attributing the result to an active hurricane season in which it saw record claims totaling £3.31 billion ($5.68 billion).

But a year later, Lloyd's "benefited from strong underlying conditions and an exceptionally low level of catastrophes," said Lloyd's chairman, Lord Peter Levene, in a statement.

The Lloyd's market reported a 12.1% increase in net written premiums to £13.20 billion ($25.83 billion). Gross premiums written rose 9.6% to £16.41 billion ($32.11 billion).

In 2006, Lloyd's had a combined ratio of 83.1%, an improvement over the 111.8% reported in 2005.

Net assets for the Central Fund, which acts as a claims backstop for syndicates operating in the market, had net assets of £843.0 million ($1.65 billion) at year-end 2006, up 25.8% over the end of 2005.

Lord Levene warned that the favorable results may not continue throughout 2007.

"It would be unrealistic to expect such a favorable claims experience this year. With a trend for more frequent and severe natural catastrophes, we must continue to underwrite for profit," he said in the statement.

Meanwhile, Equitas Ltd.—the runoff reinsurer for Lloyd's syndicates' pre-1993 long-tail liabilities—has completed the first phase of a deal with Berkshire Hathaway Inc. that could provide it with $7 billion in reinsurance cover and ultimately end the liabilities of Lloyd's names reinsured into the vehicle.

Under the deal, which was announced last October, Berkshire unit National Indemnity Co. has reinsured Equitas' liabilities and has provided an additional $5.7 billion in cover to Equitas. In return, National Indemnity will receive Equitas' assets—totaling £4.90 billion ($8.49 billion) as of March 31, 2006—as well as a premium from Equitas and a contribution from Lloyd's.

National Indemnity also has acquired Equitas Management Services Ltd., which will continue to manage the runoff of Lloyd's pre-1993 business.

In a statement, Equitas said that the deal had received all necessary approvals. The transaction had been approved by the U.K. Financial Services Authority, and the New York Insurance Department had approved amendments to the Equitas American Trust Fund that were required.

Equitas will continue to exist and now will work toward a transfer of all liabilities of names into Equitas or a special-purpose vehicle, the company said in a statement.

Subject to High Court approval, once the transfer of liability from Lloyd's names to a limited liability company is complete, Equitas has the option to purchase a further $1.3 billion of reinsurance cover from National Indemnity.

Under the terms of the deal, the Berkshire Hathaway subsidiary has the option to acquire the company once the transfer of liabilities is completed.

Following the Equitas announcement, Fitch Ratings upgraded its financial strength rating on the Lloyd's market by one notch, to A+.

Stuart Collins contributed to this report.

AIRMIC to rank insurers on claims

By SARAH VEYSEY

LONDON—The United Kingdom's risk management association is looking at ways to develop a model to measure insurers' willingness to pay claims.

Paul Hopkin, technical director at the London-based Assn. of Insurance & Risk Managers, said the buyer body was interested in developing a sophisticated model to give insurance buyers objective data about insurers' willingness to pay.

When risk managers are judging the performance of their insurers, or looking to change insurers, price is an easy way to benchmark, said Mr. Hopkin.

And credit ratings can give an idea of insurers' ability to pay claims, he said.

But a way of judging willingness to pay would be "a helpful extra component" for risk managers when assessing their insurers, he said.

Mr. Hopkin said that, to his knowledge, no objective model for measuring willingness to pay exists.

He said that while AIRMIC members sometimes get superb service when they make claims, this is "by no means the norm."

Buyers want their insurers to be fair and transparent, Mr. Hopkin said.

There are ways in which insurers' willingness to pay claims promptly can be judged, he said, such as how often they appoint loss adjusters and whether they have key performance indicators on responding swiftly to correspondence, among other things, Mr. Hopkin said.

For some lines of coverage—business interruption, for example—claims are not always paid in full, said Mr. Hopkin.

AIRMIC plans to conduct a pilot study into willingness to pay business interruption claims with its partners and loss adjusters, he said.

AIRMIC's partners, which include insurers and brokers, provide the association with funds to undertake training and education, among other things.

Business Insurance
PERSPECTIVE

Business interruption case highlights need for clarity

By Jess B. Millikan
and Stacey E. DiCicco

Jess B. Millikan is a shareholder at law firm Bullivant Houser Bailey P.C. and chairs the firm's insurance coverage department. Stacey E. DiCicco is an associate at Bullivant. Both are based in the firm's San Francisco office.

A recent pair of decisions by the 8th U.S. Circuit Court of Appeals provides a unique view of opposing lines of reasoning with regard to what constitutes "direct physical loss" for purposes of business interruption insurance.

In *Source Food Technology Inc. vs. United States Fidelity & Guaranty Co.*, the 8th Circuit initially held, under Minnesota law, that a direct physical loss had occurred but later filed a superseding opinion finding no evidence of a direct loss. The result of these two decisions appears to confirm that actual physical contamination is required to establish a direct physical loss for purposes of business interruption insurance.

The crux of the issue in *Source Food* was whether an embargo that prevented shipment of uncontaminated beef products could constitute a "direct physical loss" under the policyholder's business interruption insurance.

In early 2003, the U.S. Department of Agriculture closed the Canadian border to imports of Canadian beef and beef products due to a mad cow disease outbreak. At the time of the embargo, Source Food's Canadian supplier had shipped a truckload of beef that was lost when the truck could not cross the border. Since the Canadian supplier was its sole supplier, Source Food shut down its business while it secured an alternate supplier.

It submitted a claim for business interruption benefits to its insurer USF&G. Both sides agreed that the beef product in the truck was uncontaminated and USF&G denied the claim based on the lack of a "direct physical loss." The trial court granted USF&G's summary judgment motion, finding that an embargo of an uncontaminated product was not a loss covered under business interruption insurance. Source Food appealed.

The original appeals court opinion, written by Judge Gerald W. Heaney, reversed the district court and held that direct physical loss can exist without structural damage to property. Judge Heaney relied heavily on *General Mills Inc. vs. Gold Metal Insurance Co.* and *Sentinel Management Co. vs. New Hampshire Insurance Co.*, interpreting them to equate physical damage with "functional impairment" and finding "direct physical loss" despite the lack of tangible injury or destruction.

In the *General Mills* case, the policyholder recovered the cost of lost oats because the oats, which the parties conceded were safe for human consumption but sprayed with an unapproved pesticide, were barred from sale by the U.S. Food & Drug Administration. In *Sentinel*, the owner of an apartment building recovered the cost of asbestos abatement.

Judge Heaney reasoned that Source Food suffered a physical loss of the beef on the truck stuck in Canada—a loss sufficient to trigger business interruption coverage for all losses caused by the embargo.

On rehearing and after Judge Heaney's retirement, Judge Raymond W. Gruender wrote a superseding opinion, holding that Source Food had not suffered a direct physical loss. He found that in *General Mills* and *Sentinel*, both turned on actual physical contamination of the property: in *General Mills*, the treatment of oats with pesticides; in *Sentinel*, the presence of asbestos in the apartment building. Accordingly, Judge Gruender held that functional impairment—absent physical contamination—is not sufficient to create a direct physical loss.

Does this rule apply to less tangible property such as computer software?

Two opinions addressing this issue, *American Guarantee & Liability Insurance Co. vs. Ingram Micro Inc.* and *Southeast Mental Health Center vs. Pacific Insurance Co. Ltd.*, both held that lost programming configurations or data corruption constituted direct physical loss because "physical damage is not restricted to the physical destruction or harm of computer circuitry but includes loss of access, loss of use, and loss of functionality."

However, this rule is not necessarily different from that of *Source Food*. Loss of functionality in the computer cases resulted from power outages that left the computers with different data and programming information than before the outage. In essence, the software sustained a technological form of physical damage.

Taken as a whole, *Source Food* and its predecessors articulate a rule that mere functional impairment is not enough; there must be physical damage or contamination to establish a direct physical loss under business interruption insurance. At the time of writing this article, a petition for rehearing by Source Food is pending with the 8th Circuit Court of Appeals.

Regardless of its eventual outcome, though, the lesson of these cases is the same one we've heard so often before: Pay attention to the language of the policy. A small effort "upfront" to make sure that both parties understand the risks that are intended to be covered and that the policy accurately reflects them, will be rewarded later, when losses happen.

Procedures faulted at Ohio comp bureau

Revisions proposed to prevent corruption cited in report

By JOANNE WOJCIK

COLUMBUS, Ohio—Inadequate policies and procedures within the Ohio Bureau of Workers Compensation and Industrial Commission allowed illegal and inappropriate activity to occur, according to a 2005-2006 audit report released last week.

Meanwhile, the state auditor is still investigating whether some employers' workers comp insurance rates may have been improperly lowered through the use of so-called manual overrides, in which officials deliberately changed rates that were set by formula.

The audit highlights four key findings: improperly monitored investments; deficiencies and an overall lack of control in the rate-setting process; poor internal communication; and abuse of power by a senior manager.

In particular, the audit states that former Chief Financial Officer Terrance Gasper accepted cash and other benefits from financial managers seeking to do business with Ohio's monopolistic workers compensation fund, which provides coverage to 280,000 employers in the state representing about two-thirds of the state's workers. Self-insured plans cover the rest of Ohio's workers.

Mr. Gasper, former BWC chief financial officer, pleaded guilty on June 7, 2006, to state and federal charges involving accepting bribes in return for bureau business. Mr. Gasper, who left the BWC in October 2004, is scheduled to appear in Franklin Common Pleas Court for sentencing on April 26.

The audit report also recommends specific actions the BWC can take to ensure that proper safeguards are in place to prevent a recurrence of illegal and/or inappropriate activity in the future.

"This is an important step toward restoring public trust and accountability within the Ohio Bureau of Workers Compensation," State Auditor Mary Taylor said in a statement. "The audit clearly reflects weaknesses in the system that escalated into major problems allowing for fraud, theft and corruption to occur."

The BWC responded positively to the audit report's findings.

"We're obviously pleased that the audit is complete, and BWC is going to continue to scrutinize and improve upon the internal controls that we have in place and will put in place going forward," a spokesman for BWC said. "The auditor did address many of the changes we've made thus far, but certainly we recognize that we have additional steps that we need to take to make sure we are properly serving the employers and employees of Ohio."

AUDIT RECOMMENDATIONS

- Monitor investments with external investment managers on a regular basis to ensure that all transactions are appropriate.
- Implement an effective communications system to ensure that pertinent information is being shared properly so complete and accurate financial reporting can be accomplished.
- Promote ethical behavior among all employees, especially senior managers.
- Initiate a thorough review of record retention requirements and implement a policy that ensures that the organization is properly following the record retention. schedule as set forth by Ohio law.

Source: Ohio Auditor General's office

SCIF: Calif. orders audit

CONTINUED FROM PAGE 4

lowing issues:

- SCIF must transfer internal audit oversight to the board or an independent audit committee.
- Establish an audit committee comprised exclusively of board members to maintain oversight and communication with internal and external audit functions to ensure the integrity of SCIF's financial statements, internal controls, compliance with legal and regulatory requirements, as well as the findings of internal and external audits.

Immediately establish a chief financial officer position and a chief investment officer position, neither of which currently exists.

Limit the general counsel's responsibilities to legal services to maintain objectivity and avoid potential conflicts of interest.

Immediately dismiss or place on administrative leave all members of SCIF's management who knew of, or who by virtue of their positions should have known of, improper payments made by SCIF.

Adopt a clear code of ethics for board members and management staff to avoid the types of conflicts of interest that have occurred at SCIF in recent years.

Through a spokesman, Ms. Cain described Mr. Poizner's requests as "very reasonable."

"In fact, many of his suggestions are things we are already working to implement. We look forward to working cooperatively with his office," she said.

Managed care: Health care cost increases expected to remain stable

CONTINUED FROM PAGE 4

ums stable, it's difficult to say that any company is truly managing health care costs, given that they continue to rise at an unsustainable rate, analysts say.

Health care costs "simply cannot continue to grow," said Bradley Ellis, director at Fitch Ratings in Chicago.

Although there will be further efforts to contain costs via initiatives such as benefit buydowns, analysts say they anticipate cost trends will increase slightly in 2007, likely by fractions of a percentage point. "I think to some extent things are going to be fairly stable," Ms. Rosen said. "I think it might uptick slightly, but it's not going to be huge."

Federal and state efforts to manage rising health care costs and provide coverage for uninsured citizens will be the key factor to monitor this year for the managed care companies, particularly those that are dependent on government-funded business, such as Humana. Enrollment in the insurer's Medicare Advantage programs grew about 80% last year to just over 1 million lives and premium revenues increased 89% to $2.3 billion.

"A.M. Best is always cautious on any company that is reliant on government funding, whether it's Medicare or Medicaid," Ms. Rosen said.

Congress is analyzing the level of Medicare reimbursements, which could be problematic for insurers as federal officials have reduced reimbursements in the past, analysts say. "You really don't know when they're going to pull out the rug from under you," Mr. Zaharuk said.

Humana officials acknowledge the problems in traditional Medicare, with President and CEO Mike McCallister referring to the Medicare benefit as an "out of control entitlement program driven by rising cost and the power of demographics."

Mr. McCallister, though, said he does not accept the concept that Humana is being overpaid for its Medicare services. "It's a politically charged term," he said during the company's fourth-quarter earnings conference call.

State mandates for health insurance coverage, meanwhile, likely will result in a shift in growth in the commercial market from large and midsize employer-sponsored plans to the individual/small group market, Mr. Zaharuk said.

After a relatively slow year for mergers and acquisitions in the health care sector in 2006, the first notable deal in 2007 was announced earlier this month by UnitedHealth Group Inc. The Minnetonka, Minn.-based insurer's proposed acquisition of Las Vegas-based Sierra Health Services Inc. has been met with vocal opposition by consumer and provider groups (*BI*, March 19).

The acquisition, though, does not signal a trend of major M&A activity as fundamental factors likely will limit large deals in the in the health insurance market, analysts say. For example, the largest insurers—UnitedHealth and WellPoint—now have limited properties they can acquire due to their dominant market positions.

In addition, the profitability of the managed care companies works against M&A activity, Ms. Rosen said. "As plans have become financially sound, they've all become higher priced," she said.

Reinsurers: This year's profits unlikely to match stellar results of 2006

CONTINUED FROM PAGE 6

deploy," and the increased capital means more competition, said Mr. Klauber. "Rates are coming down in just about every line of business, so it's hard to put up the type of returns you did last year," he said.

"Having said that, we're still a long way off from periods in the late '90s or even early 2000s" when the underwriting cycle was at its depth. "That means returns will probably stay in the high 16% to 18% range, give or take a catastrophe here or there," Mr. Klauber said.

"The reserve positions are solid," Mr. Gallant said. "I think underwriting cash flow is good (and) investment yields are stable. The question mark is the weather."

"The absence or pickup of natural cat activity is going to set the tone for results this year," said Mr. Gwynn. "I think even if we had very light cat activity again this year, the reinsurers would have a difficult time matching last year's results, if for no other reason than the increased price softening."

How companies manage this declining rate environment is "going to be a key factor," said Mark Rouck, senior director with Fitch Ratings Ltd. in Chicago. "Companies are doing a better job managing their aggregates than they had historically" and the modeling sophistication is greater.

Another factor to be taken into consideration is Florida. "The state is now providing the bulk of the reinsurance in Florida," said Ms. Coogan-Pushner. "That is basically going to reduce reinsurers' premiums significantly," she said.

"There's a question in terms of what (the legislation) will do to the property market in Florida, and more broadly in the U.S, and whether or not that may impact pricing outside of Florida in casualty and other areas outside of property," said Damien Magarelli, a director with rating agency Standard & Poor's Corp. in New York.

Meanwhile, prices are softening, say observers.

"The January renewal cycle definitely showed signs of softening across most major lines of business," except for U.S. catastrophe-prone coastal areas, said John L. Ward, chief executive officer of Cincinnati-based Cincinnatus Partners L.L.C., an advisory firm specializing in the insurance industry.

But, he added, there are "not nearly the indications of softness that we're seeing in the primary market, so there'll be a bit of a disconnect between the reinsurance market and the primary market in the U.S., with the net pricing pressure on the primary carriers," he said.

"I think as we go through the year, looking at July renewals, we'll see more pressure" on rates, said Mr. Gallant. "Jan. 1 prices are down 5% on average. You had prices down 10% or so in casualty lines, but up modestly in the property area."

"But as we move towards midyear, I expect downward pressure across the board, so we could see sort of average prices down 5% to 10% by July 1," Mr. Gallant said.

In another indication of a softening market, John Laubach, a senior financial analyst with Oldwick, N.J.-based A.M. Best Co. Inc., said there has been some weakening in treaty terms and conditions, although "most of them are minor to moderate at this point."

2006 RESULTS FOR U.S. REINSURERS

Ranked by net reinsurance premiums written. All amounts in thousands of dollars.

Reinsurer	Net reinsurance premiums written 2006	Net reinsurance premiums written 2005[11]	Policyholder surplus	Net income (loss) 2006	Loss & loss adjustment expenses 2006	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 2006	Combined ratio 2005
National Indemnity Co.[1]	$4,140,362	$3,147,413	$35,562,569	$6,671,176	$1,743,904	47.8%	$498,340	12.0%	59.8%	113.0%
Transatlantic/Putnam Reinsurance Co.	3,310,911	3,089,634	3,059,483	408,609	2,205,159	67.9	921342	27.8	95.7	112.9
Swiss Reinsurance America Corp.[2]	3,093,882	4,457,170	7,468,135	(725,672)	3,348,148	90.8	1,274,755	41.2	132.0	115.2
Munich Re America Corp.[3]	2,560,729	1,253,205	3,851,060	617,498	1,777,570	69.3	647,847	25.3	94.6	214.7
Everest Reinsurance Co.	2,187,128	2,289,178	2,704,121	298,746	1,504,294	70.2	549,762	25.1	95.3	117.4
Odyssey America Re./Odyssey Reinsurance[4]	1,980,522	2,098,116	2,501,582	608,031	1,391,788	68.6	541,593	27.3	96.0	120.1
Berkley Insurance Co.	1,800,712	1,739,247	2,178,722	442,620	1,188,984	68.3	451,942	25.1	93.4	97.5
General Re Group[5]	1,730,657	1,987,961	8,710,414	708,765	775,589	43.1	896,564	51.8	94.9	117.6
PartnerRe U.S.[6]	717,325	677,737	652,541	66,581	534,666	74.2	229,513	32.0	106.2	120.4
Folksamerica Reinsurance Co.	715,638	737,764	1,153,276	46,856	523,728	74.6	215,415	30.1	104.7	129.7
XL Reinsurance America[7]	549,239	515,417	2,133,606	172,486	375,163	69.3	69,811	12.7	92.8	101.1
Praetorian Insurance Co.	511,509	511,509	398,715	51,622	290,531	61.0	77,916	15.2	82.0	105.2
Axis Reinsurance Co.[8]	508,218	573,627	550,893	38,624	291,323	68.9	121,416	23.9	76.2	88.4
QBE Reinsurance Corp.	468,754	427,462	545,583	44,682	263,846	99.4	159,383	34.0	93.5	95.0
American Agricultural Insurance Co.	428,812	441,587	484,515	24,392	376,500	85.2	77,649	18.1	91.0	138.5
Endurance Reinsurance Corp. of America	322,409	271,629	571,353	63,407	168,253	59.5	129,057	40.0	93.5	96.4
Platinum Underwriters Reinsurance Inc.	307,276	601,760	530,822	117,980	135,880	35.8	135,777	44.2	101.3	115.7
The Toa Reinsurance Co. of America	283,858	275,359	404,599	39,661	213,010	75.2	74,095	26.1	80.0	114.1
SCOR US Group/SCOR Reinsurance[9]	91,524	123,092	464,616	7,942	106,646	99.4	31,077	34.0	133.4	174.0
EMC Reinsurance Co.[10]	66,268	92,588	96,628	14,571	50,174	68.6	15,886	24.0	92.6	91.1
Total for Top 20	**$25,775,733**	**$25,311,455**	**$74,023,233**	**$9,718,577**	**$17,265,156**	**67.0%**	**$7,119,140**	**27.6%**	**94.6%**	**118.6%**
Totals for all companies	**$25,834,026**	**$25,330,697**	**$74,538,706**	**$9,679,883**	**$17,339,873**	**67.1%**	**$7,186,912**	**27.8%**	**94.9%**	**129.4%**

1. Underwriting results exclude assumptions from affiliated General Re Group. 2. Represents only part of Swiss Re Group's business, including the GE Insurance Solutions business acquired from General Electric Co. in June 2006, and includes a number of impacts, including cessions to the parent as well as cessions to former GEIS entities that were retained by GE. 3. Includes the combined results of Munich Reinsurance America Inc., American Alternative Insurance Corp., and The Princeton Excess & Surplus Lines Insurance Co. 4. Includes combined results of Odyssey America Re Corp., Clearwater Insurance Co., Hudson Insurance Co., Hudson Specialty Insurance Co. and Clearwater Select Insurance Co. 5. All data presented for the North American property/casualty segment of the General Re Group. Underwriting results exclude certain intercompany transactions and other adjustments. 6. Includes the combined results of Partner Reinsurance Co. of the U.S. and its subsidiary PartnerRe Insurance Co. of New York. 7. XL Reinsurance America's net underwriting results consist of its net pooled share of the combined underwriting results of the XL America Group Pool. All pool members are wholly-owned subsidiaries of XL Reinsurance America. 8. Excludes reinsurance business of Axis Capital Holdings Ltd. written in Bermuda. 9. SCOR US Group includes the following companies: SCOR Reinsurance Co. and General Security Indemnity Co. of Arizona. 10. All reinsurance is issued in the name of Employers Mutual Casualty Co. 11. Total net premiums written shown for December 2005 are those reported in the December 2005 Reinsurance Underwriting Report.

Source: Reinsurance Assn. of America

Design: Employers focus on most effective treatments to shape cover

CONTINUED FROM PAGE 1

are the ultimate decision makers regarding what their health plans cover, until recently most have relied on benefit consultants and third-party administrators to help them decide the content of their benefit plans, said Bruce Kelley, leader of health data solutions at Watson Wyatt Worldwide in Minneapolis.

But as health care costs continue to escalate, employers are becoming more involved in setting coverage parameters. In such cases, they are looking to medical literature to help them decide what to cover and what to exclude, industry experts say.

For example, after research determined that removing diseased portions of the lung in patients with advanced chronic obstructive pulmonary disease did not improve patients' quality of life, many employers began excluding such treatment from their benefit plans, Mr. Kelley said.

Conversely, some employers have begun covering bariatric surgery to treat obesity because "the evidence suggests that there is a group of individuals where bariatric surgery is a good alternative," said Ken Sperling, senior vp for national accounts at CIGNA Healthcare in Bloomfield, Conn.

Another way employers have begun applying evidence-based medicine in plan design is by generally substituting generics for prescription drugs, or lowering copayments for plan members using high-performance networks of providers who adhere to medical protocols and, therefore, produce the best outcomes, Mr. Sperling said.

A few employers recently took a further step by experimenting with what is called evidence-based plan design, which is defined as offering more generous benefits for prescription drugs and medical services that are supported through clinical evidence and lesser benefits for those drugs and services that are unproven and/or unsafe given a specific patient's needs.

Achieving the highest ROI

"Most employers have already cost-shifted as much as they can. So now they have to come up with creative solutions," said Dr. A. Mark Fendrick, a professor of internal medicine at the University of Michigan in Ann Arbor and director of the Center for Value-Based Insurance Design, which was formed in 2005 to support this concept. "To ultimately get to the highest ROI for health care dollars, we need to target our efforts on both patient and physician incentives in a specific, clinically nuanced way."

Although the initial intent of evidence-based design was to reduce barriers to care, "over time, "evidence-based plan design will evolve to start addressing wasteful unproven interventions," said Jennifer Boehm, a principal at Hewitt Associates Inc. in Atlanta. "The plan is to exclude services that are not medically necessary."

For example, in implanting stents, an evidence-based plan would limit coverage to only those patients who would gain the most benefit, such as those having heart attacks, Dr. Fendrick said.

Emerging medical information technology, such as electronic health records, will help facilitate evidence-based plan design, said Dr. Lonny Reisman, chief executive officer of New York-based ActiveHealth Management Inc., which has been working with Marriott International Inc. on designing its benefit plan.

"What we're asking the insurers and (pharmacy benefit managers) to do is administer the claims based on information that we provide, and compare each member's individual data against evidence-based literature," he explained.

Indeed, sophisticated information technology could tell a plan administrator that a patient who is prescribed a beta blocker for heart failure should have no copayment, but that another patient taking the same drug for performance anxiety should have a copay, Dr. Fendrick said.

Ultimately, evidence-based plan design will tailor coverage to an individual's specific health care needs, he said.

"We're on the verge of a very innovative and emerging era," said Ms. Boehm. "I really do think this is about having enough real-time data and clinical decision support to identify what's right for one patient but might not be right for another. Because we're individual biological beings, this is where we have to move to. It's going to be an evolution as with all things in this arena. But we're on our way."

NBGH health plan effort puts the focus on evidence

The National Business Group on Health, a Washington-based consortium of the nation's largest employers, has formed a committee to promote evidence-based benefit design, and Lincolnshire, Ill.-based benefit consultant Hewitt Associates Inc. has been working with Dr. A. Mark Fendrick and Michael Charnow, a professor of health care policy at Harvard University in Cambridge, Mass., to develop a model for employers seeking to implement evidence-based plan design (see related story).

A few NBGH-members, such as Marriott International Inc. in Bethesda, Md. and Pitney Bowes Corp. in Stamford, Conn., already have begun experimenting with the concept, which has reduced or eliminated copayments for drugs in certain therapeutic classes that have proven to be effective in treating conditions such as heart disease and diabetes.

Another member of the NBGH committee, Juno Beach, Fla.-based FPL Group Inc., is using evidence-based medicine to determine which preventive services to cover in its plan, according to Melissa Miller, director of employee benefits and services at FPL, which is the parent company of Florida Power & Light.

For example, FPL's plan offers incentives to ensure that women have baseline mammograms at age 35, or everyone at least 50 years old receives colonoscopies, and that children receive immunizations.

"We're aligning it with what the evidence is saying is the most appropriate level of care, or if you have a family history," Ms. Miller said.

Although FPL has yet to set limits on care for procedures that the medical literature has not shown to be helpful, "there are discussions about it," Ms. Miller said. "I don't think anyone at this point has been pushing that, although I think that over time, we might see it go that way. This is very early on."

—By Joanne Wojcik

Value-based plan model in the works

Hewitt Associates Inc. based in Lincolnshire, Ill., is working with researchers at the University of Michigan and Harvard University to develop a model that will help employers implement evidence-based benefit plan design.

The objective is "to take their academic and research orientation and marry that with our financial and actuarial acumen to come up with some plan design models that might be able to help organizations figure out cost impact" if they implement value-based plan design, said Jennifer Boehm, a principal at Hewitt in Atlanta.

She estimates that the group is about 90 days away from introducing a preliminary model.

"Over time, clients are going to push us to get more and more sophisticated and as these designs evolve to take into account medical services for conditions, it's only going to get more complicated and more sophisticated. But we're certainly going to give it a try with some of the basic designs that are out there today," Ms. Boehm said.

—By Joanne Wojcik

OIL: Energy mutual ups aggregate limits

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them retain those (members) in the Gulf...but most of the people that have been talking about leaving are those that don't have a substantial number of risks in the Gulf of Mexico," said an energy market source who did not wish to be named.

OIL's membership dropped to 74 shareholders following the departure of nine members that elected not to renew their policies last year (see box, page 3).

A spokeswoman at ex-member American Electric Power confirmed the Columbus, Ohio, company left the OIL structure in 2006, and its coverage was "replaced with purchases in the commercial market."

Another OIL member that left is Praxair Inc., a Danbury, Conn.-based, maker of specialty gases. "Praxair did leave that group in December, and since then we have replaced that capacity with traditional insurance," said a spokesman for Praxair.

Former member Duke Energy Corp. replaced its OIL coverage with a quota share arrangement with several other insurers led by AEGIS Insurance Services.

"We went that route because that coverage better fit our current lower risk business portfolio" said a spokesman for Charlotte, N.C.-based Duke. "Probably the major reason is the spin-off we did of Spectra Energy Corp. So we no longer have high-risk assets located in the Gulf," he said.

Of the nine shareholders that exited the OIL structure effective Jan. 1, those that also belonged to Oil Casualty Insurance Ltd.—Duke, Atmos Energy Corp., Koch Industries Inc. and NiSource Inc.—continue to be OCIL members.

Current OIL shareholders have until April 16 to give notice of withdrawal from the mutual, which would be effective May 31.

"I think it's too early to postulate about how many people will leave and how many will stay," OIL's Mr. Hutchings said.

In a December 2006 energy market review, Willis Group Holdings Ltd. said "Perhaps the most obvious and enduring benefit of OIL membership over the years has been the sense of community and the networking opportunities that membership undeniably provides, and it might be this very factor which prevented more of an exodus of OIL during 2006."

However, Willis said, "as the commercial market begins to soften, there is no doubt that other members will now also be considering their long-term position by the time of the next renewal season in June/July 2007."

Some companies may look to the London and Bermuda markets to replace the capacity obtained through OIL, but "it can be difficult to withstand the commercial market cycle," said Brian C. Schneider, an analyst with Chicago-based Fitch Ratings.

"In the long term, I think AEGIS will benefit the most" from OIL's loss of members, Mr. Schneider predicted.

OCIL membership holds steady despite lower limits and rating

HAMILTON, Bermuda—The excess liability insurance unit of the OIL Group of Cos.—Oil Casualty Insurance Ltd.—also held its annual general meeting of shareholders last month, during which it elected new directors and reviewed the operations of the company in 2006.

James F. Hughes III was elected chairman for OCIL and Mark Wilson was named vice chairman.

Senior Vp and Chief Operating Officer Jerry Rivers noted that despite its downgrade out of the A range last November by New York-based Standard & Poor's Corp.—along with a move by OCIL to drop its limits and increase attachment points—no shareholder members have submitted notification of their intent to leave the structure.

OCIL currently has 75 shareholders with $1.4 billion in assets.

Under a new underwriting strategy deployed to reduce financial statement volatility, policy limits will be reduced to a maximum of $100 million on all policies effective on or after June 1, Mr. Rivers said.

As of Nov. 30, 2006, average limits written by OCIL were $117 million, while in the prior-year period they were $121 million, according to a company statement.

Additionally, as of Jan. 1, the average attachment stood at $293 million, up from $273 million in 2006 and $247 million in 2005, the statement said.

—By Rupal Parekh

Parity: Rival measures may scupper coverage mandate

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"The Senate HELP bill is absolutely as far as we can go. Indeed, we have bent over backwards to go that far," said Neil Trautwein, vp and employee benefits policy counsel with the National Retail Federation in Washington.

"The House bill would set a terrible precedent by saying a plan has to cover any condition for which there is a name or a code. The employer loses control in deciding what services its plan will cover," said Paul Dennett, vp-health policy at the American Benefits Council in Washington.

No one knows whether either chamber would be prepared to compromise and accept the other branch's position on the issue. But all agree that compromise will be difficult.

"It is difficult to see how this issue will get resolved," Mr. Dennett said, adding, though, it is still very early in the legislative process.

"There are some very fundamental differences," said Katie Strong, director of congressional and public affairs for the U.S. Chamber of Commerce in Washington.

Complicating matters is that the House measure has massive support among House members—more than 260 representatives are co-sponsors—while the Senate bill also enjoys broad support in that chamber. Additionally, neither side has reached out to the other to work out this and other differences, lobbyists say.

Whichever approach prevails, most employers will have to expand their coverage of mental health disorders.

Both bills, for example, would require employers to provide the same financial cost-sharing requirements for mental health coverage as they do for other medical conditions. For example, if a group health care plan covered 80% of medical treatment expenses, it would have to do the same for mental health care expenses.

In addition, discriminatory treatment limitations would be banned. That would mean an end to common plan designs in which a maximum of 20 or 30 annual visits to mental health care therapists are covered, with no limits imposed on the number of visits to physicians treating other medical conditions.

Similarly, health care plans could not impose a limit on the number of inpatient days for treatment of mental disorders if they did not impose the same limit for other medical conditions.

That would be a big change from the 1996 law that bans discriminatory annual and lifetime dollar limits, which were common before Congress banned them, for coverage of mental health care expenses, but permits other discriminatory cost designs.

Forced by the 1996 law to do so, employers scrapped those dollar limits and imposed new limits, such as covering 50% of a claim for mental health care services but paying 80% of other medical claims' costs.

While parity advocates have been lobbying for years to expand the 1996 law, this year was viewed as a breakthrough year, with Sen. Kennedy defusing employer opposition by bringing employers into the negotiating process. At the same time, with the Democrats regaining control of the House, House Republican leaders who had blocked parity bills previously no longer are in a position to do so.

Some say eventually legislators—if a compromise between the two bills can't be reached—just might walk away from the issue. "When an issue comes up year after year, legislators get worn down" and get tired of it, said Mark Ugoretz, president of the ERISA Industry Committee in Washington.

Family entitled to comp benefits after worker killed while on leave

By DAVE LENCKUS

ATLANTA—The family of a worker who was killed in a traffic accident while on leave is entitled to workers compensation benefits under Georgia's "continuance employment" doctrine, a divided Georgia Supreme Court has ruled.

In the case, Ray Bell Construction Co. had provided Florida resident Howard King a vehicle and an apartment while he worked on a company project in Jackson, Ga.

While on leave to attend to personal business in August 2002, Mr. King traveled to Tennessee and back to Georgia, where he used his company truck to haul personal belongings to a storage facility. On his way back from the storage unit to either his apartment or work site, Mr. King was killed in a traffic accident.

Mr. King's ex-wife sought dependency benefits for the Kings' son. But Ray Bell and its workers comp insurer, St. Paul Fire & Marine Insurance Co., denied the claim, arguing that Mr. King's death did not arise out of and in the course of his continuous employment.

In its ruling last Monday in *Ray Bell Construction Co. et al. vs. King*, the Georgia Supreme Court decided in a 4-3 opinion to uphold decisions of two lower courts to award the benefits to Ms. King.

The court's majority determined that Mr. King was killed after he had completed his personal business and had returned to his continuous employment duties as a traveling employee. Mr. King was in continuous employment with Ray Bell when he was within the general proximity of his worksite or his company-provided housing, the majority ruled.

But the dissenting justices argued that Mr. King was off duty and still on leave when he was killed. Under those circumstances, his injuries "did not arise in the course of or out of his employment as a matter of law," the dissenting justices stated in their opinion.

Liberty: Bid-rigging charges will proceed

CONTINUED FROM PAGE 1

proceed against nine of Liberty Mutual's subsidiaries (see box). However, the holding company for Liberty Mutual was dismissed from the amended complaint on grounds of personal jurisdiction.

Liberty Mutual sought dismissal of the various charges for several reasons, including that agents and brokers do not owe a fiduciary duty to their clients and that, even if they did, Liberty Mutual did not induce any breach of such duties; and that the officials' complaint does not plead the fraud claims "with sufficient particularity," the judge's ruling states.

Judge Fried rejected those arguments, though, and gave Liberty Mutual 20 days to respond to the court order.

Reacting to the ruling, Liberty Mutual said it is both pleased and disappointed with the court's decision.

"We are pleased that Liberty Mutual Holding Co. was dismissed from the matter. We are disappointed that the court did not accept our substantive arguments. We continue to believe that the matter needs to be resolved through the judicial process. This is this first step in that process and we fully expect that we will prevail eventually," the company said in a statement.

Calls to New York Attorney General Andrew Cuomo's office were not returned, nor were calls to the offices of Illinois Attorney General Lisa Madigan and Connecticut Attorney General Richard Blumenthal, who brought similar allegations last year in lawsuits against Liberty Mutual.

SUBSIDIARIES STILL IN SUIT

Under last week's ruling, Boston-based Liberty Mutual Holding Co. Inc. has been dismissed from a bid-rigging suit brought by the New York attorney general's office against Liberty Mutual. The following subsidiaries will continue to face charges in court:

Liberty Mutual Insurance Co.

Liberty Mutual Fire Insurance Co.

First Liberty Insurance Co.

Liberty Insurance Co.

Liberty Marine Underwriters Inc.

Employers Insurance Co. of Wausau

Wausau Business Insurance Co.

Wausau General Insurance Co.

Wausau Underwriters Insurance Co.

Source: Court documents

Numerous insurers, including American International Group Inc., Zurich Financial Services Group and ACE Ltd., have settled charges over their alleged involvement in a bid-rigging scheme with Marsh.

Liberty Mutual is the only insurer that vowed to fight the charges, saying that its business practices have been lawful and calling officials' settlement demands "excessive and unreasonable" (*BI*, May 8, 2006).

Only one other industry company—broker Acordia Inc.—has said it was unwilling to settle such charges; late last year the broker and its parent, Wells Fargo Bank N.A., declared that they would vigorously fight claims by three states that it accepted nearly $200 million in undisclosed commissions from insurers (*BI*, Dec. 25, 2006).

One attorney said the dismissal of the Liberty Mutual holding company should not significantly alter the case.

"I think what the decision reflects is that there was no allegation of the holding company's active participation in the alleged scheme that would have an impact in New York justifying the exercise of personal jurisdiction over it," said David E. Wood, principal at Wood & Bender L.L.P. in Ventura, Calif., which represents corporate policyholders in disputes with insurers.

"If the end game is to get a large monetary settlement and an injunction against certain practices, then you want to make sure that the target of those goals has plenty of money and is the company actually doing the alleged wrongful acts in the marketplace, in the trenches," Mr. Bender said.

"If that's the case, then (Liberty Mutual's) subsidiaries would appear to satisfy both of those concerns," he said.

News In Brief

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Flagstone shares sold for $13.50 each. Shares closed Friday at $13.48.

AXIS to acquire Media/Professional

AX S Capital Holdings Ltd. has agreed to purchase Media/Professional Insurance, with plans to grow the managing general underwriter. Under the deal, Bermuda-based AXIS will acquire the assets and operations of Kansas City, Mo.-based Media/Professional from its parent, Aon Underwriting Mangers, a division of Chicago-based broker Aon Corp. The transaction, terms of which were not disclosed, is expected to close during the second quarter of 2007.

PBGC takes over plan at auto parts maker

The Pension Benefit Guaranty Corp. is taking over a pension plan sponsored by bankrupt auto parts manufacturer Collins & Aikman Corp. The Collins & Aikman plan, which has about 21,000 participants, is 58% funded, with $434 million in liabilities and $253 million in assets. The PBGC expects to be liable for about $161 million of the $181 million funding shortfall.

GAO urges better OSHA disaster planning

Better planning would help the Occupational Safety and Health Administration protect workers responding to disasters such as 2005's Hurricane Katrina, according to a report issued last week by the Government Accountability Office. The report recommended that the departments of Labor and Homeland Security should direct the heads of both OSHA and the Federal Emergency Management Agency to work together to accomplish such goals as deciding the types and magnitude of disasters in which OSHA will be involved.

Bell Canada to phase out retiree benefits by 2018

Bell Canada Inc. will begin eliminating retiree health care, dental, vision and life insurance benefits for future retirees starting in 2012, the company said. The Montreal-based telecommunications giant said it would phase out these benefits over the next 10 years. Eligible employees retiring before Jan. 1, 2012, will continue to receive the benefits, while employees retiring between Jan. 1, 2012, and Jan. 1, 2017, will be entitled to company-paid medical coverage until they reach age 65. After Jan. 1, 2017, retiring employees will not be entitled to company-paid benefits but will have access to optional health plans.

Best reports drop in impaired insurers

Fifteen property/casualty insurers became financially impaired in 2006 despite the industry's record results last year, according to a study by Oldwick, N.J.-based A.M. Best Co. Inc. But the impairment rate of 1-in-233 companies was half the historical rate for the past 38 years, according to the report, "15 Property/casualty Insurers Identified as Impaired for 2006." Best designates an insurer as financially impaired as of the first official regulatory action taken by an insurance department, which can include supervision, rehabilitation or liquidation, among other actions. Severe hurricane losses in 2004 and 2005 were the leading cause of the impairments.

Aon launches global risk consulting unit

Aon Corp. has launched a risk consulting, captive management and risk engineering unit called Aon Global Risk Consulting. AGRC is a combination of Aon's former captive services group and the company's risk consulting and risk engineering operations. The change follows the January launch of Aon Global, which brought together several of Aon's global operations. Stephen Cross is chief executive officer of the unit and Philip Stamp is chairman.

Best downgrades P&I club to B++

A.M. Best Co. Inc. has downgraded its financial strength ratings of The Steamship Mutual Underwriting Assn. (Bermuda) Ltd. and London-based The Steamship Mutual Underwriting Assn. Ltd. to B++ from A-. The rating action against the Bermuda protection and indemnity club reflects "potential volatility" in its "risk-adjusted capitalization, the continuing challenge the club faces in underwriting profitability and its reliance on investment income," Oldwick, N.J.-based Best said in a statement.

OSHA: Federal regulations don't pre-empt state tort laws

CONTINUED FROM PAGE 3

laws guarantee, she said.

The 3rd Circuit case centers on the 2002 death of construction worker Charles Lindsey, who was crushed when a tractor he was operating rolled over at a job site in Franklin Township, N.J. The equipment, a sideboom pipe-laying tractor manufactured by Caterpillar Inc. of Peoria, Ill., did not have a rollover protection cage.

While OSH Act regulations mandate that manufacturers install rollover cages on some tractors, they do not require the cages on sideboom pipe-laying tractors.

Another tractor maker, though, had equipped its version of the tractors with the cages as a standard safety feature. In addition, an Occupational Safety and Health Administration representative wrote in his postaccident report to Mr. Lindsey's employer that the agency encouraged employers to use only tractors with cages.

Mr. Lindsey's widow, Rosario Lindsey, filed a product liability suit against Caterpillar in New Jersey state court, but the manufacturer argued that the OSH Act pre-empted such litigation.

In ruling for Caterpillar, a federal district court judge last year determined that Ms. Lindsey's state law claim conflicted with the federal safety standard on the tractor's rollover protection structure. As a result, the safety standard pre-empted the state product liability law claim, the court ruled.

To support its ruling, the district court cited a New Jersey Supreme Court decision reached earlier that year in another material-handling equipment case. In that case, the plaintiff sued a forklift manufacturer that produced equipment with warning devices that complied with OSHA regulations. The plaintiff, however, argued that an additional warning device would have prevented a workplace accident.

In ruling for the manufacturer, the New Jersey Supreme Court determined that the plaintiff's claim conflicted with federal safety regulations because the additional warning devices the plaintiff sought could make work sites more dangerous.

But the 3rd Circuit panel said the forklift case involved a limited number of warning devices allowed by OSH Act regulations. In contrast, the OSH Act tractor regulations are silent on rollover cages, the appellate panel noted. It also pointed out that the New Jersey Supreme Court described its forklift decision as having a "narrow" application.

The 3rd Circuit panel then turned to the "clearly articulated" state law savings clause in the OSH Act.

The OSH Act does not "enlarge or diminish or affect in any other manner the common law or statutory rights, duties, or liabilities of employers and employees under any law with respect to injuries, diseases, or death of employees arising out of, or in the course of, employment," the appellate court said. "State law claims that fall within the scope of this savings clause are not pre-empted."

In addition, "the regulatory language exempting sideboom pipe layers from the requirement for rollover protective structures cannot reach beyond the authority Congress granted. Therefore, the absence of a requirement for an employer does not implicate third-party duties for a manufacturer."

The decision is "an important opinion for manufacturers," said employer attorney Jonathan Wetchler, a partner with Wolf, Block, Schorr & Solis-Cohen in Philadelphia.

"It gives them an approach to analyze whether federal law provides them a safe harbor for how a product is manufactured," he said.

"It's a matter of whether OSH regulations support, contradict or don't speak at all to the issues in the state tort claim," Mr. Wetchler said.

Manufacturers also should determine whether OSHA has issued any guidance letters like the one it sent to the employer in the 3rd Circuit case, Ms. Pacaro said. Those letters could significantly help a plaintiff, she said.

Caterpillar's attorney did not return calls.

But Ms. Lindsey's attorney, Robert G. Bauer of Abraham, Bauer, & Spalding P.C. in Philadelphia, said the defense has indicated they may appeal.

Mr. Bauer called the 3rd Circuit's decision a "flabbergasting reversal of fortune." Given the number of differing rulings on the issue, Mr. Bauer said he is "not sitting here confident in the ultimate outcome" of the case.

Rosario Lindsey vs. Caterpillar Inc., 3rd U.S. Circuit Court of Appeals, March 26; No. 05-4406.

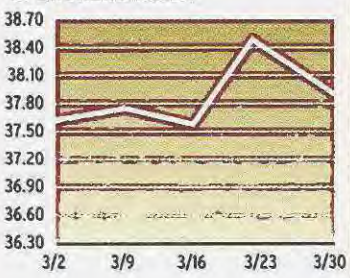
Stock Index

[3/26 -3/30]

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

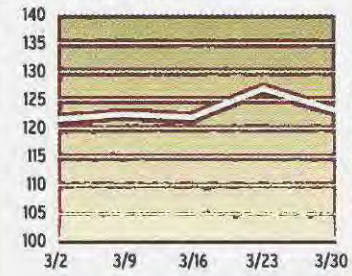
BI STOCK INDEX

BI BROKERS INDEX



BI INSURER/REINSURERS INDEX

BI MANAGED CARE ORGANIZATIONS INDEX



Percentage change of BI *Stock Index vs. key indicators*

BI STOCK INDEX	3217.59	-0.05%
DOW JONES	12354.35	-1.01%
S&P 500	1420.86	-1.06%

LARGEST GAINS

NYMAGIC Inc.	2.92%
Selective Insurance Group	2.62%
Axis Capital Holdings	1.71%
Endurance Specialty	1.68%
IPC Holdings Ltd.	1.66%

LARGEST LOSSES

UnitedHealth Group Inc.	-6.26%
UNICO American Corp.	-4.74%
Argonaut Group Inc.	-4.26%
Alleghany Corp.	-4.21%
CNA Surety Corp.	-4.13%

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

ADA suits not just business

A litigant who is in the business of suing businesses for not making their businesses disabled-friendly is not a business.

That March 23 ruling by the 9th U.S. Circuit Court of Appeals deals a blow to California businesses–especially restaurants–that have been looking for a way to stop paraplegic Jarek Molski from suing them under federal and state disability laws. Mr. Molski has sued hundreds of businesses for failing to comply with the statutes.

But California businesses and a federal court have characterized Mr. Molski as a "vexatious litigant" who exploits the disability acts for economic gain, because he does not first seek alternative dispute resolutions. Under the California statute, successful plaintiffs can recover damages.

In Mr. Molski's litigation against restaurant owner M.J. Cable Inc., a Cable executive admitted in a federal court trial that the restaurant's owners knew the Woodland Hills, Calif., eatery did not comply with the disability laws.

Still, the jury ruled against Mr. Molski, and the trial judge refused to grant him a new trial. The judge ruled that, because of his history of financial gain from numerous lawsuits, the jury considered Mr. Molski a business that is not entitled to the protection that the ADA affords individuals.

But in reversing the trial judge, the 9th Circuit ruled that "neither the district court nor the defendant provide any support for concluding that a person may be considered a business and not an individual because of a history of litigiousness."

In addition, the federal appeals court ruled that plaintiffs do not have to frequent a business to sue it for violating the ADA.

Business Insurance END PAGE

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Crash of rare Ferrari no joke for Griffin

Auto underwriters may be steering clear of policy submissions from actor-comedian Eddie Griffin.

Last week, Mr. Griffin crashed–and totaled–a rare Ferrari reportedly worth $1.5 million while taking laps at Irwindale Speedway in California.

The car–dubbed a "Ferrari Enzo" after the Italian carmaker's founder–is apparently one of only about 400 of its kind ever produced.

Worse yet: The Enzo reportedly belongs to Mr. Griffin's boss, Daniel Sadek, the executive producer of Mr. Griffin's next movie, "Redline."

Calls seeking information on the car's insurance coverage were not returned.

Mr. Griffin's film credits also include "Norbit" and "Undercover Brother."

ZUMA PRESS

Actor Eddie Griffin, above, just moments after escaping injury in the crash of a rare and pricey Ferrari owned by "Redline" director Daniel Sadek, right.

Bestseller's theory may be fact or fancy, but it's not plagiarism

Great minds may think alike, but that doesn't mean one of those minds possesses ownership of an idea.

Such was the opinion of a British court, which last week rejected a lawsuit by two authors against the publisher of best-selling novel "The Da Vinci Code." In their suit, the individuals contend that the novel's author, Dan Brown, plagiarized their 1982 nonfiction work "The Holy Blood and the Holy Grail" in crafting the plot of "The Da Vinci Code."

Both books suggest a conspiracy by Christian leaders to cover up that Jesus Christ married Mary Magdalene and they had a child, with that bloodline continuing to this day.

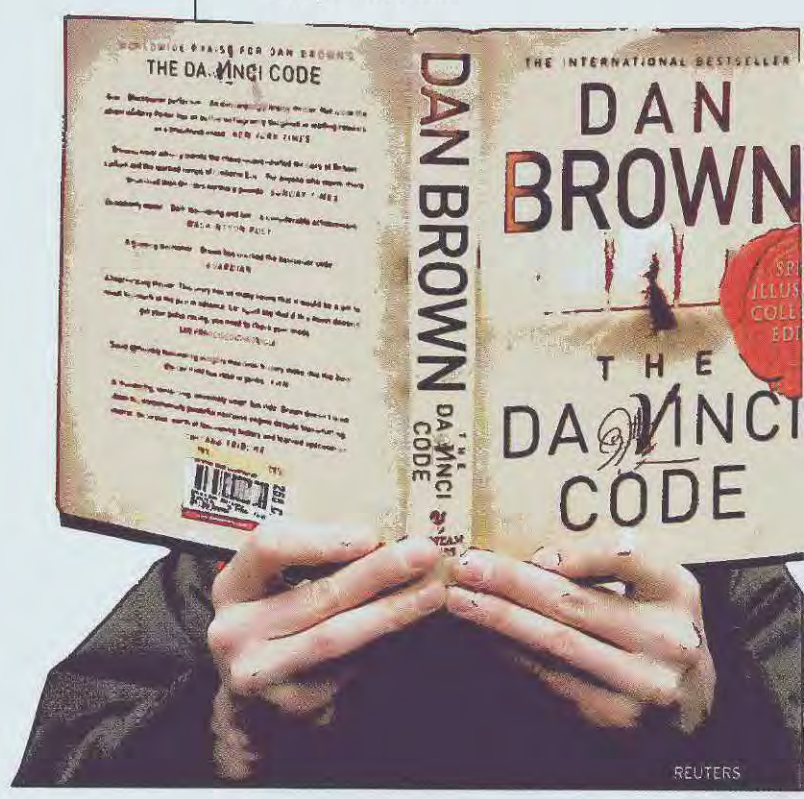
Britain's Court of Appeal in London said copyright law protects an author's labor in researching and writing a manuscript. However, the court said that does not include facts, theories and themes.

Mr. Brown's novel has sold more than 40 million copies since its March 2003 release and has been made into a feature film. He testified last year before a lower court even though he was not named in the suit brought by Michael Baigent and Richard Leigh against Random House Inc.

In April of 2006, Justice Peter Smith ruled that Random House had not breached the copyright. The judge said the claim was based on a "selective number of facts and ideas artificially taken out of the book for the purposes of this litigation."

In a twist that will delight fans of a novel so replete with codes and puzzles, the name of a key character, Sir Leigh Teabing, looks suspiciously like a deliberate anagram of Mr. Leigh's last name and a scrambled version of Mr. Baigent's surname.

The plot thickens.



REUTERS

A mystery most foul

Talk about environmental exposures–how do you deal with about 15 million gallons of partially treated sewage that's simply disappeared?

According to the Grand Rapids Press, that's just what happened recently in Kent County, Mich.

The sewage happened to be in a leaking storage lagoon. From there, it flowed into a sinkhole and then–well, nobody knows.

Fifteen million gallons of sewage–even partially treated sewage–would seem pretty difficult to lose. But so far, testing has provided no clue as to the sewage's whereabouts.

So, for the time being, the case of the missing sewage remains unsolved and the extent of the environmental impairment–if any–is still unknown. But perhaps it will just be a matter of following your nose until the mystery's solved.

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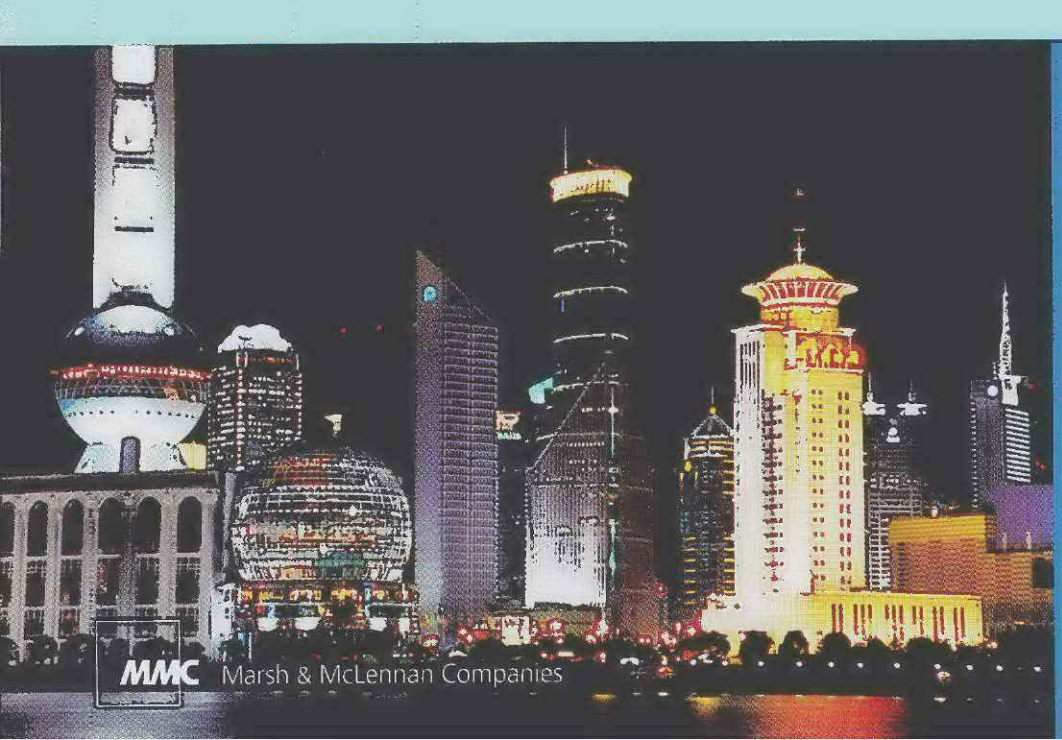

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