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INSURER FAILURES HIT 10-YEAR LOW IN 2007, S&P SAYS / PAGE 3

SUPREME COURT LIMITS COURT REVIEWS UNDER ARBITRATION LAW / PAGE 4

In Brief

Humana faces investor lawsuit

Humana Inc. faces a securities lawsuit for allegedly making false and misleading statements in its earnings reports related to its Medicare prescription drug plans. The Louisville, Ky.-based insurer misled the market by issuing false and misleading statements or concealing material facts about adverse trends in its pharmacy claims, according to the lawsuit, filed in the U.S. District Court for the Western District of Kentucky.

Medicare Rx subsidy deadline extended

The deadline for employers to complete the final reconciliation of their applications for the Medicare Retiree Drug Subsidy has been extended by three months, to June 30, for plan years ending in 2006. Employers

See **IN BRIEF** page 21

International NEWS

Publicly traded Canadian companies will face shareholder lawsuits unless they take steps to improve disclosure in financial statements of their risks and liabilities related to environmental issues; risk managers in Italy are concerned about growing employer liability exposures.

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AP PHOTOS

New York City and various contractors face thousands of lawsuits from individuals who claim they were sickened during the emergency response to the Sept. 11, 2001, terrorist attack and the subsequent cleanup effort.

WTC health suits can go forward

Appeals court rejects NYC's bid for immunity

By JOANNE WOJCIK

NEW YORK—Thousands of individuals who claim they were sickened during the World Trade Center attack and cleanup can pursue lawsuits against New York and the city's contractors, a federal appeals court ruled last week.

Plaintiffs in the litigation include construction workers, police officers and firefighters who say they suffer from respiratory problems stemming from their exposure to toxins at the site of the Sept. 11, 2001, terrorist attack.

The city and its contractors have argued that they are immune to the suits, but the 2nd U.S. Circuit Court of Appeals last week said the lawsuits will have to proceed in order for a district court to determine whether the city and its contractors have immunity under various state and federal laws designed to shield such entities in times of civil crisis.

New York and its contractors currently face more than 10,000 personal injury lawsuits that have been consolidated in U.S. District Court for the Southern District of New York in Manhattan.

Meanwhile, a captive insurer set up to respond to WTC-related injury claims has won a victory in its battle with insurers over paying to defend against the suits. The city thus far has spent $100 million in defense costs, attorneys say.

See **WTC** page 20

Retiree health care returning to work?

Legal decision, new designs help renew interest

By JERRY GEISEL

WASHINGTON—As a long-running legal controversy about the design of retiree health care plans has been resolved, the future of the plans may be brightening.

The final step came last week when the U.S. Supreme Court declined to intervene and let stand a federal appeals court ruling that upholds the right of the Equal Employment Opportunity Commission to implement a regulation that exempts retiree health care plans from age discrimination law.

That rule was triggered by an August 2000 appeals court decision that said the plans were subject to the Age Discrimination in Employment Act. Initially, a wave of anxiety ran through the employer community as nearly all corporate plans provide smaller benefits to older retirees, due to the availability of Medicare, than younger retired workers, exposing them to lawsuits had the ruling become national law (see story, page 19).

VIEW: The complete Erie County timeline at www.*BusinessInsurance.com*

Just as that controversy has a happy ending for employers, the future of retiree health care plans—once thought to be dying because of their escalating costs—may be improving.

After sharp declines throughout the 1990s, the percentage of large U.S. employers offering retiree

See **RETIREE** page 19

AIG says comp peers cheated on premiums

Charges other insurers underreported writings

By DAVE LENCKUS

CHICAGO—In the latest twist in a decades-long saga of workers compensation insurance irregularities, American International Group Inc. charges that others in the workers comp industry illegally reduced their losses and conspired to damage AIG in violation of federal racketeering laws.

Fighting a $1 billion racketeering lawsuit filed against the insurer last year, AIG contends in its March 17 counterclaim that the two dozen defendant insurers and a national workers comp organization routinely took illegal measures to misrepresent the insurers' workers comp premium volume from the mid-1980s through the mid-1990s.

AIG IN SHARE DISPUTE: Insurer charges that ex-chief Greenberg, other former execs violated fiduciary duty in control of AIG shares. Page 3.

The artificially lowered premium volume from workers comp risks covered in the voluntary market reduced the insurers' state-mandated participation in loss-plagued assigned-risk plans, AIG charges in its counterclaim, filed in federal district court in Chicago.

Indeed, the defendants engaged in the same kind of premium reporting chicanery that they have accused AIG of employing to underreport workers comp premiums, the insurer charges.

In its 112-page filing, AIG itemizes illegal measures that specific insurers allegedly used to reduce their reported premium volume. As evidence, AIG notes regula-

See **AIG** page 20

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P/C insurers post profits amid soft market

Underwriting results still respectable, but concerns emerge over future returns

By JUDY GREENWALD

Commercial property/casualty insurers continue to report favorable underwriting results despite the softening market, boosted by both the absence of major catastrophes and the impact of past rate hikes.

But next year could be a turning point amid softening rates, observers say.

The 13 major U.S. property/casualty insurers surveyed by *Business Insurance* reported $23.99 billion in 2007 net income, a 23.8% decline from 2006. Excluding New York-based American International Group Inc., which posted a 55.9% drop in net income to $6.2 billion, the insurers would have reported a 2% increase.

AIG's net income reflected an $11.47 billion pretax charge for a net unrealized market valuation loss related to AIG Financial Products Corp.'s super senior credit default swap portfolio (see story, page 19).

Among other survey results:

- Net premiums written for the 13 insurers increased 2.8% to $141.55 billion.
- Insurers reported a 90.8% combined ratio, a slight deterioration from 90.3% in 2006.
- Policyholder surplus increased 9.3% to $145.76 billion.

Large commercial insurers, including Travelers Cos. Inc., Hartford Financial Services Group Inc. and Chubb Corp., reported good underwriting results, said James B. Auden, senior director at Chicago-based Fitch Ratings. AIG was "more challenged" because of its subprime exposures and derivatives, "but their underwriting performance was pretty good," he said.

90.8%

COMBINED RATIO: P/C insurers saw a slight deterioration from 90.3% in 2006, but underwriting results generally remain good.

"It was still a very strong year, driven by very light catastrophe losses and continued benign claims inflation—and that's despite the increasing pressure on pricing," said Mark Lane, an analyst with William Blair & Co. in Chicago. "It looks like 2006 will end up being a record year for underwriting margins," with combined ratios deteriorating in 2007 due to pricing pressure. "And

See **RESULTS** page 18

FIVE LARGEST RECEIVERSHIPS IN 2007

Ranked by assets as of year-end 2006, in millions of dollars

Company	State	Type	Total assets
Northwestern National Ins. Co. of Milwaukee, Wis.	Wisconsin	P/C	$79.7
Universal Health Care Ins. Co. Inc.	Florida	Health	$78.0
Benicorp Ins. Co.	Indiana	Life	$45.3
Municipal Ins. Co. of America	Illinois	Life	$15.9
National Annuity Co.	Utah	Life	$11.9

Source: Standard & Poor's Corp.

Insurer insolvencies fall to lowest in 10 years

Solid profits, lack of catastrophes set the tone

By JEFF CASALE

The number of U.S. insurance companies placed under regulatory supervision continues to decline, hitting its lowest point in a decade in 2007, according to an article released last week by Standard & Poor's Corp.

New York-based S&P reported 10 insolvencies for 2007, down from 11 in 2006, 16 in 2005 and 19 in 2004. S&P said that "several sector-specific factors" contributed to the overall decline. The rating agency noted that the property/casualty sector decreased its number of insolvencies to four in 2007, down from eight in 2006. It is the lowest number for the sector in the past decade, S&P analysts said.

The low number can be attributed to a mild hurricane season and high profits for the U.S. P/C industry, analysts wrote, adding that S&P maintains its stable outlook for the sector in 2008. Better underwriting, an improved premium rate environment and a strong focus on improving enterprise risk management are key factors that S&P said contributed to the improved results.

S&P said, however, that it expects net written premiums to "decline modestly" in 2008. With "top-line growth now negative and loss costs and underwriting expenses expected to continue growing," underwriting income will decline, S&P said. Investment income can help offset the decline, but analysts expect insurers' combined ratio will increase "three to four" percentage points to 96% to 98% this year.

Meanwhile, the life and health insurance sectors saw increases in those companies placed on S&P's insolvencies list this past year. Three small life insurance companies were placed on the list, up from two in 2006. Three health insurance companies, including Universal Health Care Insurance Co. Inc., became insolvent, up from one in 2006.

S&P has a stable outlook on both the life and health sectors, but said that the life sector will continue to be affected by low interest rates, product and portfolio exposure to equity markets and modest demand.

The health sector's profitability could hinge on the results of this year's elections. Pending reforms could "significantly change their business models and profitability," analysts wrote.

AIG battling Greenberg over shares held by SICO

$20B of stock misappropriated, suit charges

By JEFF CASALE

NEW YORK—American International Group Inc. has fired another salvo in the three-year legal battle with former Chairman and Chief Executive Officer Maurice R. Greenberg, accusing him and six other former company officials of misappropriating $20 billion in company stock.

New York-based AIG filed the suit last week in the New York Supreme Court in Manhattan claiming that Mr. Greenberg and officials at Starr International Co.—Howard Smith, Edward Matthews, Ernest Stempel, L. Michael Murphy, John Roberts and Houghton Freeman—breached their fiduciary duty by seizing the block of AIG stock in 2005 that was meant to protect the insurer from "hostile takeovers" and provide incentive compensation to employees.

A Starr International spokesman dismissed the legal action as an attempt to divert attention from current AIG operations.

AIG alleges in its complaint that when the seven "seized control of SICO," a private firm formerly affiliated with AIG, they went back on "decades-old obligations" as fiduciaries of AIG, and that the stock was "converted into a private investment vehicle for the benefits of Greenberg and the other defendants."

"This new action is a protective measure to preserve our free-standing claims against these individuals," a spokesman for AIG said. "We had to file (the suit) to protect the stock for the purpose that it was intended for."

The spokesman added that the defendants refused to sign an agreement that would have "stopped the clock" on a three-year statute of limitations for claims of breach of fiduciary duty.

The suit contends that Mr. Greenberg and Mr. Smith, AIG's former chief financial officer, "breached their fiduciary duties to AIG" in the time between losing their executive positions in 2005 and leaving the insurer's board of directors. During that time, the complaint states that Mr. Greenberg overthrew SICO's board, removing nine AIG directors. The suit alleges that the six other defendants consented to the move.

AIG's suit does not specify any damages.

This latest filing is in addition to a still-pending suit that AIG filed in federal court in September 2005, in which the insurer sued Mr. Greenberg for control of roughly 12% of outstanding AIG common stock that SICO owns. That was a counterclaim to a suit that SICO brought against AIG in July 2005, which claimed the insurer had property that belonged to SICO, including a $15 million art collection.

Mr. Greenberg resigned from AIG in March 2005 amid federal and state investigations of the insurer's accounting practices.

Reacting to the latest suit, a spokesman for Starr International said in a statement: "AIG's new lawsuit merely repeats the same claims that it has been asserting in federal court for three years. Having apparently concluded that the federal case is not going well, AIG is now trying an end run around its own federal lawsuit. This transparent attempt by AIG to distract attention from the mismanagement and breach of fiduciary duties of its current executives and board—misconduct that has cost AIG shareholders more than $60 billion this year alone."

As of March 18, SICO directly held 228.5 million shares of AIG. Based on last Friday's closing price of $42.80, the stake is worth $9.78 billion.

House measure seeks benefits parity for prosthetic care

Federal push comes after several states enact mandate

By COLLEEN McCARTHY

WASHINGTON—Legislation that would require group health plans to cover prosthetic care at the same level as other medical and surgical care has been introduced in Congress, but its prospect of passage is unclear, experts say.

Under the Prosthetic Parity Act introduced in the House of Representatives earlier this month by Rep. Robert Andrews, D-N.J., with bipartisan support, group health plans also could not "impose any annual or lifetime dollar limitation on benefits for prosthetic devices and components unless such limitation applies in the aggregate to all medical and surgical benefits."

While the legislation says health insurers have started limiting prosthetic costs that they will cover at "unrealistic levels," health insurers and employers say the extra costs of a prosthetic coverage mandate likely would be passed down to employers in higher premiums.

"It's worrisome because the employer loses control over what they are paying for," said Steve Wojcik, vp of public policy at the Washington-based National Business Group on Health.

The federal push for parity for prosthetic coverage gained momentum after achieving some success at the state level in which nine states have passed such laws. Colorado was the first state to pass a prosthetic parity measure in 2000, with New Jersey and Indiana becoming the latest states to pass similar measures this year. Similar proposals are being considered in 30 other states. However, because of a pre-emption provision in the Employee Retirement Income Security Act, state laws do not apply to health care plans that are self-funded. The federal legislation would apply to both self-funded and fully-insured plans.

"The main goal is to create a nationwide standard of coverage that is consistent and appropriate so we can secure protection for the thousands of amputees who are facing enormous obstacles," said Morgan Sheets, director of the Amputee Coalition of America, the Knoxville, Tenn.-based advocacy group that has championed the legislation.

Coverage for prostheses varies widely, and a growing number of insurers are limiting coverage by imposing low dollar caps and restrictions, the ACA says.

Many private health plans cap coverage at $2,500 or $5,000 a year or limit a patient to one device per lifetime, according to a 2006 ACA survey of its members' health plans. In addition, 29% of amputees with private health insurance had prosthetic coverage reduced during the past three years while 8% had coverage eliminated completely, according to 2007 ACA data.

The cost of prosthetics ranges from less than $100 to $15,000 for basic devices while mechanical and computer-assisted models can cost as much as $30,000, according to the ACA.

While proponents say providing parity of prosthetic coverage would boost health insurance premiums by less than $1 per month, employer groups warn that any benefit mandate impacts health insurance affordability and puts additional financial pressure on employers.

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AP PHOTOS

Last week, the fishing vessel Alaska Ranger sank about 120 miles off the coast of Alaska, killing at least four crew members.

Rise in shipping demand pushing up losses: IUMI

Increase in claims expected to continue in 2008

By GLORIA GONZALEZ

NEW YORK—The number of ship losses continues to climb, partly due to increased shipping demand, according to a recent report by the International Union of Marine Insurance.

Currently, claims for 82 total ship losses have been reported for 2007, but that number could increase to 112 losses if claims increase at the same rate as they did in 2006, according to New York-based IUMI, which represents marine underwriters worldwide.

In 2006, 92 total losses were reported, which was 37% higher than early estimates. Weather remains the major cause of total losses, while collisions are the next most common cause.

In 2006, 727 serious partial losses were reported—a 6% increase over the prior year—and 914 serious partial losses have already been reported for 2007, according to IUMI. Machinery damage is the primary cause of serious partial losses.

A key factor driving the higher losses is the "shipping boom" that is forcing ships and crews to work harder than ever, according to Deirdre Littlefield, president of IUMI. Since 2002, the volume of goods transported by sea has risen by 50% while the value of these goods has risen by more than 110%, according to IUMI.

IUMI predicted that the upward trend in shipping losses would continue in 2008.

A total loss occurred last week when the Alaska Ranger, a fishing vessel owned by the Seattle-based Fishing Co. of Alaska, sank about 120 miles off the coast of Alaska, killing at least four crew members. The American Steamship Owners Mutual Protection & Indemnity Assn. Inc. provided insurance coverage for the vessel, but the extent of coverage is unclear.

Rising shipping losses, though, are happening at a time when the marine insurance market is extremely competitive and premiums are flat, Ms. Littlefield said.

"Underwriters are struggling to obtain realistic increases in their pricing of risks," she said in a statement. "Risk calculation, not risk taking, must be the underwriter's primary concern."

High court limits arbitration reviews

Supreme Court says contracts must follow Federal Arbitration Act

By MARK A. HOFMANN

WASHINGTON—A Supreme Court decision in a case involving an arbitration agreement between a landlord and tenant could affect other arbitration arrangements, such as those in reinsurance, experts say.

Other observers say the court's 6-3 ruling in *Hall Street Associates L.L.C. vs. Mattel Inc.* might discourage some businesses from using arbitration. The general counsel of the American Arbitration Assn. disputes that view and said the type of agreement upon which the case centered is relatively rare.

The case involved an arbitration agreement between the toymaker and property owner concerning an Oregon site Mattel leased from Hall Street. Hall Street sued Mattel for contamination of the property after Mattel gave notice that it intended to terminate the lease, according to court papers. The U.S. District Court for the District of Oregon approved an agreement to arbitrate the case. The agreement provided for judicial review of the arbitrator's decision beyond that provided by the Federal Arbitration Act.

At first, the arbitrator held for Mattel, but Hall Street moved to have that overturned. The court sent it back to the arbitrator, holding that the arbitrator reached an erroneous conclusion about the applicability of a state environmental law to the case. The arbitrator then found in favor of Hall Street. Mattel appealed to the 9th U.S. Circuit Court of Appeals, which reversed the lower court's original decision that vacated the arbitrator's award in favor of Mattel. Hall Street then appealed to the U.S. Supreme Court.

On March 25, the high court

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401(k) fee suits draw federal interest

Labor Department files brief in support of workers in Deere litigation

By MARK BRUNO

WASHINGTON—The Department of Labor has sent a quiet but strong signal that it is keeping a close watch on the growing collection of 401(k) fee lawsuits—and that it will intervene in these cases if it deems necessary, experts say.

Without much fanfare, the Labor Department recently elected to formally voice its position on a 2006 lawsuit that workers at Deere & Co. filed against the company and Fidelity Investments. That suit, which alleged 401(k) participants at Deere were being charged unreasonable and undisclosed fees and expenses, was dismissed by a federal judge last June, a move that was viewed as good news for the roughly dozen other corporations that have been hit with similar suits over 401(k) fees, including Exelon Corp., Lockheed Martin Corp. and General Dynamics Corp.

But now the Labor Department is saying, not so fast. On March 19, it filed a brief in the 7th U.S. Circuit Court of Appeals supporting the Deere workers' claims and requested that the judge's earlier ruling be reversed in appeals court, where the case has been since the end of last year.

The filing of the brief, while subtle, is "incredibly significant," noted Gregory Ash, a partner in the employee benefits group of Spencer Fane Britt & Browne L.L.P. and head of the firm's ERISA litigation practice.

"They didn't have to get directly involved here, they pick and choose their battles carefully," Mr. Ash said. "The Department of Labor trolls the courts for unique issues that they believe are critical and must be addressed. Clearly, they saw this as an excellent platform to directly voice their opinions on the fee suits."

As the primary enforcer of the Employee Retirement Income Security Act, the Labor Department has the opportunity to "really flex its muscle" and influence courts reviewing these 401(k) suits, Mr. Ash added.

Jerome Schlichter, the attorney at St. Louis-based law firm Schlichter Bogard & Denton L.L.P. who represents the Deere workers, as well as plaintiffs in similar suits against the Boeing Co., Caterpillar Inc., Exelon and General Dynamics, said the Labor Department's intervention "reaffirms our position in the case."

The appeals court will likely await responses to the brief from both Deere and Fidelity. These responses are expected to be filed some time in the next two months.

Deere officials did not return calls seeking comment. A Fidelity spokesman said the firm still believes the judge's dismissal last year was correct, and added that Fidelity will file a response to the brief shortly.

Mr. Schlichter emphasized that in each of the other cases in which he represents workers suing their employers over 401(k) fees, judges have refused to dismiss the cases. The Deere case "has been the lone exception," he said, adding that he is "planning and expecting trials" in

See **401(k)** page 6

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401(k): Fee suits draw federal interest

CONTINUED FROM PAGE 4

many of these other cases later this year.

Labor Department officials were unavailable to comment on the brief. Labor Secretary Elaine L. Chao said in a statement that, "A top priority of the Labor Department is protecting 401(k) plans through improved disclosure and transparency of plan fees and conflicts of interest."

But benefits attorneys said that by voicing its opinion on the Deere case, the department has sent a message that all of the courts need to carefully examine the claims of 401(k) participants in each of the individual suits currently pending.

"This is a relatively new area for the courts," said Ronald Richman, partner in the employee benefits practice at law firm Schulte Roth & Zabel L.L.P. in New York. The Labor Department "is saying that the judge made the wrong decision in dismissing the claims."

In the Deere case, three workers filed a suit in 2006 alleging that the company's $2.5 billion 401(k) plan offered investment options to participants with fees and expenses that were "excessive" and "unreasonable."

The suit also named Fidelity, which provided both mutual funds and recordkeeping services to Deere, as a defendant for allegedly charging the excessive fees. As a result, both Deere and Fidelity breached their fiduciary responsibilities to 401(k) participants under ERISA, the suit alleged. The workers also claimed that Deere and Fidelity failed to disclose details of a revenue-sharing arrangement between the two companies.

According to court documents, the fees on the 20 primary Fidelity funds offered in the Deere plan varied from 0.7% of assets for the Spartan Fund (an S&P 500 fund) to 1.01% for Fidelity's Diversified International Fund.

Federal Judge John C. Shabaz dismissed the Deere workers' arguments that these fees were excessive, noting that participants had a wide range of fund options and fees to choose from, and also pointing out that Deere employees could have opted to use a brokerage window in the 401(k) plan that provided access to roughly 2,500 other funds.

In their original complaint filed in 2006, the Deere workers also alleged that the revenue-sharing arrangement between Fidelity affiliates involved "millions of dollars" of costs that were "far in excess of reasonable fees for the administrative and/or investment services" provided to the Deere 401(k) plan by Fidelity. The claim similarly alleged that the revenue-sharing activities inflated Deere's 401(k) expenses and caused the company to pay above-market value for administrative and investment services.

Last summer, however, Judge Shabaz granted Deere and Fidelity's request to dismiss the case. For one, the judge cited section 404(c) of ERISA, which he said protected the two companies from fiduciary responsibility. This section essentially provides safe harbor to a fiduciary if it presents employees with adequate investment options and makes it clear to participants that they are responsible for independently selecting their investment vehicles.

"The judge basically said that the participants themselves chose to invest in the more expensive funds," said Robert Rachal, senior counsel in the employee benefits group at Proskauer Rose L.L.P. "Because participants were presented with other options, the fiduciaries weren't responsible for the losses. That's not the way the DOL sees it, apparently."

The judge also noted in his dismissal that companies are not mandated to disclose details of revenue-sharing arrangements. The Labor Department contended in its brief that "ERISA's duties of prudence and loyalty" suggests such issues deserve to be examined despite the lack of specific regulatory requirements.

The judge's dismissal last year was perceived to be a boon to companies hit with these suits, Mr. Rachal said, since it suggested employees might not have much leverage against their employers.

"But the decision was too quick," he said. "This is an issue that requires and deserves exploration and more of a factual-based action from the courts, rather than a quick, cursory decision. And that's exactly what the DOL, at the very least, is saying here."

Mark Bruno is a reporter for Financial Week, a sister publication of Business Insurance.

Commentary

Change in location lets other regions shine

PAUL WINSTON

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

Late last month, I traveled to Dubai to participate in the World Insurance Forum, which drew about 350 insurance and reinsurance executives from Bermuda, the United States, Europe, the Middle East and the Far East.

It's not an easy place to get to; taking about 20 hours of total travel time from Chicago. But the benefit of such a long journey is that losing almost an entire day in transit seems to have negated what might have been a nasty case of jet leg; or else it's just that my internal clock never figured out what time it was the entire time I was away.

Like many people who have attended the biennial WIF in years past at its home base of Bermuda, I was skeptical that relocating to Dubai in the off year made sense other than financially, due to the support it received from the Dubai International Financial Center to host the event. I was pleasantly surprised to be proved wrong.

The WIF, despite its lofty title, has long been primarily a showcase for the many world-class companies that call Bermuda home. Even though it has executives from U.S. and European companies as panelists, they often had subsidiaries or strong business ties to Bermuda that did little to change my perception that the event was largely an opportunity for the island to strut its stuff.

COMPLETE COVERAGE of the World Insurance Forum in Dubai will be published April 7 in *Business Insurance Europe* and on *www. BIEurope.com.*

Changing the setting so radically to Dubai gave Bermuda companies—which accounted for a big share of this year's panelists as well—a chance to demonstrate that they truly are players on the world stage and can hold their own in markets far from home. They demonstrated expertise in global issues and an appetite for expansion, as well as knowledge about the developing markets of the East, that would not have been as apparent delivered from a stage in Bermuda.

I don't necessarily advocate returning to Dubai (though I have 50 U.A.E. dirhams, about $16, to get rid of somehow), but I would strongly encourage the organizers of the WIF to continue to put the world in World Insurance Forum by exploring other venues—especially ones that might also attract risk managers, who are in short supply in the Middle East.

As at many major insurance conferences, the question of where property/casualty fortunes might be headed was a major theme. The perennial questions were asked: How soft will the market get? How long will this downturn in the cycle last? Will underwriting discipline remain intact? What will turn the market?

Those questions have always been difficult to answer. This year, they seemed more challenging than usual, given the fears of a U.S. recession, financial market turmoil and the unpredictability of losses from hurricanes, terrorism and unknown risks.

Global warming was discussed and how the insurance industry might do more to use its financial leverage to help reduce greenhouse gas emissions. None of the panelists seemed willing to engage in social/environmental reform by charging exorbitant premiums to penalize companies like airlines, energy companies or manufacturers that have a large carbon footprint. One audience member offered a simple proposal: Abandon the standard insurance "uniform" of wool suits and neckties that requires multiple megawatts to power air conditioning to make individuals comfortable, as was the case at the WIF setting in Dubai.

The insurance industry's so-called war for talent also was raised during the meeting. As the industry expands, how it can attract the best and the brightest to developing markets in the Middle East and Far East? The same problem faced by the insurance industry in the West—wunderkinds are more attracted to other financial services sectors, such as investment banking and mortgage securitization—is also seen in the East.

"For a graduate in the Middle East the insurance sector is a last resort," said Wasef Jabsheh, vice chairman and CEO of International General Insurance Co. Ltd. of Jordan, from the audience. "We set up two years ago. We offer generous salaries, the opportunity to work abroad, but engineers want to work for construction companies and accountants and lawyers just won't come to insurance. It's very difficult."

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Business Insurance OPINIONS

Court ruling protects retiree health benefits

THE WHEELS OF JUSTICE have turned slowly, but surely and correctly, in a controversy involving the design of retiree health care plans.

Nearly eight years ago, the 3rd U.S. Circuit Court of Appeals ruled that federal age discrimination law applied to retiree health plans.

In brief, that ruling gave a green light for Medicare-eligible retirees to sue their former employers if they didn't receive the same health care benefits or if the employers didn't spend the same amount of money for health care coverage as they did for younger retirees.

In the real world, benefit offerings for the two groups of retirees rarely are equal. That's not because of discrimination, but because retirees 65 and older are eligible for Medicare and don't have the same need for health care coverage from their former employers.

While the 3rd Circuit ruling may have mandated benefit equality, the inevitable result would have been less health care coverage for retirees. At a time when many employers were questioning whether they could afford retiree health care coverage, they wouldn't have upgraded benefits for Medicare-eligible retirees. Benefits for younger retirees would have been reduced and possibly eliminated for all retirees.

In the real world, benefit offerings for the two groups of retirees rarely are equal.

It took some prodding by employers and organized labor for the Equal Employment Opportunity Commission to see the disastrous consequences that would resulted from the 3rd Circuit ruling.

Eventually, the EEOC saw the light and made a rule that exempted retiree health plans from age discrimination law. Unfortunately, a misguided suit by AARP blocked the EEOC from implementing its rule until last year. Any uncertainty as to the future of that rule came to an end last week when the Supreme Court declined to get involved, allowing the rule to stand.

The end of the legal controversy, as we report on page 1, comes as employers are redesigning their plans to try to provide meaningful and affordable benefits. Fortunately, a court ruling will not get in the way of that effort.

Nontraditional alliance helps industry cause

TOO OFTEN, LAWMAKERS view issues involving insurance as being of interest only to the insurance industry.

So we're glad that a broader-based consortium has coalesced to oppose a couple of insurance-related ideas that supposedly promote the public interest when we believe they will actually harm it. Those ideas are to expand the already stressed National Flood Insurance Program to cover wind damage, and to create new federal programs that would require Washington to bail out state disaster funds or to reinsure state property/casualty insurance programs.

The consortium includes two insurance organizations that might be expected to oppose such a government intrusion into a functioning private market—the Reinsurance Assn. of America and the Assn. of Bermuda Insurers and Reinsurers.

But it also includes unlikely allies such as the Consumer Federation of America, the Competitive Enterprise Institute and the National Wildlife Federation. These groups, which aren't known for agreeing on many things, nevertheless recognize that expanding the NFIP and putting the federal government on the hook for state mistakes is not in the interest of the economy, the environment or the consumers that such an expansion supposedly would protect.

We're glad to see the insurance industry partnering with nontraditional allies, and wish this effort well. If it proves successful, we hope this broad-based consortium could be a model for other common-sense efforts in the future.

Letters to the editor

'Hard-market residue' affects current pricing

Readers of these pages continue to be provided with spot-on information concerning falling pricing in the property and casualty arena. However, one has to wonder if this is due to more-than-plentiful capacity and lower combined ratios among other issues. Perhaps we should reflect on the residue of hard-market pricing and coverage grants being afforded in the casualty marketplace today.

Hard-market pricing in the primary casualty arena drove the risk management community to increase deductibles or retentions, assuming more risk than before. While these assumptions of risk were initially met with trepidation and angst by some buyers, in the years that followed, these customers became more comfortable with these retentions and renewed at these same levels.

Despite the soft-market pricing which followed, few buyers repaired back to the lower levels retained. One could surmise that the product of this change in the profile of risk being transferred equates to less insurance

See **LETTERS** page 14

Write us

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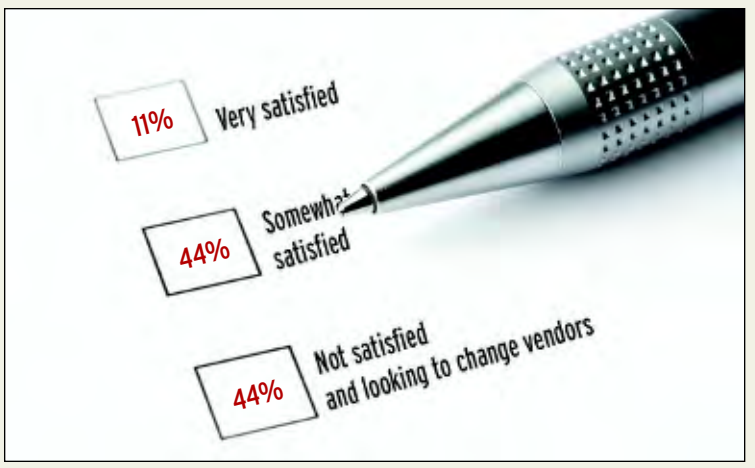
Online Poll at www.businessinsurance.com

How satisfied is your organization with the health care benefit providers with which it does business?



NEXT WEEK'S POLL: *Is the property/casualty industry doing enough to partner with other industries to reach its political goals?*

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

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Business Insurance
PERSPECTIVE

Contamination clouds insurability of NBCR risks

Jack Seaquist is a senior manager at AIR Worldwide Corp. in Boston.

By Jack Seaquist

The Terrorism Risk Insurance Program Reauthorization Act of 2007 that became law last year extends the federal backstop another seven years. It now covers losses due to domestic terrorist groups while maintaining other terms, including current "make available" provisions.

The backstop continues to cover losses from certified terrorism events irrespective of weapon type. However, the program does allow policy exclusions that are currently applied to losses arising from causes other than terrorism. For example, while there are no allowable exclusions for workers compensation losses, property insurers exclude certain losses from nuclear, biological, chemical and radiological events, invoking the nuclear hazard and pollution exclusions that exist in many policies.

Indeed, the availability of insurance coverage for such contamination is scant. Both the Government Accountability Office and President's Working Group on Financial Markets, in their reports issued in 2006, acknowledged the industry's understandable lack of appetite for NBCR and concluded there is little potential for any future market development.

While the reauthorization does not mandate NBCR coverage, which had been proposed by the House of Representatives, it does require a study of the issue by the GAO, results of which are due at the end of this year. The study is to examine "the availability and affordability of insurance coverage for losses caused by terrorist attacks involving NBCR materials, the outlook for such coverage in the future, and the capacity of private insurers and state workers compensation funds to manage risk associated with NBCR terrorist events," according to the act.

In anticipation of the GAO study, it is important to understand the insurability aspects of NBCR contamination. While there are similarities in the effect of contamination across these weapons types, here the focus is on nuclear contamination. For nuclear and radiological attacks, excluded losses stem from the widely adopted nuclear hazard exclusions, which eliminate coverage for losses from radiation or radioactive contamination.

In the case of a nuclear bomb—a worst-case scenario—there are four predominant damage effects:

- Blast and shock
- Thermal radiation
- Initial nuclear radiation
- Residual nuclear radiation contamination, or fallout

In a surface nuclear burst, earth, dust and debris are mixed up in the fireball and contaminated. Larger particles immediately fall back to earth, while the smallest particles may remain suspended in the atmosphere, dropping gradually over extended distances, even circling the globe. This residual nuclear radioactive contamination could represent an entirely new kind of exposure for property insurers.

Cleanup of this contamination is a daunting proposition. All contaminated material (buildings and surface material) must be dismantled, removed from the scene and rebuilt over a prolonged period.

Radioactive contamination spreads over substantial distances. The critical question is: How much residual contamination is acceptable? The lower the acceptable level, the greater will be the area needing decontamination and the more intense will be the decontamination effort.

Decontamination standards for radioactivity were originally developed to handle accidental releases and legislated cleanup of hazardous sites. They were not developed for intentional contamination caused by terrorists in cities. For the general public, the U.S. Nuclear Regulatory Commission requires its licensees to limit maximum radiation exposure to 100 millirem— or mrem, which is the unit used to measure the equivalent dosage of radiation absorbed by the human body—per year above the normal background level of radiation exposure. However, the NRC specifies a level of no more than 25 mrem per year following a cleanup after an NRC license termination. An even tougher standard—15 mrem per year—is established by the Environmental Protection Agency for other sites with radioactive contamination.

How do cleanup standards affect an insurer's exposure to radiological contamination? In an analysis by the Department of Energy's Pacific Northwest National Laboratory, the area requiring cleanup after a 0.7 kiloton nuclear bomb, a small device, increases from 179 square kilometers to 1,430 square kilometers (111 square miles to 887 square miles) when the cleanup standard is raised from 100 mrem per year to 15 mrem per year. This is an eightfold increase in area and at least that much in resulting costs.

The status of cleanup standards as they might apply after a terrorist attack is now the domain of the Department of Homeland Security. However, in its guidance for the late cleanup phase, there is no stated numerical standard. Instead, a process is prescribed for reaching a consensus well after the attack.

"Rather, a process should be used to determine the societal objectives for expected land uses and the options and approaches available, in order to select the most acceptable criteria," according to the DHS' Protective Action Guides for Radiological Dispersal Device and Improvised Nuclear Device Incidents.

Insurers contemplating availability of property coverage for radiation contamination thus face considerable uncertainty. Should the key stakeholders decide to implement the stringent EPA standard, the ground-up event cost could be eight times greater than if the standard defined for general population exposure were used. Also, the applicable standard will not be selected until after the event has occurred. This uncertainty must be resolved in legislation if insurance coverage is to be made available for all of the currently excluded NBCR losses.

Proceed with caution when reporting a D&O claim

William A. Boeck is senior vp, insurance and claims counsel for Lockton Financial Services in Kansas City, Mo.

By William A. Boeck

Directors and officers liability insurers want to know what is going on with the companies they insure.

Most companies want to communicate openly with their insurers. While you might think D&O policies would be structured to encourage such communication, as demonstrated by the terms governing reporting of potential claims, that isn't always the case. Paradoxically, reporting a potential claim can be the basis for an insurer's declination of coverage.

Virtually all D&O and similar professional liability policies are written on a claims-made basis. For coverage to apply, the claim must be made while the policy is in effect. D&O policies usually give policyholders the option to provide notice during the policy period of circumstances that could give rise to a claim. If the insurer finds the notice to be sufficient, any future claim based on the circumstances described in the notice will be deemed to have been made when the notice was given.

For those unfamiliar with the policy terms and conditions, the decision whether to provide notice of a potential claim might seem easy. Telling an insurer about a situation that may result in a claim and thereby locking in coverage should be a great idea, right? Not necessarily. If the insurer does not accept the notice as valid and effective, a future claim based on the facts in the notice may not be covered under any policy.

It is not at all certain that an insurer will accept a notice of potential claim as valid and effective. Indeed, they are much less likely to do so now than in years past. Older policy forms typically required only that policyholders submit a general description of the circumstances on which a future claim would be based. Such notices were seldom rejected as insufficient.

Today, most policy forms require notices of potential claims to include a significant amount of very specific information. Policies typically require policyholders to identify the potential claimants and insured defendants, wrongful acts likely to be alleged, dates the acts were committed, reasons for anticipating a claim and how the policyholder became aware of the circumstances being reported. If an insurer deems a notice to be lacking, a policyholder may try and shore it up by supplying additional information.

See **D&O** page 12

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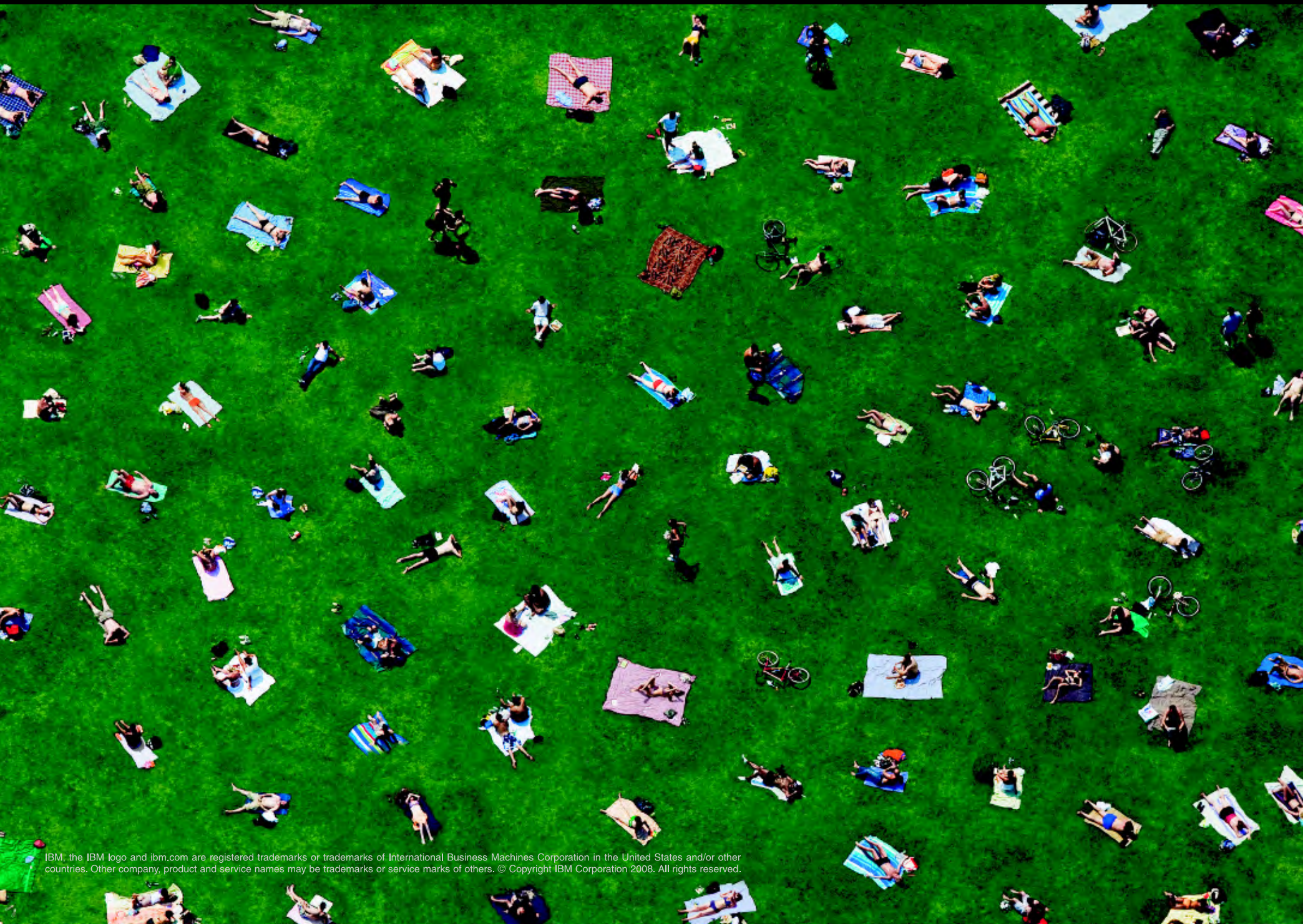


Business Insurance
PERSPECTIVE

Ask A Casualty Actuary

Setting loss reserves takes art and science

This month's column on actuarial issues in the casualty field is written by Richard E. Sherman, president of Richard E. Sherman & Associates Inc. in Ashland, Ore.

By Richard E. Sherman

Q: How much uncertainty is there in loss reserve projections?

A: A loss reserve is an estimate of total future payments to settle current open claims. Also included are future payments on claims arising from incidents that occurred previously, even though a claim has not yet been filed.

Because projections of loss reserves are forecasts of future events, they are subject to a significant level of uncertainty. Those future events are the decisions made in settling individual claims and contingencies affecting the magnitude of claim payments, such as changes in the medical condition of the claimant or statutory or judicial decisions affecting the rights of claimants. The further into the future those payments are made, the greater the uncertainty as to the amounts. So, reserves for excess workers comp are much more volatile than those for property.

One common way to get a handle on reserve variability is to apply three or more different reserving methods and note how much the projections differ. This exercise may seem unnecessary to accountants, whose training encourages them to apply one acceptable method and book the results. Applying multiple methods often raises questions requiring further investigation. Why does the paid projection indicate a loss reserve that is 50% higher than that indicated by an incurred projection? Understanding how shifts in handling claims and the settlement environment may cause such differences can be illuminating.

Sometimes, a reserve method will depend on one or more explicit assumptions, such as the future rate of inflation. When this is the case, one can input a range of inflation assumptions and observe how much the indicated reserve varies.

Sometimes, a reserve method will depend on one or more explicit assumptions, such as the future rate of inflation. When this is the case, one can input a range of inflation assumptions and observe how much the indicated reserve varies.

Another approach is to simulate the claims settlement process. From past history, we can see how the number of claims can vary from year to year. We note how frequently claims of different sizes have occurred. For example, suppose 1% of claims historically have been more than $10,000 and 0.1% have been more than $1 million. We can then feed such statistics into a computer model that simulates how much total losses for a given number of claims can vary. This exercise might indicate that future payments will differ from the best estimate by more than 10% roughly half the time, and by more than 25% one-third of the time.

Keeping a track record is yet another approach. How far off have past estimates been? The reserve held at year-end 2000 can be compared with the total of all subsequent payments, plus all current case reserves. While it would not be surprising if that year-end 2000 reserve proved to be way off when only a few claims were involved, what is troubling is that the total reserve can be off significantly, even for a large insurer with thousands of claims. One would think that with a large volume of claims, a high level of accuracy would be achieved. While this is true in a relative sense, the tendency of the future to behave differently than the past is an inherently irresolvable problem.

Follow-up studies have shown that it is not uncommon for that year-end 2000 reserve to be off by more than 10% about two-thirds of the time. Typically, the larger the insurer, the less often they are off by more than 10%. But even for the largest insurers, the year-end 2000 reserve tends to be off more than 10% half of the time. And they might be off by more than 25% more often than one would like to think. There are clear parallels for self-insurance program reserves.

Uncertainty about loss reserves is the primary reason that regulators are concerned about insurers having an adequate amount of surplus (net worth) to weather the possibility of adverse variations of actual future payments from booked reserves. A complex series of analyses goes into the regulators' determination of the amount of risk-based capital that each insurer should have.

Since loss reserves are inherently uncertain, why devote so much energy to estimating them? Typically, they account for the lion's share of an insurer's or a self-insurance program's liabilities. Coming up with an unbiased best estimate of loss reserves is critical to determining an adequate funding level for the next fiscal year.

In setting loss reserves, it makes sense to add a reasonable provision for adverse deviation above that best estimate. In estimating the size of that provision, applying some of the approaches mentioned above can be quite helpful. Having in mind the chances that very large losses could occur is important, since the presence or absence of large claims is the biggest contributor to uncertainty about the future payout on current claims.

D&O: Proceed with caution when reporting a claim to an insurer

CONTINUED FROM PAGE 10

The policy may require it to do so during the policy period, however.

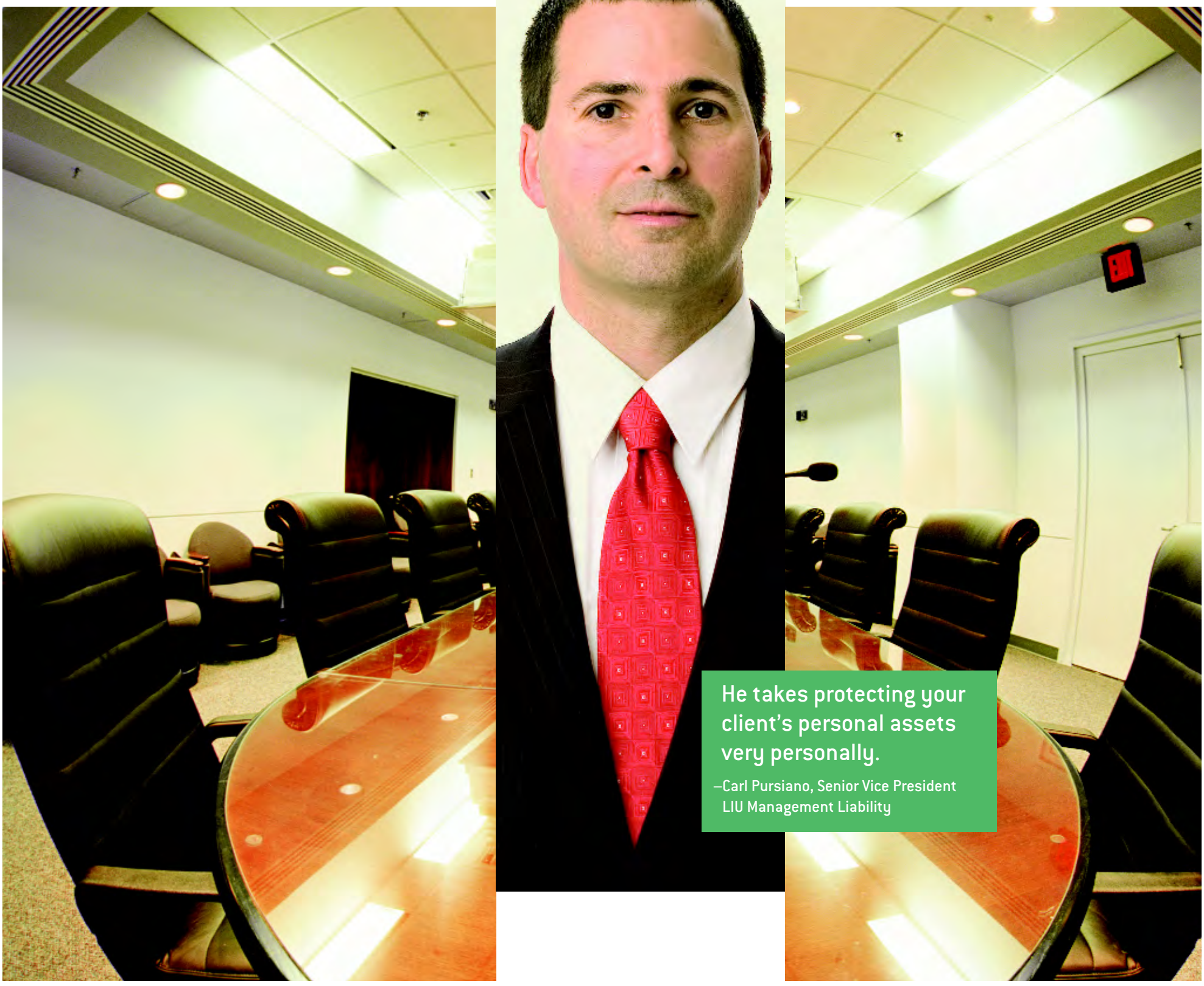
Policyholders might be forgiven for thinking that the notice provisions of modern policies require a degree of clairvoyance. Most insurers understand the problem, and try to be flexible where policyholders have made a good effort to supply the information required by the policy. However, as a handful of court decisions over the past couple of years demonstrate, insurers take the specific information requirements of notice clauses seriously, and do not hesitate to litigate the sufficiency of notices of potential claims when they firmly believe the requirements have not been met.

Generally speaking, courts have carefully enforced the information requirements for notices of potential claims. They have held that general notices, such as one stating that a policyholder's bankruptcy could give rise to D&O claims, are inadequate.

While courts have avoided making stringent technical readings of notice requirements, they have required policyholders to provide each piece of information required by a policy, and have held that an insurer is not required to engage in conjecture or perform an investigation to find information missing from a policyholder's notice.

An insurer's rejection of a notice of potential claim can be fatal to coverage in the event a claim is ultimately made. D&O and other claims-made policies exclude claims arising from circumstances reported to insurers under earlier policies. Such "prior notice" exclusions will apply even if an insurer rejected an earlier notice of potential claim. To be sure, it would be highly unusual for the same insurer to reject a notice of potential claim under one policy and invoke a prior notice exclusion in a subsequent policy. A replacement insurer (or a replacement excess insurer) might not hesitate to raise such a coverage defense, however. Indeed, at least one court held recently that a prior notice exclusion could apply under just such circumstances.

Given the very real risks flowing from a policyholder's failure to provide all of the specific information required by policy notice clauses, where policies make reporting of potential claims optional, companies need to carefully consider whether to provide such notice at all. A policyholder might be better off simply waiting for a claim to be made. If the decision is made to report the potential claim, great care must be taken to give the insurers all of the specific information required by the policy. Failure to do so, and to work closely with insurers' claims staff to manage the acceptance of the notice, could be catastrophic.



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Market Moves

Gallagher acquires two companies

ITASCA, Ill.—Arthur J. Gallagher & Co. has acquired Bankers Financial Benefits of Oklahoma City and Splinter Group Inc. of Park Ridge, Ill.

Terms of the agreements were not disclosed.

Bankers Financial Benefits is an employee benefits consultant and brokerage that specializes in the banking and manufacturing industries. It will continue operating at its Oklahoma City location.

Splinter Group is a retail broker offering risk management, employee benefits and commercial property/casualty services. It will relocate to Gallagher's headquarters in Itasca, Ill., Gallagher said.

Smith Lanier & Co. purchases Insuramerica

LOGANVILLE, Ga.—Smith Lanier & Co. has acquired Loganville, Ga.-based Insuramerica Aviation Inc. Terms of the agreement were not disclosed.

Insuramerica will be a subsidiary of the 140-year-old brokerage and will retain its name, employees and location, West Point, Ga.-based Smith Lanier said.

Global Risk Holdings purchases Florida TPA

MAITLAND, Fla.—Global Risk Holdings and management members of Maitland, Fla.-based North American Risk Services Inc. have purchased all outstanding shares of NARS from Clarendon National Insurance Co.

NARS provides property/casualty third-party administration services. Raleigh, N.C.-based GRH is a consortium of insurance management companies specializing in providing services to insurers, brokers, self-insureds and associations.

Executives obtain majority ownership

STERLING HEIGHTS, Mich.—Longtime executives Daniel Gorczyca and Louis Lapiana have acquired a majority stake in U.S. Health Holdings Ltd. of Sterling Heights, Mich.

Mr. Gorczyca is president and Mr. Lapiana is executive vp of Automated Benefit Services Inc. and U.S. Health & Life Insurance Co., both units of U.S. Health Holdings.

U.S. Health Holdings administers benefits for employers and municipalities, provides actuarial services, and invests in technology and health insurance industry advances.

U.S. Re Cos. moves headquarters

PEARL RIVER, N.Y.—U.S. Re Cos. Inc. has moved its headquarters from Manhattan to Pearl River, N.Y. The company said the new location will house its executive offices and operational and support services, including technology and actuarial services.

The financial services and reinsurance brokerage's address is One Blue Hill Plaza, third floor, P.O. Box 1574, Pearl River, N.Y. Telephone: 845-920-7100; fax: 845-920-7160.

N.J. insurance exchange to buy National Atlantic

FREEHOLD, N.J.—National Atlantic Holdings Corp. said it has agreed to be acquired by a subsidiary of Palisades Safety & Insurance Assn., a New Jersey-licensed insurance exchange.

Palisades Safety has agreed to pay $6.25 in cash for the outstanding common stock of National Atlantic, a Freehold, N.J.-based property and casualty insurer.

The deal, expected to close in the third quarter, is subject to the approval of National Atlantic's shareholders.

New York signs pact for emergency training

NEW YORK—The New York City Office of Emergency Management has signed a contract with the simulation division of Environmental Tectonics Corp., which makes and installs equipment for the aerospace and biomedical industries, to design an advanced disaster management simulator training system.

The contract calls for the Orlando, Fla.-based simulation division of Environmental Tectonics to develop a turnkey, multidiscipline team-training system and a comprehensive library of customized training scenarios, post-event reviews and evaluations.

The training system will become part of New York's citywide incident management system, according to an Electronic Tectonics statement.

Aon gets approval to add to China branches

CHENGDU, China—The China Insurance Regulatory Commission has approved a proposal by Aon-Cofco Insurance Brokers Co. Ltd. to set up a branch in Chengdu, the capital of China's Sichuan province.

Aon-Cofco is a Shanghai-based 50-50 joint venture of Chicago-based Aon Corp. and Cofco Ltd., an oil and food importer and exporter.

The latest approval adds to existing Aon branches in Beijing, Nanjing and Guangzhou, China.

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 new product offerings appear in Products & Services. Please send Market Moves news to: Kristin Gunderson Hunt, *Business Insurance*, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; *khunt@businessinsurance.com*. P&S items should be sent to Colleen McCarthy at *cmccarthy@businessinsurance.com* and C&G items should be mailed to Joe Walker at the above address or e-mailed to *jwalker@businessinsurance.com*.

Arbitration: Ruling could affect reinsurance

CONTINUED FROM PAGE 4

upheld the appeals court's 2006 ruling in favor of Mattel, but remanded the case to the lower court because of some unrelated issues. Writing for the majority, Associate Justice David Souter held that the Federal Arbitration Act's grounds to seek modification of awards are exclusive and cannot be altered by private contract.

The court's decision could have some bearing on reinsurance arbitration agreements, according to lawyers specializing in the area.

"There are several ways in which this decision can impact the drafting of arbitration clauses in reinsurance agreements," said Elliott Kroll, a partner at Herrick, Feinstein L.L.P. in New York. "Clauses that attempt to modify applicable law" by requiring the parties to follow "state arbitration statutes or alter the scope of judicial review of an award—to either broaden or narrow such review—are clearly subject to this decision. It will also be interesting whether arbitration provisions which attempt to give the cedent a choice of litigation or arbitration will be impacted by this decision. The clear, positive aspect of this decision is to provide a greater sense of finality to the arbitral process consistent with concept of efficiency of dispute resolution," he said.

"Generally people consider arbitration final, but there are challenges at times. This will reinforce the notion that parties cannot by contract change the modality of finality," Mr. Kroll said.

"I think it has some effect," said Nick DiGiovanni, a partner in the Chicago office of Locke Lord Bissell & Liddell L.L.P.

"It really would affect those agreements that try to expand or contract the opportunities for any of the parties to arbitration to either challenge or expand the federal court's rights to examine an award. In the reinsurance world, it's relatively unusual for an arbitration agreement to try to do that," Mr. DiGiovanni said.

> **'The clear, positive aspect of this decision is to provide a greater sense of finality to the arbitral process.'**
>
> Elliott Kroll, Herrick, Feinstein L.L.P.

Others said the ruling may make arbitration less attractive to some businesses.

"If you can't even contract for judicial review now, small-business owners will be less inclined to arbitrate because they cannot be sure that they will get justice," said Karen Harned, executive director of the National Federation of Independent Business' Small Business Legal Center in Washington, which filed a brief supporting Hall Street.

"The ruling limits the extent to which parties can agree to have their arbitration disputes reviewed through an appeal in court," said Quentin Riegel, vp-litigation and deputy general counsel at the National Assn. of Manufacturers in Washington, which was not involved in the case. "Some companies may find that unacceptable if they are not confident in the ability of an arbitrator to apply the law properly to the dispute," thus discouraging arbitration, he said.

The general counsel for the New York-based American Arbitration Assn. hailed the decision as a "good" for arbitration.

"The reason is it maintains arbitration as a cost-effective and expeditious way for resolving disputes," said Eric Tuchmann. "If agreements for expanded judicial review are enforceable—and that's what the case was about—then arbitration becomes a prelude to litigation, which is completely contrary to its intended goal," he said.

"In actual practice, these agreements for expanded review are very rare, but this impacts the policy implications for arbitration, which are these competing goals of finality and cost-effectiveness on one hand and party autonomy on the other," Mr. Tuchmann said.

Hall Street Associates L.L.C. vs. Mattel Inc. U.S. Supreme Court. No. 06-0989; March 25, 2008.

Letters to the editor

CONTINUED FROM PAGE 8

being purchased and prospectively fewer losses being paid by the respective carriers. Improved loss ratios are a nice feature as well, until the need for extra premium drives competition to where we are today.

In addition, at times like these, one may pause to reflect on primary casualty coverage currently being traded in the market. While premium and loss statistics serve to color a picture of the market with a certain hue, have we ever looked at the scope and breadth of the general liability policies being traded today in comparison with those same forms of coverage from several years back? What is deemed as "clarifications on intent of cover" translates to most savvy buyers and brokers alike as less coverage being afforded than that which once was.

Perhaps this is another reason why carrier results are positive. Less insurance is being provided to the commercial buyer, which has to lead to improved results. If not, why "clarify the intent of cover" in the first place? While some may disagree, suggesting that terms are negotiable, I would submit that while rates continue to be reduced, most underwriters do so with integrity towards maintaining coverage and form.

Yes, capacity, competition and attractive loss ratios do drive the market. Other, less apparent reasons are doing so as well.

Joseph M. Buono, CPCU
Senior Vp
Wells Fargo Insurance Services
New York

Mental health deserves same level of coverage as medical care

TO THE EDITOR: I am writing to show my disappointment in your March 10 opinion regarding the mental and health parity bill that requires the same level of medical care. Your statement, "If there is logic (Rep. McKeon's comments) in such an overly broad requirement, other than enriching mental health care providers, it escapes us. What the provision effectively says is regardless of whether a few people or many have a diagnosis in the manual, all such disorders require coverage." You are exactly right that Webster's dictionary defines health as "the condition of being sound in mind, body and spirit."

Whether "some" people have bipolar (disorder) or many have diabetes, they all require certain levels of care, not for how many people are diagnosed but based on the level of the individual's diagnosis and treatment required. Health coverage includes the entire person, not pieces of it. It seems to me that the major concern would be to develop ways to manage the care providers and rate the quality of care. That is how they should be using their money to manage the health care of their insureds. Politicians should not make medical decisions on how many people have this or that disease or to determine what mental or physical disease should be covered or not. Mental health care deserves the same level of coverage as medical care.

Nina T. Brollier, PHR
Vp, Human Resources
Workers Compensation Fund
Murray, Utah

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Parity: Prosthetic coverage legislation may face hurdles in Congress

CONTINUED FROM PAGE 4

"Companies will lose the ability to cover what their resources will allow," Mr. Wojcik said.

While the success at the state level may increase pressure to pass the federal bill, health care experts say it is difficult to predict how the bill will fare in Congress.

"It is very difficult to pass mandatory health care legislation. There is a lot of resistance in Congress to do it," said Tom Billet, a senior consultant with Watson Wyatt Worldwide in Stamford, Conn.

Parity for prosthetic coverage may face hurdles similar to those experienced by mental health parity legislation, he said.

The House earlier this month cleared its version of the mental health parity legislation on a 268-148 vote (*BI*, March 10). That action, following last year's Senate passage of a more limited parity measure, sets the stage for a conference committee to try to work out the differences between the two bills. Congress first passed mental health care parity legislation in 1996 and the latest bills would expand that law.

"Look how long it has taken to produce bills on mental health parity legislation. This can be an arduous process," Mr. Billet said.

Aside from the mental health care parity measure, other health care benefit mandates that Congress has approved include a 1978 law that requires group health care plans to provide the same coverage for pregnancy and childbirth; a 1986 law that requires employers to extend group health coverage to former employees and dependents in termination of employment, death and divorce situations; and another 1996 law that requires health plans to offer at least 48 hours of inpatient coverage after a vaginal birth and 96 hours of coverage after a Caesarean.

International NEWS

Disclosing environmental risks a growing concern in Canada

New Ontario rules boost publicly traded companies' liabilities

By GLORIA GONZALEZ

TORONTO—Publicly traded Canadian companies must improve disclosure of environmental risks and liabilities in their financial statements or face shareholder lawsuits, legal and environmental experts say.

Companies trading securities in Ontario will have to comply with new regulatory guidelines designed to ensure that environmental issue disclosure complies with securities legislation and provides meaningful information to make investment decisions. Failure to comply with the guidelines would increase litigation exposure for Canadian companies from shareholders alleging misrepresentation, inadequate or incomplete disclosure.

"This is a far more comprehensive requirement for disclosure around the environmental footprint of Canadian companies," said Alister Campbell, president and chief executive officer of Zurich Canada in Toronto. "It's going to ensure that companies more vigorously evaluate their environmental exposures."

In a recent review of 35 companies for which the Ontario Securities Commission is the principal regulator, the OSC found that many companies relied on generic environmental disclosures in their financial statements and only a few had appropriately detailed environmental risk disclosures.

Many companies listed on the Toronto Stock Exchange, for example, included a standard discussion of environmental estimates in their financial statements with little or no analysis or did not discuss the environmental estimates at all, the commission found. One company simply stated that it is responsible for its share of environmental costs and maintains insurance for environmental risks, but there is no guarantee that insurance will cover all environmental claims, according to the OSC review.

"We are of the view that boilerplate disclosure is insufficient because it does not specifically identify how the estimate relates to that issuer, and therefore does not provide meaningful information to investors," the OSC said.

One of the reviewed companies did provide a detailed analysis of its environmental liabilities, including a breakdown of estimated reclamation costs for both its closed and open mines and provided the basis and methodology to make the estimates, according to the OSC review.

The OSC declined to identify the companies reviewed but said they operate in environmental services, industrial products, mining, oil and gas, steel, transportation services or utilities sectors.

"They key is (the OSC) is trying to make people step up and illustrate to their financial investors that there is environmental risk and the degree of environmental liabilities," said Greg Dunn, vp and environmental manager for Canada for XL Insurance in Toronto. "There's a focus on making sure every organization's financial statements are correct, so I think from that respect it's important."

The commission, though, did not state the extent to which companies must examine and estimate potential environmental liabilities.

"I think that's one of the sleeper issues—to what extent a company has to uncover those liabilities and disclose them," said Robert Fishlock, senior environmental partner at Blake, Cassels & Graydon L.L.P. in Toronto. "I don't know what the answer is to what that disclosure should be, but it's very much a moving target."

Adequate and complete financial statement disclosure has added importance since passage of Bill 198, a 2005 amendment to Ontario's securities law that created civil liability for inaccurate or incomplete disclosures in the secondary market. Alberta, Manitoba, Quebec and Saskatchewan have followed with similar laws (*BI*, Nov. 14, 2005).

"Obviously, a failure to make proper disclosure of material environmental issues could give rise to liability to issuers, directors and officers, and others caught within the scope of these rules," said Christopher Jones, a partner in the Blake securities group in Toronto.

Bill 198 eliminated the reliance barrier that had barred many class action lawsuits, so investors will not have to prove they relied on the environmental disclosures to file a claim, he said. "If someone can demonstrate that there was a misrepresentation in the adequacy of prior disclosure, then there is a liability issue," Mr. Jones said.

Certain companies may have a harder time providing adequate environmental disclosure than others, but corporations generally have access to this information and will be able to respond to the new disclosure requirements, said Shawn Denstedt, a Calgary-based partner and co-chair of the environmental group of Osler, Hoskin & Harcourt L.L.P. "It's just going to be a much bigger task than it has been in the past," he said.

Energy companies, for example, already assess environmental exposures due to other regulatory obligations, so it would be relatively straightforward for them to provide adequate disclosure. However, financial institutions will have to enhance their disclosure of environmental risks.

Risk managers, brokers and insurers are already evaluating environmental risks as part of the underwriting process and can use this information to provide the required public disclosure, Zurich's Mr. Campbell said.

"My instinct in this case is that the risk managers for publicly traded companies will have thought through all of these already," Mr. Campbell said.

DISCLOSURE REQUIREMENTS

The Ontario Securities Commission has issued guidelines to ensure Canadian companies that trade on the Toronto Stock Exchange adequately disclose environmental risks and liabilities. The guidelines require companies to:

- Provide detailed discussions of their estimates of environmental liabilities and explain that the estimates are "highly uncertain."
- Quantify costs associated with environmental protection requirements and the actual or potential effect on financial and operational results.
- Evaluate and describe the actual or potential effect that a company's environmental policies may have on operations, including qualifying the costs associated with these policies when the information is reasonably available and would provide meaningful information to investors.
- Discuss in detail risks related to national or international environmental laws material to a company's operations, including whether the company is in compliance with these laws and the costs of compliance.

AP PHOTOS

Fire investigators inspect a plant owned by German steelmaker ThyssenKrupp A.G. near Turin, Italy, where a blaze last December killed seven workers.

Manufacturers in Italy face heightened liability

Risk managers seek cultural shift to make workplace safety No. 1

By MICHAEL BRADFORD

MILAN, Italy—A deadly plant fire in northern Italy and legislation that increases penalties against companies that fail to protect their workers have Italian risk managers worried about growing employer liability exposures.

The risk managers met earlier this month to discuss the issue during a seminar held in conjunction with the annual general assembly of the Associazione Nazionale dei Risk Manager e Responsabili Assicurazioni Aziendali, the Italian risk management association. The country needs a cultural shift, risk managers said, if businesses are to properly address the widening liability.

"For risk managers, it is one of the most important concerns because the culture in Italy is such that loss prevention is not at the top," said Paolo Rubini, ANRA's vice chairman and director of risk management at Telecom Italia S.p.A. in Milan.

Workplace safety and employer liability have come under scrutiny lately in Italy after a December fire at a ThyssenKrupp A.G. steel plant in Turin killed seven workers. The blaze triggered a public outcry against unsafe working conditions, with thousands marching in Turin to demand safer workplaces. Much of the public's anger was aimed at ThyssenKrupp, including charges that it operated an unsafe plant.

In a statement, ThyssenKrupp said there was no confirmation that safety violations contributed to the fire.

Employer liability is a key topic in Italy, particularly after the ThyssenKrupp fire, said Mauritzio Micale, corporate risk and insurance management director at STMicroelectronics N.V., which has its manufacturing facilities in Italy.

"Our management is asking about employers liability," said Mr. Micale. "They want to know about the coverages, directors and officers exposure," and other issues that could leave them vulnerable, he said. "People are becoming scared because at the end of the day the legal responsibility is with the employer."

"This subject is very hot," said Marco Terzago, risk manager with SKF Industrie S.p.A., a bearing manufacturer in Airasca, Italy. "There is an increase in the number of accidents on the job," and the ThyssenKrupp fire has stirred the public and politicians to act.

As the general public has become more focused on workplace safety, the Italian Council of Ministers recently passed a decree that is expected to come into force later this year and will increase penalties levied against employers that are found to violate workplace safety regulations, Mr. Terzago said.

Last August, a decree was passed revising previous law and modifying penalties that can be assessed against companies that violate corporate governance regulations, Mr. Terzago said. Under the legislation, companies that violate health and safety regulations can face the same restrictions on their business activity that previously were levied only for governance missteps, he said.

The revised law calls not only for employers to police their own operations in complying with health and safety regulations, but also creates liability in some cases if subcontractors violate those rules, a measure that Mr. Terzago said is particularly hard on companies. "It says you have to put in a system of controls that is very difficult to implement."

The current climate of safety awareness could bring benefits, but it is in danger of slipping past before Italians can use it to make meaningful changes, according to Mr. Micale. "Safety is a topic everyone is willing to listen to," he said.

Italian companies need to focus on making safety an ingrained part of the work culture and lifestyle, said Mr. Micale. Training, information resources, awareness programs and other efforts are needed, he said.

Even with its reputation of taking workplace safety somewhat lightly, Italy is not as far behind some other countries in managing the employer liability exposure, said Roberto Muscogiuri, risk manager at Enel S.p.A., a Rome-based utility.

Mergers and acquisitions seen continuing in 2008

Expect more mergers and acquisitions this year, many observers say.

Driving the trend, they say, will be the industry's overcapitalization; lack of organic growth in a softening market; desire for business and geographic diversification; and the weak dollar, which is likely to attract foreign investors.

"I've actually been somewhat surprised that we haven't seen more consolidation activity, but it could be we're just in the early stages of the softening market," said John D. Gwynn, managing director at Memphis, Tenn.-based investment firm Morgan Keegan & Co. Inc.

Capital market uncertainty "provides less attractive financing options for an acquisition," said James B. Auden, senior director at Chicago-based Fitch Ratings. "That may be a hindering factor at the moment."

"With the weak dollar, I think it's highly likely that foreign companies will be coming into this market and spurring more M&A activity," said John L. Ward, chief executive officer of insurance consultant Cincinnatus Partners L.L.C. in Cincinnati. "The economics are there. It's a logical next step."

"I think it's a good time to buy," said Cliff Gallant, an analyst with Keefe, Bruyette & Woods Inc. in New York. "A lot of the property/casualty companies have a good reserve position, and with the dollar being weak, it's pretty attractive" for foreign firms that are likely to be interested in smaller P/C insurers.

"There'll be a steady and pretty healthy M&A market," although volume will be down from last year, said Jim Amen, a partner with Philo Smith & Co., a Stamford, Conn., a boutique investment bank specializing in insurance.

"There are more buyers than sellers at the moment, even with the credit market problems," said Mr. Amen, who said activity could pick up at the end of the year. "Most of the interest is in specialty commercial insurers."

"There's been quite a bit of activity already over the past 12 months," which has slowed recently "because of the volatility in the stock market and the weakness in commercial lines overall," said Mark Lane, an analyst with William Blair & Co. in Chicago.

But "lack of growth, the need to diversify both by line of business and geography" will push consolidation. "I think sellers are…adjusting their expectations down because valuations have come down so much over the last six months," Mr. Lane said.

"That might take a quarter or two, but the drivers of consolidation are there, and we expect to see more as the stock market stabilizes a little bit," he said.

—By Judy Greenwald

Results: P/C insurers' net income declines

CONTINUED FROM PAGE 3

you're seeing pressure on top-line premium growth," which became more severe as the year went along, he said.

The industry is at a point "where we're going to see further loss ratio deterioration and pressure on revenues, where fewer companies will earn an adequate return on capital," Mr. Auden said.

Competition intensified this year, Mr. Lane said. "We see nothing stopping that in the near term. Margins are still at well above average; returns are still well above average; claims inflation is still benign; and although we don't think that is sustainable, underwriters are reacting to that and getting more aggressive," he said.

"We think it's going to be sort of a slow grind over the next year to year-and-a-half, as the market adjusts to a more competitive pricing environment," Mr. Lane said.

"It's hard to tell if this is really going to be a more shallow soft market as some people seem to be arguing, or if we're just in the early stages of what had happened in the mid-'90s through 2001," said John D. Gwynn, managing director at Memphis, Tenn.-based investment firm Morgan Keegan & Co. Inc. "Unfortunately, the only way we'll know for sure is in retrospect."

Others say the extremes of the cycle have moderated.

"The primary issue is execution through a softening market," said Andrew Colannino, vp in the P/C division for Oldwick, N.J.-based A.M. Best Co. Inc.

"I think because of the pricing tools that are out there, and the good fundamentals in the industry and the financial transparency from Sarbanes-Oxley, that the peaks won't be as high as they have been in the past, and the valleys won't be as deep," he said.

Insurers' enterprise risk management capability today is the "basis for encouragement that the pricing cycle this time around may be a bit shallower and a bit shorter than past ones. We've been referring to it as a soft landing," said Thomas S. Upton, managing director of financial services ratings, North American insurance, for Standard & Poor's Corp. in New York.

But 2008 "is going to be the moment of truth for that, because pricing is coming down" and competition is increasing, Mr. Upton said.

> **'We think it's going to be sort of a slow grind over the next year to year-and-a-half, as the market adjusts to a more competitive pricing environment.'**
>
> Mark Lane, William Blair & Co.

"The magnitude and the breadth of the softening is a concern," said John L. Ward, chief executive officer of Cincinnati-based Cincinnatus Partners L.L.C. "Virtually all lines of commercial business are in double-digit softening mode and with no signs that is going to turn anytime soon. So there will continue to be pressure on results over the next 12 to 24 months."

"We still have a stable outlook for the industry," said Jeff Berg, senior vp with New York-based rating agency Moody's Investors Service. While pricing is expected to moderate over the near to medium term, "there still are lines of business where there's reasonable profitability," he said.

Observers also note that the industry has an excess of capital, which could lead to more stock buyback programs, competitive underwriting, and increased mergers and acquisitions (see story).

"The industry's never been very good at reducing capital voluntarily," and "we don't see that being any different this time," Mr. Lane said. "We think it's going to be a slow process of underlying margin deterioration until underwriters become a little more disciplined, and that could take a couple of years, absent some sort of unusual loss scenario."

Cliff Gallant, an analyst with Keefe, Bruyette & Woods Inc. in New York, said, "We're seeing a lot of share repurchasings and some increasing of dividends." But insurance company managers are trying to be cautious because the subprime credit crisis may make it more difficult to raise capital.

"They're trying to husband capital a little more carefully than you might otherwise expect" given their current capital positions, Mr. Gallant said.

Mr. Upton said there also is concern—should there be a repeat of the catastrophes of 2005—whether the capital markets would replace lost capital as quickly as the markets did following that year.

"Companies are managing their capital position very carefully" and are "acutely aware of the fact that a superabundance of capital retained within an organization inevitably leads to bad pricing decisions," Mr. Upton said.

Property/casualty insurers' 2007 year-end results

Ranked by net income. All amounts are in thousands of dollars.

	Corporate					Property/casualty operations			
	Net income	Percent increase (decrease) 2007-2006	Consolidated revenues 2007	Combined ratio 2007 [1]	Combined ratio 2006 [1]	Net premiums written 2007	Percent increase (decrease) 2007-2006	Policyholder surplus 2007	Percent increase (decrease) 2007-2006
American International Group Inc.	$6,200,000	(55.9%)	$110,064,000	90.3%	89.1%	$47,067,000	4.9%	$37,705,000	15.4%
Travelers Cos. Inc.	4,601,000	9.3	26,017,000	87.4	88.1	21,618,000	2.2	22,878,000	9.2
Hartford Financial Services Group Inc.	2,900,000	7.4	25,900,000	90.8	89.3	10,440,000 [2]	(2.1)	19,204,000	1.7
Chubb Corp.	2,807,000	11.0	14,107,000	82.9	84.2	11,872,000	(0.8)	12,950,000	14.0
ACE Ltd.	2,578,000	11.8	14,154,000	87.9	88.1	11,598,000	(1.4)	16,677,000	16.8
Liberty Mutual Insurance Co.	1,518,000	(6.6)	25,961,000 [2]	103.0 [2]	101.7 [2]	17,199,000	11.9	14,154,000	16.7
Cincinnati Financial Corp.	855,000	(8.0)	4,259,000	90.3	94.3	3,117,000	(1.9)	4,306,000	(9.4)
CNA Financial Corp.	851,000	(23.2)	9,885,000	94.8	96.4	6,773,000	(3.7)	8,511,000	4.6
SAFECO Corp.	707,800	(19.6)	6,208,800	91.4	87.3	5,639,800	–	2,958,600	(24.3)
American Financial Group Inc.	383,200	(15.5)	4,404,700	83.3	87.6	2,712,400	2.0	2,158,800	(11.0)
Old Republic International Corp.	272,466	(41.4)	4,091,031	91.9	90.3	2,122,055	4.4	2,536,764	9.7
RLI Corp.	175,867	30.6	652,345 [2]	71.4 [2]	84.1 [2]	538,763	(2.3)	774,422	2.4
Argo Group International Holdings Ltd.	143,800	35.7	1,000,000	99.4	93.9	854,200	0.9	947,000	23.3
Cumulative	**$23,993,133**	**(23.8%)**	**$246,703,876**	**90.8%**	**90.3%**	**$141,551,218**	**2.8%**	**$145,760,586**	**9.3%**

(1) Includes dividends (2) Statutory
Source: BI survey, company reports

Subprime-related claims to hit P/C insurers over time

The subprime mortgage crisis could affect property/casualty insurers because of the still undetermined amount of claims they may have to pay stemming from the coverage they provided to financial institutions, observers say.

They note, though, that these directors and officers and errors and omissions claims payments are likely to be spread out over a period of years.

Thomas S. Upton, managing director of New York-based Standard & Poor's Corp.'s financial services ratings, North American insurance, said while estimates of insurers' exposure to D&O and E&O claims range as high as $20 billion, "we don't see the basis for accurately projecting that at this time."

The exposure "will depend on a number of factors as this situation plays out," he said. When that happens, it "will probably be significant, but its realization will also be spread out over a period of time. It isn't like a $20 billion hurricane that hits overnight."

Observers say the credit crisis will not significantly affect P/C insurers' investment portfolios.

"You'll see some level of capital writedowns in the investment portfolios, which are credit sensitive, but not anywhere near what you're going to see in the life insurance industry," said Mark Lane, an analyst with William Blair & Co. in Chicago.

According to the Insurance Information Institute, life insurers' investment portfolios are more heavily weighted to mortgage loans and real estate than are property/casualty insurers' portfolios.

Most P/C insurers are very conservative in their investments and are "not reaching for high investment yields, so I think they're relatively OK," said Cliff Gallant, an analyst with Keefe, Bruyette & Woods Inc. in New York.

The stocks of both New York-based American International Group Inc. and Bermuda-based XL Capital Ltd. have "been under a lot more pressure over worry about their holdings," said Mr. Gallant.

Both, though, are "more than just simple property/casualty companies," Mr. Gallant said. "For the most part, the industry is in a pretty good position."

AIG's 2007 net income reflected an $11.47 billion pretax charge for a net unrealized market valuation loss related to its AIG Financial Products Corp.'s super senior credit default swap portfolio. XL's year-end results reflect $1.5 billion in charges that are primarily related to its investment in financial guarantee insurer Security Capital Assurance Ltd.

James B. Auden, senior director at Chicago-based Fitch Ratings, said another element in the credit crunch is problems related to financial guarantee insurers and their ratings downgrades.

He said P/C insurers do have very big positions in insured municipal bonds, but the underlying credit quality of the original bond issues are "still generally very strong."

P/C insurers are "more buy-and-hold investors, and they're generating decent enough cash flows, they don't need to sell these investments now, so they should be able to hold them to maturity and not have realized losses," Mr. Auden said.

—By Judy Greenwald

Retiree: Health care plans exempt from Age Discrimination in Employment Act

CONTINUED FROM PAGE 1

health care has been stable in the past few years and even rose slightly last year, according to research by benefit consultant Mercer L.L.C. in New York.

There are other signs of renewed employer interest in retiree health care plans. Since its launch in 2005, the number of employers joining a program that enables colleges and universities to sponsor retiree health care plans has climbed to 52 from 29, with more institutions expected to join.

"There is a growing confidence in our program," said Ken Cool, president of Emeriti Retirement Health Solutions in New Windsor, N.Y.

Competitive advantages

A key driver in offering retiree health care plans, experts say, are corporate concerns that, without such programs, employees will work longer than they or their employers want because the employees can't afford to buy coverage on their own, potentially keeping unproductive workers on the job and blocking advancement of talented younger employees.

Without a retiree health care plan, "You create a workforce management issue. Some employees, who may no longer be fully engaged and would rather be retired, stay on," said Dave Osterndorf, a principal with Towers Perrin in Milwaukee. "That is a negative result for employers and employees and that is why employers are again taking a look at these plans," he added.

Additionally, some employers say that offering retiree health care plans will give them a competitive advantage at a time when many organizations have folded their programs.

"It will give us a distinct advantage in recruiting and retaining employees," said Bill Detwiler, associate vp-human resources and business services at Southern Methodist University in Dallas, which joined the Emeriti program in January.

Plan designs differ

Even so, the plans that are being put in place are radically different and cheaper than the retiree health plans that once dotted the corporate universe.

"These are not your father's plans," said Rick McGill, a consultant in the Atlanta office of Hewitt Associates Inc. Benefit levels under the newer designs are not guaranteed and retirees are not protected from medical cost inflation, Mr. McGill added.

Indeed, because those old-style plans were designed to provide a defined health care benefit, employers were fully exposed to escalating liabilities that resulted from increased life expectancies and medical inflation. Those costs were more than many employers could afford and such plans continue to dwindle.

"There is no going back to where we once were. Employers are not signing up for unlimited liabilities," said Michael Thompson, a principal with PricewaterhouseCoopers L.L.P. in New York.

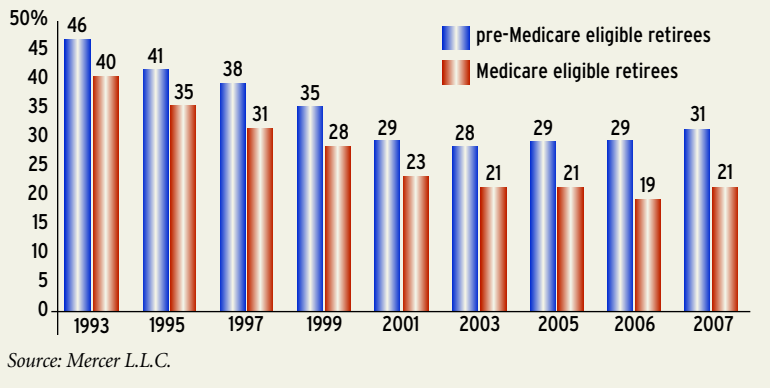
By contrast, the new-style plans largely are defined contribution, meaning employers are limiting their liability to a fixed amount.

"The employer defines the amount. The employer agrees to contribute X amount per month," said Rich Stover, a principal with Buck Consultants L.L.C. in Secaucus, N.J.

While the designs vary, today's plans typically center on accounts to which employers, and sometimes employees, contribute. When they retire, former workers can use the accumulated contributions to pay premiums for health coverage, including Medicare premiums and costs that fall under plan deductibles.

For example, under a new program that Ford Motor Co. began offering in January to pre-Medicare and Medicare-eligible non-union retirees, it contributes $1,800 a year per person plus another $1,800 for that person's spouse to a health reimbursement arrangement. For pre-Medicare retirees, Ford continues to provide health care plans, though its contribution is capped at what it paid in 2006, with retirees paying future cost increases.

Under Southern Methodist's plan, employees age 40 and older contribute $50 a month pretax to accounts, which SMU matches. Employees also can make additional contributions.



Retiree health care plan designs unaffected by appeals court decision

WASHINGTON—A federal appeals court decision that threatened to expose employers with mainstream retiree health care plans to a torrent of age discrimination suits ultimately had no impact on plan design.

Initially, there was disbelief when the 3rd U.S. Circuit Court of Appeals in August 2000 ruled that the Age Discrimination in Employment Act applied to retiree health care plans.

Under that ruling, the court said ADEA allows suits against employers that provide a lower level of benefits to older retirees than to younger retirees.

To prevent a charge of age discrimination, the court ruled, an employer would have to equalize health care benefits provided to retirees eligible for Medicare and retirees under age 65 or spend the same amount of money for health care benefits for the two groups.

This so-called equal-benefits/equal-cost safe harbor is a part of the ADEA, but prior to the 3rd Circuit ruling, it had been applied only to benefits provided to active employees, not retirees.

In a single stroke, the decision put virtually all corporate retiree health care plans in legal jeopardy. Typically because of Medicare, which retirees become eligible for at age 65, older retirees receive smaller health care benefits than younger retirees.

After initial alarm, though, employers did not change the design of their retiree health care plans.

"Employers took a wait-and-see attitude. There really was a feeling that reason would prevail," said Cara Jareb, director of retiree medical benefits consulting with Watson Wyatt Worldwide in Arlington, Va.

Indeed, as Dave Osterndorf, a principal with Towers Perrin in Milwaukee noted, complying with the ruling would have required drastic action.

Few, if any, employers could afford to boost Medicare-eligible retirees' benefits equal to what they provided to younger retirees. Most likely, employers would have either reduced younger retirees' benefits to put them in line with benefits provided to older retirees, or employers would have eliminated retiree health care plans, experts said.

While the Equal Employment Opportunity Commission, the federal agency that enforces ADEA, initially embraced the appeals court ruling, strong lobbying from employers and unions prompted the EEOC to move away from it. In 2001, the EEOC said it would not enforce the ruling and, in 2004, it proposed a rule exempting retiree health care plans from ADEA, assuring employers they could continue to offer a two-tier system of benefits without having to fear age discrimination suits.

The EEOC's change in position ended any lingering employer concerns about the 3rd Circuit decision, Ms. Jareb said.

Still, it wasn't until this month that the issue finally came to an end. After the EEOC in 2004 proposed its ADEA retiree health care plan exemption rule, the AARP sued to block its implementation and was initially successfully.

Ultimately, courts said the rule could be implemented and last week the Supreme Court declined to intervene, effectively allowing the rule to stand.

—By Jerry Geisel

WTC: Health suits allowed to proceed

CONTINUED FROM PAGE 1

Liability shield

Partially upholding a 2006 district court ruling, the 2nd Circuit Court ruled that further fact-finding by the courts is necessary before it can be determined whether state or federal laws granted the city and its contractors immunity from the Sept. 11-related lawsuits. In addition, the appeals court said it could not rule on defendants' argument that claims are pre-empted by a state law, as it lacked jurisdiction to do so.

In response to the city and contractors' arguments that failure to grant them immunity would make contractors less likely to respond in future disasters, the appeals court wrote: "We observe that private contractors, unlike volunteers or conscripts, are paid for their services and able to pass along the cost of liability protection to the government, either by including the cost of liability insurance in their contract or by seeking indemnification from the government."

In response to the ruling, Marc Jay Bern, a partner at Napoli Bern Ripka L.L.C., the New York law firm representing the plaintiffs, said: "The heroes of 9/11 have the green light, finally, to go forward in trials and ultimately to get the just compensation that is well-deserved for the time that they spent in selfless work in cleaning up the site following the attacks."

However, Michael Cardozo, the city's corporate counsel, said the appeals court "did not reject the city and contractors' immunity defense, but held only that the district court correctly ruled that the immunity could not be disposed of without further development in the district court of facts pertinent to that immunity."

Still, he said, New York and its contractors "are disappointed with the court's decision" but are "confident that as the facts unfold in the district court, the city and contractors will be found to be immune from lawsuits over our response to the terrorist attack."

He also said the city is considering whether to appeal the decision.

Defense cost ruling

In a separate but related action, the U.S. District Court for the Southern District of New York

See **WTC** next page

AP PHOTOS

Rescue personnel work amid the rubble of the former World Trade Center in New York one day after terrorists flew two planes into the Twin Towers on Sept. 11, 2001.

AIG: Accuses other workers comp insurers of illegally cutting losses

CONTINUED FROM PAGE 1

tory fallout that many of those insurers have faced as a result.

In violation of the federal racketeering law, several insurers in recent years have used their positions as board members of the workers comp reinsurance pool in which they all participated to cover up their premium reporting misdeeds, AIG charges.

At the same time, the insurers—including Hartford Financial Services Group Inc., Liberty Mutual Insurance Co. and Travelers Cos. Inc.—have attempted to force AIG to make up for its premium reporting shortfalls multiple times and have tried to damage the insurer's reputation, AIG charges.

The pool, the National Workers Compensation Reinsurance Pool, consists of 600 insurers that share losses generated by poor workers comp risks that cannot obtain coverage in the voluntary market. Those risks must purchase coverage through states' residual markets.

Pool members share the losses by reinsuring the workers comp underwriters that states assign to provide coverage to residual market policyholders. Each pool member's share of a state's residual market losses is based on the member's share of that state's total voluntary market premium volume.

AIG's suit also names the Boca Raton, Fla.-based National Council on Compensation Inc., which administers the pool. AIG contends the NCCI has failed to address the pool's premium underreporting problems despite conducting several examinations that highlighted the issue.

AIG argues that the defendants' scheme drove up losses for other NWCRP members that accurately reported their workers comp premium volume.

AIG also alleges that the scheme inflated the insurer's own workers comp pool losses, even though AIG admitted in a $1.64 billion settlement with then-New York Attorney General Eliot Spitzer that it had underreported its premium volume since 1974.

As part of the January 2006 settlement with Mr. Spitzer, AIG apologized for its actions and agreed to establish a $343 million fund to compensate the NWCRP.

But the pool asserts that the fund is inadequate.

The pool negotiated with AIG for more than a year after the Spitzer settlement in an effort to get the insurer to add to the fund. Negotiations between the two sides broke off last year, however. The pool asserted that AIG refused "to own up" to its conduct.

AIG complained in court papers that it could not settle because the pool refused to provide financial information that would allow the parties to reconcile all pool members' accounts.

In May 2007, the NWCRP sued AIG in federal court in Chicago, seeking $1 billion in damages (*BI*, May 28, 2007).

Separately, workers comp insurers in Minnesota also filed federal racketeering and state law charges against AIG, claiming the state's $1.2 million share of the Spitzer settlement was inadequate (*BI*, July 23, 2007). However, a federal district court on Friday dismissed the case, though the plaintiffs can refile their state law charges in state court.

AIG countersued the NWCRP last year but filed its case in New York state court. Because of the pending action in Chicago, a New York judge dismissed AIG's action.

In its latest lawsuit, AIG listed several measures that the defendant insurers used to underreport their workers comp premium volume.

For example, AIG charged that the insurers:

- Passed along their assigned risk plan expenses to voluntary market policyholders but then either did not record revenue from those charges or inappropriately coded them as revenue from another line of business.
- Delayed reporting a portion of their voluntary market premiums until a later period when the insurers calculated they could achieve better results in the residual market.
- Falsely reported policyholders' payroll information and then accounted for a portion of the workers comp premium they collected as premium from another line of coverage.

In recent years, NWCRP board members have tried to sabotage AIG by blocking states from drawing on the fund AIG established after settling with Mr. Spitzer, a measure designed to force AIG to contribute far more than it owes the pool, the insurer said.

The board members also prevented NCCI from conducting investigations and disclosing information that would show premium underreporting by other pool participants, including the board members, AIG contends. Those amounts would reduce the amount AIG owes the pool, it asserts.

AIG also claims the board members have engaged in a deliberate effort to damage the insurer's reputation by preventing the insurer from resolving the issue.

In a written response, the NWCRP stated: "Refusing to own up to its own false reporting conduct, AIG has now filed false claims frivolously attacking the National Pool's Board of Governors for taking action against AIG to legitimately protect the financial interests of the remainder of the participating companies of the National Pool."

Representatives of Hartford, Liberty Mutual and Travelers would not comment.

A representative of one pool member, which did not wish to be identified, said the Spitzer settlement did not address some premium reporting problems that AIG's own general counsel identified in a 1992 memo. The pool attempted for 18 months to resolve the issue with AIG, but "AIG essentially refused to cooperate."

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News In Brief

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must make sure that the applications include all of the information for each plan member required by the Centers for Medicare and Medicaid Services for payment under the program. The tax-free government subsidy is available to employers that provide drug benefits to Medicare-eligible retirees that are at least equal to drug benefits available under Medicare Part D.

Xerox has D&O cover to help fund pact

Xerox Corp. has up to $100 million of directors and officers liability insurance limits to respond to its $670 million settlement of a securities class action lawsuit, according to a source. Chubb Corp., which wrote $25 million of limits, led the coverage, and Marsh Inc. placed the program, the source said. National Union Fire Insurance Co. of Pittsburgh, Pa., a subsidiary of American International Group Inc., also provided Xerox $25 million of low excess layer limits, according to sources. National Union had attempted to rescind its coverage, but a New York state court thwarted the insurer in November 2004. The settlement resolves an eight-year-old securities lawsuit.

Accounting firm forms Dempsey Partners

Forensic accounting and consulting firm Dempsey, Myers & Co. has formed Dempsey Partners L.L.C. Based in Wilton, Conn., the new firm is led by John D. Dempsey and 10 other senior executives in New York, Chicago, Dallas, Houston, San Francisco and Los Angeles. Dempsey Partners will focus on business interruption risks as well as large property damage assessments, disaster response consulting, forensic analysis, corporate and employee fraud investigations, and commercial litigation services.

Prescription benefit cost hikes slowing

U.S. employers have adopted a range of options in their benefit plans to moderate rising pharmacy costs, mainly through promoting the use of generic drugs, a survey concludes. Prescription drug costs in 2007 rose an average of 9.3% among employers with 500 or more employees, while overall medical costs rose 5.1%, according to a recent survey by Mercer L.L.C. By comparison, a 2000 survey revealed that drug benefit costs rose an average of 18.3% and health benefit costs rose 6.6%.

Aspen gets approval for Lloyd's syndicate

Aspen Insurance Holdings Ltd. has received approval from Lloyd's of London to establish a new Lloyd's syndicate. Syndicate 4711, which will start underwriting in April, renews certain participations on selected classes of business currently written by its existing U.K. company, Aspen Insurance UK Ltd. These classes include energy, marine, hull, liability, transportation-related liability, aviation and certain types of specialty reinsurance lines. Aspen executives said the company plans to write approximately $100 million in premiums through Syndicate 4711 this year.

Generali gets OK for nonlife in China

Italian insurance giant Assicurazioni Generali S.p.A. has received approval to open a nonlife branch in Daqing, China. Generali China Insurance Co. Ltd. was formed in April 2007 as a 50/50 joint venture between the Trieste, Italy-based insurer and China National Petroleum Corp. Generali and CNPC have operated a joint venture life insurance company, Generali China Life Insurance Co. Ltd., since 2002 in the Guangdong province. The property/casualty branch has 500 million yuan ($70.9 million) in registered capital and will write both personal and commercial lines coverages.

Ironshore unit to write health care liability

Property/casualty insurer Ironshore Inc. is launching IronHealth, a division that will write risks in the health care liability sector. IronHealth, which will be based in Simsbury, Conn., initially will focus on hospital professional liability, managed care errors and omissions liability and long-term care professional liability, according to its Bermuda-based parent company. Ironshore formed in 2006 as a property insurer and subsequently launched specialty divisions IronPro, writing professional liability coverages, and IronBuilt, writing builders risk and contractors liability.

MMC names CEO for Kroll unit

Marsh & McLennan Cos. Inc. has named Ben Allen president and chief executive officer of Kroll Inc., the company's risk consulting and technology group. Mr. Allen, who was appointed chief operating officer of Kroll in July 2007, succeeds Simon V. Freakley, who was named CEO of a newly formed MMC corporate advisory and restructuring unit.

WTC: NYC, contractors denied immunity from lawsuits

CONTINUED FROM PREVIOUS PAGE

ordered the city's excess insurers to defend the city and its contractors in the personal injury cases.

U.S. District Judge Alvin K. Hellerstein, the judge appointed to oversee all WTC-related litigation, also ordered the insurers to work out among themselves how much each will pay.

Those insurers, which collectively wrote $75 million in excess umbrella coverage, include certain underwriters at Lloyd's of London, certain London Market insurance companies, Assicurazioni Generali S.p.A. and General Security Indemnity Co. of Arizona.

Liberty Mutual Fire Insurance Co. of Boston, which had provided $4 million in primary coverage, settled with the city a little over a month ago.

The city also has an additional $1 billion in excess coverage through WTC Captive Insurance Co., a nonprofit captive formed in December 2004 with a $1 billion grant from the Federal Emergency Management Agency as part of the Air Transportation Safety and System Stabilization Act.

'The heroes of 9/11 have the green light, finally, to go forward in trials.'

Marc Jay Bern,
Napoli Bern Ripka L.L.C.

ATSSSA was passed shortly after the Sept. 11, 2001, terrorist attacks to limit the liability of New York and airline companies, provide funding to compensate victims, and authorize creation of a captive insurer that would both defend and indemnify the city against claims associated with the WTC disaster. The act capped the city's liability at $350 million or its insurance coverage limits, whichever is greater.

In a statement, WTC Captive said it was pleased with the district court's coverage decision and said it would work with Lloyd's and the London insurers to determine how much each should pay.

WTC Captive, which has been paying defense costs on behalf of New York and its contractors in the underlying litigation, filed the suit against the other insurers. Those insurers have asserted various reasons why they have not been providing defense cost coverage, including late notice of claims and a pollution exclusion in the policies.

"We believe, based on the plain language of the contracts, that there is an unambiguous pollution exclusion, which should result in the insurers not being responsible for defense costs with respect to the respiratory claims," said Fred Reinke, a partner at Dewey & LeBoeuf L.L.P. in Washington, who represents the insurers. "We also believe that it was premature for the court to grant summary judgment to the WTC Captive in light of several open factual issues that need to be resolved," he said.

One of those factual issues yet to be addressed is whether New York's contractors' insurance is likely to respond to any of the claims, Mr. Reinke said.

He also said the insurers are considering appealing the decision.

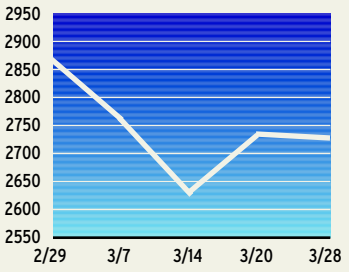
In Re: World Trade Center Disaster Site litigation, 2nd U.S. Circuit Court of Appeals, 06-5324-cv; March 26, 2008. Also: WTC Captive Insurance Co. Inc. vs. Liberty Mutual Fire Insurance Co., et. al.; U.S. District Court for the Southern District of New York; 07 Civ. 1209 (AKH); March 21, 2008.

Stock Index

[3/24 - 3/28]

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

***BI* STOCK INDEX**



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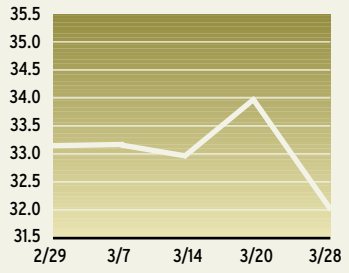
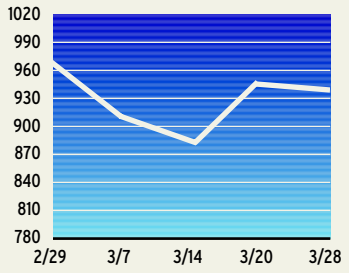
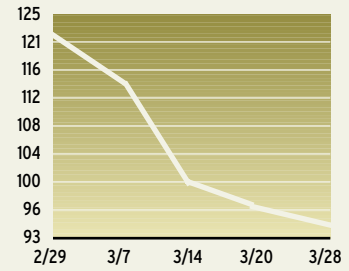


***BI* INSURER/REINSURERS INDEX**



***BI* MANAGED CARE ORGANIZATIONS INDEX**



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

***BI* STOCK INDEX**	2734.08	0.02%
DOW JONES	12216.40	-1.17%
S&P 500	1315.22	-1.07%

LARGEST GAINS

Gainsco Inc.	11.14%
AXA	8.81%
SCOR S.A.	6.67%
AEGON N.V.	5.34%
Fairfax Financial Holdings	5.15%

LARGEST LOSSES

Ambac Financial Group	-13.28%
Selective Insurance Group	-13.10%
XL Capital Corp.	-7.90%
Citigroup Inc.	-7.42%
Allmerica Financial Corp.	-7.33%

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

Business Insurance END PAGE

Contributing: Jeff Casale, Mark A. Hofmann, Dave Lenckus, Colleen McCarthy

KRISTA KENNELL/ZUMA PRESS

Oprah Winfrey faces a lawsuit charging that she stole the idea for her show 'Oprah's Big Give.'

Two become members of Oprah's lawsuit club

Don't count lawsuits among Oprah Winfrey's favorite things.

The reigning queen of daytime television is fending off two lawsuits, one filed by a former fan claiming she was injured in a mad dash for seats at Ms. Winfrey's talk show in Chicago and another claiming Ms. Winfrey stole the idea for her reality TV show "Oprah's Big Give."

Orit Greenberg is seeking $50,000 in damages, claiming Harpo Studios failed to control the crowd when she was pushed down the stairs in December 2006, suffering "severe and permanent injuries."

Meanwhile, Darlene Tracy of Boston filed a copyright infringement suit claiming she created and presented the idea for a reality TV show called "The Philanthropist" to Ms. Winfrey's producers in early 2005. While a federal judge reportedly dismissed the lawsuit earlier this month, Ms. Tracy has appealed.

The queen of talk isn't talking publicly about either suit.

A spokeswoman for Harpo Studios reportedly said the organization does not comment on pending litigation. However, the spokeswoman in another report said Ms. Tracy's claims are "without merit."

Store throws a curve in Red Sox promotion

It's a sales promotion that Chicago Cubs fans would love to see their team spoil by winning its first World Series championship in 100 years (really, that's no exaggeration).

Other Major League Baseball teams also could—and more likely will—have the opportunity to cross up the customers of Jordan's Furniture, which again is offering free furniture if the Boston Red Sox repeat their 2007 championship season. Just as it did last year, the East Taunton, Mass.-based retailer, a subsidiary of Berkshire Hathaway Inc., has purchased insurance to cover at least a portion of the cost of any giveaway.

Thousands of customers who purchased items from Jordan's Furniture over a six-week period during a similar promotion last year ended up with free furniture after the Red Sox won the 2007 World Series.

This year, the promotion period of March 25-April 27 is eight days shorter, and the BoSox have to do more than just win the World Series. The team has to win the first four games of the best-of-seven MLB championship. The Red Sox swept last year's Series with the Colorado Rockies, but the 2007 furniture promotion was based only on the team winning the baseball crown, even if that had taken all seven games.

A Jordan's Furniture spokeswoman acknowledged that the store's customers face lower odds of winning free furniture this year, but she would not discuss changes in the promotion or the store's insurance coverage.

But a baseball statistic suggests that Jordan's Furniture likely will not be filing a claim after the fall classic in October, even if the Red Sox repeat. In baseball's modern era beginning in 1903, only the New York Yankees have swept the World Series in consecutive years, according to the Baseball Almanac. Boston's nemesis did it three times: in 1927 and 1928, 1938 and 1939, and in 1998 and 1999.

Customers of Jordan's Furniture hope Red Sox ace Josh Beckett can help the team sweep this year's World Series.

NYT PHOTOS

Drag race ends with charge of comp fraud

Some people will do almost anything to get Hannah Montana tickets—even if it involves fraud.

Garrett Dalton, 41, a Connecticut correctional officer who was collecting workers compensation due to a back injury, reportedly was suspended from his job and arrested after news crews photographed him competing in a radio station-sponsored 40-yard dash—in high heels and a dress—to win Hannah Montana tickets.

Mr. Dalton, who was charged with one count of workers compensation fraud and faces up to 20 years in prison if convicted, is scheduled to appear in New Haven Superior Court on April 8, reports said.

Mr. Dalton injured his back on June 11, 2007, while lifting a box of toilet paper and soap at the New Haven Correctional Center, reports said. By Nov. 14, 2007, when he returned to work, he had collected more than $5,200 in benefits.

However, on Oct. 17, 2007, news crews and photographers allegedly filmed him running the dash while clad in women's clothing and carrying an egg on a spoon in an effort to score much-coveted Hannah Montana tickets.

Mr. Dalton didn't win the race, but his boss reportedly spotted his picture in the newspaper.

Come on baby, light my fire and marine

Members of the The Doors and an insurer have been involved in disputes arising from recent tours by a partial version of the band.

ZUMA PRESS

It's not the end, my friend, for Doors keyboardist Ray Manzarek's attempt to get St. Paul Fire & Marine Insurance Co. to cover an "advertising injury" he suffered in a dispute with Doors drummer John Densmore.

The two have been feuding for years over Mr. Manzarek's touring with guitarist Robby Krieger, the Doors' other surviving member, as The Doors of the 21st Century.

The original Doors dissolved following the 1971 death of frontman Jim Morrison.

Mr. Densmore sued Mr. Manzarek and his Doors Touring Inc. for, among other things, economic loss and damage to his "reputation and stature by causing people to believe that he was not, and is not, an integral and respected part of The Doors band, or is one member who can be easily replaced by another drummer," according to court papers.

A state trial court found Mr. Manzarek liable on some claims but awarded no damages. In the process, Mr. Manzarek and the touring company rolled up legal fees of more than $3 million. He attempted to collect some of that from commercial general liability coverage issued by St. Paul that covered "advertising injury" and other exposures.

Mr. Manzarek notified St. Paul in early 2003 of the Densmore suit; St. Paul responded that it was investigating the claim but believed it was not covered. In March 2003, the insurer denied the claim. Mr. Manzarek sued St. Paul, but in 2006, the U.S. District Court for the Central District of California dismissed the claim.

Last week, a three-judge panel of the 9th U.S. Circuit Court of Appeals ruled that the district court erred by dismissing Mr. Manzarek's complaint, abused its discretion by failing to allow Mr. Manzarek and DTI to amend the complaint, and told the court to reconsider the issue.

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