

Business Insurance

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\$5

Late News

Tizzio retires from AIG

Thomas R. Tizzio, senior vice chairman, general insurance, for American International Group Inc., has retired from AIG. Mr. Tizzio, 68, who served as president of AIG from 1991-97, joined the insurer in 1967. He will remain an honorary director and will serve as an adviser to New York-based AIG.

Delphi to freeze DB plans

Financially troubled auto parts manufacturer Delphi Corp. intends to freeze its two massively underfunded pension plans covering salaried and hourly employees as part of its strategy to emerge from Chapter 11 bankruptcy. Delphi said it will stop accruals on Oct. 1 in its plan covering hourly U.S. employees and will freeze its salaried employees plan on Jan. 1, 2007. It will set up new defined contribution plans for hourly employees more than seven years from retirement and salaried employees "that include flexibility for both direct company

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Inside



FAIR OR FOUL?

Insurers deny injury claim for Astro Jeff Bagwell.

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EMERGENCY CARE

Casino opens worksite clinic in New Orleans.

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CRISIS FALLOUT

Zurich settles with Spitzer, other states

Bid-rigging, finite probes cost insurer \$325 million

By **RUPAL PAREKH**

NEW YORK—Zurich Financial Services Group Inc. last week cleared a key hurdle in efforts to resolve probes into its practices, agreeing to pay \$153 million to resolve allegations of bid rigging and improper use of finite reinsurance brought by officials in New York, Connecticut and Illinois.

The three-state pact comes on the heels of a \$171.7 million agreement over similar charges of bid rigging the Swiss insurance company reached with several states earlier this month (*BI*, March 23). And the second settlement, which came just days after the first was announced, nullifies a provision in the earlier pact that would have permitted Zurich to recover millions of dollars in the event policyholders failed to collect on all of the

money available.

The earlier deal—of which \$151.7 million is earmarked for policyholder restitution, while \$20 million will go toward paying the states' investigation fees and legal costs—was struck with attorneys general from California, Florida,

Hawaii, Maryland, Massachusetts, Oregon, Pennsylvania, Texas and West Virginia, along with Florida's insurance commissioner. Virginia's attorney general has since also joined that settlement, a company spokesman said.

Under the terms of last week's settlement, the insurer will pay \$88 million to Zurich's U.S. policyholders harmed by bid-rigging activities (see story, page 20). In addition, a total of \$65 million—\$39 million to New York and \$13 million each to Connecticut and Illinois—will be used to pay penalties to the three states.

Officials had alleged the company was one of several insurers that took part in a scheme with New York-based broker Marsh & McLennan Cos. Inc. to rig the process of bidding for excess casualty insurance policies.

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WHO GETS WHAT?

Complex compensation deal explained

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NOT-SO-RISKY BUSINESS

Pact sheds more light on finite deals

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Employers seek time on pension reforms

Urge start date delay until 2008

By **JERRY GEISEL**

WASHINGTON—As congressional conferees try to agree on a compromise pension funding reform measure, business groups are urging federal legislators to delay the effective date of the proposed law by one year.

Sen. Mike Enzi, R-Wyo.—chairman of the 27-member committee that has just begun the process of ironing out differences in the very different measures passed by the House and Senate—had hoped to produce a final bill by the end of this week, before legislators take a two-week recess.

But House Majority Leader John Boehner, R-Ohio, said last week it wasn't realistic to expect an agreement on a final bill until legislators return in mid-April.

A developing consensus among lobbying groups is that an agreement, in fact, may



Sen. Mike Enzi, R-Wyo., chairs a congressional committee considering pension funding reforms that business groups say should not be implemented until 2008 to allow employers time to prepare.

See **PENSIONS** / page 22

Insurer profits point to rate cuts as P/C cycle turns

By **JUDY GREENWALD**

Commercial property/casualty insurers are likely to have a highly profitable year in 2006, but insurance buyers can expect a return to intense competition in 2007 as the market softens, say observers.

Meanwhile, the industry reported strong results for 2005, despite the high catastrophe losses. "It's interesting to see how well the industry withstood the pounding of the catastrophe losses" and still emerged "in pretty good shape," said Cincinnati-based independent insurance analyst John L. Ward.

The 14 insurers surveyed by *Business Insurance* posted a 7.8% increase in net income in 2005, to \$21 billion. This compares with a 23.7% increase for the nine months

ended Sept. 30, before the hurricanes' impact was felt.

Among other results from *BI*'s survey:

- The insurers reported a 101.3% average combined ratio for the year, vs. a 99.8% combined ratio for the comparable period a year earlier. They had reported a 98.2% combined ratio for the first nine months.

- Net premiums written increased 5.3%, to \$133.77 billion.

- Policyholder surplus increased 12.1%, to \$77.77 billion.

Overall, despite the hurricanes, "it was obviously a highly profitable year for most companies in the business," said John D. Gwynn, managing director at Morgan Keegan & Co.

See **P/C RESULTS** / page 14



INTERNATIONAL NEWS

CYCLONE STRIKES

Insurers face losses of more than \$200 million after Australian storm.

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FILM FLOPS

Insurer loses in dispute with broker over film financing insurance losses.

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AON

Focus

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*Identifying a workplace shooter
is the difference between recognizing
cognitive and primal aggression.*

APRIL 3, 2006

Employers must understand workplace violence to prevent it



Dr. John Byrnes is CEO of the Center for Aggression Management.[®] He advises employers on methods to protect employees and companies from aggressive employee behavior. Dr. Byrnes can be reached at john_byrnes@aon.com.

Recent workplace shootings remind us that the threat of workplace violence is very real. These situations also underscore the fact that current methods employers use—called conflict resolution and anger management—are not enough to predict and prevent workplace violence, because they are reactive by nature. In order to truly make a difference and decrease the potential that workplace anger will result in a violent act, employers must observe and measure aggression prior to conflict.

The main reason employers fail to anticipate deadly violence before it happens is because most are looking for the wrong signs. These signs make up the difference between primal and cognitive aggression.

Primal aggression is based on the primal instincts of fight or flight. It is fueled by adrenaline and shows itself in identifiable body language and behavior. This type of aggression is demonstrated by an individual who loses control and attacks. It includes demonstrating disjointed and anxious behavior, making little eye contact or, conversely, staring and having a quick temper. And, it is not the kind of aggression that typically results in planned, conscious and deliberate aggressive acts, like workplace shootings.

Cognitive aggression, on the other hand, is based on hostile/malicious intent. It is fueled by determination and purpose, and is indicative of an individual who wishes to evoke terror. The key to identifying this behavior, however, is much different from

identifying someone who demonstrates primal aggression, yet many employers fail to recognize these signs.

To overcome this challenge, it is important, first, for employers to understand that scheming to attack another human is not instinctual. In order to do this, the aggressor must disconnect from the person who is the focus of aggression. As this process transpires, the attacker expresses identifiable and measurable behavior and body language. Such signs include demonstrating distance, fixating on a viewpoint, being overly competitive and distrustful, and taking action without consulting others. This is the kind of behavior to which employers seeking to decrease the risk of a workplace shooting should pay attention.

In sum, employers looking out for primal aggression in employees are likely to miss the signs of cognitive aggression that may result in workplace shootings. They will also likely focus their attention on curing primal aggressions through conflict resolution and anger management, but these methods are of little use when it comes to cognitive aggression.

The key to recognizing this type of aggression before it reaches a breaking point is training. Employees and human resources professionals must be taught how to recognize and measure both forms of aggression, and they must be equipped with the skills needed to move aggressors away from violence.

Go to www.aon.com/focus to receive Aon Focus by e-mail.

As corporate director pay levels out, companies may find new ways to attract talent

Recent analysis of corporate director compensation suggests that pay increases are modest. Directors are expected to attend myriad board, audit committee and compensation committee meetings throughout the year, spending a number of hours preparing for and participating in each meeting. Time demands, combined with scrutiny and accountability of board members, will likely influence directors to serve on fewer boards, resulting in a shrinking pool of future candidates. Companies should consider new strategies, such as greater D&O protection or other benefits, to attract talented candidates. To read the full report, visit www.aon.com/techseminars.

FASB overhauls rules for pensions and other post-retirement benefits

Company balance sheets may show larger liabilities for pensions and post-retirement benefits, as well as reduced shareholders' equity, under a new proposal by the Financial Accounting Standards Board (FASB). The FASB is expected to present a two-phased overhaul for current pension and post-retirement benefits accounting rules. In the first phase, the FASB will propose that employers include the funded status of their pension and post-retirement benefits on balance sheets. In the second phase, the FASB will reconsider most aspects of the existing standards of accounting for pensions and post-retirement benefits jointly with the International Accounting Standards Board. For other regulatory developments, visit www.aon.com/focus.

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everyone in our organization.
How can we be sure everyone is safe?"**



Aon's Center for Aggression Management uses a proprietary approach to comprehensive prevention of workplace aggression and violence. Our experts teach companies across the nation how to identify, measure and manage aggression before conflict occurs, in order to decrease the likelihood of a workplace violence event.

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Inside

National statute of repose for workplace goods weighed

A House bill would create a national 12-year statute of repose for workplace goods. Page 4

Anderson Kill has advice for hurricane-hit policyholders

Attorneys work to educate policyholders on post-hurricane dealings with insurers. Page 6

Congressional conferees must fix pension system

Defined benefit plan sponsors need system improvements, an editorial says. Page 8

Employers say they fear retiree funds are lacking

Employers report they doubt workers are saving enough for on-time retirement. Page 16

Online poll - [3/27 - 3/31]

Merger and acquisition activity among property/casualty insurers over the next 12 months will:



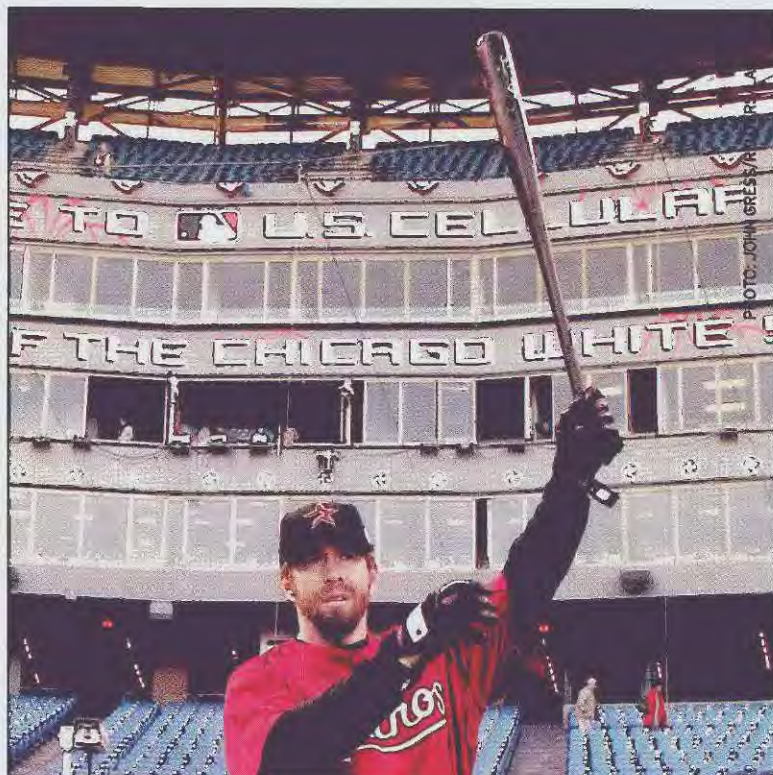
Participate in BI's online polls at www.businessinsurance.com.

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Houston Astros first baseman Jeff Bagwell, taking batting practice before the 2005 World Series, is at the center of a disability claim dispute.

Astros call CIGNA off base on denial of disability claim

By GLORIA GONZALEZ

HOUSTON—The injured right shoulder of baseball player Jeff Bagwell has become a sore subject for his baseball team and its insurer.

The first baseman's injury is at the center of a dispute between the Houston Astros baseball team and CIGNA Corp. related to an insurance policy purchased by the team to cover the Astros if Mr. Bagwell were to become totally disabled.

The team filed a claim for approximately \$15.6 million in January, saying an injury to

Mr. Bagwell's right shoulder has left him totally disabled. But CIGNA denied the claim last month, a decision the Astros plan to challenge in court unless the insurer reverses its position, according to the team's lawyer.

A key part of the dispute arises from the fact that Mr. Bagwell, who had surgery on the shoulder in June 2005, played at the end of the regular baseball season and in the baseball playoffs in September and October 2005.

See **ASTROS** / page 23

Executives outline terror cover plan at NAIC forum

By GLORIA GONZALEZ

NEW YORK—The insurance industry may be inching closer to developing a long-term proposal for handling terrorism exposures that would reduce, but not eliminate, the federal government's role in insuring the risks.

While the industry realizes that Congress is unlikely to renew the Terrorism Risk Insurance Act in its current form, a proposal being developed by a committee of chief executive officers of large property/casualty insurers still envisions the federal government providing a backstop to any catastrophic terrorism insurance losses.

Edmund Kelly, chairman, president and chief executive officer of Liberty Mutual Group, laid out the basic proposal at a public hearing of the National Assn. of Insurance Commissioners' terrorism insurance implementation working group last week in New York.

Mr. Kelly is chair of the 15 person Property and Casualty CEO Roundtable, which is developing a proposal for insuring terrorism risks that aims to provide sufficient protection to policyholders while creating a stable market for the risks and easing concerns about federal involvement in such a program.

One of the key points that the committee seeks to reinforce is the industry's position that there exists insufficient capital to absorb catastrophic terrorism risks.

The industry failed to convince Congress of the permanent lack of capital during last

year's TRIA renewal debate, said Mr. Kelly, who emphasized that his comments reflect the views of his company rather than those of the committee.

In addition, the committee's proposal contends that the insurance market in general is regulated and not a truly free market, which speaks to one of the key criticisms by members of Congress during the renewal debate—that the handling of terrorism risk is a free-market issue and the industry should develop a free-market solution.

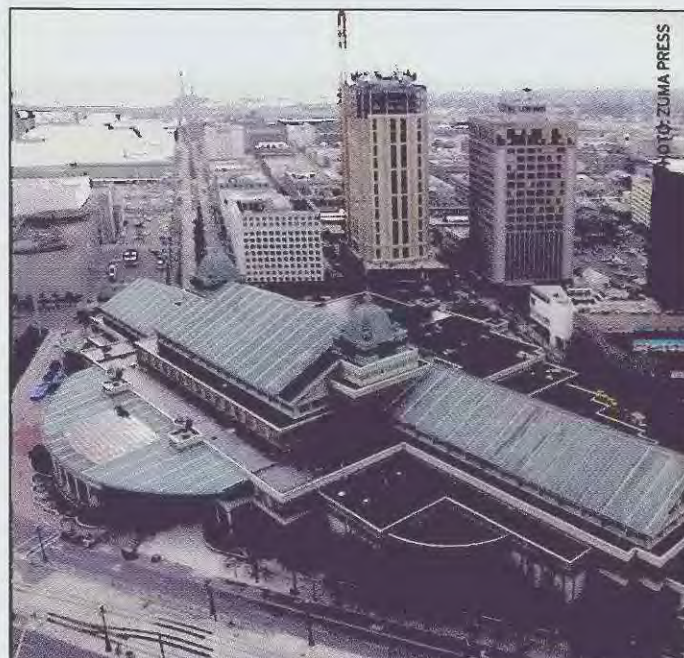
"While many of us certainly agree with that philosophy in concept, we have to recognize there are some instances where the free-market response will be to withdraw from the market," said New York Superintendent of Insurance Howard Mills, who also spoke at the hearing.

The structure envisioned by the industry executives would have three tiers: individual company retentions; continued private financing of the risks through some form of reinsurance, catastrophe bonds or other private-market mechanisms; and a federal backstop.

The first two layers would increase over time, causing the federal backstop to recede, Mr. Kelly said.

"However, there will never be a time when a federal backstop is not needed," he said.

The executives plan to have a formal proposal finalized by late June or early July, Mr. Kelly said. "Success is not assured, but I am confident that our industry can come together on a sensible long-term proposal," he said.



Harrah's New Orleans Casino, shown here on Jan. 1, reopened for business Feb. 17 with a staff of 1,600, 90% of whom were former employees.

Harrah's launching onsite health clinic in New Orleans

By JOANNE WOJCIK

NEW ORLEANS—In response to the dearth of medical services available in New Orleans following Hurricane Katrina, Harrah's Entertainment Inc. is opening a clinic for its employees and their dependents at its newly reopened casino there.

The Las Vegas-based casino giant also hopes that providing basic health care services on site will make it more attractive to potential employees at a time when labor is in short supply due to the displacement of many workers when their

housing was destroyed by the August 2005 storm.

Although Harrah's has three other worksite clinics and had intended to establish the New Orleans facility eventually, it moved up the opening date when it became evident that the medical infrastructure in the Big Easy was not rebounding as quickly as was needed.

In the wake of Katrina, the city of New Orleans was left with only 456 staffed hospital beds, compared with 2,269 before the devastating storm forced levees to break and

See **HARRAH'S** / page 22

Pitney Bowes tool encourages workers to live healthier

By JOANNE WOJCIK

STAMFORD, Conn.—Pitney Bowes has found a creative and economical way to encourage its employees to take better care of their health.

By collaborating with one of its wellness vendors, the Stamford, Conn.-based office machine maker has developed an interactive wellness software program for its employees at a cost that is much lower cost than would have been the case had the company built it itself.

and vegetables? You can remember that number easily," Dr. Fabius said.

For Pitney Bowes, the numbers range from 0 to 100: 0% tobacco use; five fruits and vegetables a day; 25 or lower body mass index; 30 minutes of daily exercise; and 100% seatbelt use.

"If you can get a population just to do those things and drive home these metrics for at least three years, you can drive healthy behaviors that lead to lower health care costs," Dr. Fabius said.

With the software, employees must answer questionnaires three times a year that include questions on each of the five categories. Employees who participate and show improvement in any of the key lifestyle areas receive credits toward their contributions to the following year's health plan premiums.

For example, an employee can receive a \$25 credit if he or she completes a health risk appraisal given by that employee's individual health plan. Pitney Bowes offers its 24,000 U.S. employees the choice from among 44 different self-insured health plans, administered by Minnetonka, Minn.-based UnitedHealth Group, Broomfield, Conn.-based Aetna Inc. and several other major insurers, according to Dr. Pawlecki.

An employee who completes the health risk appraisal and also responds to one of the surveys can earn up to \$75 in credits, and an employee who takes the appraisal and answers all three surveys receives up to \$200 in credits. The way the questionnaires are designed, employees' responses will indicate whether they have made improvements in their lifestyles.

Because Pitney Bowes introduced the software in January, it is too early to determine what impact it has had on the company's health care costs, according to Dr. Pawlecki.

He said, though, that participation appears to be increasing, adding that employees will be given the opportunity to respond to their second questionnaire during April.



And under its development agreement with Chadds Ford, Pa.-based CHD Meridian Healthcare L.L.C., Pitney Bowes' software will be repackaged and sold to other employers beginning later this year.

However, CHD Meridian, which also plans to use the software for its own employees, must find a new name for the product, said Dr. Brent Pawlecki, Pitney Bowes' associate medical director in Stamford, Conn.

Now called "Count Your Way to Health," the software uses numbers to show how simple wellness can be.

"Most of the software programs out there are very sophisticated," said Dr. Ray Fabius, president and chief medical officer at CHD Meridian. "They include health risk appraisals that are 10 pages long or more. They even include biometric numbers like blood pressure and cholesterol, blood sugar. It can be overwhelming for an employee to try to synthesize all of these recommendations into an action plan."

"In addition, at the employer level, where they're trying to rally the population around healthy behaviors...this kind of approach really resonates. For example, did I eat my five fruits

Retaliatory discharge suit can move forward: Court

By JUDY GREENWALD

ST. LOUIS—A rental car company manager who was terminated in 2002 less than a month after complaining of sexual harassment by her supervisor can pursue a retaliatory discharge claim against her former employer, said a federal appellate court in overturning a lower court decision dismissing the case.

Wednesday's 2-1 majority decision by the 8th U.S. Circuit Court of Appeals in *Terri Wallace vs. DTG Operations Inc.* notes that although Terri Wallace was not in fact terminated by her employer until 28 days after she complained about her supervisor's conduct, the decision to terminate her was made

just 15 days later.

The company said Ms. Wallace was terminated from her position as a Dollar Rent-A-Car station manager at Kansas City International Airport because of a business downturn following the Sept. 11, 2001, terrorist attacks, said the opinion.

But Ms. Wallace "was the only management employee in the Midwest region actually terminated due to the downturn in business" and she was the company's only Midwest employee actually terminated that year, according to the opinion.

Further evidence supporting Ms. Wallace's retaliation charge included comments by a regional manager that reflected animus

and inconsistent application of a policy restricting transfers that did not permit her to move elsewhere, said the opinion.

The decision also points to "shifting explanations" for Ms. Wallace's termination. "At her termination, no one for the company suggested that performance factored into the termination decision," said the opinion. "Nevertheless, in these proceedings, the company raises performance issues as a make-weight and non-retaliatory motive for Ms. Wallace's termination."

"While a jury certainly need not resolve the factual issue of retaliatory intent in favor of Ms. Wallace, we believe that it reasonably could," said the opinion.

Need for federal cat fund debated

Panel mulls government-backed reinsurance pool

By MARK A. HOFMANN

WASHINGTON—The insurance industry's response to the 2005 hurricanes demonstrates that the private insurance market can handle natural catastrophe losses without a federal backstop, according to the president of the Washington-based Reinsurance Assn. of America.

"I defy you to name one bankruptcy that came as a result" of last year's record hurricane losses, Franklin W. Nutter challenged his audience late last month during a panel discussion at a symposium on catastrophic risk insurance sponsored by the Washington law firm of Wiley Rein & Fielding L.L.P. and the University of Connecticut School of Law's In-

surance Law Center. Mr. Nutter said the federal government, rather than create a catastrophe fund, should concentrate its efforts on such matters as mitigation and enforcing building codes.

Paul Mattera, senior vp-government affairs for Liberty Mutual Group in Boston, also argued against setting up some sort of federal catastrophe fund. Like Mr. Nutter, he stressed that private markets are working, pointing out that, despite last year's catastrophe losses, the property/casualty insurance industry still made a profit. Mr. Mattera said that "while we can't rule out the need for state catastrophe funds where there is a demonstrable market failure," any such mechanisms should be temporary. A federal catastrophe fund

would distort the insurance market by providing underpriced reinsurance, he added.

That was not a position shared by all other members of the panel, though.

"We need to challenge our imaginations, because things keep getting worse," said Edward Collins, managing counsel for Northbrook, Ill.-based Allstate Insurance Co. Allstate belongs to and funds a recently created organization called ProtectingAmerica.org, which is seeking enactment of H.R. 4366, the Homeowners Insurance Protection Act. The measure would create a federally backed reinsurance pool to enhance the availability and afford-

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Tort reform bill still in committee

Measure would give relief to some manufacturers

By MARK A. HOFMANN

WASHINGTON—The House Judiciary Committee this week could complete consideration of a bill that would create a national 12-year statute of repose for workplace goods.

The Workplace Goods Job Growth and Competitiveness Act—H.R. 3509—would pre-empt existing state laws that protect manufacturers of workplace goods from product liability after their products have been used for a specific amount of time by creating a uniform federal standard.

H.R. 3509 would apply only in situations where the injured party was eligible for workers compensa-

tion and where the injury did not involve a toxic substance such as asbestos. It would not apply to consumer goods.

The measure is supported by the National Assn. of Manufacturers and other business groups. Consumer groups oppose the bill, claiming that it unfairly strips workers of basic rights.

Judiciary Committee Chairman James Sensenbrenner, R-Wis., had hoped to vote the bill out of committee on March 29. Committee Democrats who oppose the bill had prepared about 10 amendments, only three of which were dealt with before Rep. Sensenbrenner adjourned the committee last week. He told members of the

panel that he would resume consideration of the measure this week.

A national statute of repose would ensure a fairer system and enhance the international competitiveness of U.S. businesses, said Lawrence Fineran, vp-regulatory and legal reform policy for NAM in Washington.

"The fact is there are lawsuits involving products that are 80, 90, 100 years old. There should come a point when the law recognizes that the manufacturers should no longer be held liable. If the machine were defective, it would likely be found in the first 10 or 12

See TORT REFORM / page 19

LOTS OF HEAT. A LITTLE WATER.

THE PERFECT RECIPE FOR A SAUNA.

OR A DISASTER.



WAUSAU PROPERTY AT WORK. A building material supply client of ours recently moved into a larger building. Despite the extra space, it still had inventory stacked nearly to the ceiling. This presented a bit of a problem for the existing sprinkler system, which was not designed for high-pile storage. The system didn't have the necessary water and pressure to combat the type of intense fires that could result from the primarily wood materials. Our loss prevention experts estimated the entire \$4 million inventory could be lost in a fire. Working together, we found a solution



that appealed to both the company and its landlord. The existing system was replaced with one designed for high-pile storage and the building was outfitted with new heaters to prevent the pipes from freezing. In addition to protecting its inventory, the company saved almost \$30,000 a year in premiums. It's all part of Wausau TotalValueSM and our commitment to lowering your clients' total cost of risk. A commitment backed by the financial strength of the Liberty Mutual Group. To learn **PRICE ≠ COST.** more, visit wausau.com or contact your Wausau representative.

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Attorneys warn buyers to document cover

By MICHAEL BRADFORD

NEW ORLEANS—Property owners and contractors should be taking careful steps as they rebuild the hurricane-battered Gulf Coast to avoid what policyholder attorneys are calling insurance coverage traps.

One of the smartest moves policyholders can make to protect themselves in coverage disputes that arise after such catastrophes is to thoroughly document all agreements and conversations with insurers, said Joshua Gold, New York-based attorney and shareholder with Anderson Kill & Olick P.C.

It sounds like basic advice, Mr. Gold acknowledged, "but we've seen so often that even large, sophisticated policyholders with large risk management groups don't always do a good job of documenting their meetings and phone calls."

Mr. Gold, speaking at a one-day seminar—sponsored by Anderson Kill—on recouping losses from last year's hurricanes in New Orleans last week, said that when policyholders make verbal or informal

agreements with insurers, "you do that at your own risk. ... What we always say is that when you are dealing with your insurance company, when you're dealing with an adjuster on the other side of the table, everything needs to be confirmed in writing."

Document with correspondence every meeting and telephone call, Mr. Gold advised around 75 seminar attendees, most of whom were policyholders. "To not do that puts you in a terrific bind later on," he said, "when the dispute escalates and perhaps you're in court" and memories are fading as to "what exactly transpired. It's very, very important to lock insurance companies into their representations of coverage, or the lack thereof in their view."

The seminar featured a lineup of Anderson Kill attorneys and business partners who made presentations on a number of hurricane-related coverage issues. J. Robert Hunter, director of insurance with the Washington-based Consumer Federation of America, was the keynote speaker.

William G. Passannante, an attorney and shareholder in Anderson Kill's New York office, said policyholders often lack a clear picture of their coverage because insurers take so long to issue policies.

"It's a remarkable business where you're charged thousands, hundreds of thousands or millions of dollars for a stack of paper and it's not delivered for a year. It happens all the time," Mr. Passannante said.

Policyholders, though, are having some success by demanding receipt of their policies faster, Mr. Passannante said, as "turmoil in the brokerage market" in recent years has led to more responsiveness by intermediaries and insurers.

"Another big trap" for policyholders, according to Mr. Gold, involves "some sort of time-sensitive provision."

Notice of loss is the most common such provision, he noted, but there are two other provisions that often trip up policyholders.



After Katrina inundated New Orleans, many policyholders are facing claims disputes with their insurers.

good idea to file a preliminary proof of loss" while reserving the ability to amend it as the loss develops, Mr. Gold said.

Courts have ruled that policyholders lose their coverage if they do not meet the timing requirement and have admonished them for not filing partial proof of loss, he warned.

There also is a "suit limitation clause" found in property coverage that policyholders have to watch for, Mr. Gold said.

The clause is a "very, very strict provision" that sets down how much time a policyholder has from the date of loss to file a lawsuit against the insurer, Mr. Gold noted. "There only are a few courts that ever have excused a policyholder for failing to bring suit" within the period specified in the coverage, he said.

A proof-of-loss statement is required within a certain amount of time detailing how much was lost, the damages that triggered the claim and other information, Mr. Gold said. "You have to be extremely careful with those kinds of requirements, because I am hard pressed to think of any kind of business interruption loss that you are going to be able to quantify definitively in a short period of time," he said.

Rather than filing nothing while quantifying the loss, "it's always a

Insurers seeking forum change in lawsuit on storm surge damage

By MICHAEL BRADFORD

JACKSON, Miss.—A lawsuit seeking to force insurers to pay for Mississippi property owners' damage caused by Hurricane Katrina's storm surge is back in state court—for now.

The suit—originally filed in September 2005 in the Chancery Court of Hinds County, Miss., by Mississippi Attorney General Jim Hood—charges that insurers are refusing to honor policies that should pay for the damages from water pushed ashore by the storm.

Katrina ravaged Mississippi's Gulf of Mexico coastline when it slammed ashore Aug. 29, 2005, and caused massive damage from wind and rising water. The controversy over whether the damages should be excluded from policies that insurers say were not intended to cover flood losses has spawned several lawsuits, the one by Mr. Hood being among the most notable.

The suit charges that insurers issued policies "that insure against loss and damages from hurricane wind; however these policies attempt to exclude from such coverage any property loss resulting directly or indirectly from damage caused by water, whether or not driven by wind."

Insurers, asserting the damage in Mississippi caused by the surge was flooding that is excluded by their policies, were successful in having the case moved to federal court in Jackson, Miss., by argu-

ing that issues related to the National Flood Insurance Program are involved, which means federal law must apply.

The federal court, though, later reconsidered its decision to hear the case, based on motions submitted by Mr. Hood, and sent the case back to the state chancery court in March.

Now insurers are seeking to have the case moved back to federal court.

State Farm Insurance Co. and Allstate Insurance Co., two of the defendants in the lawsuit, have filed motions asking the federal court to reconsider whether it will hear the case, according to a spokeswoman for the Washington-based American Insurance Assn.

While the parties in that case wait to learn where it will be heard, other, similar lawsuits are pending.

The AIA spokeswoman said there are several such lawsuits in the courts but could not say how many have been filed.

One class-action lawsuit in state court in Baton Rouge, La., filed by Louisiana homeowners and businesses, seeks to have insurers pay for damage from water that entered New Orleans from two levees that were breached by Katrina's storm surge.

The breaches do not fall within standard "act of God" or "rising water" exclusions, the suit charges, because the breaks were due to negligence in the design, construction and maintenance of

the levees and because the water was pushed into the city by a windstorm.

The insurers are responsible, therefore, because their policies include coverage for negligent acts and windstorm damages, the suit says.

The AIA spokeswoman, commenting on such lawsuits in general, said that insurers have long held that damage from flooding of the sort experienced by property owners from Katrina is excluded under standard property policies.

Insurers, meanwhile, are encouraged by a recent ruling in a case filed by a Mississippi homeowner seeking to force Allstate to pay for damage caused by water pushed ashore by Katrina.

A federal judge in Jackson, Miss., denied Allstate's motion to dismiss the suit, but insurers are interpreting part of the ruling to mean that the flood exclusion in Allstate's policy is valid.

The AIA, the Indianapolis-based National Assn. of Mutual Insurance Cos. and the Des Plaines, Ill.-based Property Casualty Insurers Assn. of America issued a joint statement following the ruling saying that while the groups would have preferred the case be dismissed, "the underlying opinion is good because it strongly suggests that the court understands that the explicit water damage/flood exclusion in the policy does exclude coverage for hurricane-driven water (also known as 'storm surge')."

Updated RMS model riles critic of industry

NEW ORLEANS—A catastrophe modeling firm that recently changed its methodology to reflect higher insured losses expected from more frequent hurricanes is driving up property insurance rates to the benefit of the modeler's clients, a policyholder advocate contends.

The modeling company, though, counters that is a simplistic view of an objective process that actually is disruptive for insurers.

Risk Management Solutions Inc.'s recent upgrade of its catastrophe models using near-term projections estimates that annualized insurance losses will rise by an average of 40% across the Gulf Coast, Florida and the southeastern United States, compared with losses previously calculated using long-term historical averages (BI, March 27). Projected losses are 25% to 30% higher in the mid-Atlantic and northeast coastal regions than under previous calculations.

That change "means rates go up double-digit for everybody," said J. Robert Hunter, director of insurance at the Consumer Federation of America in Washington.

Mr. Hunter, speaking at a seminar held last week in New Orleans by Anderson Kill & Olick P.C., a New York-based policyholder defense law firm, said he co-authored a letter sent to the president of the National Assn. of Insurance Commissioners and insurance commissioners in Gulf Coast states outlining his concerns with RMS' actions and suggesting that it might be time to regulate catastrophe modelers.

"If we assume the worst—that

they were driven by politics and not science," Mr. Hunter said of RMS' move to change its methodology, "you better regulate them. And we claim that it was driven by politics."

"Our mission as a company is to provide the best objective quantification of catastrophic risk," Paul Vandermarck, executive vp of Newark, Calif.-based RMS, said in an interview. "So we are completely apolitical."

As for whether insurance premiums will rise, "we don't have a stake in that debate," said Mr. Vandermarck.

He said modeling changes are "very disruptive for our clients," which include insurers and reinsurers that interact with each other. While an increased risk could mean prices rise, it could also mean that insurers will need more capital to underwrite the risks they face, Mr. Vandermarck noted.

Even with the change, RMS clients will continue to have access to previous modeling methodology that uses long-term historical averages in its forecasting, according to Mr. Vandermarck.

A spokesman for AIR Worldwide Corp. in Boston said the modeler is developing a new methodology based on near-term projections but is advising clients to consider projections under its established methodology as well as the new model. EQE-CAT Inc., an Oakland, Calif.-based modeler, confirmed that it also is developing a new near-term methodology and will offer its clients that service along with its modeling based on longer historical averages.

—By Michael Bradford

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Editorial

Let's fix pension system

AS MORE EMPLOYERS move away from defined benefit pension plans, a reasonable question to ask might be whether it is necessary for Congress to complete action on pension reform funding legislation.

The short answer, for many reasons, is yes. First, while employers in ever-increasing numbers are phasing out their defined benefit plans, that doesn't mean every employer is freezing its plans.

Plenty of employers want to keep such plans, and legislation is much needed to protect the interests of those employers as well as the interests of employers that are freezing their plans and will have to continue to fund and administer those arrangements until there are no longer participants drawing benefits. That means so-called "frozen plans" could be around for decades.

Sponsors of all plans—frozen or not—deserve a better system than the current one. For starters, they deserve a system in which employers are compelled to fund—over a reasonable amount of time—the benefits they have promised, which the legislation now before a congressional conference committee would do. That would be a big and vital change from today's loophole-ridden system in which benefit promises can be made without being adequately funded, resulting in

huge losses for the government's pension insurance program and ever-higher premiums for the employers that fund that program.

Employers also deserve better than the current restriction that prevents them from making extra contributions to their pension plans in good financial times. Building such cushions for the future would reduce the likelihood, during times when turns in the economic cycle erode the value of plan assets, that employers would have to boost contributions when they could least afford it. The bills before conferees would, to varying degrees, allow for such saving for a rainy day.

Finally, employers with cash balance plans and those that want to move to those arrangements deserve certainty that their plans could pass legal muster provided they follow a basic standard: that pay and interest rate credits provided to older employees are at least equal to those given to younger employees. This is an issue Congress should have resolved long ago but did not, with legislators being bamboozled by a handful of demagogues. The House bill before conferees provides this welcome clarification, though only prospectively. We encourage conferees to make the clarification retroactive and, through that action, keep more employers in the defined benefit plan system.

Act now to ensure terror cover

THE PROPERTY/CASUALTY insurance industry is wasting no time in addressing the problem of providing terrorism insurance. And that's more than justified, because where terrorism insurance is concerned, there's definitely no time to waste.

As we report on page 3, a group of industry chief executive officers early this summer intends to offer a consensus plan for a public-private partnership to provide terrorism coverage. That will allow buyers, regulators and lawmakers several months to review the proposal before the Treasury Department must issue its report to Congress on the state of the terrorism insurance marketplace.

Time is of the essence even though the current federal terrorism insurance backstop—itsself a considerably scaled-back version of the backstop created by the Terrorism Risk Insurance Act of 2002—doesn't expire until Dec. 31, 2007. No one should have forgotten how last year's legislative effort to extend even a diminished backstop beyond the initial Dec. 31, 2005, sunset, stretched on well into December. Some buy-

ers didn't know until the last minute whether they would have terrorism coverage as the new year dawned.

There's no good reason anyone should have to go through that kind of ordeal again. To be sure, some key members of Congress and the administration don't think that a federal role in guaranteeing terrorism coverage is justified, that insurers will be able to somehow come up with a rational underwriting system for insuring what should only be viewed as an uninsurable risk. Every effort must be made to persuade them otherwise.

Insurers alone cannot and should not be expected to bear the burden of insuring the uninsurable. There is no magic market solution to the problem of insuring against terrorism, and simply saying that there is—as some on Capitol Hill and in the administration insist upon doing—doesn't make it so.

Dec. 31, 2007, will be here before long. The sooner there is something in place to guarantee the continued availability of terrorism coverage, the better.

Schillerstrom



In an effort to ensure continuing timely coverage of risk management, insurance and benefit-related news, *Business Insurance* has formalized a list of its reporters' assigned beats. This list is not intended to be exclusive but rather to represent core subject areas of importance to *BI* readers. *BI* welcomes ideas and tips from readers on these and other areas. Following is a list of the beats and the principal reporters for each:

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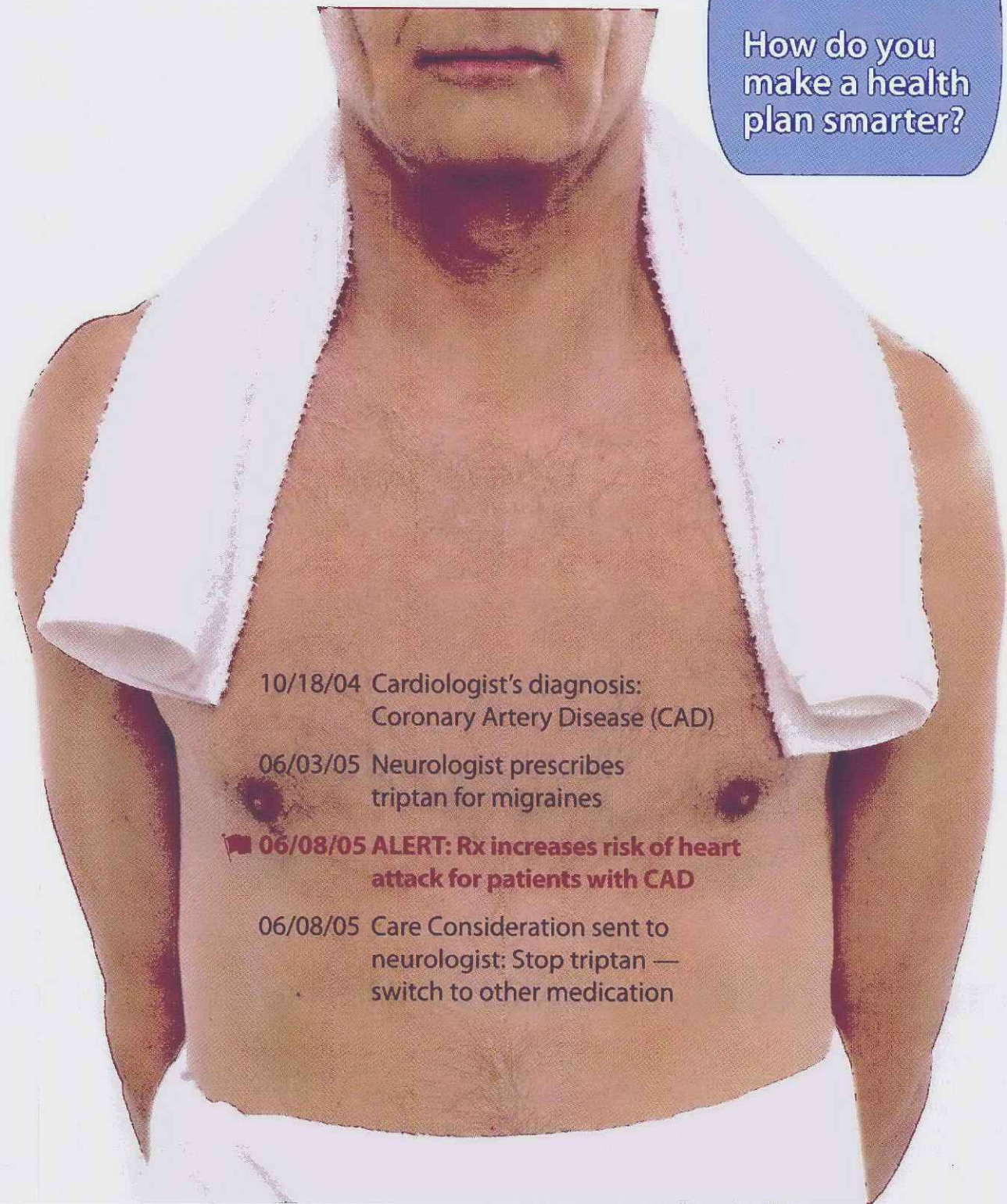
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By Dr. Jeffrey Hummel

Perspectives

Weighing disease management

Evaluating factors to curb employee health care costs

Ask employers or benefits managers what causes them sleepless nights and they may tell you that surging costs for employee health care coverage are a major source of anxiety.

Statistics validate their concern. According to a 2005 study conducted by the Commonwealth Fund, chronic conditions in the United States, including asthma, obesity, heart failure and diabetes, result in lost worker productivity approaching \$260 billion annually. So, when initial studies suggested that redesigning health care management programs to focus on individuals with chronic illnesses, benefits managers took notice. This approach—identifying people with chronic conditions and empowering them to manage their own health—is called disease management.

While some studies have found a return on investment for DM programs, others cast doubt on these claims. There are three reasons for this. First, most commercial DM programs limit cost by using only selective parts of the proven chronic care model. Second, cost evaluations have been plagued by

methodology errors resulting in outcomes that suggest improvement where a more rigorous study would not. Finally, there has not been sufficient time to evaluate whether DM programs can curb health care costs over several years. When assessing disease management programs for your organization, you should consider several factors, including both external and internal considerations.

External considerations include managing disease, fragmentation and evaluation.

- **Managing Disease:** Successful DM programs focus on helping employees/patients assume full responsibility for their health. This involves teaching patients about their disease and complications, giving them the tools for self-monitoring and supporting behavior change. Information technology is crucial to tracking clinical indicators for patients with chronic diseases in order to respond with timely educational and health care interventions. These should be the physician's responsibility, but standard medical practices are poorly situated to do this for many reasons, including the current reimbursement structure, lack of com-

puterized clinical information systems and antiquated practice workflows. Some plan sponsors, however, realized that chronic disease is very expensive. They recognized that a method to identify and manage these conditions, and their associated costs, was needed.

- **Fragmentation:** Fragmentation of U.S. health care has contributed to DM's ambiguous record. Most DM programs are offered by large organizations that hold contracts with health plans and government agencies such as Medicaid. Although health coaches working for DM companies can successfully engage patients in ways that many physician practices cannot, they need to improve their outreach to physician practices. Since most clinics have patients from dozens of insurers, any one DM effort will apply to only a fraction of a physician's patients. The communications that physicians receive from DM companies generally consist of a letter about select patients with no obvious way to use the information in the clinical workflow. As a result, information from these companies typically goes unused by physicians.

- **Evaluation:** The greatest chal-

lenge in showing return on investment for DM is finding a valid control group with which to compare costs. Many DM companies estimate control costs, or use patients who didn't sign up for the program. Both will significantly overestimate program savings. Often, DM companies focus efforts on patients with the highest costs from the previous year. Patients with outlier utilization, though, usually have lower costs the following year due to a concept known as "regression to the mean," a phenomenon in which, after an acute health care episode, utilization and costs naturally decrease without any kind of intervention. Unless this is taken into account, cost savings will be exaggerated.

Internal considerations include employee demographics, risk stratification and measuring return on investment.

- **Employee demographics:** Older employees will have increased prevalence of diabetes and heart disease, so disease management efforts should focus on reducing the risk of avoidable complications including heart attack, stroke and kidney failure. For a younger population, efforts should focus on causes

of absenteeism or decreased on-the-job performance including depression, allergies/asthma, smoking cessation and obesity.

- **Risk stratification:** Although it is important to apply programming where it will be most effective, ranking employees for more intensive interventions should be done based on risk factors and not simply by previous health utilization.

- **Measuring return on investment:** A company contracting for DM should define how cost savings will be measured. An experienced, independent auditor can then accurately measure return on investment. There is simply too much of a conflict of interest to allow a DM company to monitor itself, and the company that has employees who are enrolled may also have an interest in showing that the project was money well-spent.

Dr. Jeffrey Hummel works in health information technology and disease management at Qualis Health, a Seattle-based nonprofit health care quality improvement organization with offices in Washington, Alaska and Idaho.

Comp payment does not lawsuit over misconduct

The Court of Appeals of New Mexico ruled that an employee's receipt of workers compensation benefits did not bar the employee from suing the employer for willful misconduct.

Philip Salazar, an employee of Torres Concrete Co., was injured after being instructed by his employer to start a truck by pouring gasoline into the carburetor. While Mr. Salazar was doing so, the employer instructed his son to climb into the cab and start the engine. Mr. Salazar was unaware that the truck's ignition was to be started. When the son started the ignition, the engine ignited the container of gasoline in Mr. Salazar's hand. The resulting fire severely burned Mr. Salazar. Mr. Salazar was awarded workers compensation benefits and settled his claim for indemnity benefits.

Thereafter, Mr. Salazar sued the employer, seeking monetary damages for willful misconduct of the employer. The trial court ruled for the employer and dismissed Mr. Salazar's lawsuit. He appealed.

On appeal, the question before the court was whether Mr. Salazar was precluded from pursuing his claim for damages for willful misconduct because he had already received workers compensation benefits. The court noted that the workers compensation laws were designed for accidental events or acts, not willful or intentional acts. Furthermore, the court said it is not

the worker who should give up anything when his employer has committed a willful or intentional injury upon him. "It is the employer who should be penalized by giving up something because he has violated the bargained-for rules of the game and destroyed the equilibrium of a fair and equal balance," the court said. Thus, the court concluded that the employee's receipt of compensation under the Workers Compensation Act does not bar his tort claim against the employer for damages caused by the employer's intentional or willful conduct. The trial court decision was reversed, and the case was sent back for further proceedings.

Salazar vs. Torres, Court of Appeals of New Mexico, Sept. 12, 2005, certiorari granted Nov. 2, 2005 (BI/01/A.-\$10)

No duty to defend without advertising injury

Under California law, "advertising injury," as used in a commercial general liability insurance policy, required widespread promotion to the public, according to a decision of the 9th U.S. Circuit Court of Appeals.

This case concerned the duty of an insurer to defend the insured against claims under a policy covering advertising injury. From 1996 to 1999, Thom Hayward was employed by In Sync Media-San Francisco, a provider of pre-press ser-

Legal Briefs

vices to advertising agencies. In 1999, Mr. Hayward joined In Sync's competitor Andresen Color of San Francisco Inc. In Sync sued Andresen and Mr. Hayward, alleging misappropriation of trade secrets. Centennial Insurance Co. insured Andresen under a CGL policy. The insurer denied it had a duty to defend or indemnify because the complaint alleged breach of the shareholder agreement and disclosure of confidential information, neither of which fell within either the personal injury or advertising injury definitions in the CGL policy. The trial court ruled for the insurer. In Sync appealed.

The appellate court said that In Sync's complaint, as it pertained to potential advertising injury, was limited on its face to allegations of solicitation of customers. The court noted that In Sync alleged that Mr. Hayward breached his obligation to In Sync by "speaking with and soliciting customers of In Sync...in connection with his plan to move over to Andresen." Because In Sync's complaint alleged wrongful solicitation, and not advertising, the court said that the complaint on its face absolved the insurer of the duty to defend. The trial court decision was affirmed.

Hayward vs. Centennial Insurance Co., 9th U.S. Circuit Court of Appeals, Dec. 5, 2005 (BI/05/A.-\$10)

Golf tourney trip is compensable

Injuries that an employee sustained in an auto accident as he was driving home after leaving a golf tournament organized by his employer occurred during the course and scope of his employment, according to a Missouri appellate court.

Hartford Insurance Co. hired Mark Custer as a claims adjuster in Springfield, Mo. Later, Mr. Custer was transferred to Hartford's office in Kansas. By then he was working as a claims coordinator. An important part of his job was entertaining clients and agents. Hartford provided him with a company car as his job involved extensive travel. In his job capacity, Mr. Custer also participated in golf games with insureds and agents on at least a weekly basis. In September 1997, Mr. Custer attended a golf tournament organized by Hartford. He had received an e-mail from Hartford giving him details of the day and suggesting that he be available for dinner with agents after the event. Shortly after leaving the golf club to head home, Mr. Custer's company car was struck by another car, and he was severely injured. Mr. Custer filed a claim for workers compensation in Missouri, as allowed under state law since that was where he was hired. An administrative law judge found in his favor. Hartford appealed to the Industrial Commission, which affirmed the award.

Hartford appealed.

On appeal, Hartford argued that Mr. Custer was not on a special errand for his employer and that there was no mutual benefit to the employer in Mr. Custer's going home. But the court said that employees whose work entails travel away from the employer's premises are held in the majority of jurisdictions to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown. Viewed as a whole, the court said that the record supported a finding that Mr. Custer was an employee whose work entailed travel away from the employer's premises. Furthermore, the court said there was no evidence that Mr. Custer ever deviated from his work-related duties. The court affirmed the award of benefits.

Custer vs. Hartford Insurance Co., Aug. 23, 2005, motion for rehearing and/or transfer to Supreme Court denied Oct. 4, 2005; application for transfer denied Nov. 22, 2005 (BI/04/A.-\$10)

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available, at \$10 each, by sending a check payable to Mayo H. Stiegler, to Business Insurance 360 N. Michigan Ave., Chicago, Ill. 60601-3806. Provide the listed number for each opinion ordered.

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Cat fund: Federal backstop role debated

Continued from page 4

ability of homeowners insurance in catastrophe-prone areas. The bill would not, though, provide any reinsurance for commercial risks.

Catastrophes are not an insurance issue, said Mr. Collins. Instead, they represent national security and economic issues, he said. Mr. Collins also urged that authorities promote better building codes and land use regulations as part of a larger strategy for dealing with catastrophes.

Everyone on the panel was in agreement that the government should do a better job regarding catastrophe mitigation, that catastrophe insurance pricing should be risk-based and that all levels should do a better job dealing with the aftermath of catastrophes, observed Robert Litan, senior fellow at Washington's Brookings Institution.

Like Mr. Collins, Mr. Litan said he favors a federal role in reinsuring against large natural catastrophes. "If the big one happens, (the federal government) does not go out of business" like private entities might, he said.

Mr. Litan recently published a Brookings policy brief, titled "Preparing for Future Katrinas," in

which he called on the federal government to "formally acknowledge and implement what it has already become—an insurer of last resort

"Government funds—whether they are state or federal—are, at best, a last resort."

Franklin W. Nutter
Reinsurance Assn. of America

for mega-catastrophes." A government catastrophe reinsurance program, he argued in the policy paper, could be modeled on the federal terrorism insurance backstop initially created by the Terrorism Risk Insurance Act of 2002, whereby losses would have to reach a specified percentage of an insurer's or the insurance industry's total premium for a covered line before federal money would flow.

Mr. Nutter raised questions, though, about using TRIA as a model for a government backstop. "Be careful what you ask for," he warned.

Insurers pushed hard for the cre-

ation of TRIA after the terrorist attacks of Sept. 11, 2001, and again for a two-year extension of the act last year, he acknowledged. But in exchange for the government backstop, he said, insurers are required to offer coverage, receive no rate regulation relief and are forced to assume higher retentions. "Government funds—whether they are state or federal—are, at best, a last resort," Mr. Nutter said.

And the likelihood of a federal catastrophe fund becoming a reality any time soon is extremely slim, said Mr. Mattera. He noted that a united insurance industry almost failed in its efforts to extend TRIA's insurance backstop last year, and there is no agreement among insurers on whether a catastrophe fund is necessary.

Another difference between the two federal fund proposals is that a market failure clearly arose following the Sept. 11 attacks, said Mr. Mattera, while no market failure followed last year's hurricanes. "There's no way in hell a federal cat fund could pass," he said.

Paul Kochenburger, executive director of the University of Connecticut School of Law's Insurance Law Center in Hartford, moderated the discussion.

Industry contemplates possibility of nonrenewal of TRIA extension

By MARK A. HOFMANN

WASHINGTON—Insurers are working urgently to devise a workable long-term solution to the problem of providing terrorism insurance, according to a senior trade group official.

"There's an extreme amount of urgency" to formulate a response to "a risk that is basically uninsurable," said J. Stephen Zielezienski, senior vp and general counsel of the American Insurance Assn. in Washington. "If we don't develop something in the next few months," the industry could face the same situation as it did late last year as the federal terrorism insurance backstop created by the Terrorism Risk Insurance Act of 2002 approached its Dec. 31, 2005, sunset, he said.

Mr. Zielezienski made his remarks during a discussion of catastrophic risk insurance sponsored by the Washington-based law firm of Wiley Rein & Fielding L.L.P. and the University of Connecticut School of Law's Insurance Law Center late last month in Washington. Former District of Columbia Insurance and Securities Commissioner Lawrence Mirel, currently a partner at Wiley Rein & Fielding, moderated the session.

Congress did not approve an extension of a scaled-back federal terrorism insurance backstop until Dec. 17, 2005, and President Bush signed it on Dec. 22. But the extended backstop will end on Dec.

31, 2007, and members of Congress may have no appetite for another extension. In fact, another member of the panel—Glenn Westrick, senior counsel to the U.S. House of Representatives Financial Services Committee's Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises—said that while members "inherently" understand the terrorism insurance problem, most would agree that a straight extension of the current backstop would be unwise. Nevertheless, lawmakers remain interested in the terrorism insurance issue, particularly as it relates to nuclear, biological, chemical and radioactive risks, and have directed the Government Accountability Office to prepare a report on those risks, he said.

"Dec. 31, 2007, might seem like a long way off, but it's not," Mr. Westrick said.

Gregory Heidrich, senior vp-policy development and research for the Des Plaines, Ill.-based Property Casualty Insurers Assn. of America, said there had been concern among insurers "there would be a sigh of relief" once the president signed the bill into law and that efforts to address the terrorism insurance market's problems would be put off for months. That did not happen, he said.

No consensus proposal, however, has been unveiled yet.

Howard Mills, New York superintendent of insurance, said that the insurance industry has been "very

good" in presenting its message, but that Congress needs to hear from other economic sectors regarding problems associated with both terrorism insurance and natural catastrophe insurance. Mr. Mills said that he has told insurance brokers to get "big, big clients who are not insurers" to present their concerns to Congress.

One such noninsurer participant in an earlier symposium panel made just such a case for a public/private approach to terrorism insurance.

Jeffrey D. DeBoer, president and chief executive officer of the Washington-based Real Estate Roundtable, said he's not certain that a case can be made that the natural catastrophe insurance market has failed; the problem appears to be that people simply aren't buying flood insurance or other catastrophe-oriented coverages. "Maybe people can mitigate against flood and hurricanes," but the idea that they can mitigate against terrorism "is a red herring," he said.

"We are in a war, which the president reminds people daily," said Mr. DeBoer. "This is a societal risk for our country."

The residents of metropolitan areas deemed to be at high risk of terrorist attack—such as New York and Los Angeles—should not be asked to bear all of the risk, he said. Terrorism is an attack on the way of life of people in such low-risk areas as Missouri and South Dakota as well, said Mr. DeBoer.

COMINGS & GOINGS — INDUSTRY



Ms. Zak



Ms. Roman



Mr. Huffman

Insurers:

Houston-based HCC Insurance Holdings Inc. has appointed **John N. Molbeck Jr.** president and chief operating officer, a position he held from 1997 to 2002. Most recently, Mr. Molbeck was chief executive officer of the North American subsidiary of Jardine Lloyd Thompson L.L.C.

AIG Global Energy has named **Thomas Morelli** president of the casualty division in New York. Previously, he was head of the primary casualty unit responsible for North America.

Also at AIG Global Energy, **David Hawksby** has been named president of the property division. Previously, he was president of the American International Underwriters energy division.

Philadelphia-based ACE USA has named **James J. Malloy** senior vp and regional executive officer for the company's Southwest region. Mr. Malloy, who will be based in Dallas, previously was a resident vp for AIG.

Also at ACE, **Karen Sawyer** has been named senior vp, national customer retention manager, for Philadelphia-based ACE Risk Management. Previously, she was the New York branch manager for ACE Risk Management.

Brokers:

Hilb Rogal & Hobbs Co. has named **John Lyon** president and CEO of its Connecticut branches in Hartford, Conn. Previously, he was a vp and Northeast region practice leader.

Mesirow Financial has appointed **Fran L. Jurkovic** senior vp of Mesirow Financial Insurance Services Inc. in Chicago. Most recently, she was a regional assistant vp at AIG.

Atlanta-based Beecher Carlson has named **Zulma Marquez Zak** senior vp in its executive liability practice in Los Angeles. Before joining Beecher Carlson, Ms. Zak was co-founder of ECM Insurance Services Inc.

Reinsurance:

Pembroke, Bermuda-based RenaissanceRe Holdings Ltd. has promoted **Ross Curtis** to the position of senior vp of the catastrophe reinsurance unit. Previously, he was an international property catastrophe

underwriter.

Managed care:

Norfolk, Va.-based ValueOptions has named **Barbara B. Hill** CEO. Before joining ValueOptions, she was chairman and CEO of Woodhaven Health Services.

Mount Laurel, N.J.-based AmeriHealth has appointed **Judith L. Roman** president and CEO of AmeriHealth New Jersey. Before her promotion, she was vp of provider relations.

Other providers:

Elizabeth Woods Brooks has joined Buck Consultants as director in the communication practice in Stamford, Conn. Previously, she was senior communication consultant and global quality leader for the communications practice at Watson Wyatt Worldwide.

Also at Buck, **Dan Walter** has been appointed principal in the compensation practice in the San Francisco office. Previously, he was a senior vp and director in Smith Barney's stock plan services group.

Jack J. Johnsey has been named senior vp-project solutions at The Jacobson Group in Chicago. Previously, he was senior vp of sales at SHPS Inc.

Mercer Human Resource Consulting has appointed **Mark Green** European head of benefits outsourcing in London. Most recently, he was director of business and technology strategies at MBNA Europe Bank. **John D. Huffman** has been appointed senior vp of business development for third-party administrators Pinnacle Risk Management Services and Advantage WorkComp Services in Phoenix. Before his promotion, he was vp of marketing and business development.

Business Insurance would like to report on senior-level changes at commercial insurance companies and service providers. Please send news of recently promoted, hired or appointed senior-level executives to: Joe Walker, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; jwalker@businessinsurance.com. Photos should be sent to: Kathy Barnes, kbarnes@businessinsurance.com.



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P/C results: Strong performance in 2005 despite high cat losses

Continued from page 1

Inc. in Memphis, Tenn.

"After three years of hard-market pricing trends, most companies benefited from the margin improvement in most of their lines of business. Obviously, companies that had property or property cat exposures were the exception," said Mr. Gwynn.

Excluding the hurricanes, 2005 produced "one of the best years on record for the last 20 years, and even with the hurricanes, the commercial insurers did reasonably well," explained Adam Klauber, managing director at Cochran, Caronia & Co. in Chicago.

"Returns on capital were very strong, growth was solid—not great, but solid—and underwriting ratios were obviously very strong, so all in all, a pretty good year despite having some significant hurricane losses," Mr. Klauber said.

Results will be strong this year as well, say observers.

"It's a cyclical business, so at some point we'll get back" to a soft market, said James B. Auden, senior director at Chicago-based Fitch Ratings. "But for '06, it still looks like if you have a reasonable book of business and you're a stronger underwriter, you should be able to make a

decent underwriting profit if the wind doesn't blow too hard."

Results this year will be helped by an improved underwriting environment, which reflects higher rates for cat-exposed business, and stabilization in noncatastrophe-exposed

"I think we could expect to see property prices continue to increase through midyear renewals," given higher capital requirements from rating agencies and upward revisions of Katrina losses.

Mark Lane
William Blair & Co.

business, said Peter C. Streit, an analyst with Williams Capital Group in New York.

Furthermore, the 10-year Treasury note interest rate increased from 3.9% at the end of the second quarter to about 4.7% now. "That should lead to higher investment yields and

more significant growth in net investment income," said Mr. Streit.

"I think we could expect to see property prices continue to increase through midyear renewals, given the higher capital requirements from the rating agencies and upward revisions of losses from Hurricane Katrina," said Mark Lane, a principal and research analyst with William Blair & Co. in Chicago.

However, "if history is any indicator, we still expect the underlying trend to be one of softening," said Mr. Lane.

"Excluding catastrophe losses, we think results will be relatively stable with last year," Mr. Lane added. "And we should see some pickup in written premium growth relative to last year, because you're getting rate increases in certain parts of the market and pricing's more stable, at least today, than it was in the first part of 2005."

"We think '06 should be much tougher," Cochran, Caronia & Co.'s Mr. Klauber said. "Although pricing was relatively stable for Jan. 1 renewals, we think pricing is going to deteriorate in the second half of the year and, at the same time, reinsurance costs are going up, so we think it's going to be more challenging to produce the types of returns we saw

in '05" this year and next.

"It would be easy for '06 to have strong earnings compared to '05, but I don't necessarily view that as a big win for the industry," in light of last year's catastrophes, said Mr. Ward.

"There's no question that we're in the midst of a softening market, and while the impact of the catastrophes appears to have perhaps slowed that trend or offered a pause in the softening cycle, it looks like that softening market will continue, and so that will add some pressure to results in the foreseeable future," said Mr. Ward.

Reserves are another concern, he said. While the negative surprises in connection with major reserve development of recent years "are behind us for the most part, it looks like there still is likely a reserve deficit in the commercial sector." It is a declining deficit, "but, nevertheless, there are going to be some more reserve issues in the foreseeable future ahead," said Mr. Ward.

This year's results will be bifurcated, said Mr. Gwynn. "I think the liability side of the business is going to continue to see pricing declines throughout 2006, probably picking up steam as the year moves along, which is typical for this stage of the

soft market."

Margins will compress as a result, "although probably, for the year, still at very satisfactory levels," he said.

Next year "is going to be the interesting year," with continued pressure on pricing and margins slipping, said Mr. Gwynn.

New York-based Moody's Investors Service's concerns are focused on 2007 and beyond and what happens to pricing in the market, said Moody's analyst Jeffrey Berg.

"I think that, in general, the story will be whether there is underwriting discipline," said Mr. Berg. "If pricing slips meaningfully and companies seek to grow top line, that could spell problems for '07 and '08. But if the discipline can be maintained, and we can continue this soft landing in pricing, that will allow the market to do much better in '07."

Other observers say they are also concerned about 2007.

Michael Dion, senior equity analyst at Sandler O'Neill & Partners L.P. in New York, said excluding the possible impact of hurricanes in 2007, more companies will be looking for growth opportunities, "and that, I think, in turn, will probably drive down pricing further and could depress results."

Property/casualty insurers' 2005 year-end results

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

	Net income	Corporate Percent increase (decrease) 2005-2004	Consolidated revenues 2005	Combined ratio 2005 ¹	Combined ratio 2004 ¹	Property/casualty operations Net premiums written 2005	Percent increase (decrease) 2004-2005	Policyholder surplus 2005	Percent increase (decrease) 2004-2005
American International Group Inc.	\$10,477,000	6.5%	\$108,905,000	104.7%	100.3%	\$41,872,000	3.1%	\$24,508,000	18.8%
Hartford Financial Services Group Inc.	2,274,000	7.5	27,083,000	93.2	95.3	10,483,000 ²	5.1	7,100,000	0.7
Chubb Corp.	1,825,900	17.9	14,082,300	92.3	92.3	12,282,600	1.9	8,900,000	13.4
The St. Paul Travelers Cos. Inc.	1,622,000	69.8	24,365,000	101.3	107.7	20,386,000	7.2	18,002,000	19.1
ACE Ltd.	1,028,000	(10.8)	13,088,000	99.6	96.4	11,792,000	2.6	11,812,000	20.0
Liberty Mutual Insurance Co.	1,027,000	(17.5)	21,161,000	105.4 ²	105.5 ²	13,944,000 ²	5.6	9,869,000	12.9
SAFECO Corp.	691,100	22.9	6,351,100	91.1	91.5	5,810,500	2.4	3,691,900	7.6
Cincinnati Financial Corp.	601,970	3.1	3,767,322	89.2	89.8	3,076,183	2.6	4,646,951	(1.1)
Old Republic International Corp.	551,421	26.8	3,805,912	91.5	90.7	1,889,362 ²	11.1	2,168,300	8.0
CNA Financial Corp.	264,000	(37.9)	9,862,000	123.6 ²	105.4 ²	7,069,000 ²	(3.0)	6,975,000	0.3
Ohio Casualty Corp.	212,700	65.7	1,702,400	94.2	99.6	1,449,400 ²	(0.3)	1,004,500	3.3
American Financial Group	206,600	(42.6)	4,038,300	99.0	94.8	2,447,600	9.8	2,187,100	5.6
RLI Corp.	107,134	46.7	569,302	86.0 ²	92.2 ²	494,565 ²	(3.3)	692,941	11.1
Argonaut Group Inc.	80,500	12.1	786,200	98.7	99.8	769,400	14.9	716,100	18.7
Cumulative	\$20,969,325	7.8%	\$239,566,836	101.3%	99.8%	\$133,765,610	5.3%	\$77,765,792	12.1%

¹ Includes dividends. ² Statutory.
Source: B/I survey

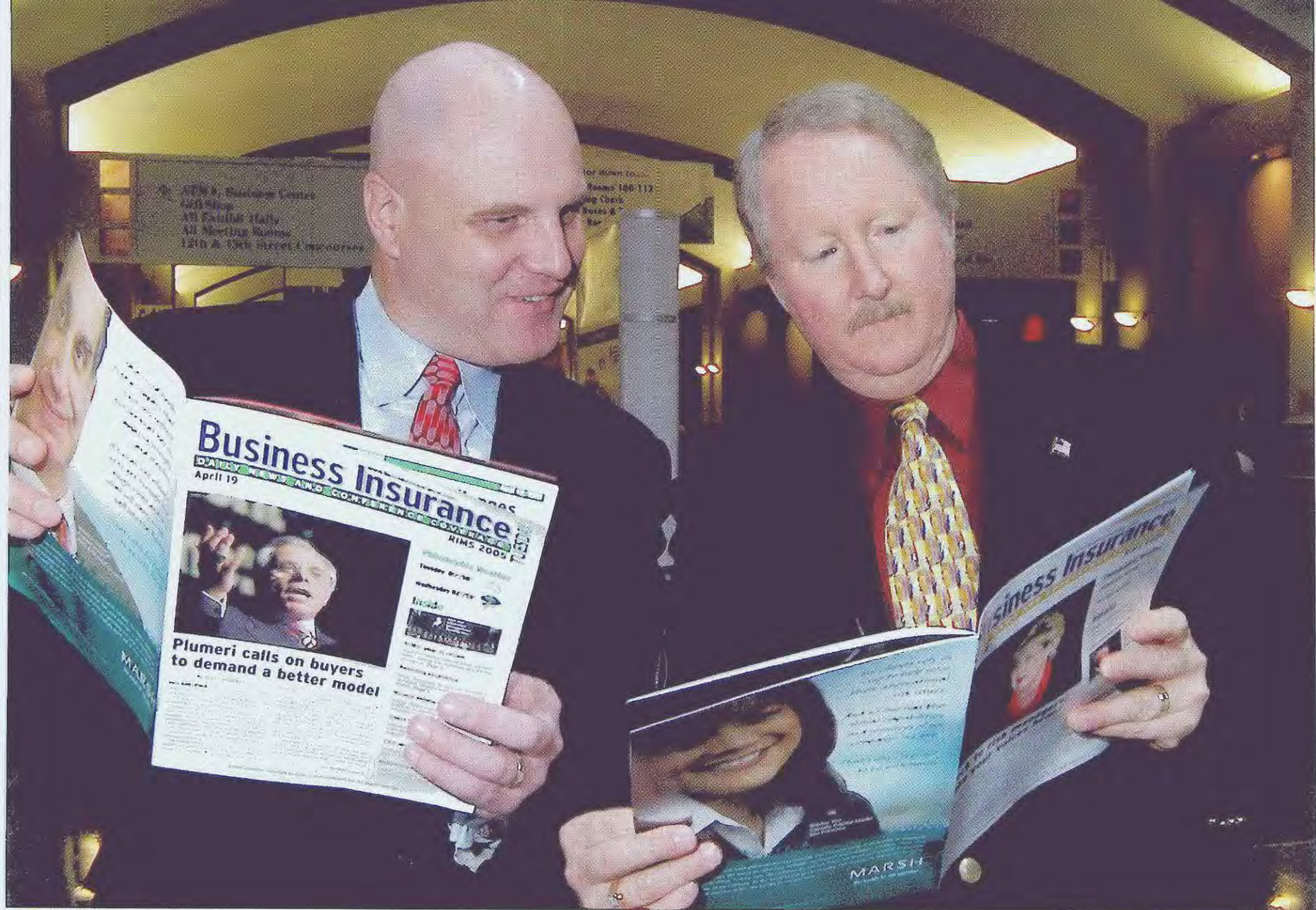


Photo: Michael Marcotte

Lance Ewing (L) and Chris Mandel, RIMS past presidents.

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Between the Lines

Compiled by Joanne Wojcik

NRA targets workplace gun bans

Employers that ban guns in the workplace are being targeted by the National Rifle Assn., which is lobbying state lawmakers nationwide to pass legislation allowing employees to pack heat on the job.

Many employers have long prohibited employees from bringing guns to work, both to prevent workers from "going postal" and to shield themselves from legal liability. But the NRA maintains that taking guns away from employees will only make them more vulnerable to workplace violence, and to back up this assertion, the organization cites data from the National Institute for Occupational Safety and Health that found about 80% of the workplace homicides that occurred in 2001 were committed during robberies.

Legislation debated last week in Florida would subject employers to up to five years' imprisonment or a \$5,000 fine if they restrict workers' Second Amendment right to bear arms, provided that the weapons are kept under wraps in employees' locked vehicles. Similar measures were passed in Alaska and Minnesota last year, but neither imposes felony charges on employers. NRA-backed guns-in-the-workplace bills are also pending in Alabama, California, Georgia, Indiana, Missouri, New Hampshire, Tennessee, Utah and Virginia.

But some employers are sticking to their guns, so to speak. In Oklahoma, for example, employers have filed a lawsuit that so far has been successful in holding up enactment of a law passed there last year that would have subjected employers to a year of imprisonment and a \$500 fine if they punish their gun-toting employees.

Apples meet in British court

John Lennon may have suggested that Strawberry Fields are forever, but another type of fruit also has had a lasting impression on the Fab Four.

In response to the success of the iPod and iTunes, the surviving Beatles are back in the courtroom with Apple Computer Inc. founder Steve Jobs over the use of the Apple trademark.

This long and winding road of litigation dates back to 1976, after Mr. Jobs founded Apple Computer using a bitten apple as its logo. The Beatles sued, arguing that the use of the apple infringed on the copyrighted logo used by the band's Apple Corps Ltd. recording company, a Granny Smith. The two adversaries also met in 1989 after advances in technology made it possible for the Macintosh to synthesize sound. In addition to paying more than \$26 million

to the Beatles for infringing on their copyright, Mr. Jobs agreed to stay out of the music business to settle both cases.

That settlement led to a dispute between Mr. Jobs and his insurers, which refused to provide a defense. Apple initially won a \$17.8 million judgment in a California court, which was overturned on appeal.

But winning in the courtroom may not come easy this time for Britain's legendary pop icons, as the judge who heard the case in London's High Court last week is said to be an iPod user.

Studying the benefits of a chew

Employers that want their employees to quit smoking should consider encouraging another oral fixation: chewing gum.

According to the Wm. Wrigley Jr. Co., chewing can reduce stress, improve mental focus and even manage weight. To back its claim, the Chicago-based gum maker is launching a multimillion-dollar Wrigley Science Institute to study the benefits of chewing gum.

In fact, because it is so recognized for helping alertness and easing tension at the same time, the U.S. armed forces have included chewing gum as part of field and combat rations since World War I, Wrigley claims.

Tips and feedback from readers are welcome. Please send information to joajcik@businessinsurance.com.



Employers fear retiree funds lacking

By JERRY GEISEL

A majority of employers don't think a significant percentage of their workforce will have sufficient income to retire at a reasonable age, according to a new survey.

The survey of more than 1,000 employers, released last week by Chicago-based Aon Consulting, found that 32% of respondents believe that between half and nearly three-quarters of their employees will not have sufficient income to retire between ages 62 and 65, while 37% say between one-quarter and nearly half of their employees won't have enough income to retire between those ages.

Additionally, employers are skeptical about whether employees adequately understand how to invest 401(k), 403(b) or 457 savings plan assets. Just 19% said employees knew to a "very great extent" or "great extent" how to invest savings plan assets, while 63% said employees knew to "some extent" or "little extent" how to invest plan assets.

That lack of widespread understanding of how to invest plan assets comes as a growing number of employers phase out their defined benefit plans—for which employers retain investment risk—with new employees and sometimes current workers receiving all future pension benefits through 401(k) and other defined contribution plans. In such plans, employees direct contributions made by themselves and their employers.

In the last few weeks, such well-known companies as General Motors Corp., Unisys Corp. and WellPoint Inc. announced freezes to their defined benefit plans.

Just over two years ago, Aon Consulting parent Aon Corp. itself started to phase out its defined benefit plan. Employees hired as of Jan. 1,

2004, are covered in a 401(k) plan and in a second defined contribution plan in which Aon's contributions are based on employees' years of service. Employees hired before then are covered in a defined benefit plan and a 401(k).

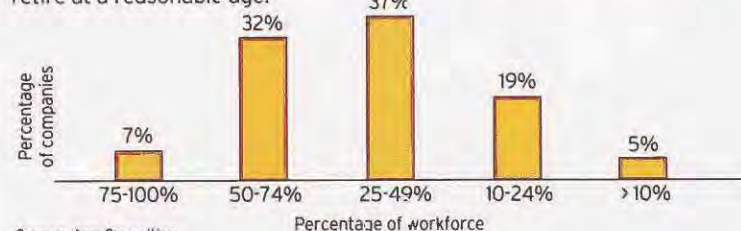
As more companies move to a defined contribution plan-only approach, they will likely, according to information provided by survey

matching contributions, making it more attractive for employees to contribute. Unisys, which will stop benefit accruals in its defined benefit plan after Dec. 31, will, effective Jan. 1, 2007, boost its 401(k) plan match to 100% of employees' deferrals up to 6% of pay, compared to its current match of 50% of employees' deferrals up to 4% of pay.

According to the Aon survey, the

No stashed cash

Percentage of employers' workforce not likely to have enough income to retire at a reasonable age.



respondents, face a key problem: a significant percentage of employees may not contribute to the plans, losing an opportunity to save on a pretax basis for retirement as well as forgoing company matching contributions.

For example, 7% of respondents said less than 25% of eligible employees contribute to 401(k) and other savings plans, while 19% said between 25% and 49% of eligible employees make contributions. Only 42% of respondents said between 75% and 100% of eligible employees contribute to the plans.

To ease this problem of low employee participation in defined contribution plans, the latest wave of employers phasing out their defined benefit plans are taking a variety of approaches.

Some, for example, like GM, are making automatic contributions to 401(k) plans, while many others are sweetening their 401(k) plan

most common matching formula employers now use in their 401(k) plans is a match of 50% on employees' deferrals. For example, 39% of respondents said they matched 50% of employees' deferrals, while 29% said they matched 100% of deferrals, while 17% matched less than 25% of deferrals.

The corporate move away from defined benefit plans, according to the survey, is unlikely to change course. For example, among respondents now not offering a defined benefit plan, 84% said they would not consider offering a plan, while 12% said they would consider it if the cost of such plans could be predicted each year.

Copies of "2006 National Employee Benefits Trends Survey Findings" are available by e-mailing aonsurvey@aon.com or calling 800-438-6487.

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Australian cyclone damages estimated

Losses may reach \$282 million

By ELIZABETH FRY

INNISFAIL, Australia—Insured losses from Cyclone Larry, which devastated parts of northeastern Australia earlier this month, could reach \$400 million Australian (\$282.2 million), according to an initial estimate.

The storm, which packed winds of up to 180 mph, struck Innisfail, Australia, and other areas in Queensland on March 20, causing widespread damage to buildings and crops.

Insurers likely will face losses of between \$300 million (\$211.7 million) Australian and \$400 million Australian as a result of the storm, according Standard &

Poor's Rating Services.

"Claims lodgment was initially slow because of the difficulty of access in many areas," said Michael Vine, director of S&P's financial services group in Melbourne. "In a number of cases, estimated losses would reach the maximum event-retention level and then be protected by reinsurance cover, but already reinsurers have acknowledged exposure to the event."

Mr. Vine calculated that the insured losses will be split between insurers and reinsurers.

Claims largely have been related to property damage, including

See LARRY / page 19



A sugar mill in Innisfail, Australia, was damaged by Cyclone Larry. Insured damages from the storm have been estimated as between \$300 million Australian and \$400 million Australian.

HHH to appeal ruling in film finance case

JLT ruled not liable for losses

By CAROLYN ALDRED

LONDON—HHH Casualty & General Insurance Ltd. plans to appeal a London High Court ruling that it cannot claim tens of millions of dollars from its broker, JLT Risk Solutions Ltd., for film finance insurance losses, a lawyer for the defunct Australian insurer said last week.

Although Mr. Justice Langley ruled that JLT owed a duty of care to HHH after it had placed the risk, the judge concluded that the broker's breach of that duty was not responsible for the loss caused by the insurer.

The case is the latest in a mass of litigation surrounding the insurance industry's attempts to underwrite film financing during the late 1990s that has cost insurers tens of millions of dollars (BI, Dec. 16, 2002; June 11, 2001; June 5, 2000).

The London-based law firm of Eversheds, which represented JLT, estimates that the film finance insurance debacle has resulted in at least 50 pieces of litigation in five jurisdictions.

"This is the end of the road in this series of litigation, and most of the other litigation now has been concluded or settled," according to Nigel Wick of the London-based law firm of Holman Fenwick & Willan, which represents HHH.

Mr. Wick noted, though, that HHH will be seeking leave to appeal from the judge shortly.

The HHH/JLT case involved a series of three slates of made-for-television films known as Hollywood 1, Hollywood 2 and Hollywood 3, to be produced by the London-based film company Flashpoint Ltd. and financed through notes issued by Jersey-based special-purpose vehicle Hollywood Funding Ltd.

The redeemable notes were held by Law Debenture Trust Corp. (Channel Islands) Ltd. on behalf of the investors. To obtain ratings from Standard & Poor's Corp. on the notes, LDT bought pecuniary loss indemnity policies from HHH that would cover any

shortfall in the films' revenues to pay back the note holders.

As a result of a shortfall of "very substantial amounts," HHH paid out a claim on the H1 films of \$15.6 million in August 1999, a claim of \$14.7 million on the H2 films in February 2000 and a claim of \$25.1 million on the H3 films in June 2000, according to court papers.

Under insurance and reinsurance policies that used the same policy wordings and

See JLT / page 19

Panel makes case for workplace rehab

By SARAH VEYSEY

LONDON—Risk managers should try to convince their employers of the business case for improving workplace rehabilitation programs, emphasizing that such efforts may result in reduced premium rates for compulsory employers liability insurance, according to panelists at a seminar.

The seminar was hosted by the Assn. of Insurance & Risk Managers and the London-based law firm of Weightmans Solicitors in London last month.

David Ireland, the risk manager at Vinci P.L.C. and a former chairman of AIRMIC, facilitated the discussion. Mr. Ireland said AIRMIC

maintains that rehabilitation should be part of an overall strategy of absence management.

Mr. Ireland said that while there is increasing support for the concept of workplace rehabilitation, some organizations still are unsure how to establish programs to rehabilitate injured or ill employees. But putting in place such a program "pays for itself" in terms of cost savings, he said.

In the United Kingdom, employers liability is a compulsory insurance coverage. This, said Lord Philip Hunt, the minister for Work and Pensions in the House of Lords, is a challenging issue for employers.

See AIRMIC / page 19

Australian, U.K. creditors approve HHH settlement

Initial payments to be made in summer

By ELIZABETH FRY

SYDNEY, Australia—Australian and U.K. creditors of collapsed insurer HHH Insurance Group would receive an average interim payment of 5 cents on the Australian dollar under an agreement approved last week.

Creditors in Australia and the United Kingdom last week voted to accept the interim payment, to be paid in June or July, under schemes of arrangement established to accelerate payments of HHH liabilities.

A further average payment of 5 cents on the dollar will be made at year-end, said HHH's liquidator Tony McGrath of the Sydney-based firm of McGrath Nicol Partners.

HHH was insolvent by \$5.3 billion Australian (\$3.74 billion) when it was placed in provisional liquidation in March 2001.

The 1,500 creditors of the various HHH companies include the Australian government, which has paid \$600 million Australian (\$423.4 million) in the past three years to HHH policyholders through a claims support scheme for personal lines policyholders and is seeking repayment. The majority of policyholder creditors included in the schemes are commercial lines policyholders.

The size of the payments will vary depending on from which HHH

See HHH / page 19

Updates

SVB Holdings to form new U.K.-based unit

SVB Holdings P.L.C. has announced plans to raise about £110 million (\$192.2 million) to set up a U.K.-based insurance company and to restructure the group. SVB, which currently operates two Lloyd's of London syndicates, will set up a new holding company, Novae Group P.L.C. The company will continue to write business at Lloyd's but will set up a new U.K.-based company to write U.K. liability business for small and midsize companies outside the Lloyd's market, said Matthew Fosh, chief executive of SVB. The new company will be called Novae Insurance Co. Ltd.

Equitable considering sale of annuities book

Equitable Life Assurance Society announced last week that its financial strength has improved due to investment gains and that it may consider selling its book of annuities, among other possible developments. London-based Equitable was forced to close to new business in late 2000 after failing to find a buyer in the wake of a House of Lords ruling that the company owed guaranteed annuity rate policyholders about £1.50 billion (\$2.25 billion) after underfunding such plans.

Aon Consulting names new chief executive

Robert Middleton has been appointed chief executive of Aon Consulting in the United Kingdom, the London-based human capital consulting arm of Aon Corp. Mr. Middleton, who currently is managing director of Aon Consulting in London, will succeed Ron Amy, who will remain as chairman of the unit and will assume greater global leadership responsibilities. Mr. Amy will continue as chairman and chief executive of Aon Asset Management Ltd., among other things, Aon said in a statement.

Engineering firm to erase pension deficit

London-based engineering company Ivensys P.L.C. has announced a nine-year funding plan aimed at erasing its defined benefit pension plan deficit. Ivensys said it would pay £105 million (\$183.4 million) on March 31, 2006, and contributions of £20 million (\$34.9 million) in each of the years ending March 31, 2007, and 2008, followed by annual contributions of £35 million (\$61.1 million), adjusted for inflation, until the deficit is eliminated. As of Sept. 30, 2005, the company's plan had a funding deficit of £325 million (\$567.8 million), Ivensys said.

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LEGAL NOTICE

IN THE HIGH COURT OF JUSTICE
 CHANCERY DIVISION
 COMPANIES COURT
 No. 1842 of 2006
 IN THE MATTER OF

NRG VICTORY REINSURANCE LIMITED (formerly known as VICTORY INSURANCE COMPANY LIMITED and THE VICTORY REINSURANCE COMPANY LIMITED)

AND IN THE MATTER OF THE COMPANIES ACT 1985

NOTICE IS HEREBY GIVEN that, by an order dated 27 March 2006 made in the above matter the Court has directed that a meeting (the "Creditors' Meeting") of the Scheme Creditors (as defined in the scheme of arrangement hereinafter mentioned) of the above named company (the "Scheme Company") be held on 23 May 2006 at the offices of Clifford Chance LLP, 10 Upper Bank Street, London E14 5JJ, commencing at 15:00 (London time). All Scheme Creditors are requested to attend at such place and time either in person or by proxy.

The purpose of the Creditors' Meeting will be to consider and, if thought fit, to approve (with or without modification) a scheme of arrangement proposed to be made between the Scheme Company and the Scheme Creditors pursuant to Section 425 of the Companies Act 1985 ("Scheme").

The Chairman of the Creditors' Meeting will address Scheme Creditors generally on the Scheme and on issues relevant to voting immediately prior to the commencement of the Creditors' Meeting.

Scheme Creditors may vote in person at the Creditors' Meeting or may appoint another person, whether a Scheme Creditor or not, as their proxy to attend and vote in their place.

Notice of the Creditors' Meeting and the statement required to be provided to creditors pursuant to Section 426 of the Companies Act 1985, together with Voting Forms and Forms of Proxy for use at the Creditors' Meeting, have been circulated to known Scheme Creditors as well as brokers and other intermediaries. Copies of these documents, as well as the Information Memorandum (incorporating the Estimation Methodology), the Scheme and blank Forms of Proxy and Voting Forms may be obtained by attending at, or on written application to, the Scheme Company, c/o NRG Victory Management Services Limited at the above address, marked for the attention of Martin Baker or Ms Lyn Davies during normal business hours on any day (other than a Saturday or Sunday or public holiday) prior to the day appointed for the said Creditors' Meeting. They may also be downloaded and printed from the Website www.nrg-solventscheme.co.uk

Scheme Creditors are requested to lodge the completed Form of Proxy and Voting Form with the Scheme Company, c/o NRG Victory Management Services Limited, Charter House, Park Street, Ashford, Kent TN24 8EQ, United Kingdom, Fax: +44 (0) 1233 722 601 or email: scheme.manager@nrgv.co.uk, marked for the attention of Martin Baker or Ms Lyn Davies, by no later than 17:00 (London time) on Friday 19 May 2006. Forms may also be handed in at the registration desk prior to the commencement of the Creditors' Meeting. Faxed and e-mailed Forms of Proxy and Voting Forms will be accepted if legible but Scheme Creditors are requested to send the originals, to be received by the Scheme Company, c/o NRG Victory Management Services Limited at the above address by no later than 17:00 (London time) on 30 May 2006.

Each Scheme Creditor or his proxy will be required to register his attendance at the Creditors' Meeting prior to its commencement. Registration will commence at 14:00 (London time) on the day of the Creditors' Meeting.

The Court has appointed Alan John Boyce, Chief Executive of the Scheme Company or, failing him, Paul Anthony Brereton Evans of PricewaterhouseCoopers LLP, to act as Chairman of the Creditors' Meeting and has directed the Chairman of the Creditors' Meeting to report the result of the Creditors' Meeting to the Court.

If approved by the requisite majority of Scheme Creditors, the Scheme will be subject to the subsequent approval of the Court. Any policyholder who has any questions concerning the action he is required to take should contact the Scheme Company c/o NRG Victory Management Services Limited (Attention: Martin Baker or Ms Lyn Davies), Charter House, Park Street, Ashford, Kent TN24 8EQ, United Kingdom, Tel: +44 (0) 1233 722600; Fax: +44 (0) 1233 722 601; email: scheme.manager@nrgv.co.uk

Note: Creditors of the Scheme Company's Canadian Branch:

Scheme Creditors who hold policies issued by the Scheme Company's Canadian branch will be entitled to view the Creditors' Meeting by way of a video link from Toronto. However, Scheme Creditors should note that only Scheme Creditors who are present (in person or by proxy) at the Creditors' Meeting taking place in London will be able to be heard at the Creditors' Meeting or be counted for voting purposes. Thus, a Scheme Creditor who only views the Creditors' Meeting by way of this video link will not be deemed to be present at such Creditors' Meeting for the purpose of voting on the Scheme unless he has also completed a Form of Proxy authorising someone (who may be the Chairman of the Creditors' Meeting) to attend and vote at the Creditors' Meeting in London on its behalf. Scheme Creditors wishing to take advantage of such video link should attend at the offices of Stikeman Elliott LLP at 5300 Commerce Court West, 199 Bay Street, Toronto, Ontario, M5L 1B9, Canada on 23 May 2006 and ask for Elizabeth Pillon. The video link to the Creditors' Meeting will commence at 10:00 (Toronto time). Scheme Creditors should allow sufficient time for arrival and registration.

LEGAL NOTICE

LEGAL NOTICE

IN THE HIGH COURT OF JUSTICE
 CHANCERY DIVISION
 COMPANIES COURT

NO: 1813 OF 2006

IN THE MATTER OF "WINTERTHUR" SWISS INSURANCE COMPANY
 - and -

IN THE MATTER OF TENECOM LIMITED
 - and -

IN THE MATTER OF THE FINANCIAL SERVICES AND MARKETS ACT 2000
NOTICE

NOTICE IS HEREBY GIVEN that on 13 March 2006 "Winterthur" Swiss Insurance Company ("Winterthur") and Tenecom Limited ("Tenecom") applied to the High Court of Justice, pursuant to section 107(1) of the Financial Services and Markets Act 2000 (the "FSMA"), for an Order sanctioning the transfer to Tenecom of general insurance business of Winterthur's branch in the United Kingdom. The business to be transferred was originally written by H.S. Weavers Underwriting Agencies Limited on behalf of Winterthur.

Copies of a report on the terms of the scheme (the "Scheme") prepared pursuant to section 109 of the FSMA (the "Independent Expert's Report") and a statement setting out the terms of the Scheme and containing a summary of the Independent Expert's Report can be obtained free of charge from the website at www.winterthur.com/weavers, by writing to KMS Insurance Services Limited, America House, 2 America Square, London, EC3N 2LU, United Kingdom, or by emailing winterthur.1elpdesk@kmsl.co.uk.

The proposed transfer will result in the business carried on by Winterthur being carried on by Tenecom. The proposed transfer will secure the continuation by or against Tenecom of any legal proceedings by or against Winterthur that relate to rights and obligations in respect of the transferred business. All claims being dealt with before the transfer by Winterthur will, following the transfer, be dealt with by Tenecom; all claims arising after the transfer will be dealt with by Tenecom.

The application is directed to be heard before the Companies Court Judge at the Royal Courts of Justice, Strand, London WC2A 2LL on 12 May 2006 and any person (including any employee of Winterthur or Tenecom) who alleges that he or she would be adversely affected by the carrying out of the Scheme may appear at the time of the said hearing in person or by Counsel. Any person who intends so to appear, and any policyholder of Winterthur or Tenecom who dissents from the Scheme but does not intend so to appear, should give not less than two clear days' prior notice in writing of such intention or dissent, and the reasons for that intention or dissent, to the solicitors named below.

Dated April 3, 2006.

Lovells (Ref: C4/CSR), Atlantic House, Holborn Viaduct, London EC1A 2FG
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AIRMIC: Insurers urged to reward rehab efforts

Continued from page 17

But, he said, there is evidence to suggest that employers that intervene early to get injured or ill employees back to work may see reductions in the employers liability premiums they are charged.

And Lord Hunt said that the government was keen to work with the insurance industry to encourage insurers to reward companies that have good workplace rehabilitation programs in place with lower rates for employers liability insurance. A ministerial group in the Department for Constitutional Affairs currently is looking at this issue, he noted.

Queries about how to handle employee ill health are among those most commonly addressed to the Engineering Employers Federation, according to Sayeed Khan, chief medical adviser to the labor union.

Early intervention is key to successfully rehabilitating an ill or injured employee, according to Dr.

Khan. "The window for successful intervention is four to six weeks," he said.

When corresponding with employees' general practitioners—who typically provide employees with sick notes—employers should ask not just for the diagnosis but for the "functional problem" that the employee has that is preventing that employee from returning to work, Dr. Khan said. This enables employers to better rehabilitate employees, he noted.

If an employer is setting up a program for workplace rehabilitation, it must ensure that it has communicated to employees and managers about the plan, said Dr. Khan. Employers should also look at the factors that influence the short-term absences of staff, he said. For example, circumstances such as the nature of an employee's commute to work or the area's climate may influence whether that employee attends work on any given day.

Setting up an absence manage-

ment policy at Rolls Royce P.L.C., a multinational company with about 21,000 staff members in the United Kingdom, was a lengthy process, according to the company's chief medical officer, Dr. Ian Lawson. The company looked at absence data, conducted surveys and trained managers and staff before rolling out the policy, he explained.

Dr. Lawson advised other employers considering implementing such policies to manage long-term absences separately from short-term absences. He also warned employers to be sure that they take a consistent approach to the management of absences to ensure that staff members do not feel they are being unfairly treated or discriminated against.

Certain cases of illness or injury should be fast tracked so that they do not develop into chronic cases, Dr. Lawson advised. And employers should make use of data and set targets for absence reduction, he said.

Tort reform: Time bar measure

Continued from page 4

years," or even sooner, he said.

"Beyond that, the longer it's out of the manufacturer's control, the more likely it is that any problems are due to lack of maintenance and upkeep or alteration of the machine's workings. That's why Japan and the European Union both have a 10-year statute of repose for all products," said Mr. Fineran. The more favorable Japanese and E.U. statutes of repose can put U.S. companies at a competitive disadvantage, he said.

A veteran consumer advocate questioned whether any product liability problem for workplace goods even exists.

"I don't think this is a horrible problem, I certainly don't think that businesses are clamoring for

this legislation," said Pamela Gilbert, an attorney with the Washington law firm Cuneo Waldman & Gilbert L.L.P.

"It's terrible legislation....A defective product that was defective on the day of manufacture is a defective product and just because an injury occurs many years later, does not justify taking the injured person's rights away," she said.

Ms. Gilbert said that the bill might harm smaller businesses because it could add to workers compensation costs.

"One of the results of a bill like this is to put more costs on employers and the workers compensation system. Many tort reform bills are examples of where big business is benefiting and small businesses are harmed," she said.

JLT: Ruling clears broker of liability for film loss

Continued from page 17

were all placed by JLT, HIH retained 20% of H1 and of H2 and 12.5% of H3. AXA Reinsurance S.A. and New Hampshire Insurance Co., a New York-based unit of American International Group Inc., underwrote most of the reinsurance.

AXA and New Hampshire, however, refused to pay the losses, claiming there had been a breach of warranty because fewer films had been made in each slate than had been stated in the insurance contract. According to the insurers, only five H1 films were made instead of the six slated; eight H2 films were made instead of 10; and four H3 films were made instead of five.

The films that were made include: "Dish Dogs," "Jack of Hearts" and "Kiss Toledo Goodbye."

A series of lawsuits in which HIH sued its reinsurers and they counter-sued eventually resulted in a

July 31, 2002, U.K. Court of Appeal decision that dismissed HIH's reinsurance claim (*BI*, Aug. 12, 2002;

HIH "has failed to prove that the loss for which it claims was caused by a breach of duty by JLT."

Mr. Justice Langley

Jan. 14, 2002). HIH then started litigation against JLT claiming negligence.

Although Mr. Justice Langley ruled that JLT "was in breach of duty in failing properly to alert HIH to the reductions in the number of films," HIH "has failed to prove that the loss for which it claims was

caused by a breach of duty by JLT."

According to the judgment, HIH paid the H1 claims "without taking legal advice and without knowing whether or not their reinsurers would agree to accept liability to indemnify HIH."

Meanwhile, HIH paid the H2 and H3 claims "with the knowledge that (most of) its reinsurers would not indemnify them and were advised that they and HIH had good legal grounds for not paying the claim."

According to the ruling, the consequences for HIH of an unfavorable security rating or bad publicity from S&P in the event of nonpayment "would have hit HIH badly, given that the financial markets (in London and Australia) were by this time starting to get anxious about HIH."

According to the judge, "the pressure applied by Standard & Poor's and HIH's financial weakness were substantial factors in the decisions to pay."

Larry: Cyclone loss estimates

Continued from page 17

buildings, cars, boats, and farm machinery, with business interruption claims also expected in Innisfail and the surrounding area.

Innisfail, a small town on the northeast tip of Australia, is a major tourism destination because of its proximity to the Great Barrier Reef.

The footprint of the cyclone's damage, while very wide, did not hit major metropolitan centers, keeping insured losses at a moderate level.

"Much of the crop damage is uninsured," says Mr. Vine. "Crops are generally uninsurable against a cyclone...because cyclones are

common events and the price of insurance would be too high," he said.

Nevertheless, the combined effects of Cyclone Larry, the ongoing softening of premium rates, and further possible losses from Cyclone Glenda, which crossed Western Australia's Pilbara coast last Thursday, hitting the small coastal town of Onslow, could limit insurer profits in 2006 after strong results in 2005.

Glenda, which did not hit any major metropolitan areas, moved inland Friday, causing widespread heavy rain. No damage estimates have been released.

2006 Readers Choice Awards

What companies are the best in the industry? Who's tops in terms of service, value, reputation and innovation? If you read *Business Insurance*, we want to know what you think.

With our second annual Readers Choice Awards, *Business Insurance* will let our readers again choose the top industry companies in 11 different categories relating to risk management and employee benefits. The winners will be announced and profiled in the Aug. 21 issue of the magazine. The categories are:

- Best overall commercial lines retail insurance brokerage.
- Best overall commercial property/casualty insurer.
- Best employee benefit consulting firm
- Best managed health care organization.
- Best property/casualty reinsurer.
- Best reinsurance intermediary.
- Best surplus lines insurance company.
- Best insurance wholesaler.
- Best risk management consulting firm.
- Best employee assistance program provider.

• Best third-party claims administrator.

The 2005 Readers Choice winners were identified through confidential balloting by subscribers of the magazine. While *Business Insurance* provided alphabetical lists of the 10 largest companies in each category for convenience, voters were able to write in candidates if their top choice was not on the lists. Companies receiving the highest vote totals were declared the winners in each category, and profiles appeared in the Oct. 10, 2005, issue.

This year, voters will have the opportunity to explain why they consider a company to be the best in its field. Voting for the 2006 Readers Choice Awards will again be confidential but must be completed by the end of Friday, July 28.

To see a list of the 2005 winners and to cast your vote this year, please visit www.BusinessInsurance.com/ReaderAwards, where registered subscribers also have access to a wealth of daily news and resources from the leading weekly magazine covering risk management, insurance and employee benefits.

HIH: Policyholders to receive partial payments

Continued from page 17

company creditors bought coverage.

Mr. McGrath estimated that creditors of HIH Casualty & General Insurance Ltd. would receive between 15 cents and 25 cents on the dollar; that FAI General Insurance creditors will receive between 25 cents and 35 cents on the dollar; creditors of CIC Insurance Limited and World Marine & General Insurances Pty Ltd. would receive up to 40 cents on the dollar; FAI Reinsurance Pty. Ltd. creditors would receive 50 cents on the dollar; creditors of FAI Traders Insurance Co. Pty Ltd., FAI Insurances Ltd., HIH Underwriting and Insurance (Australia) Pty Ltd. will receive less than 5 cents on the dollar.

Having been approved by credi-

tors, the payment must now receive court approval in Australia and the U.K.

Mr. McGrath said in a statement that the scheme provided several benefits for creditors, including allowing final payment far earlier than would occur under a traditional liquidation.

Mr. McGrath said he had collected \$2 billion Australian (\$1.41 billion) so far in the liquidation of HIH, and that further regular payments to creditors will be made over the next seven years.

He declined to say what the ultimate payout figure would be, claiming the outcome depended upon the particular company creditors had claimed against, as well as any legal issues surrounding their particular claim. Further, he said, the

results for each creditor will depend on the actual level of claims received and agreed compared with current actuarial estimates of those claims.

Payments will also be affected by Section 116 of the Insurance Act 1973 and section 562A of the Corporations Act 2001, according to Mr. McGrath. Section 116 states that an insurance company in liquidation must use its assets in Australia to satisfy its Australian creditors before other creditors are paid, and Section 562A states that the same company must first pay any proceeds received from reinsurance to any creditors whose debts arose as part of a claim against an insurance policy. Where these sections conflict, Section 116 priorities override the Section 562A priorities.

CRISIS FALLOUT

Zurich: Tri-state agreement mirrors earlier AIG settlement

Continued from page 1

Zurich's role in the scheme was twofold, officials from the three states say in settlement documents. In instances in which Zurich was the incumbent on the lead layer of business, Marsh tried to protect Zurich's incumbency, giving the insurer an unfair competitive advantage by seeking out noncompetitive bids from other insurers, the regulators said. Where Zurich was not the incumbent on the lead layer, it agreed to provide fake quotes to protect the incumbent, they say.

Additionally, the officials alleged that Zurich's participation in manipulating bids was not limited to excess casualty insurance or its use of Marsh as the broker for the coverage (see related story).

As part of its settlement, Zurich did not admit to violating U.S. federal or state laws, though the com-

pany did issue an apology for its improper conduct, acknowledging that "certain of its employees violated both acceptable business practices and Zurich's own standards of conduct by engaging in improper bidding practices," as well as certain finite reinsurance transactions used to mask the stability of its earnings (see related story).

Zurich's deal represents the second settlement reached with an insurer stemming from bid-rigging probes launched by New York Attorney General Eliot Spitzer. Last month, New York-based American International Group Inc. agreed to pay \$375 million to compensate policyholders that may have been harmed by bid rigging, as part of a \$1.64 billion settlement with various officials (BI, Feb. 13).

The agreement mirrors AIG's settlement in requiring Zurich to im-

plement many of the same reforms and bans on contingent compensation, such as halting the payment of contingents on excess casualty coverage in the United States through 2008 and banning such incentives for any line of business if insurers representing 65% of the gross written premiums on that line do not pay such commissions.

Like AIG, Zurich will also be required to meet additional reinsurance reporting obligations relating to reinsurance transactions and to support potential legislation and regulations in the United States to abolish contingent commissions for insurance products or lines.

While AIG Chief Executive Officer Martin Sullivan announced in the wake of AIG's settlement that it plans to discontinue paying contingent commissions—even after its ban has been lifted after 2008—

Zurich does not plan to follow suit.

"We will continue to pay them, except where prohibited by law, regulation or agreement that we've entered into," a spokesman for Zurich said. According to the spokesman, Zurich promised to support the abolition of contingent commissions on the grounds that "if banning contingent commissions is something the market moves toward and it accomplishes goals of more transparency ... then that's something we can support."

No refund

Furthermore, by entering into the tri-state settlement, Zurich forfeited its right to collect millions of dollars it previously could have been refunded under its pact with 10 states earlier this month. Under the terms of its 10-state agreement, if money were to have remained in the \$151.7 million policyholder restitution fund after all aggrieved clients were paid their apportioned share, Zurich would have recovered as much as nearly \$30 million (BI, March 27).

Under its subsequent three-state settlement last week, though, Zurich is now prohibited from receiving any such so-called "settlement credit," thereby "increasing by \$29.9 million the recovery consumers will receive as part of" the separate 10-state agreement, Mr. Spitzer said in a statement.

According to a source familiar

with the matter, ensuring that Zurich could not recover those funds was a key sticking point for the three state attorneys general, who would not have settled with the company unless it agreed to not seek or accept the money.

According to Zurich, the impetus behind entering two separate agreements with state attorneys general rather than a single combined agreement was to be "responsive to the needs and priorities of each state," it said in a statement.

As a result of both settlements, the insurer will book charges of \$324.7 million in the first quarter of 2006.

"We do not anticipate these agreements will have a significant impact on either our overall financial strength or that the settlement costs are likely to affect our ratings," Zurich said in a statement.

"The agreements concluded within the last two weeks represent significant progress in Zurich's efforts to resolve the uncertainty associated with certain industrywide practices. This industry, like others before it, is undergoing a transformation, and these agreements will bring greater clarity to how Zurich will move forward to serve producers and customers in this new era of transparency," James J. Schiro, Zurich's chief executive officer, said in a statement.

Zurich said it continues to cooperate with all regulatory investigations.

Settlement requires prompt payouts from Zurich fund

Excess casualty clients must be paid by Feb. 7, 2007

By RUPAL PAREKH

Under the terms of the three-state settlement Zurich Financial Services Group Inc. reached last week with attorneys general in New York, Illinois, and Connecticut, Zurich by no later than May 8 must create an \$88 million fund to provide restitution to harmed policyholders.

Eligible participants in the fund are U.S. policyholders that bought or renewed Zurich excess casualty policies—with the exception of workers compensation policies—through Marsh Inc. in between Jan. 1, 2000, and Sept. 30, 2004.

Zurich has until July 10 to calculate the amount each eligible policyholder may receive, based upon gross written premiums paid from 2000 through 2004. By July 24, Zurich must send a notice to all eligible policyholders, informing them of their potential refund and noting that the amount paid could increase if there is less than full participation by eligible policyholders. Those policyholders then have until Dec. 27 to respond to the restitution offer.

On or before Feb. 7, 2007, Zurich must pay all participating policyholders their share of the fund. Money remaining in the fund as of Dec. 8, 2007, will be distributed among participating policyholders on a proportional basis.

Policyholders that elect to join the three-state agreement will be required to waive their right to any compensation that may be

obtained through a parallel nationwide settlement Zurich reached earlier this month related to bid-rigging charges brought by regulators in 10 states, which will provide a total of \$151.7 million in restitution to policyholders (BI, March 27).

"To receive payment from our settlement, a policyholder must sign a release which would prohibit them from receiving payment" from the parallel multi-state settlement, a spokesman for New York Attorney General Eliot Spitzer said.

That settlement, which awaits court approval, stems from a memorandum of understanding Zurich reached with plaintiffs in a nationwide class action lawsuit pending in a New Jersey district court against several commercial insurers and brokers accused of involvement in improper broker compensation and insurance placement practices.

"There's still an open chapter in this book," said James R. Wagner, a partner with Howrey L.L.P. in Washington.

Since the parallel multistate settlement and principal terms for Zurich's settlement of class action claims have yet to be approved—and there is not yet a plan of allocation and timetable for distributing the \$151.7 million in restitution from the parallel settlement—"policyholders definitely have to sit tight to see what's happening...and to determine whether or not they are getting adequate compensation out of the settlement with Mr. Spitzer, or would likely get a bet-

ter result out of the" 10-state settlement, Mr. Wagner said.

As part of the decision process, eligible policyholders should take into account the actual level of harm suffered as a result of Zurich's bid-rigging actions, he added.

"The good thing about Spitzer's agreement," said Mr. Wagner, is that "if policyholders don't think that they want to pursue a damages claim, or that the amount of compensation is enough, they can get money pretty quickly," because payments to policyholders must be made within the next year.

Major policyholders in Connecticut affected by Zurich's actions include Bridgeport Hospital in Bridgeport, units of Jacksonville, Fla.-based Fidelity National Financial Inc., Hexcel Corp. of Stamford and Hubbell Inc. of Orange, Connecticut Attorney General Richard Blumenthal said in a statement.

Industrial goods manufacturer Hexcel Corp.—which last year was among policyholders that accepted a settlement offer as part of New York-based Marsh & McLennan Cos. Inc.'s \$850 million deal with regulators to end charges of fraud and bid rigging—said that it is still too early to tell whether the company will tap the restitution fund created by the agreement Zurich reached with Mr. Spitzer and the Illinois and Connecticut attorneys general.

"We'll evaluate the offer when it's delivered to us," a Hexcel spokesman said.

ZFS agreement details 'circular transactions,' new reporting rules

By JUDY GREENWALD

NEW YORK—Zurich Financial Services Group Inc.'s latest settlement with New York Attorney General Eliot Spitzer and other officials sheds more light on investigations into the insurer's use of finite deals and other reinsurance practices and requires Zurich to institute reinsurance reporting rules designed to prevent abuses.

In particular, the settlement documents provide further detail on a 1998 deal between Zurich Reinsurance (North America) Inc.—which later became Conventum Holding Ltd.'s now-defunct U.S. reinsurance arm, Conventum Reinsurance (North America) Inc.—and Armonk, N.Y.-based bond insurer MBIA Inc.

In the "assurance of discontinuance and voluntary compliance" signed by Zurich, the officials also detail how certain Zurich subsidiaries used nontraditional reinsurance to bolster ZFS' results.

In addition, the agreement notes that the settlement does not resolve New York Insurance Superinten-

dent Howard Mills' current examination of Zurich American Insurance Co., "including the superintendent's review of certain reinsurance contracts with Hannover Re and Swiss Re."

A spokesman for the New York Insurance Department said he cannot comment on the recent examination of Hannover Re and Swiss Re because it is ongoing. A spokesman for Hannover, Germany-based Hannover Re Group had no comment, and representatives of Swiss Reinsurance Co. could not be reached.

In language similar to that used in American International Group Inc.'s settlement agreement with Mr. Spitzer earlier this year (BI, Feb. 13), the agreement also details reinsurance reporting obligations, including a requirement that, beginning in July, for five years ZFS annually submit a review of its ceded and assumed reinsurance.

This report should include documentation "concerning the economic intent and the risk transfer analysis evidencing the proper ac-

CRISIS FALLOUT

Finite: Settlement includes new reporting rules

Continued from previous page

counting treatment" for all reinsurance contracts on or after January, 1994, "for which risk transfer is not reasonably considered to be self-evident," states the agreement.

Zurich has also agreed to establish a training and education program for all employees with supervisory responsibility for accounting, financial reporting and public disclosure functions in the United States.

'Circular transactions'

The settlement agreement states that, "in a series of transactions from 1991 to 2001, where legitimate reinsurance was unavailable, these ZFS subsidiaries, in order to decrease their reserves and to accelerate their profits, reported that they had obtained reinsurance on unprofitable books of business.

"In reality, they had obtained no such coverage. Instead, they had paid a small fee to various off-shore reinsurance companies to issue reinsurance contracts while simultaneously, through separate contracts, returning the coverage to another ZFS insurance subsidiary.

"By using the off-shore companies and different divisions of ZFS,

these ZFS subsidiaries were able to avoid reporting these circular transactions to their auditors and regulators and improperly bolster ZFS' earnings," it says.

A footnote explains that "Zurich was able to accelerate its profit from these circular transactions by reducing the reserves (which count as liability) it had established to pay for losses on the policies."

The settlement also provides more details on the Converium-MBIA transactions.

Last year, MBIA twice restated its results from 1998 onward to reverse reinsurance credits it took against a \$170 million loss it incurred guaranteeing bonds issued by a bankrupt unit of Allegheny Health, Education & Research Foundation. This included a \$70 million reinsurance credit it had taken against the AHERF loss under contracts with Converium.

MBIA has set aside \$75 million for an anticipated settlement of federal and state investigations into its use of retroactive reinsurance to cover the \$170 million AHERF loss.

According to the agreement, in 1998 MBIA had approached Zurich Re and proposed it provide the bond insurer with a \$70 million

loss contract that would carry a nominal premium.

"In exchange for taking this loss, Zurich Re would receive a separate reinsurance contract calculated to compensate Zurich Re for the amount it had lost under the original contract and provide a profit," says the agreement.

"Zurich Re accepted the arrangement on the condition that its losses be capped, so that it would not lose money on the deal," the agreement states. However, "MBIA's auditor refused to sign off on the deal because of the cap on losses," the agreement notes.

Zurich Re and MBIA then entered into a new agreement "involving two other insurance companies and a series of reinsurance contracts that obscured the lack of risk transfer in the deal and the cap on Zurich Re's losses," states the agreement.

An MBIA spokesman had no comment, nor did MBIA's auditor, New York-based PricewaterhouseCoopers L.L.C.

MBIA last year received a Wells notice from the Securities and Exchange Commission, informing MBIA that the commission was considering filing civil charges against it for violating securities laws.

Max Re to review its use of finite risk contracts

Warns of possible restatement

HAMILTON, Bermuda—Max Re Capital Ltd. may have to restate and reduce its earnings by as much as \$50 million for 2001 through 2005, pending a review of three finite risk retrocessional contracts written in 2001 and 2003, says the company.

Max Re Executive Vp and Chief Financial Officer Keith S. Hynes said the company discovered the potential problem itself and voluntarily informed the U.S. Securities and Exchange Commission of it late last month.

Two of the contracts were written with the same counterparty in 2001 and the third was written with another counterparty in 2003, said Mr. Hynes.

"They were of similar structure, which is why we're looking at all three of them," said Mr. Hynes, who did not provide additional information.

Max Re's audit and risk management committee is conducting a review to determine whether the company properly accounted for the contracts, including whether they contain sufficient risk trans-

fer to meet the requirements of Financial Accounting Standard No. 113, according to the company.

The company said it believes that the cumulative adjustment from these contracts would reduce retained earnings at Dec. 31, 2005, by not more than \$50 million, or about 4% of the reinsurer's \$1.22 billion in shareholder's equity.

Mr. Hynes said the \$50 million represents the difference between accounting for the transactions as financial reinsurance and as deposit accounting.

Mr. Hynes said it is unclear how long it will take to resolve the issue.

"We hope it's short," but in light of the SEC's involvement "it's impossible to say," he said.

Max Re reported \$6.7 million in 2005 net income last month because of natural catastrophes, compared with \$133.7 million in net income in 2004.

The company raised \$284.1 million in a public common share offering during last year's fourth quarter.

—By Judy Greenwald



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Pensions: Speculation grows over tight-lipped conferees

Continued from page 1

not be reached until late May. Business groups say that wouldn't give regulatory agencies enough time to develop the rules and guidance employers will need to comply with the most sweeping set of pension changes since the enactment of the Employee Retirement Income Security Act nearly 32 years ago.

"This is a massive undertaking. It is going to take a lot longer than six months for employers to prepare for these changes. We have asked Congress to delay the effective date" to January 2008, said Bob Shepler, director-corporate finance and tax for the National Assn. of Manufacturers in Washington.

How receptive conferees will be to a delay isn't known, but some lobbyists say the longer it takes conferees to reach an agreement, the likelihood increases that the effective date will be pushed back.

"There is a growing recognition that some things will have to be pushed back until 2008," said Janice Gregory, senior vp with the ERISA Industry Committee in Washington.

The bill is being put together in a very private way. There are no public meetings of conferees, with members meeting informally

or discussing issues in telephone conversations.

Information about what has been discussed is difficult to obtain. Not only are conferees saying little, they also have instructed their aides to say nothing.

"There has been a gag order," said Aliya Wong, director of pension policy at the U.S. Chamber of Commerce in Washington.

"We don't know exactly where in the process they are," added Mr. Shepler.

Still, lobbyists speculate that the legislative process will be one in which a handful of members of the conference will try to hammer out an agreement among themselves and then present it to the full conference for their approval. Those key members include Sen. Enzi; Sen. Charles Grassley, R-Iowa, who chairs the Senate Finance Committee; Sen. Max Baucus, D-Mont., the ranking minority member of the Finance Committee; Rep. Bill Thomas, R-Calif., who chairs the House Ways and Means Committee; and Rep. Boehner.

Despite the information blackout, lobbyists say they have picked up indications that one of the first issues conference committee leaders

are trying to resolve is whether organizations with noninvestment grade ratings on their debt would be required to make extra contributions to their pension plans, if those plans are underfunded.

Under the Senate-passed bill, employers whose plans are less than 93% funded and who lack invest-



"Having specific relief in the law for a company or an industry doesn't strike me as the best way to legislate."

Rep. John Boehner, R-Ohio

ment grade ratings would be required to use certain actuarial assumptions—such as assuming that every plan participant eligible for early retirement would take it—that would increase reported liabilities, requiring employers to kick in additional contributions. The House-passed bill lacks such a requirement.

Business groups earlier complained that such a requirement

could hit companies with extra cash calls for their pension plans at a time when they could least afford it. And that could lead to more pension failures, with companies unable to meet the demand for extra contributions, lobbyists say.

While conferees may be talking about the credit rating issue, it is

able actuarial assumptions to value plan liabilities.

Rep. Boehner, at a news briefing last week, reiterated his general opposition to industry specific relief. "Having specific relief in the law for a company or an industry doesn't strike me as the best way to legislate," he said.

Rep. Boehner said rather than providing specific industry relief, "I would rather find a different way of trying to provide reasonable and responsible help to those who need it."

Aside from trying to fashion compromises on the credit rating and airline relief provisions, conferees also face big challenges in reaching an agreement on how much protection cash balance and other hybrid plans should have from age discrimination suits and on the interest rate assumptions used to value plan liabilities.

The two bills, though, have similar provisions that decrease the time employers would have to fund plan liabilities, limit the ability of employers with underfunded plans to improve benefits and allow employers to contribute to their plans even when the plans are fully funded.

Harrah's: Hurricane aftermath prompts employer to set up health care program

Continued from page 3

flood the city, according to the U.S. Government Accountability Office in Washington.

Among the casualties was Charity Hospital, the city's only Level 1 trauma center, which was closed after its basement flooded, ruining its electrical system. New Orleans officials have said the hospital cannot be saved because of exposed asbestos and bacteria that flourished in the late summer heat.

Provider networks also were significantly disrupted when physi-

cians were forced to flee the city along with other inhabitants, according to HealthLeaders-InterStudy, a Nashville, Tenn.-based company that provides managed care industry data and analysis.

After the storm, "we had as a concern the availability of quality health care in New Orleans," explained Anthony Sanfilippo, Memphis, Tenn.-based president of the central division for Harrah's, whose responsibilities encompass all of the properties that were affected by Katrina.

"Many physicians have relocated to other areas, and New Orleans is going to have to reassess and rebuild its health care system," he said.

So when the company began planning its casino reopening, "we started to look at issues such as not only the repair of the building but also the availability of services for our team members. And we quickly said, because of our experience with health clinics in other locations, that we thought it would be a terrific benefit to have a health clinic that was available to all of our employees in New Orleans," Mr. Sanfilippo said.

The clinic will provide a variety of basic health care and other services (see related story).

Harrah's currently operates three other health clinics, located in Tunica, Miss.; Atlantic City, N.J.; and Lake Tahoe, Nev.

The Tunica clinic was the first to open in March 2005, because that casino is located in a rural area with little access to quality medical services, explained Dave Beech, a consultant in the Los Angeles office of Watson Wyatt Worldwide Inc. who works on the Harrah's account.

Because it is located in an urban area, Harrah's New Orleans clinic probably would have been "a couple of years away," according to Mr. Beech. But "because health care is really spotty down there right now, they decided to move up the timeline on New Orleans," he said.

"When we were doing our strategic plan, New Orleans was on our map. When the hurricanes hit, we had to pull back. But Anthony (Sanfilippo) said, 'We needed to open

"Many physicians have relocated to other areas, and New Orleans is going to have to reassess and rebuild its health care system."

Anthony Sanfilippo
Harrah's Entertainment Inc.

because this covered such a broad area—literally well over 100 miles—it's a lot of ground that has to get rebuilt," said Mr. Sanfilippo.

But when Harrah's New Orleans Casino reopened on Feb. 17, it had a staff of 1,600, 90% of whom were prior employees, he said. Mr. Sanfilippo attributed much of the retention to the services—which also included housing assistance—the company has provided to its workers since the storm.

This feat "surprised many people in New Orleans, because many businesses were struggling to staff 25 or 50 people," he said.

Within a week after Katrina, Harrah's also worked with its vendor, Cleveland-based Whole Health Management Inc., to set up temporary health clinics in Biloxi, Miss., and Baton Rouge, La., to help its employees and their families, according to Mr. Sanfilippo. They operated for about 45 days following the storm.

the clinic.' He realized how dire the situation was," recalled Juliet Vestal, director of health care management for Harrah's in Las Vegas.

Health benefits experts who have seen Katrina's devastation firsthand were supportive of Harrah's decision to provide basic health care services to its employees and their families onsite.

"This is a very good move," said Kip Wall, former chief executive officer of the Office of Group Benefits for the state of Louisiana who is now a lawyer in private practice in Baton Rouge, La.

"The medical services infrastructure in New Orleans has been severely damaged, he said. In addition, "there is a labor shortage, and to hire and retain qualified people you have to provide them with some type of assurance that basic services are going to be available," said Mr. Wall, who is with the firm of Simon, Fitzgerald, Cooke, Reed & Welch.

Indeed, "the issue is being able to collect a workforce and supplies,

In-house clinic offers treatment to staff

NEW ORLEANS—The Harrah's Entertainment Inc. onsite clinic in New Orleans will provide a host of services to Harrah's employees and their dependents.

Juliet Vestal, director of health care management for Harrah's in Las Vegas, said that in addition to providing basic medical services, the clinic will also provide wellness education, employee assistance program services and pharmacy benefits. Basic medical services will include diagnosing and treating of illness and minor injuries, and providing immunizations, X-ray and lab services.

Employees and their dependents who are enrolled in a Harrah's employer-sponsored medical plan will pay a co-payment

of \$10 per visit to use the clinic, while those who are not covered by Harrah's will pay \$30, explained Anthony Sanfilippo, Memphis, Tenn.-based president of the central division for Harrah's.

All of the payments will be made via payroll deduction, Ms. Vestal added.

The clinic, which is being operated by Cleveland-based Whole Health Management Inc. and is staffed by their providers, is slated to open April 24. The facility will initially provide services between 8 a.m. and 6 p.m., Monday through Friday, but the hours and days of operation may change depending on demand, Ms. Vestal said.

—By Joanne Wojcik

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Astros: Policy wording causes disagreement

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"It really makes no sense that Mr. Bagwell was healthy enough to start game one of the World Series and then somehow became totally disabled in the off season," said Ty Buthod, a partner with Houston-based Baker Botts L.L.P. who represents Connecticut General Life Insurance Co., the legal entity of Philadelphia-based CIGNA.

According to the Astros, though, the fact that Mr. Bagwell played in the World Series has no bearing on the legitimacy of its claim because Mr. Bagwell was diagnosed as being totally disabled on Jan. 12, after being examined by Dr. James Andrews, a prominent sports medicine orthopedic surgeon at the Alabama Sports Medicine & Orthopedic Center in Birmingham, Ala.

"That is ludicrous on its face, in our opinion," said Wayne Fisher, a partner with Houston-based Fisher, Boyd, Brown, Boudreaux & Huguenard L.L.P., who represents the team. "As a result of the examination, Dr. Andrews concluded that Jeff Bagwell was totally disabled from playing baseball and so advised Mr. Bagwell and the Astros."

After the team received Dr. Andrews' diagnosis, it filed an insurance claim and provided information on the examination to the insurer. But CIGNA took the position that there was no new injury or accident that led to Mr. Bagwell becoming totally disabled and denied the claim on March 13.

"The company couldn't find any

accident or injury or change in Mr. Bagwell's condition from the end of the 2005 season to the time he was said to be totally disabled," Mr. Buthod said.

According to the Astros, the policy wording requires the claim to be paid because it provides

"It really makes no sense that Mr. Bagwell was healthy enough to start game one of the World Series and then somehow became totally disabled in the off season."

**Ty Buthod
Baker Botts L.L.P.**

for coverage for any bodily injury, sickness or disease that leads to Mr. Bagwell's total disablement. The insurance policy provides that if Mr. Bagwell were to become totally disabled during the off season, the Astros would be eligible for benefits, Mr. Fisher said. "The policy doesn't require—as we read it—any new accidental injury," he said.

The Astros purchased the policy in January 2001. The policy expired on Jan. 31 of this year.

Under this insurance policy, there is no formal appeals process,

but the insurer would consider any more information on Mr. Bagwell's condition during the policy's effective period that the Astros can produce, Mr. Buthod said. "We will certainly consider anything else the Astros want to send us," he said. "As far as we're concerned, the matter is over. Whether the Astros want to file suit is their decision."

Mr. Fisher said he was planning to ask the insurer to reconsider last week and would probably give the company several weeks to do so. But if the insurer does not change its position, the Astros will file a lawsuit to force it to pay the claim, he said.

Mr. Bagwell was participating in a rehabilitation program supervised by the team's physician during spring training, but the Astros announced on March 25 that he decided not to continue his rehabilitation and training for the upcoming 2006 season because of his shoulder injury and will instead pursue surgical options to remove bone spurs in his right shoulder. The club placed the 37-year-old player on the 15-day disabled list with right shoulder arthritis and bone spurs.

Mr. Bagwell is the team's all-time leader in home runs, with 449 home runs and 1,529 runs batted in during his 15-season Major League career, encompassing 2,150 career games. Mr. Bagwell won Rookie of the Year honors in 1991 and the Most Valuable Player award in 1994.

Late News

Continued from page 1

contributions and company matching of employee contributions," Delphi said. The Pension Benefit Guaranty Corp. last year estimated that the two plans had \$4.1 billion in unfunded benefits that the PBGC would have to guarantee if the plans folded.

Florida Legislature OKs tort reform bill

The Florida Senate has given final approval to a measure that would repeal the imposition of joint-and-several liability in civil cases. H.B. 145, which had already been approved by the House, calls for replacing joint-and-several liability with a system of proportionate liability under which defendants have to pay only their relative share of the damages at issue. Last week's Senate vote sends the measure to Republican Gov. Jeb Bush, who has said he will sign the bill.

Firms lag on bird flu plans, report finds

While 70% of the businesses surveyed about the possible impact of the avian flu say that a pandemic would hurt their bottom line, less than half—47%—have a business continuity plan in place, according to a new study by Mercer Human Resource Consulting. The "Avian Flu Pandemic Preparedness Report," which was based on the responses of 450 companies in 38 countries, found that about one-quarter of the Asian companies had budgeted for avian flu preparedness, compared with only 7% in the United States. Respondents in Hong Kong and Singapore were among the best prepared.

FASB proposes rule on pension plan disclosure

Publicly held companies, for fiscal years ending after Dec. 15 would have to report their pension and other postretirement plans' funded status on their financial balance sheets, the Financial Accounting Standards Board proposed last week. Under current FASB rules, employers must disclose postretirement plan assets and liabilities as notes to their financial statements but not in the statements themselves. FASB said a balance sheet recognition requirement will increase the transparency and completeness of

financial statements for shareholders, creditors, employees, retirees and other users.

Broker pay disclosure is improving: AIRMIC

A survey by the London-based Assn. of Insurance & Risk Managers found that 64% of respondents receive automatic disclosure of earnings from their brokers. This compares with 32% of respondents who said their brokers automatically disclose earnings in a similar study undertaken in June 2005. Seventy-three percent of survey respondents said they are happy with the information their brokers provide them about earnings, compared with 44% in the June study. AIRMIC surveyed 124 companies during March; the June 2005 survey had 125 respondents.

Lexington to reduce net exposure to cats

Lexington Insurance Co. plans to reduce its net writings for commercial and residential properties by 20% to 25% in regions where hurricanes and other natural catastrophes are most likely to generate losses, a spokesman said. California, Florida, Hawaii, New Orleans and parts of Texas are among the areas where Lexington is limiting its catastrophe exposure. The moves were announced by Kevin Kelley, chairman and chief executive officer of Lexington, during an investor conference last week. The American International Group Inc. unit expects to raise rates up to 30% on coverage in catastrophe-prone areas, and policyholders likely will pay 10% to 25% more in noncatastrophe areas.

Mississippi drops annual RRG fee

Mississippi Gov. Haley Barbour has signed legislation that will eliminate the \$500 annual registration fee now paid by risk retention groups that are licensed outside the state but provide coverage to policyholders in the state. The bill, though, does require out-of-state RRGs to register by March 1 of each year with the Mississippi Insurance Department—a requirement allowed under the federal Risk Retention Act—and to provide a listing of premiums written in the state. The measure will go into effect July 1.

BI Stock Index [3/27 - 3/31]

Up-to-the-minute data for all 85 companies that comprise the BI Stock Index can be found at www.businessinsurance.com.

Percentage change of
BI Stock Index vs. key indicators

BI Stock Index	
2956.04	-0.50
Dow Jones	
11109.32	-1.51
S&P 500	
1294.82	-0.62

Source: FinancialContent Inc. (<http://financialcontent.com>)

Largest gains

Gainsco Inc.	13.26%
Meadowbrook Insurance	6.87%
Baldwin & Lyons Inc.	6.63%
NYMagic Inc.	5.78%
USI Holdings Corp.	4.88%

Largest losses

Vesta Insurance Group	-30.00%
Fairfax Financial	-7.27%
CNA Surety Corp.	-7.11%
Cincinnati Financial	-4.36%
Unitrin Inc.	-3.53%

Weekly change by market segment

Brokers	1.28%
Insurers/reinsurers	-0.15%
Managed care organizations	-0.24%

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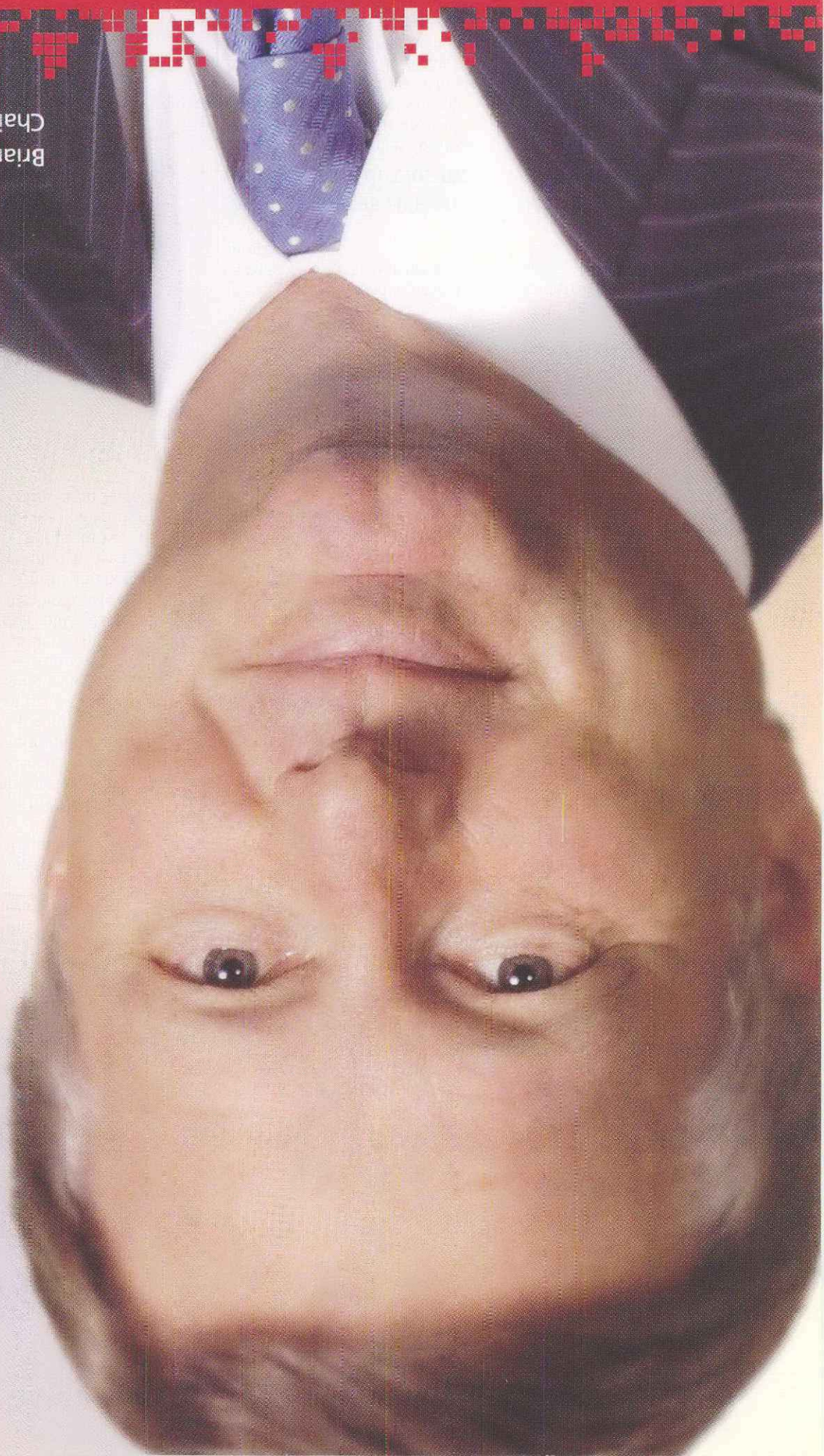
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New Online Poll: How quickly after binding a risk do you usually receive accurate, complete policy documents?

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Brian Storms
Chairman and CEO, Marsh

*Managing risk in today's
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environment requires
sophisticated solutions
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We're leading the way
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the challenges of
a globalized economy.*

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