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\$4

Struggling MRM mulls options

By GAVIN SOUTER

HAMILTON, Bermuda—Mutual Risk Management Ltd. is reviewing its options, including a possible sale, as it struggles with financial problems and ratings downgrades.

Robert A. Mulderig, chairman and chief executive officer of the Hamilton, Bermuda-based insurer and captive manager, said last week that MRM is exploring strategic alternatives, including becoming part

of a more stable company.

And despite the difficulties MRM faces, the company still has some attractive businesses that could interest a stronger rival, observers say.

Last April, XL Capital Ltd. and other investors sought to help MRM turn its fortunes around. But MRM's long-running problems came to a head last week when it reported a net loss of \$86.2 million for 2001. As part of that announcement, MRM disclosed that it had

added \$61.5 million to its loss reserves and had violated some of its debt agreements. In addition, the company confirmed that it still faces problems collecting on several reinsurance contracts.

And despite an announcement that MRM was in negotiations to sell its fund administration business, Hemisphere Management, for \$110 million to help pay down its debt, rating agency A.M. Best Co. downgraded two MRM units, Le-

gion Insurance Group and IPC Group, to B from A. In addition, Standard & Poor's Corp. downgraded Legion and another unit, Villanova Insurance Co., to BBB from A and then few days later downgraded them further to BB.

Inadequate capital is just one of several problems MRM faces, said Joyce Sharaf, managing senior financial analyst at Oldwick, N.J.-based Best. In particular, questions

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Late News

Conseco seeking D&O coverage for settlement

Conseco Inc. is suing several of its insurers to fund a \$120 million settlement of a shareholder class-action lawsuit. To fulfill the settlement agreement, Conseco must obtain payments from its directors and officers liability insurers by March 8. The agreement calls for Conseco to place \$106 million in an escrow account by that date, with the remainder to be paid later, according to a filing with the Securities & Exchange Commission. Conseco's primary D&O insurer, National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc., has paid its \$10 million in policy limits toward the settlement. Conseco is continuing to sue its remaining D&O insurers. Conseco's first excess insurer, Royal Insurance Co., has placed its \$15 million in policy limits in escrow but has reserved its rights to review and litigate over its obligations.

Judge OKs some suits against health plans

A federal judge in Miami last week ruled that plaintiffs may proceed with lawsuits against six managed care organizations, charging, among other things, that the plans used deceptive marketing practices. Allowed to proceed were six complaints filed under the federal Racketeer Influenced and Corrupt Organizations Act, as well as suits charging that the health plans violated certain duties under the Employee Retirement Income Security Act by imposing gag orders on doctors that prevented providers from discussing the financial arrangements they have with health insurers. In addition, the judge ruled that some plaintiffs could claim under ERISA that the managed care companies used a misleading definition of "medical necessity." The defendants in the various suits are Aetna Inc. and its Prudential Healthcare unit, CIGNA Corp., Health Net Inc., Humana Inc. and United HealthCare.

Court sides with insurer on pollution exclusion

The Connecticut Supreme Court last week ruled that the sudden and accidental pollution exclusion bars coverage for pollution that

See LATE NEWS/page 2

Loss would be biggest in agency's history

PBGC steels for hit from LTV plans

By JERRY GEISEL

WASHINGTON—The saga of LTV Corp.'s massively underfunded pension plans is coming to an expensive end.

The Pension Benefit Guaranty Corp. announced this month that it expects to take over and terminate three pension plans sponsored by the bankrupt Cleveland-based steelmaker, which has shut down its operations.

The termination will be by far the largest and most costly in the 27-year history of the PBGC, the federal agency that guarantees employers' defined benefit pension plan benefits. Nevertheless, the loss will not threaten the agency's solvency, observers say.

According to preliminary agency estimates, the LTV plans are underfunded by more than \$2.0 billion, with about \$4.3 billion in liabilities and \$2.2 billion in assets.

The PBGC's precise liability is not yet known, though the agency almost certainly will not be liable for the full \$4.3 billion in benefits promised to LTV plan participants. Under federal law, the PBGC does not guarantee all promised benefits. For example, a phased-in schedule is used for recent benefit improvements.

But whatever the PBGC's actual liability for the LTV plans turns out to be, the March 31 takeover of those plans will result in the agency's biggest loss ever. Up to now, the PBGC's biggest loss

stemmed from the 1991 and 1992 terminations of several Pan American World Airways Inc. pension plans, a total loss the PBGC calculates at \$841 million.

In addition, the takeover of the LTV plans will place a significant administrative burden on the PBGC. The plans cover about 82,000 people, which is about 60% more than the previous

See LTV/page 22



LTV Corp. has shut down its plants and is expected to terminate its pension plans.

PHOTO: AP/WIDE WORLD

Game over: K&K, TIG ending ties

By SALLY ROBERTS

FORT WAYNE, Ind.—K&K Insurance Group's longstanding ties with TIG Insurance Group appear to be ending.

Since 1986, Fort Wayne, Ind.-based K&K has been the exclusive managing general agency for Irving, Texas-based TIG on several sports, leisure and entertainment programs, including programs for professional sports teams and leagues, motor racing and amusement parks. About 20% to 25% of TIG's gross written premiums come through K&K.

Neither K&K nor TIG would comment on their relationship, but a number of observers who asked not to be identified say K&K is seeking new insurers to write the former TIG programs.

One of these could include K&K sister company Virginia Surety Co. Inc. Chicago-based Aon Corp., the parent company of K&K and Virginia Surety, is in the process of spinning off its underwriting operations.

In addition to TIG, K&K also is an MGA for OneBeacon Insurance Group, Westport Insurance Corp. and Great American Insurance Cos. on sports, leisure and entertainment business.

TIG Holdings Inc., the former holding company for TIG's insurance and reinsurance operations, has been fighting to turn itself around since its initial public offering in 1993 amid a softening market. Through the mid-1990s, TIG shifted the focus of its primary insurance busi-

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**'John Q' seen as
catalyst for
health care
debate/ 3**



Inside

Structured settlement safeguards urged

Despite the enactment of new federal rules to protect individuals who sell their structured settlements, employers and insurers say that 20 states and the District of Columbia still need to adopt specific regulations. **Page 4**

A new ball game for securitization

In his Commentary, Senior Editor Rodd Zolkos makes a big-league pitch for risk securitization. **Page 6**

Seek appropriate genetic bias laws

As Congress considers legislation to prevent genetic discrimination, employers should encourage lawmakers to draft measures that are fair, reasonable and consistent with existing law, this week's editorial says. **Page 8**

Making the best use of company captives

As the market hardens, companies should look at a broad range of uses for their captive insurers, according to a speaker at the recent American Bankers Assn.'s Insurance Risk Management Annual Conference and Meetings. **Page 12**

Financial reinsurance under scrutiny

Finite risk and financial reinsurance contracts are coming under regulatory scrutiny in the United Kingdom and Australia, as officials focus on whether such products allowed insurers that later collapsed to mask financial difficulties. **Page 17**

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REPORTING WEEKLY ON CORPORATE RISK, EMPLOYEE BENEFIT AND MANAGED HEALTH CARE NEWS

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CONTINUED FROM PAGE ONE

did not occur abruptly. In *Buell Industries Inc. vs. Greater New York Mutual Insurance Co.*, Connecticut's high court held that the pollution exclusion clearly requires an abrupt discharge of pollutants to trigger coverage. Interpreting "sudden" to instead mean "unexpected," as the policyholder suggested, would make the exclusion's suddenness requirement "mere surplusage," the court ruled. The court also rejected Buell's argument that its pollution liabilities at two landfills in Waterbury, Conn., should be covered under the personal injury provisions of its two general liability insurance policies. Allowing coverage under those provisions would render the pollution exclusion "a dead appendage" to each of Buell's policies, the court ruled.

FSR, union urge terrorism backstop

The Financial Services Roundtable and the Building and Construction Trades Department of the AFL-CIO have sent a joint letter to President Bush, calling for the creation of a federal terrorism insurance backstop. "We know of no more urgent an issue facing the economy and our organizations," wrote FSR President Steve Bartlett and Building and Construction Trades President Edward C. Sullivan in their Feb. 20 letter to the White House. "The lack of insurance has had a chilling effect on lending for large commercial projects, and though the breadth of the negative impact may not be fully evident, there is no doubt that lenders are steering money away from projects that lack insurance," they wrote. The letter also noted that "insurers cannot afford to provide" workers compensation and group life coverage where there are large aggregates of people. FSR is a trade association of financial services companies.

California HMO enrollment down: Report

The percentage of insured California workers enrolled in health maintenance organizations dropped to 48% in 2001, down from 55% in 2000, according to an annual survey of benefit managers. The decline in HMO enrollment marks a reversal of the steady increase seen since 1994,

Late News

when 35.3% of insured workers were enrolled in such plans, according to the report, produced by the Menlo Park, Calif.-based Kaiser Family Foundation and the District of Columbia-based Health Research & Educational Trust. Enrollment in point-of-service plans rose to 25% from 19% in 2000, while participation in preferred provider organizations remained relatively steady at 26%. The report was based on responses from 846 benefit managers working for privately owned companies throughout the state.

AIB insured for some fraud

Allied Irish Banks has an insurance policy that may cover losses from a suspected \$691 million fraud at the Dublin, Ireland-based bank. AIB Chief Executive Michael Buckley said that the company has an insurance policy that could pay out if an investigation shows that the bank had been defrauded and that the perpetrators had benefited financially. AIB

said it is investigating a U.S.-based employee of the bank's Allfirst Treasury subsidiary in Baltimore. The alleged fraud involves attempts to conceal exchange-market trading losses. The employee has denied any wrongdoing. Bankers blanket bonds, the fraud coverage historically purchased by banks, are triggered only if the perpetrator benefited financially. Rogue-trader coverage, introduced after the 1995 collapse of London's Barings P.L.C., has no such requirement for fraud claims. Market

sources in London said AIB does not have rogue-trader coverage.

Health care benefits valued most: Hewitt poll

A majority of employees rank health care benefits as the most important employer-provided benefit, a survey released Friday shows. The survey of 528 workers, conducted by Lincolnshire, Ill.-based Hewitt Associates L.L.C., found that 55% say health care benefits are the most important benefit. Hewitt's survey also showed that employees are more willing to accept greater responsibility for making health care decisions than some employers believe. The survey states that 88% of employees are "extremely or somewhat" comfortable with taking on more responsibility for selecting health plans, providers and coverage levels. In a recent Hewitt survey of employers, 61% of employers said employees are willing to take on that responsibility.

Lack of terror cover could force closures

The Assn. of Insurance & Risk Managers is warning the U.K. government that some businesses may have to shut down unless the

airmic

government can work with the insurance industry to find a "long-term answer to the risk management problem of terrorism." AIRMIC said a confidential survey of 40 of its members, undertaken in January in conjunction with the Assn. of British Insurers, showed that "if current

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All the material in the Late News column, as well as other content in this week's issue, is generated from daily news postings that appeared on the Web site in the previous week.

Legal battle erupts over 'blackmail' by ex-Near North employees

Near North taking complaint to rival Aon

CHICAGO—A legal battle between two Chicago-based brokerage giants continues to heat up.

On Friday, Near North Insurance Brokerage Inc. withdrew its emergency motion, and a discovery schedule was set in the brokerage's noncompete suit against three former executives who joined rival Aon Corp. last year.

Near North had filed an emergency motion last Tuesday in Cook County Circuit Court, alleging that it was subject to "a campaign of extortion" by three former senior level employees. The three are now working at Aon despite noncom-

pete agreements, according to Near North court filings.

Near North alleges that the three ex-employees, Tim Gallagher, Matthew Walsh and Dana Berry, tried unsuccessfully to gain control and part ownership of the brokerage as well as unwarranted payments. The ex-employees subsequently engaged in "blackmail" to lure Near North's clients to Aon by spreading "tales of improper conduct on the part of Near North and its CEO," including alleging accounting irregularities in Near North's premium trust fund, court papers say.

A spokeswoman for Near North said that the emergency motion was filed to expedite discovery and disposition in the suit filed Jan. 22 so the broker could add Aon as a defendant.

A spokesman for Aon Corp. declined to comment.

Michael Segal, former chairman and chief executive officer of Near North National Group, resigned from the company last month after he was named in a federal complaint for allegedly misappropriating as much as \$20 million in premium trust funds. That complaint was subsequently dismissed. A fed-

capacity to insure liabilities was reduced, companies would be forced to drastically alter their business practices, if not cease trading entirely in certain sectors." AIRMIC said the survey respondents came from a broad range of industry sectors but that no further details could be made public.

Rising medical costs contribute to Aetna loss

Aetna Inc. has reported a \$279.6 million loss for 2001, compared with a \$127.1 million profit for the previous year. Hartford, Conn.-based Aetna cited rising medical costs, lower net investment income and lower fees as factors behind the loss. The results also reflect a \$125.1 million aftertax charge in the fourth quarter stemming from Aetna's plan to reduce its workforce by about 6,000. Aetna said these factors were partially offset by lower operating expenses. Revenues for the year decreased 6.1%, to \$25.19 billion.

Briefly noted

The board of directors of **Blue Cross & Blue Shield of Kansas** is appealing the Kansas Insurance Department's recent decision to deny the company's purchase by Indianapolis-based Anthem Blue Cross & Blue Shield. Kansas Insurance Commissioner Kathleen Sebelius rejected the plan earlier this month, saying that it would reduce BC/BS of Kansas' surplus and would increase rates for small-group and individual policyholders in the state....Medical malpractice insurer **MIIX Group** has been downgraded to B- from A- by A.M. Best Co. The rating agency said it was concerned about the level of Lawrenceville, N.J.-based MIIX's loss reserves and the state of its operations in light of numerous management changes over the past two years....Catastrophe reinsurer **IPC Holdings Ltd.** reported a net loss of \$3.9 million for 2001, compared with a profit of \$44.2 million in 2000. The Pembroke, Bermuda-based reinsurer reported gross premiums of \$133.1 million for 2001, a 41.9% increase over 2000....Aon Corp. has named F. Marshall Turner as president-property/casualty of **Combined Specialty Corp.** Combined Specialty, the underwriting unit of Chicago-based Aon, is scheduled to be spun off later this year.

eral grand jury, however, indicted Mr. Segal earlier this month on one count of insurance fraud (*BI*, Feb. 18). The indictment alleges that Mr. Segal knew that there was insufficient money in the trust funds when he sought to renew an insurer producer license.

Near North, however, maintains that when it discovered that a question existed about its premium trust fund accounting practices, it immediately reported the issue to the state Insurance Department and retained outside experts to review its practices.

—By Meg Fletcher and Sally Roberts

401(k) 'bottoming-up' under IRS scrutiny

By JERRY GEISEL

WASHINGTON—Employers may lose an innovative and low-cost way to enable higher-paid employees to contribute more to their 401(k) plans and still have the plans pass nondiscrimination tests.

The Internal Revenue Service now is reviewing the technique, known as "bottoming up" because it involves employers making voluntary contributions to the 401(k) plan on behalf of only their lowest-paid employees.

While no final decision has been made, Paul Shultz, director of rulings and agreements in the IRS' Tax

Exempt and Government Entities Division, says the technique "has the strong impression of being abusive. It is definitely one of the things we are looking at."

Only a small percentage of employers use the technique to help their plans pass nondiscrimination tests. "While not common, it is not unheard of, either. I've had three or four clients use it," said Michael Weddell, a consultant in the Southfield, Mich., office of Watson Wyatt Worldwide.

Although not widespread, bottoming up can be a highly cost-effective way to pass nondiscrimination tests and preserve the ability of

higher-paid employees to make the maximum contributions to 401(k) plans that the law allows.

For example, one employer examining the approach found that



bottoming up would cost it \$50,000 in extra 401(k) contributions, compared with about \$1 million if a more traditional method—making an across-the-board contribution for all lower-paid employees—were used to pass the nondiscrimination

tests, said Rich Koski, a principal with Buck Consultants Inc. in Seaucus, N.J.

Bottoming up is directly tied to a basic IRS 401(k) nondiscrimination test and its impact on a company's higher-paid employees, those making at least \$85,000 a year.

Under that test, the difference in the average contributions of higher-paid employees—measured as a percentage of pay—generally can exceed the average contributions of rank-and-file employees by no more than two percentage points. The purpose of the test is to ensure that participation in the plan is not unduly skewed in favor of higher-

paid employees.

If the difference exceeds two percentage points, the plan will fail the nondiscrimination test and employers will be forced to take corrective action.

One step employers can take to ensure the plan passes the test is to limit, typically as a percentage of pay, the contributions highly-paid employees can make to the plan during the year.

The disadvantage to that approach is that if lower-paid employees contribute more than projected, highly paid employees—because of the preset limit on their contribu-

See IRS/page 20



PHOTO: ZUMA

In the new movie "John Q," Denzel Washington plays a father who takes an emergency room hostage when his insurance company denies coverage for a heart transplant for his son.

Industry hopes 'John Q' jumpstarts health care debate

By JOANNE WOJCIK

Managed care plans are viewing the newly released film "John Q" less as an indictment of them than as a catalyst for re-igniting the debate about the need for health care reform.

The American Assn. of Health Plans, the Washington-based trade organization for managed care plans, last week ran print ads in Roll Call, Congress Report, The Hollywood Reporter and Variety, asserting:

"John Q. It's not just a movie. It's a crisis for 40 million people who can't afford health care...Instead of offering solutions, some in Washington are making the problem worse—pointing fingers and even proposing new laws that will make it harder for employers like John Q's to provide quality, affordable health care."

Sometimes it seems like health plans are the only ones trying to make health care more affordable.

The fictional character John Q has the wrong answer for America's health care cost crisis. Isn't it time government, hospitals and health plans worked together to find the right one?

In the film, a frustrated father played by Denzel Washington takes over a hospital emergency room because his employer-sponsored health plan, described as "a second-tier HMO," won't cover his son's desperately needed heart transplant.

While the scenario portrayed in the movie may be "a bit over the top," its message isn't, said Karen Ignagni, the AAHP's president.

"We've seen how Hollywood can dramatically influence policy debates in Washington. Our goal is to draw attention to the problem of affordability and accessibility of health care," she said in a press release announcing the advertising campaign.

See JOHN Q/page 6

Panel says insurance industry missing 'strategic opportunity'

By RODD ZOLKOS

SOUTHAMPTON, Bermuda—The terrorist attacks of Sept. 11, 2001, marked a revolutionary change in the insurance market—and one the industry is failing to address strategically, according to one major corporate insurance buyer.

Christopher A. Duncan, vp and chief risk officer at Delta Air Lines Inc. in Atlanta, said he understands insurers' initial response to the terrorist attacks, which in his industry took the form of a drastic reduction in limits and a 7,000% increase in costs through the imposition of a \$1.25 per-passenger surcharge.

"In fairness to the insurance industry, they did what they had to do, because there was massive uncertainty going on at that time," he said.

But, speaking as part of a panel of

insurance buyers last week at the fifth Bermuda Insurance Symposium, Mr. Duncan suggested the significant issue isn't insurers' immediate response, but what comes next. Currently, with the surcharge costing airlines worldwide \$2.0 billion to \$2.5 billion a year, the insurance industry is missing a "strategic opportunity...to find those win-win scenarios instead of a win-lose," he said. "Because the situation airlines are in now is a win-lose."

It's that situation, he noted, that is prompting airlines to form a massive risk retention group to provide war risk coverage for U.S. airlines and their related contractors (BI, Feb. 11).

And, Mr. Duncan said, although insurance buyers used to be lower-tier managers in their organizations, their activities are now catching the eyes of corporate audit com-

mittees. In the current market environment, companies will devote increased intellectual capital to insurance issues, he said, and they may well opt for solutions other than purchasing insurance.

BP P.L.C. is one company that already has made such a decision, though Judith Hanratty, company secretary, conceded that such moves might be difficult for smaller businesses. "Quite simply, if you're a small or medium-sized entity in the U.K., you have a real problem with commercial property," she said.

"Somewhere or other, the (insurance) industry has failed these enterprises, who are really the bedrock," Ms. Hanratty said. "You're taking away the premium and leaving the risk with them."

"One thing we learned right See BUYERS /page 20

Three-tiered managed care system

Premera looks beyond price

By JUDY GREENWALD

MOUNTLAKE TERRACE, Wash.—Washington state's Premera Blue Cross may serve as a model for other managed care organizations when it launches a three-tiered system that includes the most efficient providers in one of the tiers.

Although tiered networks are becoming increasingly popular among health maintenance organizations, generally, the criterion for inclusion into the elite groups has been charging lower rates (BI, Feb. 11). Through its program, Premera is seeking to look beyond pure price to recognize provider efficiency, or overall cost-effectiveness.

Mountlake Terrace, Wash.-based Premera, which has 1.2 million members in Washington, Oregon and Alaska, plans to introduce pilot tiered programs in June, with a full rollout expected by January 2003. About 85% of Premera's members

are in preferred provider organization plans, with the remainder in HMOs.

The three tiers for the Premera program will be: a Foundation tier, which includes providers and hospitals deemed to be more efficient than average in their markets; an Access tier of remaining physicians and hospitals within the Premera system; and a tier of other providers and hospitals who do not have contracts with Premera.

Premera has not released details on rates or copayments for each tier. "We're still finalizing that, but it'll be enough of a difference in the market that the members will have a real choice," said Brian Ancell, Premera's executive vp of health care services and strategic development.

In addition, employers will be able to offer employees the opportunity to move among the different tiers. For instance, an employee us-

ing the Foundation tier could also use physicians within the Access tier for certain specialties.

For providers, inclusion in the Foundation tier will be based in part on Episode Treatment Groups, an illness classification system developed by Phoenix-based Symmetry Health Data Systems Inc. ETGs measure and compare health care providers' performance by identifying and classifying entire episodes of care, including both inpatient and outpatient medical treatments. The system considers not just how much a particular physician charges, but also, for example, the number of doctor visits involved in treating a particular condition.

Each provider is given an index—based on his or her patient population—that can be compared to the overall market. For instance, a physician index of 1.5 indicates that the total charges associated See PREMIERA/page 21

Structured settlement protection moves to states

Federal law mandates state oversight of cash-ins

MEG FLETCHER

Despite a new federal law addressing the issue, many supporters of structured settlements still see a need to seek legislative approval in the 21 jurisdictions that have not yet adopted requirements to protect recipients from settlement-buying companies that offer the lure of immediate, but deeply discounted, cash or credit.

Individual legislative action is

still appropriate in the 20 remaining states and the District of Columbia to establish good public policy as well as to make settlement-buying companies adhere to states' sometimes stricter financial disclosure requirements, supporters from several major trade associations say.

Structured settlements are voluntary agreements that provide long-term financial protection, primarily for personal injury victims or work-

ers compensation claimants.

The settlements protect the victims and their families against the loss or dissipation of lump-sum recoveries through deeply discounted sales. Structured settlements also benefit employers and insurers by providing cost-effective, tax-free vehicles for resolving litigation and some workers compensation claims.

Employers and the insurance community share a similar interest

in preserving the credibility of structured settlements, said Janet Bachman, vp-claims administration for the American Insurance Assn. in Washington.

A particular concern was that, if structured settlement resales became a routine marketplace practice, it could jeopardize the tax-free status of the settlements (*BI*, Jan. 18, 1999).

The recent federal legislation, H.R. 2884, which President George W. Bush signed into law last month, requires state court or administrative oversight and approval

for injury victims who choose to sell payments from a structured settlement to a third party. The federal legislation also takes steps to ensure

The law gives 'landmark protection' to Americans with disabilities and 'new flexibility to injury victims who encounter unanticipated financial needs.'

Andrew J. Larsen
NSSTA

objective oversight by detailing a process to determine which party's state laws will apply.

The new law imposes a 40% federal excise tax on any settlement-buying company that buys the rights of future payments from an injury victim, unless a state court or administrative agency first approves the transaction as being in the interests of the victim.

In addition, the state court "must take into account the welfare of the victim's dependents and find that the transaction does not contravene applicable statutes and court orders," according to the National Structured Settlements Trade Assn. in Washington.

The law provides "landmark protection" for Americans with disabilities, while "giving new flexibility to injury victims who encounter unanticipated financial needs," said Andrew J. Larsen, NSSTA president. He is also executive vp in the Washington office of GE Financial Assurance, a General Electric Co. affiliate.

The new federal law also provides certainty about the tax status of approved transactions, several supporters agreed, including the National Assn. of Settlement Purchasers.

"The federal effort is really the icing on the cake," said Bruce Wood, assistant general counsel with the American Insurance Assn. in Washington.

Despite passage of the federal law, several major insurance trade associations plan "to push this just as hard as we have in the past," to get the remaining 21 jurisdictions to adopt related laws, said John Lobert, senior vp of state government affairs for the Alliance of American Insurers in Downers Grove, Ill.

Mr. Lobert said that the insurance industry's legislative efforts would initially focus on bills pending in Alabama, Alaska, Mississippi, New York, South Carolina and Utah. He also expects supporters to introduce new bills in several other states either later this year or when the legislatures resume meeting next year.

Errors & Omissions

The Feb. 18 Commentary "Lights. Camera. Actuaries!" misidentified a character from the film "Memento." The character's name is Sammy Jankis.

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John Q: Plans criticize movie

Continued from page 3

"People who focus on the details are missing the point," agreed John Sorian, senior researcher and director of public affairs for the Center for Studying Health System Change, a nonpartisan health care policy research organization in Washington.

"Scriptwriters are trying to tap into an existing emotion on the part of the audience they seek," and "they recognize that people are still dissatisfied with the health care system."

But the film does contain some factual errors, industry observers note.

For example, the father is told his HMO will only provide \$20,000 in total coverage when he asks his employer why his son's transplant isn't insured.

"I frankly have never heard of that," said Helen Darling, president of the Washington Business Group on Health, an employer coalition. "HMOs generally provide more comprehensive care," and most employer-sponsored health plans pro-

vide coverage for catastrophic care, such as heart transplants, she said.

Also, "the movie never made clear that John Q's employer violated federal law when it changed his health plan without telling him,"

'It's way too simplistic to say that every problem in the system can be put at the foot of managed care. We are facing a crisis' of the uninsured.

Spokesman

American Assn. of Health Plans

pointed out a spokesman for the Health Insurance Assn. of America in Washington.

In the film, the benefit administrator at John Q's employer informs him that his coverage was changed from a PPO to an HMO when his hours were cut and he became a part-time worker.

Under the Consolidated Om-

nibus Budget Reconciliation Act, an employer is required to notify an employee of a loss of coverage as a result of a change in the worker's employment status. Employers also must offer the employee the opportunity to continue the coverage for an additional contribution.

This is not the first time the AAHP has responded to Hollywood filmmakers' pejorative portrayal of managed care.

"When 'As Good as it Gets' came out, HMOs tried to get out the message that chronic care management has been a hallmark of managed care since its inception," an AAHP spokesman said.

In the film, a waitress portrayed by Helen Hunt is unsuccessful in obtaining proper care for her asthmatic son through her HMO.

"It's way too simplistic to say that every problem in the system can be put at the foot of managed care," the AAHP spokesman added. "We are facing a crisis for 40 million people and probably 10 or 15 million other Americans who are underinsured."

**Viszta Insurance partners
3 column x 8
4/color**

Commentary

Making a pitch for securitization

It has been a freakishly mild winter in Chicago, but, just the same, hearing that pitchers and catchers have reported to camp always makes the rest of February a little easier to take.

Close behind, the remainder of their teams will join to "toil" beneath the hot Arizona or Florida sun of baseball's spring training sites. That means exhibition games will soon begin, and Opening Day isn't too far off. It's the time of year when hope springs eternal.

Of course, baseball isn't all that's occupying some people's minds as a new season nears. A few, no doubt, are considering things like risk securitization. Or at least they should be. Here's why.

For several years now, baseball owners have screamed poverty even as they throw millions of dollars at .220-hitting infielders. All screaming poverty, that is, except for the Yankees' George Steinbrenner.

With a Yankees payroll already exceeding the gross national product of many small countries, George is now said to be considering offering \$15 million a year to a 17-year-old locker room attendant from the Cuban national team. It might seem a lot for a locker room attendant, but the kid is a southpaw. Besides, some old-time scouts say they haven't seen anybody fold a towel like that since the legendary Walleye Pfeffernuss, the talented towel-keeper of the Warren Spahn-era Milwaukee Braves.

Break up the Yankees.

But the point is, with all that money going to ballplayers with guaranteed contracts, owners understandably get a little nervous when they think about their big-money players getting hurt. The idea of paying a glass-groined outfielder millions to spend most of the summer on the disabled list doesn't seem like good business.

And, if you bet the franchise on a 10-year, \$200 million contract with a piece of the concession revenue and four bobble-head days a year for a shortstop who suffers a career-ending injury in year two, it gets worse. Lots worse. So, like businesspeople elsewhere, ballclub owners have looked to the insurance markets to transfer their risk. Except that now, as has been noted previously in these pages, as salaries have soared, sports disability insurers have gotten reluctant to take the risk.

Which is where the realms of baseball and securitization can intersect. High premiums, lack of

capacity, why not find a way to transfer the risk into the capital markets? It's a basic risk securitization rationale, right?

There are a lot of ways the deals could be put together. A multiple tranche structure, offering varying rates of return on different classes of risk, seems one clear way to go.

Outfielders, always at risk of suffering those pesky groin pulls as they patrol their ballparks' grasslands, could be combined in one tranche offering a moderate yield. Relief pitchers could be in another, with the yield reflecting their exposure to debilitating paper cuts suffered while accommodating autograph seekers hanging over the bullpen wall.

A utility infielder tranche could be offered for institutional investors and others who are more risk averse. And, for those willing to trade high risk for high yield, there is the volatile but potentially lucrative starting pitcher tranche.

Of course, for investors who want to lock in long-term, there are always

designated hitters.

Deals could have different triggers, too. A parametric trigger, perhaps, tied to an occurrence in a specific region—say an anterior cruciate ligament injury in a star third baseman's right knee—of a certain magnitude—perhaps a 60-day stint on the D.L.

Index-based triggers could be figured against injury experience by position league-wide, like the average amount of games lost in each team's bullpen. For teams like my Cubs, though, such an approach probably wouldn't be advisable. The basis risk would be excessive.

The deals could be tweaked in various ways to increase investor appeal. Some buyers might favor repricing provisions. Imagine my beloved Cubbies are leading their division Labor Day weekend. In that case, buyers holding securities linked to the health of Cubs pitchers could opt to reset their bonds' yield, because the risk profile just changed dramatically. You know at least one starting pitcher's going down.

There's a lot to think about here, so I'll spare you my next idea for now. But, just to pique your interest, it involves the National Hockey League's group dental plan.

Senior Editor Rodd Zolkos' commentary appears periodically and on www.businessinsurance.com. He can be reached at rzolkos@crain.com.



Rodd Zolkos

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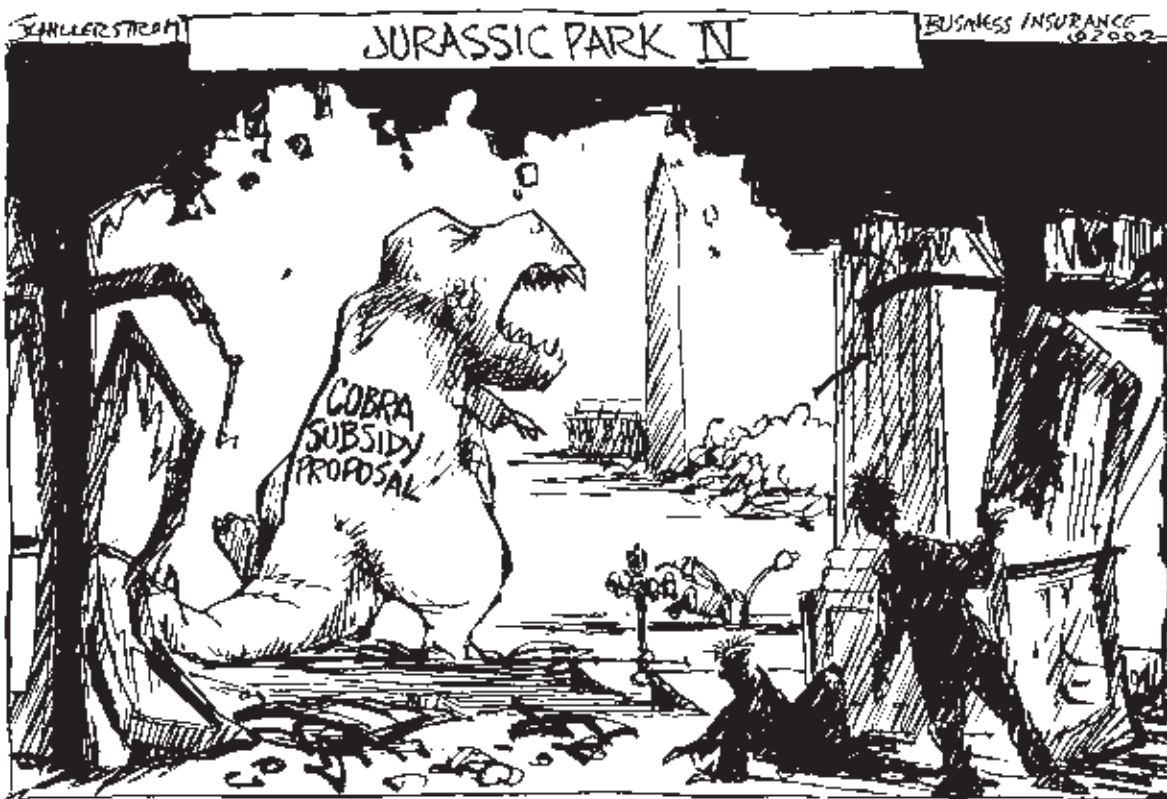
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Editorial

Legislation on genetic bias needs employer attention

THE ONGOING REVOLUTION in genetics research carries both promise and peril.

The promise comes in the hope that genetic predisposition to certain diseases can be detected and corrected before the maladies manifest themselves. The peril comes in the possibility that some job or insurance applicants will be unjustly denied employment or coverage on the basis of genetic predisposition to an ailment.

And that can mean peril for employers, too.

As we reported last week, Congress has begun moving to head off such discrimination by considering several bills designed to protect applicants for jobs or health insurance. Hearings began in the last congressional session and are likely to continue on Capitol Hill for some time.

That's good, because while no one can argue with the thrust of these bills, the employer community needs to continue to make its concerns known throughout the process to assure that well-intentioned legislation doesn't result in unintended and unduly expensive consequences.

The best way to do that is to resist any legislation that would treat victims of unjust discrimination based on genetic factors any more generously than victims of other types of discrimination.

Any genetic antidiscrimination measure should also avoid duplicating protections that existing law—such as the Americans with Disabilities Act—already guarantees.

As President Bush put it in a radio address last year in which he called for outlawing genetic discrimination, any legislation should be fair, reasonable and consistent with existing law.

That's a good philosophy to follow in this case. Unfortunately, a measure already under consideration in

both the House and Senate strays from that path. The Genetic Nondiscrimination in Health Insurance and Employment Act calls for providing compensatory and punitive damages in excess of remedies permitted by other antidiscrimination laws, including the ADA. That would no doubt mean expanded yet vaguely defined liability for employers.

It would also allow claimants to circumvent the Equal Employment Opportunity Commission's process for dealing with other employment discrimination claims even though genetic discrimination issues appear to fall within the agency's purview.

The bypass of the EEOC process would no doubt mean higher administrative costs and headaches for employers, which would be subject to litigation rather than being able to mediate or arbitrate claims through the EEOC.

Genetic discrimination has been a sleeper issue for some time, and understandably so. Mapping of the human genome, and determining how to translate discoveries made possible by the mapping into treatment for genetic-related maladies, is an ever-evolving field. Because the field is so new, few cases of possible genetic discrimination have emerged.

That gives employers time to confront the issue and make their concerns known to lawmakers before legislation is enacted, as the U.S. Chamber of Commerce, for example, already has done.

No one should suffer discrimination on the basis of a genetic predisposition to certain ailments, ailments that may never manifest themselves.

But it will take considerable work by employers to help ensure that the eventual legal cure imposed for such discrimination does not prove to be inadvertently worse for them than the evil that it is attempting to remedy.

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and miscellaneous other topics. The online forum is located at: www.businessinsurance.com/cgi-bin/board-View.pl

Letters to the Editor

Industry response to war is predictable but wrong

To the editor: Senior Editor Mark A. Hofmann's Dec. 24, 2001 Commentary, "Of Bad Times and Bad Timing," brings to mind another truism: Generals always fight the last war.

The insurance industry's response to a new war is, in most instances, to scream, then try to socialize the loss, then rewrite the policies to add exclusions and, finally, to write a new form of insurance coverage with significantly enhanced premiums. In the last 70 years, standard form general liability insurance has become a constellation of exclusions held together by threads of coverage. It is startling how little homeowners insurance, for example, covers whether it is denominated "deluxe" coverage or not. I predict that in 20 years, some genius is going to get the idea that the insurance industry should sell "comprehensive insurance."

Eugene R. Anderson

Anderson Kill & Olick P.C.
New York

Don't blame insurers for all renewal problems

To the editor: In an article in the Jan. 14 edition, "Risk Managers Place Blame on Insurers for Renewal Woes," John G. Pinner, a risk manager, takes a shot at insurance companies by blaming them for the hardening market.

"What makes them think they could operate with 120%, 130% or 140% loss ratios?" The answer: competition and risk managers who demanded premium cuts at the expense of the market's financial stability. It is odd, at best, that others in the rest of the article go on to complain about 70% increases in renewal premium, just the amount needed for the market to get whole and budget for increased claims and payouts.

The only problem with the insurance companies is that they tried to stay competitive against the onrush of underutilized capital in the market heydays.

Gary Wood

Workers Comp Fund Administrator
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Errors in comp info can inflate premiums

By Robert Kravitz

Workers compensation insurance already is one of the most expensive benefits for employers, but after the Sept. 11 terrorist attacks, most companies face steep increases in their workers comp premiums, as insurers pass on rising costs and payouts.

Employers directly affected by the disaster will cope with a greater number of claims and potentially staggering dollar amounts of individual claims—as high as \$500,000, according to some estimates.

Sept. 11 is causing a national ripple effect that will be felt by businesses over the next two years. It is too soon to quantify an across-the-board percentage increase in workers comp premiums, because the data is not available yet. What we have seen so far is that insurers are applying increases on a discretionary, case-by-case basis, with premiums rising by 100% or more in some instances.

On top of that, last year we found that nearly half of employers were overcharged for their workers compensation packages. While insurance companies do not make mistakes intentionally, errors in statistical reporting, payroll classification and general clerical mistakes can add up, costing employers thousands of dollars each year.

It also has been our experience that most

businesses are unfamiliar with the entire workers comp process. The process is confusing and the paperwork daunting. Unclosed claims, errors in statistical reporting and payroll classifications, and other mistakes could be driving up the cost of your workers comp coverage. For example, an unresolved slip-and-fall claim from a couple of years ago or an error in filing an experience work sheet could result in a huge increase in premiums. In fact, your premiums could be affected by losses going back as far as seven years.

It is possible to recover overpayment on your workers comp premiums, on policies up to 3 years old, as long as your company is not self-insured.

How can you determine whether you are overpaying for your workers comp coverage? Here's a simple test. If you're not sure about the answers to the following questions, you might be able to recover money on your premium. For example:

- When was the last time your company had a review of its workers comp experience modification factor? The experience mod is the multiplier applied to your premium that quantifies the risk for your business in terms of past workers comp claims and losses. The higher the multiplier, the more expensive your premium. If your premium rises, the experience mod ups your cost incrementally for an even steeper increase.

- With more than 900 business classifications, is your company's current classification correct? Have you ever challenged it?

- Have you been promised a discount, but the discount is not reflected in your audit statement?

- Do you have complete information from your insurer regarding discounts available to you?

- Are you confident that the past seven years of your workers comp premiums have been accurate and fair and that your company's loss information has been reported on a timely basis, with no errors or extraneous information?

Determining whether you can recover money essentially involves combing through your workers comp paper trail, in much the same way an accounting auditor examines financial statements. You will need to examine your documentation and losses for the past seven years. Here are some guidelines that can assist you as you proceed. You should:

- Determine the number of current workers comp claims filed at your company.

- Verify the accuracy of your company's current classification for filing.

- Identify potential discount programs.

You also should verify that your statistical reporting is accurate, a process best undertaken by a workers comp premium

auditor, who specializes in this type of insurance. The statistical reporting aspect of workers comp can be very complicated. We've experienced instances when a company or its insurance broker believed the reporting was correct—but we found mistakes in the paperwork that had been overlooked and the company recovered money. To make sure your documentation is exact, with no errors that could be costing you higher premiums, it's beneficial to have a checkup every few years with a premium audit.

In addition to recovering overpayments, we typically advise clients to look at their systems and procedures for administering and filing workers comp claims. Reducing the possibility for errors and making sure that claims are resolved can help to maintain a more accurate and fair premium for your business.

Every dollar recovered on workers comp essentially is found money that can go straight to the bottom line. And in this challenging time and uncertain economy, every dollar counts.

Robert Kravitz is chief executive officer of Global Risk Management, a Fort Lee, N.J.-based consultant that specializes in workers compensation risk management services.

Public policy doesn't preclude coverage of punitives

In a case of first impression in the state, the Supreme Court of Washington ruled that liability coverage in a commercial general liability insurance policy for malicious prosecution and punitive damages did not violate Washington public policy.

The Fluke Corp., a manufacturer of electrical equipment, had a CGL policy with Hartford Accident & Indemnity Co. The coverage obligated Hartford to pay damages because of "personal injury," which was defined in part as "injury, other than 'bodily injury,' arising out of....malicious prosecution." In May 1988, Fluke sued Talon Instruments and its president for patent infringement, and Talon and its president, in turn, sued Fluke for malicious prosecution. Fluke tendered the defense of that suit to Hartford, which denied coverage. Fluke then brought this suit in Washington, seeking a declaration from the court that the policy provided coverage.

While this suit was pending, a jury awarded Talon and its president \$2 million in compensatory damages and \$4 million in punitive damages. The trial court in Fluke's declaratory judgment action concluded that the CGL policy covered compensatory damages for the malicious prosecution but did not cover the punitive damages. However, the Washington Court of Appeals reversed the trial court's denial of coverage for the punitive damages.

The Washington Supreme Court then concluded that coverage for malicious prosecution did not violate public policy. The court pointed out that the policy language was clear and the type of coverage well established. According to the court, "The paramount public policy here is the commitment to upholding the plain language of contracts." With regard to the punitive damages issue, Hartford argued that the coverage would have to be negated

Legal Briefs

because Washington public policy forbids shielding the policyholder from the burden of punitive damages. However, the court said that Washington state had articulated no such public policy. The court said that it declined to conclude that insuring oneself against a disfavored penalty runs counter to public policy. The jury award was affirmed.

Fluke Corp. vs. Hartford Accident & Indemnity Co., Supreme Court of Washington, Nov. 21, 2001 (BI/02/M.-\$10)

ERISA pre-empts state law on community property

A Texas appellate court ruled that the Employee Retirement Income Security Act pre-empts state law governing community property. Thus, the court found that an ex-wife named as a beneficiary under a deceased participant's ERISA-controlled pension plan was entitled to the funds in the account, denying the benefits to the participant's wife at the time of his death.

Robert and Jean Heggy claimed they entered into a common-law marriage in March 1979. In 1984, American Trading hired Mr. Heggy. During his employment, Mr. Heggy participated in American's employee retirement plan and accrued more than \$144,000 in benefits. In December 1991, the Heggys were officially married. A few months later, Mr. Heggy retired from American. In 1994, the Heggys were divorced, and Ms. Heggy waived any interest in the retirement benefits. The following year, Mr. Heggy married again. He died in October 1995 while still married to the

second wife. While employed with American, he had named his first wife, Jean, as beneficiary of any sums remaining in his retirement account, and she was never removed as the beneficiary. Both his first and second wives sought to recover the funds, and the trial court awarded the benefits to his second wife. His first wife appealed.

The appellate court said that regarding designation of beneficiaries under an ERISA plan, federal and state courts have consistently held that ERISA pre-empts application of state law. Finding that ERISA exclusively controls the designation of plan benefits, the court said the first wife's purported waiver of Mr. Heggy's pension benefits, as provided in the divorce decree, was not effective. Thus, the court said that the second wife failed to establish entitlement to the plan benefits. The trial court decision was reversed.

Heggy vs. American Trading Employee Retirement Account Plan, Court of Appeals of Texas, Aug. 9, 2001 (BI/03/M.-\$10)

CGL policy doesn't cover sexual harassment claims

The Court of Appeals of New Mexico ruled that a commercial general liability insurance policy issued to an employer did not cover sexual harassment of employees.

Tomato Cafe had a CGL policy issued by Truck Insurance Exchange Inc. The policy covered bodily, personal and advertising injury as well as property damage, but it excluded injury to an employee arising out of and in the course of employment and any obligations under workers compensation laws.

David Smith, a former waiter at the cafe, filed suit in federal court claiming sexual harassment and a hostile work environment against the business. Specifically, Mr. Smith

contended that, during the time he worked at the cafe, his manager sexually harassed him by asking him to lunch repeatedly and by touching him in a flirtatious manner. Mr. Smith also contended that the manager harassed him by discussing the different ways the manager wanted to have sex. Truck Insurance defended the action under a reservation of rights and settled Mr. Smith's claim for \$20,500. Then the insurance company filed this action seeking a declaration from the court that it was not required to pay under the policy. The trial court ruled against the insurer.

On appeal, the insurer argued that the employee exclusion clauses expressed a blanket exclusion of all injuries to employees. Mr. Smith maintained that the clauses excluded only coverage for injuries that were covered by workers compensation. But the appellate court said that the overwhelming weight of authority is that employee exclusion clauses in CGL policies exclude coverage for sexual harassment of employees. According to the court, the exclusions in question apply to all injuries to employees arising out of and in the course of employment, whether or not they are covered by workers compensation. The court emphasized that, by definition, sexual harassment occurs at work. The trial court decision was reversed.

Truck Insurance Exchange vs. Gagnon, Court of Appeals of New Mexico, Aug. 23, 2001 (BI/05/M.-\$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. Please provide the listed number for each opinion ordered.

ABA Insurance Risk Management Annual Conference

Preparation key to successful resolution of claims

By **RODD ZOLKOS**

SAN DIEGO—Successful resolution of a large property claim requires specific actions before, during and after the loss, according to a risk manager who has seen her company through two such claims.

Speaking at the American Bankers Assn.'s Insurance Risk Management Annual Conference and Meetings this month in San Diego, Marilyn Needleman, executive director at Morgan Stanley Dean Witter & Co., shared her experiences of dealing with her company's claims following first the 1993 terrorist bombing at the World Trade Center, then the Sept. 11 attack.

'You'd be surprised how many firms have not really put together and tested and implemented a business interruption plan.'

Marilyn Needleman
Morgan Stanley Dean Witter & Co.

Successfully resolving such claims involves preloss planning, a response during the loss and steps the company should take as the claims process goes forward, the Morgan Stanley risk manager said.

A risk manager should prepare for a loss by negotiating the broadest property coverage terms and conditions possible, Ms. Needleman said.

"Avoid sublimits whenever you can," she said. She also advises obtaining provisions in the policies for receiving claims-handling expertise in the event of a large property loss. "That's not something you're going to be able to do with internal help alone," she said.

Risk managers should have a basic understanding of coverage terms and conditions, especially as they apply to the policyholder's duty after a loss and conditions pertaining to advance payments under the policies, the risk manager said. "I think your goal really should be that you don't want to be financing a loss," she said.

The company also should develop, implement and maintain a business continuity plan addressing the possibility of a large property loss. "You'd be surprised how many firms have not really put together and tested and implemented a business interruption plan," Ms. Needleman said.

And, "make sure as risk manager you're somewhere in that plan," Ms. Needleman said, adding that notification requirements and the company's other duties after the loss should be part of that plan.

It's also important to determine who in the organization will be involved in the claims process, and to communicate with representatives of all company departments that might have a role in the claim. The risk manager also needs to communicate with the company's management, preparing them for what to

expect should a loss occur.

The risk manager also should communicate with the company's broker and the insurance adjuster, determining their responsibilities and the company's expectations in advance.

Prior to a loss, the broker can sup-

port the risk manager in designing and reviewing the property program, assisting with developing a disaster plan and identifying resources that might be required in the event of a loss.

"It is important for your broker to be involved up front," said William

Rodgers, senior vp and consultant in the property practice of Willis Risk Solutions in Nashville, Tenn. "Those of us who deal with claims have worked with a lot of claims."

Likewise, the adjuster can assist with the development of an emergency plan, and simply by being

part of the team of risk manager, broker, insurance company, adjuster and other experts assembled before a loss ever occurs.

"The key to successful loss adjusting is teamwork," said Thomas Carstens, managing director of
See LOSS/next page

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Loss: Preparation important

Continued from previous page

technical services at Crawford & Co. in Chicago.

After a loss, the risk manager's immediate role is to implement the contingency plan, report the loss as soon as possible and safeguard the property, Ms. Needleman said.

Mr. Rodgers said the broker's first role during the loss is to provide proper notice to insurers. "You don't want to create a problem that doesn't exist just because it wasn't reported properly," he said. Then, the broker assists the risk manager in implementing the disaster plan.

After the loss, the risk manager should work with the broker on any potential coverage issues. "You'd be surprised how things you never thought of before the claim can all of a sudden become points of contention with respect to policy inter-

pretation," Ms. Needleman said.

And it may be necessary to secure

'You'd be surprised how things you never thought of before the claim can all of a sudden become points of contention with respect to policy interpretation.'

Marilyn Needleman

Morgan Stanley Dean Witter & Co.

the services of an accounting firm and other outside experts to help with preparing proof-of-loss and claims documentation.

Internal experts are probably capable of providing much of the nec-

essary assistance, but "do you want to engage everyone in your firm in helping you prove a loss when they really should be involved in the business of your company?" asked the Morgan Stanley risk manager.

When negotiating the settlement, the risk manager needs to know what the company must get from the insurer and what it can afford to "give away." Because a negotiation is successful only when each party considers the settlement to be fair, "When you sit down to negotiate, you have to have things that you are willing to give up," she said.

"There will always be some disagreements with regard to loss-adjustment process," Mr. Carstens said. But there will always be ways to reach a settlement, and the settlement will rarely be the initial loss assessment, he said.

ABA Insurance Risk Management Annual Conference

Global risk management returning focus to local level

By RODD ZOLKOS

SAN DIEGO—Although having decentralized risk management approach was the trend among global corporations in the 1970s, since then, companies have tended to centralize their worldwide risk management programs.

But now, "Things are kind of evolving to going back to the way we used to do business in the '70s. And to an extent, the insurance markets are driving that," said Bruce J. Eberly, Pacific Northwest regional director of Aon Corp.'s Global Business unit in San Francisco.

Participating in a panel on managing international exposures at the American Bankers Assn.'s Insurance Risk Management Annual Conference and Meetings earlier this month in San Diego, Mr. Eberly said both approaches offer advantages and disadvantages.

A centralized approach to risk management can provide consis-

tent, broad terms and conditions, consolidated buying power and can limit distractions to local management. But global programs sometimes can ignore unique local requirements, he noted.

A decentralized approach, on the other hand, can be more responsive to local management—but at the cost of fragmenting buying power and distracting local management from other tasks.

In addition, "local companies may not always meet the standards and requirements that are set by the global risk management committee," said panelist Shelia R. January, a

vp with Zurich North America in New York.

For companies with global programs, communicating with the local broker representatives in various countries is essential, Mr. Eberly said.

"Most risk managers develop an international risk management strategy, and some risk managers communicate that strategy to local

management," he said. "But what's often overlooked is communicating that strategy to local broker network representatives." Such communications are necessary to avoid working at cross-purposes, he said.

"One of the techniques that I think very seldom gets used is establishing broker local service guidelines," the Aon regional director said. "Something as simple as, 'If you see something that isn't insured, don't go trying to place it in the local marketplace, don't try to sell insurance to the local manager, tell me.'"

Another problem for companies with global programs is that "some of the carriers don't even have international networks," Mr. Eberly said. "The challenge is in fronting those local policies."

"Now, it's virtually impossible to get a carrier to put up their local paper unless they're participating in some way in the risk transfer of the program," he said.

"It is something that is not just the carriers being difficult but looking to address their own risk management requirements and mitigate some of the losses they have experienced on their fronted programs," said Ms. January of Zurich North America.

Price increases pose their own challenges, and in some cases, higher premiums are prompting some companies to use nonadmitted programs in some countries to rein in costs, Aon's Mr. Eberly said.

And in some countries, buying local policies is necessary in order to "buy back" excluded perils. That can be the case for companies looking to get coverage through terrorism pools in the United Kingdom or France, or for catastrophe perils in Spain. "The only way you can access that terrorism and catastrophe capacity is by taking out a local policy," Mr. Eberly said.



PHOTO: MICHAEL MARCOTTE

San Diego was the site of the American Bankers Assn.'s Insurance Risk Management Annual Conference earlier this month.

ABA Insurance Risk Management Annual Conference

Getting the most out of a captive

By RODD ZOLKOS

SAN DIEGO—In a hardening insurance market, there's merit to re-examining a company's captive with an eye toward determining how it can be used for the company's risks as well as for third-party business, such as its customers' exposures.

Speaking at the American Bankers Assn.'s Insurance Risk Management Annual Conference and Meetings earlier this month in San Diego, Peter A. Joy, managing director at Aon Insurance Managers (USA) Inc.

'Gone are the three-year policies. You're faced with a one-year policy, and maybe there's a new meaning to "relationship" when it comes to insurers.'

Peter A. Joy
Aon Insurance Managers
(USA) Inc.

in Burlington, Vt., cited several reasons a hardening market offers for reassessing how a company uses its captive for its own risks. Higher primary and reinsurance rates, lower policy limits, less coverage and reduced choice are among those factors.

"Gone are the three-year policies," Mr. Joy said. "You're faced with a one-year policy, and maybe there's a new meaning to 'relationship,' when it comes to a company's insurers."

Primary casualty coverage, which is actuarially predictable, can be a source of controlled third-party captive business, "if you're willing to share those predictable losses with other financial institutions," Mr. Joy explained.

Excess casualty is less predictable, though losses are foreseeable, and exposure could be retained in a captive to a point, Mr. Joy said.

"You know this is going to occur, so what's the most cost-eff-

fective way of funding for it?" he asked.

Providing some level of property coverage in the captive can afford a company the benefits of access to worldwide reinsurers and the ability to choose its own adjusters.

"The marketplace is demanding a much more meaningful retention," Mr. Joy said, so there is benefit in retaining some of that exposure in the captive.

Using the captive to combine management liability coverage—such as financial institution bond, directors and officers liability, employment practices liability and professional liability—into an integrated program can offer several potential benefits, Mr. Joy said.

By using an integrated program, the captive parent could achieve broader coverage with greater flexibility, reduced administrative burdens, greater control over the program at lower cost, and long-term stability, Mr. Joy said.

In deciding how to use the captive for its own risks, the decisions to retain or transfer risk are driven by the cost of capital and of managing volatility.

"You're trying to optimize based on capital-based risk modeling," Mr. Joy said.

Although captives traditionally have been used for certain customer risks, such as credit life and involuntary unemployment insurance, the Aon executive said he is seeing trends toward using captives for customer debt management programs, life reinsurance, mortgage reinsurance and warranties.

Because volume is key to making the customer programs work in a captive, companies moving in that direction must develop the appropriate sales culture, placing an emphasis on product training and sales-skill training, Mr. Joy said.

In addition, captives can be used for employee risks. Such possibilities include employee benefits, retiree benefits or personal lines, Mr. Joy said.

Conference attracts 175

SAN DIEGO—The American Bankers Assn.'s 2002 Insurance Risk Management Annual Conference and Meetings drew approximately 175 attendees to San Diego earlier this month.

The conference, held Feb. 3-5, centered on the theme "Navigating a Sea of Change." Sessions focused on changing insurance market conditions, as well as on such topics as money laundering, operational risk and Internet liabilities.



The next ABA Insurance Risk Management Conference is scheduled for Feb. 2-5, 2003, at the Renaissance Vinoy Resort and Golf Club in St. Petersburg, Fla. For more information, visit the association's Web site at www.aba.com.

AIU site aims to expedite claims

NEW YORK—American International Underwriters has launched a Web site that provides its commercial clients with electronic claims reporting and other capabilities.



AIU, the international property/casualty unit of American International Group Inc., developed www.aiu.com in part to allow commercial clients to submit claims online to expedite the claims-handling process and reduce errors that sometimes occur when reporting is done over the telephone or by mail.

The site provides a directory of AIU's business lines as well as information on the countries that form the AIG network. An online search can identify products a client needs in specific countries and provides contact information. Where available, users can link to sites that let them purchase coverage online.

Worldwide financial and insurance industry news also is available at the site.



Fine arts broker offers coverage on its Web site

WASHINGTON—A new Web site provides insurance and risk management information on protecting fine art.

Huntington T. Block Inc., a brokerage specializing in fine arts insurance, has launched www.huntingtontblock.com to allow museums, galleries, dealers, artists and collectors to apply for coverage, access risk management information and obtain claims information online.

The site is organized by type of individual or entity seeking coverage. Once inside, users find an overview of the special risks they face, the types of coverage available, tips on controlling losses and answers to frequently asked questions.

In addition, a direct link to the Art Loss Register allows users to access the database of stolen and missing works of art.

Intracorp provides new case management tools

PHILADELPHIA—Intracorp is expanding its Integrated Care Management System to provide risk managers, claims managers

Products & Services

and other claims professionals with new case management tools.

The software now includes a number of case management decision-support tools, outcome reporting capabilities, an empirically based savings methodology and improvements in data collection. The new platform is being rolled out to 1,000 case

managers who handle workers compensation, short- and long-term disability and automobile claims.

The new savings calculator in the Integrated Care Management System is based on databases from the National Council on Compensation Insurance and the Work Loss Data Institute. The tool

calculates savings based on benchmarks for various lines of business. The system also captures customer-specific data and features enhanced reporting capabilities that project the duration of disabilities and savings from returning workers to the job.

More information on the system is available at www.intracorp.com.

ARAG legal insurance plan adding identity theft cover

DES MOINES, Iowa—ARAG Group is including identity theft coverage as part of the group legal insurance benefits it offers to employers.

Under the coverage, an employee can call an ARAG Group specialist

who provides information on how to reduce the likelihood of identity theft.

If a plan member is victimized, a specialist will explain personal liability for the debts, show the victim how to report the theft to credit agencies and provide information on the agencies' duties to investigate.

If legal advice is needed, the specialist refers the victim to an ARAG Group network attorney for consultation.

The consultation is paid for by the legal insurance coverage benefit.

More information on ARAG Group coverages is available at www.aragggroup.com.

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National Insurance Leadership Symposium

Speed of disaster recovery dependent on planning

By JUDY GREENWALD

SAN FRANCISCO—Insurance industry companies with offices in the World Trade Center found that good communication, efficient organization, prompt efforts to replace destroyed equipment, psychological counseling and planning were all critical elements in their ability to recover quickly from the terrorist attacks that destroyed the complex, say executives.

For instance, Kemper Insurance Cos. went to great lengths that day to account for all of its New York City personnel. As a result, when a Chicago television station falsely reported that all of Kemper's WTC employees were unaccounted for, Kemper insisted upon, and got, an on-camera interview with its corporate communications director that corrected the story—thus avoiding more serious employee morale problems, said William D. Smith, president and chief operating officer of Long Grove, Ill.-based Kemper Insurance Cos. "We had a gentle discussion (with the news station) about legal liability," he said.

He and other executives spoke at a session on "capacity to recover" at the National Insurance Leadership Symposium held Feb. 10-11 in San

Francisco. Co-sponsors of the conference were the American Insurance Assn., the Council of Insurance Agents & Brokers and the Reinsurance Assn. of America in association with Russell Miller.

Although among the companies represented on the panel only Aon Corp. lost employees in the terrorist attacks—176 are listed as killed or missing—all the companies lost computer equipment and had to quickly establish replacement facilities. Furthermore, local and in some cases other employees needed counseling, the executives said.

Jerome Karter, vice chairman of SCOR U.S. Group in New York, said the reinsurer had a disaster plan in place for the Y2K computer bug, but "certainly the focus had never been that we would lose everything." Backup facilities in Itasca, Ill., helped SCOR resume operations with no apparent loss of business opportunities. The reinsurer also had other available Manhattan office space on Water Street that it had planned to sublet. "On 9-11 we pulled that off the market real fast," he said. The company's New York operations subsequently moved into that facility.

E-mail helped SCOR Re account for its New York employees and by

Sept. 14, everyone was found.

Meanwhile, fast-moving SCOR Re personnel had already bought 50 personal computers by the time the second tower fell, said Mr. Karter.

Putting aside divisions, Kemper 'came together as a single company' after the Sept. 11 terrorist attacks.

*William D. Smith
Kemper Insurance Cos.*

Underwriters worked from home while their new office space was prepared, he said.

On the first day back at work at the new offices on Water Street, executives stood by the door to greet returning employees. "This went a long way to help get their feet back on the ground," he said. Those first two days, no work was done. People visited one another and lunch was brought in from outside.

On the third day, grief counselors began to talk to people in groups of 10 to 15 and subsequently spent more time with individuals who needed it. Mr. Karter noted that until he joined one of these groups

himself, he did not know "how much I needed it." He watched the towers collapse on television while he was in Monte Carlo. "It might have been worse than being there."

Kemper's Mr. Smith described how before Sept. 11, the insurer had been divided into different fiefdoms based on where employees had worked before, but "the company came together as a single company" after the attacks.

Kemper provided grief counselors who "talked to everyone who was in the tower every day for several weeks," he said. The company also made counseling available to employees outside New York, some of whom knew victims who had worked for Aon Corp. and Marsh & McLennan Cos. Inc. "We have a lot of people who still have a lot of problems coping," said Mr. Smith.

One factor that helped Kemper recover quickly was the earlier insistence of its chief information officer, who had been at the World Trade Center during the 1993 bombing, that it acquire back-up equipment. "This allowed us, I think, to get back up and working in record time." Mr. Smith confessed he had resisted the CIO's efforts to spend millions in disaster recovery preparation. "I wouldn't

do that again. It really does work."

Thomas Rodell, managing principal of Aon Risk Consultants Inc. in Chicago, discussed the difficulties inherent in tracking down people after a disaster such as the World Trade Center attack. "You can't go by sightings," he said. The trauma caused some people to become confused and believe they had seen someone after the attack, when in fact it had been the day before. Because of this, Aon had employees confirm they had actually spoken to the person in question.

Aiding the effort to find Aon staff who may have been visiting New York that day was the company's use of only one travel agent, who was able to inform the company that there were 250 non-New York-based Aon employees in the World Trade Center area that morning. "Some were lost," said Mr. Rodell.

Mr. Rodell, who was in a meeting across the street at the Millennium Hotel, near a large picture window, when the attack occurred, said he saw some horrific things that day and has received counseling himself. "It will always be in my mind, what I saw," he said.

Also speaking during the session was Robert E. Shunk, chairman of New York-based Frenkel & Co.

National Insurance Leadership Symposium

Reinsurers encouraged to refocus on underwriting

By JUDY GREENWALD

SAN FRANCISCO—If reinsurers during the first half of the year suffer another event or series of events of the magnitude of the Sept. 11 terrorist attacks, "there's not going to be a reinsurance industry," one reinsurance executive says.

James F. Duffy, chairman of The St. Paul Cos. Inc.'s reinsurance group, said that although measures such as proposed federal backstop for terrorism reinsurance may diminish the danger by next year, he remains "concerned" about the present.

Another \$50 billion event would have a significant impact on reinsurers' surplus, and the U.S. reinsur-

ance industry is not currently in a solid enough financial position to withstand another large-scale terrorist attack, Mr. Duffy said. "That has me worried."

Mr. Duffy and other reinsurance executives speaking at a session of the National Insurance Leadership Symposium called for federal legislation that would cap the industry's losses from terrorism. The symposium, which was held Feb. 10-11 in San Francisco, was co-sponsored by the American Insurance Assn., the Council of Insurance Agents & Brokers and the Reinsurance Assn. of America, in association with Russell Miller.

The executives also stressed the need for disciplined underwriting,

which they said has become even more important in the wake of the terrorist attacks.

"We are looking at our underwriting in a very disciplined and focused way," said Nicholas J. Spaeth, senior vp, general counsel and secretary for Overland Park, Kan.-based Employers Reinsurance Corp. This is to help ensure that ERC remains "a player well into the century," said Mr. Spaeth.

Even before Sept. 11, ERC embarked on a massive project to examine how it underwrites risks. This project involves "not just price" but also such considerations as risk selection, terms and conditions, and portfolio management, including how ERC has managed its

portfolio and the types of risks it underwrites, said Mr. Spaeth.

Patrick Mailloux, president and chief executive officer of Swiss Re

'We are looking at our underwriting in a very disciplined and focused way' to help ensure that ERC remains 'a player well into the century.'

*Nicholas J. Spaeth
Employers Reinsurance Corp.*

America Corp. in Armonk, N.Y., said that even before the attacks, reinsurance companies' results were "not stellar."

Swiss Re, he said, is getting back to basics. "We are doing our homework, and doing our homework in this industry is called underwriting," he said. This means properly evaluating risk and getting the right price for it, he said.

Reinsurers' investment income is likely to be extremely low for a while, so there are "enormous pressures on underwriting from that perspective," said Mr. Mailloux. At the same time, claims costs are increasing, which means "rates have to increase to keep up with the loss trends."

Mr. Mailloux said the destruction of the World Trade Center caused a re-evaluation of risk, both because the disaster involved the unanticipated risk of terrorism and because

there was convergence of losses from several lines of business, including property, business interruption, workers compensation and life insurance.

That "was never contemplated before," he said.

As a result of these issues, "It's a good time to be an underwriter," said Mr. Mailloux.

Discussing the new reinsurance capital that has come into the business in recent months, Mr. Duffy of St. Paul said, "I look at it as meeting the demands of the marketplace." But, he added, "they, too, should demand the type of returns that are needed to manage the volatility" of reinsurance business.

Although the new reinsurers that have emerged do not have past business on their books with which to contend, reinsurance is a risky business, he said. The answer to the question of how much underwriting discipline they will exercise will be known in a year to 18 months, he said.

Providing the Lloyd's of London perspective on the reinsurance industry's reaction to the Sept. 11 terrorist attacks, Lloyd's CEO Nicholas Prettejohn said "the market has been very disciplined in its response." Mr. Prettejohn also noted that Lloyd's has appointed a special counsel for Sept. 11 to work with the market.

J. Bransford Wallace, the Nashville, Tenn.-based chairman emeritus of Willis Group Ltd., moderated the session.

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New York Business Group on Health

Health plans shifting approach as costs climb

By MICHAEL PRINCE

NEW YORK—Sharply rising health care costs are forcing employers to rethink their approach to delivering health care benefits to employees.

Employers' health care costs are projected to rise by 13% on average in 2002, on top of the 11% increase seen in 2001, Robert Shannon, worldwide partner at William M. Mercer Inc. in New York, told those

more highly managed plans, such as health maintenance organizations.

But employees have resisted the tight controls of HMOs and have demanded access to less restrictive plans, such as preferred provider organization plans. As a result of that backlash, HMOs have relinquished many of their cost-control tools, dropping prior-approval requirements and moving away from the use of gatekeeper physicians. "We have HMOs masquerading as PPOs," Mr. Shannon said.

As a result, HMOs have seen a reduction in their ability to hold down costs and are passing more costs to employers, he said. In 2001, employers' costs for HMO plans rose by 15%, while PPO costs rose by only 11.5%, he said.

Employers, he said, would benefit by moving more employees into self-funded PPOs.

Perhaps the biggest advantage to such a shift is that it would give an employer access to claims data—something fully insured HMOs don't provide. Without the data "you're just sitting in the dark," Mr. Shannon said.

Data on medical costs and a detailed breakdown of claims is crucial to helping employers understand where their health care dollars go, he said. Switching to a self-funded PPO will enable employers to obtain the data and use it to create programs that reduce health care spending.

In addition, employers looking to

hold down costs should consider shifting a larger share of health care costs to employees, Mr. Shannon noted. This includes increasing employees' share of premiums as well as raising deductibles and coinsurance levels.

"The days of the first-dollar coverage are probably over," he said.

And as employers change their health plan strategies, it is crucial that they communicate those changes to employees, said another

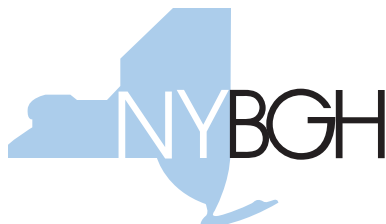
Mercer consultant, speaking at a separate conference session.

Employers must clearly and frequently communicate changes in benefit plans, said Antonio Poglianich, a Mercer principal in New York. "If people don't understand the plans, it doesn't matter how great they are," he said.

As part of their efforts to stem rising health care costs, some employers are working to turn employees into informed health care con-

sumers. Such a change requires a significant shift in employee behavior, and communication is the best way to achieve this change, Mr. Poglianich said.

And effective communication is a two-way street because feedback from employees is important to help employers shape their communication strategies, he said. This feedback could come from focus groups, interviews with employees or surveys.



attending a session at a recent health care conference sponsored by the New York Business Group on Health. And factors such as an aging workforce, increasing longevity and growing use of expensive medical technology all threaten to drive up costs for years to come, he said. As a result, employers can no longer operate "in the business-as-usual mode," Mr. Shannon said.

Although the biggest cost driver is the increased health care utilization stemming from the aging workforce, the steady erosion of the effectiveness of managed care as a cost-saving tool has also been a key factor, he said.

Over the past 20 years, employers have pushed their employees from fee-for-service arrangements into

New York Business Group on Health

Strategies can help slow cost increases

By MICHAEL PRINCE

NEW YORK—Employers are not defenseless against rising health care costs.

A number of strategies are available to help employers slow rising health care costs in the short term, said Dave Rahill, a principal with William M. Mercer Inc. in New York.

Specifically, employers have four ways to reduce health care costs, he said: self-funding health maintenance organizations, adopting tiered HMO networks, redesigning plans to include more cost-shifting to employees, and teaching employees to become better consumers. Mr. Rahill outlined these strategies at a recent health care conference in New York sponsored by the New York Business Group on Health.

Due to fewer restrictions and controls on many HMOs today, fully insured HMOs are really fully insured preferred provider organizations in disguise, Mr. Rahill said. While the idea of switching to self-funded HMOs has taken hold with some employers—the percentage of HMOs that are self-funded nearly doubled, to 13%, in 2001 from the year before—many more employers could benefit from the switch, according to Mr. Rahill.

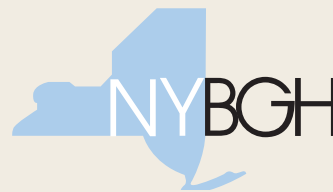
Advantages of making this move include not paying the risk charge and profit to the HMOs, as well as avoiding mandated coverage and a community rating that applies in some states. Self-funding HMOs also allows the employer to join a group purchasing arrangement. In a case study of a sample employer documented by Mr. Rahill, the employer saved 17% in a self-insured HMO compared with a fully insured plan with the same level of benefits.

Another option—using a tiered network HMO—requires employees to pay a higher copayment for choosing certain high-cost hospitals and physicians, and a lower copayment for oth-

ers. Mr. Rahill estimates that employers can save 7% to 10% of their costs by adopting such an approach.

The main challenge with this strategy is educating employees about the new approach and showing them how they can best use it for their needs.

Many employers in the past few years have redesigned their health plans and increased employees' copayments and expenses, to share with them the rising costs of health care, Mr. Rahill said. This means raising employees' deductibles, the cost of prescription drugs and out-of-pocket limits.



While this is easy to accomplish on paper, it's much tougher in practice because employees will object to the added costs, he noted. With the labor market easing for now, though, this could be the best time to push through such a plan, Mr. Rahill said.

He also suggested introducing "consumerism" to employees. Many options exist for employers in this regard, but they all present the employer with the challenge of providing price and quality information to employees, allowing them to become more educated consumers. With consumer-driven plans, "you have a giant communications challenge ahead of you," he said.

Another aspect of consumer-driven plans is creating an employee contribution strategy that makes employees better buyers of the health plans already offered. For example, the employer contribution could be set to cover a basic plan and employees would have to pay more to obtain a more expensive plan, he said.



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Business Insurance

Regulators questioning whether contracts hide fiscal woes

Financial reinsurance under microscope

By CAROLYN ALDRED

Finite risk and other financial reinsurance contracts are coming under regulatory scrutiny in the United Kingdom and Australia, as officials focus on whether such products allowed insurers that later collapsed to mask financial difficulties.

Reinsurance companies that write such contracts are trying to allay U.K. regulators' concerns that some property/casualty and life insurers are improperly using these products to plug holes in balance sheets.

Reinsurers also defend the use of such products for transferring bal-

ance sheet risk and say they are willing to help regulators evaluate the use of such contracts but that ultimately it is the ceding company that must assure it is in compliance with regulatory, accounting and tax authorities.

Finite risk contracts, which take many forms, can allow cedents to take credit for reinsurance recoverables, thereby reducing their gross liabilities. While the covers provide some risk transfer, many of the deals ultimately require ceding companies to pay for the majority of ceded losses themselves, either through additional premium payments in future years or with in-

vestment income on cash deposits the insurers place with their reinsurers.

In Australia, government hearings into the collapse of HIH Insurance Ltd. earlier this month focused on finite risk reinsurance (see story, page 20).

In the United Kingdom, regulators are focusing on financial reinsurance contracts written by Irish European Reinsurance Co. Ltd. The Dublin, Ireland-based subsidiary of GE ERC wrote contracts for property/casualty insurer Independent Insurance Co. Ltd., which became insolvent and entered liquidation last year, and for Equitable Life Assur-

ance Society, formerly one of the largest U.K. life insurers and pension providers, which closed its doors to new business last year.

These contracts, which shored up both companies' balance sheets, enabling them to pass regulatory solvency requirements and remain in business, now are being investigated by the FSA and lawyers for policyholders of the failed insurers.

There is evidence that financial reinsurance contracts are being used by both property/casualty and life insurers for "cosmetic and presentational purposes," said a spokesman for the U.K. Financial

See FINITE/page 19

Rising rates necessitate coverage reviews

By SARAH VEYSEY

LONDON—Although the insurance market was already hardening prior to Sept. 11, the events of that day were a catalyst for enormous change, underwriters and brokers said last week at a seminar in London.

In the wake of the terrorist attacks, insurers are raising rates, restricting limits, eliminating or limiting areas of coverage and demanding comprehensive underwriting

information, Martin Bailey, head of Marsh Inc.'s U.K. retail placement operations, told risk managers attending the Marsh-hosted event.

Mr. Bailey advised insurance buyers to be creative in designing their coverage programs and not to overbuy insurance.

"Review your coverage, and don't take out what you don't need," he said. "An increase in your retentions will decrease your costs."

In addition, he urged risk managers to take care in choosing

which risks they retain. "Don't allow the market to impose (choices) on you."

Mr. Bailey added that risk managers should review their selection of insurers and, where possible, create competition for their business.

David Ireland, deputy chairman of the Assn. of Insurance & Risk Managers, said risk managers had been facing higher insurance rates even before the terrorist attacks, in part because of the collapse last year of the Independent Insurance Co.

Ltd. The failure of Independent left many U.K. companies scrambling to replace their property and casualty coverages, he said. "The market responded—but at a price."

Mr. Ireland, who is group insurance director of construction company VINCI P.L.C., added that AIRMIC, the Assn. of British Insurers and the Confederation of British Industry are in discussions with the U.K. Treasury about expanding the coverage offered by Pool Reinsur-

See MARSH/next page

Swiss Re report outlines coverage proposal

Terrorism risk calls for public/private pool

By EDWIN UNSWORTH

ZURICH, Switzerland—A public/private partnership that would pool losses is the most promising way to provide terrorism insurance, a Swiss Reinsurance Co. report issued

Thursday suggests.

The Swiss Re Focus Report, "Terrorism—Dealing with the New Specter," says the Sept. 11 terrorist attacks demonstrate that terrorism risks increasingly meet fewer of the important criteria of insurability,

"particularly as it is impossible to accurately assess the probability and severity of terrorist attacks." As a result, Zurich, Switzerland-based Swiss Re concludes that terrorism risks are insurable privately only on a "very limited basis."

An effective state and private insurance program in the short to medium term should involve three elements, Swiss Re said:

- Mandatory direct insurance under which all property risks are automatically covered against terrorism risks

- A levy on current property premiums, which could be a fixed percentage or scaled according to exposure. Typically, in the United States a levy of 3% to 5% of property premium would be appropriate, Swiss Re suggests.

- A greater sharing of the loss burden by further aligning the interests of all parties—policyholders, insurers, reinsurers and government.

In addition, policyholders should carry a "significant" deductible of around 5% to 10% of insured values.

Insured losses would be pooled, and the pool reinsured beyond a given deductible by reinsurers, capital markets and governments, with the governments being the insurers of last resort. Such an approach would mean "all stakeholders bear a portion of the risk relative to their financial capacity," Swiss Re said.

A copy of the report is available at www.swissre.com.

World Updates

Allianz seeks partners for terrorism insurer

Allianz A.G. Holding is in talks with other insurers and reinsurers about forming a company to provide coverage for terrorism risks throughout Europe. Munich, Germany-based Allianz said the insurer would write property and casualty risks, though it would not cover business interruption. Allianz did not disclose the limits that would be available or the potential capitalization of the new operation, which would be based in Luxembourg. Allianz said it is seeking four partners for the project and has received positive responses from Swiss Reinsurance Co. and Zurich Financial Services Group. Munich Reinsurance Co. said it would not make a decision until the resolution of talks involving the German government, industry and insurers over terrorism reinsurance.

Lloyd's reform plan not 'panacea': Moody's

Proposals to reform Lloyd's of London's operations will likely correct many of the "structural deficiencies" of the market but won't be a "panacea," says a new report from Moody's Investors Service in London. The proposals were put before the market's members for review and comment in January. Among other changes, the reform plans call for a move away from Lloyd's three-year accounting system to generally accepted accounting principles and the elimination of unlimited liability underwriting. But the proposals do not address all of the problems that Lloyd's faces, the report says. For example, Lloyd's will likely become more dependent on corporate investors, which are more able than individual members to transfer their capital to other markets, the report notes.

E.U. seeks expansion of temp workers' rights

A new European Union directive calls for giving temporary workers in E.U. member states the same employee benefit rights as full-time employees. The draft directive, which would give temporary workers a right to the same remuneration as full-time employees doing comparable jobs, also covers temp workers' eligibility for pension plans, holiday time off and employer-paid health insurance. The proposal is due to go before the E.U. Council of Ministers in March.

Briefly noted

Lloyd's of London company **Wellington Underwriting P.L.C.** has upped its Sept. 11 loss estimate to £75 million (\$107.4 million). The group, which manages syndicates

See WORLD NEWS/page 18

TOP FIVE COSTLIEST TERRORIST ACTS

Ranked by insured property losses including business interruption and aviation hull losses, in millions of dollars (2001 price levels)

Date	Country	Event	Insured property loss	Injured	Fatalities
9/11/01	United States	World Trade Center, Pentagon attacked by hijacked airliners	\$19,000	2,250	3,122
4/24/93	United Kingdom	Bomb explodes near NatWest tower in London	\$907	54	1
6/15/96	United Kingdom	IRA car bomb explodes near Manchester shopping mall	\$744	228	0
2/26/93	United States	Bomb explodes in garage of World Trade Center	\$725	1,000	6
4/10/92	United Kingdom	Bomb explodes in London's financial district	\$671	91	3

Source: Swiss Reinsurance Co. Sigma catastrophe database

Marsh: Coverage reviews needed

Continued from previous page

ance Co. Ltd., the government-backed pool for terrorism risks. Currently, Pool Re provides reinsurance for property and business interruption losses caused by fire and explosion, but risk managers want the coverage to be broadened to include all such losses resulting from terrorism.

The impact of Sept. 11 on a primary insurance market that already was hardening was great, Dermot O'Donohoe, chief executive officer of Winterthur International Insurance Co. Ltd., told attendees. At the Jan. 1 renewals, insurers sought to manage their aggregate exposures,

he said, and buyers faced rate in-

In contrast to previous hard markets, 'In 2002, the insurance market is harder than the reinsurance market.'

David Foreman
Wellington Underwriting P.L.C.

creases "across the board—from 30% to 300%." Higher retentions were also seen across all lines, and some programs had to be restructured, he said. In addition, "long-term contracts are no longer avail-

able," he said.

David Foreman, chief underwriting officer of Lloyd's of London managing agency Wellington Underwriting P.L.C., argued that the current market is distinct from some previous hard markets.

"In 2002, the insurance market is harder than the reinsurance market," he said, noting that "this is a reversal of what is usually the case." He added that the current conditions differ from those in the last hard market in that business still can be placed "at the right price." In the last hard market, capacity virtually vanished for some lines, he said.

World Updates

Continued from previous page

1250 and 2020, had previously predicted £50 million (\$71.6 million) in losses from the terrorist attacks....Stephen Mitchell has been appointed reinsurance manager at Lloyd's of London managing agency R.J. Kiln & Co. Ltd. Mr. Mitchell was formerly reinsurance manager at Chartwell Managing Agents Ltd. He succeeds Leon Butler, who will retire from Kiln in the second quarter of 2002....Online reinsurance trading platform Inreon Ltd. has opened an office in Taiwan. Alex Chu, formerly nonlife director for ERC

Asia Pacific, will head the group's operations in Asia....Guernsey expects to avoid being included on the Organization for Economic Cooperation and Development's list of **uncooperative tax havens**. A Guernsey official said the government is in the final stage of discussions with the OECD and expects to announce this week that Guernsey has met the OECD's requirements....London-based insurer **Brit Holdings P.L.C.** has appointed Neil Witherington as senior financial analyst. He previously was managing director of Willow Information Services.

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Human Resources
National League of Cities
1301 Pennsylvania Avenue, NW
Washington, DC 20004

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REQUEST FOR PROPOSALS

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REQUEST FOR PROPOSALS

NOTICE

The Kansas State Employees Health Care Commission will issue a Request for Proposal (RFP) #04529 on March 1, 2002 for a **voluntary vision service program**. Responses may be for insured or capitated arrangements. **Closing date for responses is 2:00 p.m., Friday, March 29, 2002.**

Currently, approximately 34,600 active employees, 2,000 educational entities 9,600 retirees, 300 COBRA participants participate in the health plan. Total covered lives are approximately 86,000. Membership is increasing due to inclusion of educational entities in the State group. There are currently over 15,000 health plan members participating in the voluntary multi-level vision services plan.

If interested in receiving a copy of the RFP, please contact:

KANSAS DEPARTMENT OF ADMINISTRATION
Health Care Commission – Attn: Bonnie Long
900 S.W. Jackson Street, Room 951-S
Topeka, Kansas 66612-1251
E-mail: benefits@state.ks.us
Phone: 785-296-6280
Fax: 785-368-7180

LEGAL NOTICES

LEGAL NOTICES

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

**IN RE PETITION OF THE BOARD OF DIRECTORS OF
THE NICHIDO FIRE & MARINE INSURANCE COMPANY LIMITED,
DEBTOR IN A FOREIGN PROCEEDING**
Case No. 01-B-15987 (AUG)

NOTICE IS HEREBY GIVEN THAT, in connection with the petition filed on November 28, 2001, pursuant to Section 304 of the Bankruptcy Code (the "Petition") by the Board of Directors (the "Petitioner") of **THE NICHIDO FIRE & MARINE INSURANCE COMPANY LIMITED** (the "Company"), the United States Bankruptcy Court for the Southern District of New York (the "Bankruptcy Court") has entered a permanent injunction order dated February 13, 2002 (the "Order"):

1. Providing that the solvent Scheme of Arrangement between the Company and its Scheme Creditors (the "Scheme") shall be given full force and effect in the United States, and shall be binding on and enforceable against all persons or entities with a claim arising out of a contract of insurance, reinsurance or retrocession entered into with the Company through its agency (the "London Agency") in London, England (the "Scheme Creditors") in the United States;
2. Permanently enjoining all Scheme Creditors from taking any action in contravention of, or inconsistent with, the Scheme;
3. Permanently enjoining all Scheme Creditors from: (a) seizing, repossessing, transferring, relinquishing or disposing of any property of the Company in the United States, or the proceeds thereof, to any person or entity other than the Scheme Manager (as defined in the Scheme); (b) commencing or continuing any action or legal proceeding in connection with any claim arising out of a contract of insurance, reinsurance or retrocession entered into with the Company through the London Agency (including, without limitation, arbitration or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever), including by way of counterclaim, against the Company or the London Agency, or any property in the United States that is involved in the foreign proceeding, or any proceeds thereof, and seeking discovery of any nature against the Company or the London Agency; (c) enforcing any judicial, quasi-judicial, administrative or regulatory judgment, assessment or order, or arbitration award obtained in connection with any claim arising out of a contract of insurance, reinsurance or retrocession entered into with the Company through the London Agency against the Company or the London Agency, and commencing or continuing any act or action or legal proceeding in connection with any claim arising out of a contract of insurance, reinsurance or retrocession entered into with the Company through the London Agency (including, without limitation, arbitration or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) or any counterclaim to create, perfect or enforce any lien, attachment, garnishment, setoff or other claim arising out of a contract of insurance, reinsurance or retrocession entered into with the Company through the London Agency against the London Agency, the Company or any of its property in the United States, or any proceeds thereof, including, without limitation, rights under reinsurance or retrocession contracts; (d) drawing down any letter of credit established by, on behalf of or at the request of, the Company, in excess of amounts expressly authorized by the terms of the contract or other agreement pursuant to which such letter of credit has been established; and (e) withdrawing from, setting off against, or otherwise applying property that is the subject of any trust or escrow agreement or similar arrangement in which the Company has an interest in excess of amounts expressly authorized by the terms of the contract and any related trust or other agreement pursuant to which such letter of credit, trust, escrow, or similar arrangement has been established; except, however, no drawing against any letter of credit shall be made in connection with any commutation unless the amount has been agreed in writing with the Scheme Manager or permitted by further order of the court;
4. Requiring that all Scheme Creditors that are beneficiaries of letters of credit established by, on behalf of or at the request of, the Company or the London Agency or parties to any trust, escrow or similar arrangement in which the Company has an interest, are required to: (a) provide notice to the Scheme Manager's United States counsel of any drawdown on any letter of credit established by, on behalf of or at the request of, the Company, or any withdrawal from, setoff against, or other application of property that is the subject of any trust or escrow agreement or similar arrangement in which the Company has an interest, together with information sufficient to permit the Scheme Manager to assess the propriety of such drawdown, withdrawal, setoff or other application, including, without limitation, the date and amount of such drawdown, withdrawal, setoff or other application and a copy of any contract, related trust or other agreement pursuant to which any such drawdown, withdrawal, setoff, or other application was made, and provide such notice and other information contemporaneously therewith; and, (b) turn over and account to the Scheme Manager for all funds resulting from such drawdown, withdrawal, setoff, or other application in excess of amounts expressly authorized by the terms of the contract, any related trust or other agreement pursuant to which such letter of credit, trust, escrow or similar arrangement has been established;
5. Requiring that every Scheme Creditor that has a claim of any nature or source arising out of a contract of insurance, reinsurance or retrocession entered into with the Company through the London Agency against the Company or the London Agency and that is a party to any action or other legal proceeding (including, without limitation, arbitration or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) in which the Company or the London Agency is or was named as a party, or as a result of which a liability of the Company or the London Agency may be established, is required to place the Scheme Manager's United States counsel (Chadbourne & Parke LLP, 30 Rockefeller Plaza, New York, NY 10112, Attn: Francisco Vazquez, Esq.) on the master service list of any such action or other legal proceeding, and to take such other steps as may be necessary to ensure that such counsel receives: (a) copies of any and all documents served by the parties to such action or other legal proceeding or issued by the court, arbitrator, administrator, regulator or similar official having jurisdiction over such action or legal proceeding; and, (b) any and all correspondence, or other documents circulated to parties named in the master service list; and
6. Closing the ancillary proceedings commenced by the filing of the Petition, subject to reopening under section 350(b) of the Bankruptcy Code.

Copies of the Order, Scheme and Petition are available upon written request to the undersigned counsel below:
CHADBOURNE & PARKE LLP
Attorneys for the Petitioner
30 Rockefeller Plaza
New York, New York 10112
(212) 408-5100
Attn: Howard Seife, Esq.
Francisco Vazquez, Esq.

LOOKING FOR QUALITY RESULTS?

MARCH 4
Claims Management
Closing: Feb. 26

MARCH 11
Closing: March 5

Finite: Some contracts raising concerns

Continued from page 17

Services Authority, who said that some of these contracts appear to have little or no real risk transfer.

As a result, regulators are asking "a number of companies to renegotiate their reinsurance arrangements" and are examining the whole area of financial reinsurance and how it is accounted for by companies, he said.

"The existence of financial reinsurance treaties, of doubtful value, with unregulated reinsurers" is a source of anxiety for regulators, Sir Howard Davies, chairman of the FSA, told members of the Assn. of Risk & Insurance Managers in Lon-

don late last month.

Stephen Alexander, an attorney with Class Law, a London law firm acting for Independent and Equitable Life policyholders, said Independent's financial reinsurance contracts—which paid large ceding commissions and were instrumental in ensuring the survival of the company but whose details were not known by the insurers' board members—"raised serious issues."

Meanwhile, the Equitable Life treaty "looked to be little more than window dressing designed to impress, or perhaps even to bamboozle the regulator," said Sir Howard.

"We have found some more ex-

amples of arrangements where it is wholly unclear whether any risk has in fact been transferred, and where the motivation seems purely presentational. We have already required a number of companies to renegotiate these arrangements, where they seem to us to be unsound," said Sir Howard.

Equitable Life ran into trouble when new solvency legislation and litigation filed by some of its policyholders threatened to leave it with a £1.5 billion (\$2.14 billion) hole in its reserves. A reinsurance contract placed with GE ERC unit IRECO allowed the insurer to meet the new solvency requirements by bolster-

The Equitable Life treaty 'looked to be little more than window dressing designed to impress or perhaps even to bamboozle the regulator.'

Sir Howard Davies
Financial Services Authority

ing its balance sheet by £800 million (\$1.14 billion) in reinsurance for a premium of £150,000. The terms of the reinsurance policy "stipulated that the cost of any

claim was recouped by the reinsurer, by taking in future years any surplus in excess of that needed to support the regulatory reserves," according to a government report.

Now, circumstances surrounding the reinsurance policy, which has since been renegotiated, are being examined by lawyers representing policyholders of Equitable Life as well as the FSA and the new management of the company in runoff. At issue is a "letter of understanding" dated April 1, 1999, from Christopher Headdon, then Equitable's actuary, to IRECO, which had not previously been disclosed to the FSA or, as far as the FSA is aware, the company's auditors.

According to the FSA, "the contents of the letter raised questions
See FINITE/next page

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LEGAL NOTICES

IN THE MATTER OF BRISTOL REINSURANCE LTD - IN LIQUIDATION

AND IN THE MATTER OF
SECTION 99 OF THE COMPANIES ACT 1981
NOTICE OF 2nd DIVIDEND

NOTICE IS HEREBY GIVEN that in accordance with the provisions of the Scheme of Arrangement ("the Scheme") between Bristol Reinsurance Ltd - In Liquidation and its Scheme Creditors, a second interim dividend is to be paid to Scheme Creditors in the amount of 15%, making a total dividend to date of 49%.

Dividends will be paid in accordance with Clauses 11 and 12 of the Scheme. It is expected that dividend payments will be sent to eligible Scheme Creditors on or before 28th February 2002.

Should you have any questions relating to the payment of a dividend please contact:

Andrew Ward, PricewaterhouseCoopers, Dorchester House, 7 Church Street, Hamilton HM11, Bermuda (Fax: 441-295-1242; Tel: 441-299-7127)

PETER C B MITCHELL

Liquidator

19th February 2002

LEGAL NOTICES

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK IN RE PETITION OF PHILIP JOHN SINGER AND DOUGLAS NIGEL RACKHAM, AS PROVISIONAL LIQUIDATORS OF THE INSURANCE CORPORATION OF SINGAPORE (U.K.) LIMITED, DEBTOR IN A FOREIGN PROCEEDING Case No. 01-B-15348 (PCB)

NOTICE IS HEREBY GIVEN THAT, in connection with the petition filed on October 16, 2001, pursuant to Section 304 of the Bankruptcy Code (the "Petition") by Philip John Singer and Douglas Nigel Rackham (the "Petitioners"), as the Joint Provisional Liquidators of THE INSURANCE CORPORATION OF SINGAPORE (U.K.) LIMITED (the "Company"), the United States Bankruptcy Court for the Southern District of New York (the "Bankruptcy Court") has entered a permanent injunction order dated February 13, 2002 (the "Order"):

1. Providing that the Scheme of Arrangement (the "Scheme") between the Company and its Scheme Creditors (as defined in the Scheme) shall be given full force and effect in the United States, and shall be binding on and enforceable against all Scheme Creditors in the United States;

2. Permanently enjoining all persons and entities from taking any action in contravention of, or inconsistent with, the Scheme;

3. Permanently enjoining all persons and entities from: (a) seizing, repossessing, transferring, relinquishing or disposing of any property of the Company in the United States, or the proceeds thereof, to any person or entity other than the Scheme Administrators (as defined in the Scheme); (b) commencing or continuing any action or legal proceeding (including, without limitation, arbitration or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever), including by way of counterclaim, against the Company, or any property in the United States that is involved in the foreign proceeding, or any proceeds thereof, and seeking discovery of any nature against the Company; (c) enforcing any judicial, quasi-judicial, administrative or regulatory judgment, assessment or order, or arbitration award against the Company, and commencing or continuing any act or action or other legal proceeding (including, without limitation, arbitration, or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) or any counterclaim to create, perfect or enforce any lien, attachment, garnishment, setoff or other claim against the Company, or any of its property in the United States, or any proceeds thereof, including, without limitation, rights under reinsurance or retrocession contracts; (d) drawing down any letter of credit established by, on behalf of or at the request of, the Company, in excess of amounts expressly authorized by the terms of the contract or other agreement pursuant to which such letter of credit has been established; and (e) withdrawing from, setting off against, or otherwise applying property that is the subject of any trust or escrow agreement or similar arrangement in which the Company has an interest in excess of amounts expressly authorized by the terms of the contract and any related trust or other agreement pursuant to which such letter of credit, trust, escrow, or similar arrangement has been established; except, however, no drawing against any letter of credit shall be made in connection with any commutation unless the amount has been agreed in writing with the Scheme Administrators or by further order of the Court;

4. Requiring that all persons and entities in possession, custody or control of property of the Company in the United States, or the proceeds thereof, shall turn over and account for such property or its proceeds to the Scheme Administrators;

5. Requiring that all persons and entities that are beneficiaries of letters of credit established by, on behalf of or at the request of, the Company or parties to any trust, escrow or similar arrangement in which the Company has an interest, are required to: (a) provide notice to the Scheme Administrators of any drawdown on any letter of credit established by, on behalf of or at the request of, the Company, or any withdrawal from, setoff against, or other application of property that is the subject of any trust or escrow agreement or similar arrangement in which the Company has an interest, together with information sufficient to permit the Scheme Administrators to assess the propriety of such drawdown, withdrawal, setoff or other application, including, without limitation, the date and amount of such drawdown, withdrawal, setoff or other application and a copy of any contract, related trust or other agreement pursuant to which any such drawdown, withdrawal, setoff, or other application was made, and provide such notice and other information contemporaneously therewith; and, (b) turn over and account to the Scheme Administrators for all funds resulting from such drawdown, withdrawal, setoff, or other application in excess of amounts expressly authorized by the terms of the contract, any related trust or other agreement pursuant to which such letter of credit, trust, escrow or similar arrangement has been established;

6. Requiring that every person and entity that has a claim of any nature or source against the Company and that is a party to any action or other legal proceeding (including, without limitation, arbitration or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) in which the Company is or was named as a party, or as a result of which a liability of the Company may be established, is required to place the Scheme Administrators' United States counsel (Chadbourne & Parke LLP, 30 Rockefeller Plaza, New York, New York 10112, Attn: Francisco Vazquez, Esq.) on the master service list of any such action or other legal proceeding, and to take such other steps as may be necessary to ensure that such counsel receives: (a) copies of any and all documents served by the parties to such action or other legal proceeding or issued by the court, arbitrator, administrator, regulator or similar official having jurisdiction over such action or legal proceeding; and, (b) any and all correspondence, or other documents circulated to parties named in the master service list; and

7. Closing the ancillary proceedings commenced by the filing of the Petition, subject to reopening under Section 350(b) of the Bankruptcy Code.

Copies of the Order, Scheme and Petition are available upon written request to the undersigned counsel.

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

LEGAL NOTICES

LEGAL NOTICES

LEGAL NOTICES

THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF THE LIQUIDATION)
OF DELTA CASUALTY COMPANY)

01 CH 20445

NOTICE OF CLAIM FILING DEADLINE AND PROCEDURES

PLEASE TAKE NOTICE, that on December 4, 2001, the Circuit Court of Cook County, Illinois, entered an Agreed Order of Liquidation With a Finding of Insolvency against Delta Casualty Company ("DELTA"). Nathaniel S. Shapo, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of DELTA ("Liquidator").

TAKE FURTHER NOTICE, that on January 29, 2002, the Circuit Court of Cook County, Illinois, entered an Order Fixing Rights and Liabilities and Providing for the Filing of Claims and the Setting of Claim Filing Deadlines ("Fixing Order"). Pursuant to the Fixing Order, all rights and liabilities of DELTA and its policyholders, creditors and stockholders, and all other persons interested in its property or assets, are fixed as of December 4, 2001, unless otherwise provided in subsequent orders of the Court.

TAKE FURTHER NOTICE, that all persons, companies or entities who have, or may have claims against DELTA, its property or assets, or against a DELTA insured or policyholder, shall have the right to present and file with the Liquidator proper proofs of claim on or before December 4, 2002 at 4:30 p.m. C.D.T.

TAKE FURTHER NOTICE, that any insured under an insurance policy issued by DELTA shall have the right to present and file with the Liquidator a proper proof of claim setting forth a contingent claim on or before December 4, 2002 at 4:30 p.m. C.D.T. No contingent claim shall be allowed for purposes of participating in any distribution of estate assets that may be made at the fourth priority level [215 ILCS 5/205(1)(d)] unless such claim has been liquidated and the insured claimant has presented and filed evidence of payment of such claim to the Liquidator on or before December 4, 2003 at 4:30 p.m. C.D.T. Any contingent claim for which a proper proof of claim is filed on or before December 4, 2002 at 4:30 p.m. C.D.T., but which is not liquidated on or before December 4, 2003 at 4:30 p.m. C.D.T., may be estimated pursuant to 215 ILCS 5/209(4)(b) for purposes of participating in any distribution of estate assets that may be made at the fifth priority level [215 ILCS 5/205(1)(e)] unless otherwise directed by the Court.

TAKE FURTHER NOTICE, that the form and required contents of all proofs of claim are described in 215 ILCS 5/209. Proofs of claim, along with supporting documents, if any, are to be filed with, and may be obtained from, the Liquidator of DELTA, c/o the Office of the Special Deputy Receiver, located at 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. A proof of claim shall be deemed "filed" with the Liquidator upon the Liquidator's receipt thereof. The Liquidator reserves the right to require such additional information with respect to any claim filed with him as he may deem necessary. The Liquidator further reserves any and all defenses available to DELTA upon all filed claims. All proofs of claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR IS SET FORTH ABOVE. NO PERSONS, COMPANIES OR ENTITIES HAVING OR CLAIMING TO HAVE ANY CLAIM AGAINST DELTA, ITS PROPERTY OR ASSETS, OR AGAINST A DELTA INSURED OR POLICYHOLDER, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE PROPERLY FILED WITH THE LIQUIDATOR ON OR BEFORE DECEMBER 4, 2002 AT 4:30 P.M. C.D.T.

Cathleen M. Travis
Special Deputy Receiver

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Finite: Reinsurance products defended

Continued from previous page

about the true value of the reinsurance contract that Equitable Life had entered into in early 1999 and which was shown in its regulatory returns. The FSA concluded that, had it been aware of the letter at the earlier stage, it would not have been prepared to accept the reinsurance arrangements as providing as much security for reserving purposes as was in fact taken."

Meanwhile, Equitable Life's new management said in a letter to policyholders that it has instructed its lawyers to quiz the insurer's former directors, auditors and legal advisers about the reinsurance arrangements. If the lawyers do not get "satisfactory answers," they will start legal proceedings "if it is cost-effective to do so."

Lawyers and the FSA also are looking into a general liability stop-loss reinsurance contract

'Finite risk solutions form a constituent element and tool for modern and comprehensive risk management in insurance and reinsurance companies.'

Munich Reinsurance Co. spokeswoman

written by IRECO for the failed property/casualty insurer Independent, which collapsed last year. According to Independent's year-end 2000 annual statement, the contracts

provided £278 million (\$396.6 million) of coverage for £110 million (\$156.9 million) of premium. However, the true value of those contracts still is under investigation.

A spokesman for GE ERC refused to comment on individual contracts written by IRECO but confirmed that it and other reinsurers were working closely with the FSA on the issue of financial reinsurance. GE ERC "has worked very cooperatively with the FSA and will continue to do so," he said.

Financial reinsurance products have been used for many years and "are designed to help companies manage their risks and reduce volatility," the spokesman said.

Few other finite risk reinsurers contacted by *Business Insurance* were willing to comment on the issue. However, the world's largest

reinsurer, Munich Reinsurance Co., defends the use of financial reinsurance products as a valuable tool for managing balance sheet risk.

"Nowadays, finite risk solutions form a constituent element and tool for modern and comprehensive risk management in insurance and reinsurance companies," said a Munich Re spokeswoman. In addition to transferring risk, finite reinsurance can be used to protect the balance sheet of cedents, she said.

"We carefully pay attention to the strict compliance with all legal and statutory guidelines in markets with explicit regulations for finite risk insurance and reinsurance. We apply the same principles in nonregulated markets, too. Furthermore, we strongly and without exception recommend our business partners before closing any finite risk reinsurance transaction to seek advice, guidance and, if necessary, approval from their auditors, tax experts and local supervisory authorities," she said.

Finite risk contracts sought after to smooth results

Auditors, regulators often differ on policy use

By CAROLYN ALDRED

SYDNEY, Australia—Using financial and finite risk reinsurance products to enhance insurers' financial positions is commonplace, according to an executive of Guy Carpenter & Co. Inc.

However, there is little agreement on how the contracts have to be structured for them to be approved by accountants and regulators, said Geoffrey Bromley, U.K. chief executive of Guy Carpenter.

Testifying at a hearing on the collapse of HIH Insurance Ltd. in Sydney, Australia, Mr. Bromley noted that the degree of risk needed to be included in finite reinsurance contracts "is a very difficult concept to state clearly...and a huge business has developed worldwide as a result effectively of arbitraging

different regulatory and tax systems around the world."

The complexity and diversity of finite reinsurance contracts has been shaped by the demands of individual clients for reinsurance products, which enhance their financial position, Mr. Bromley said.

"We have a number of examples where we can ask the same question of two auditors in the same audit firm and you will get different responses as to whether...a particular contract is a true contract of reinsurance. It's a very difficult concept that regulatory systems throughout the world are still struggling with, to come to grips with," Mr. Bromley testified.

Mr. Bromley was called to testify at the Royal Commission hearing on HIH because he placed a finite reinsurance contract for FAI Insurance Ltd., which was taken over by HIH

in 1999. Losses derived from FAI's business lead to huge losses for HIH.

Responding to questioning, Mr. Bromley confirmed that FAI's head, Rodney Adler, wanted "to arrange reinsurance which would have the effect of allowing him to bring \$40 million Australian (\$20.7 million) of reinsurance recoveries on to the profit and loss account for the year end 30 June 1998."

As a result, a whole-account aggregate stop-loss reinsurance policy was written by National Indemnity Co., a unit of Berkshire Hathaway Inc., that would pay up to \$50 million Australian (\$25.9 million), increasing to an aggregate of \$80 million Australian (\$41.4 million) in the event of a \$5 billion Australian (\$2.59 billion) earthquake occurring during the five-year term of the policy. An initial premium of \$5.5 million Australian (\$2.8 million) would be paid in the first year of the contract, with four subsequent installments

of \$12.7 million Australian (\$6.6 million) each.

Conditions originally in the contract that FAI seek a letter of non-objection to the policy from the regulator and a letter of approval from its auditors were later removed at FAI's request, Mr. Bromley confirmed, and were changed to a requirement for disclosure and review.

He said inclusion of the earthquake trigger provided the risk transfer element of the policy and "there is absolutely no risk transfer if you take out the earthquake component."

Mr. Bromley told the hearing that "the whole purpose of arranging the cover was to come up with an effective structure and we were doing our best to present a structure that would pass muster." Smoothing underwriting results "together with the provision of capital is probably the most sought-after component from the reinsurance markets," he said.

Buyers: Need for stability

Continued from page 3

through the 1990s is that business is best done on the basis of mutual advantage," the BP company secretary said. "Ultimately, what it all boils down to is delivery—delivering what you promised to do."

'Eventually we'll get to the point where we won't buy insurance because everything will be uninsurable.'

*Sheila Small
Verizon Communications*

Stacey Regan, deputy treasurer-insurance at General Electric Co. in Fairfield, Conn., said that although risk managers are charged with managing volatility with regard to losses at their businesses, increasingly it seems they are also responsible for managing volatility in insurance premiums.

"The insurance industry tends to be very inside-out focused, as opposed to outside-in," Ms. Regan said. As soon as an exposure becomes apparent and a company most needs coverage, "that's when the insurance company acts to exclude it," she said.

"I think it's a real missed opportunity for the insurers to challenge themselves and say, 'All right client, we're going to work with you,'" Ms. Regan said.

Insurers and buyers have a "mutual interest" in finding solutions in the present envi-

ronment, the GE risk manager said. But insurers are failing to act on that interest, and there's a disconnect between the expectations of buyers and sellers, she noted.

And, if the situation doesn't change, "There's going to be a point in time coming very soon where our senior management really questions what we're buying," she said.

Sheila Small, assistant treasurer-risk management and insurance at Verizon Communications in New York, said that given insurers' increasing reluctance to cover many exposures, "Eventually we'll get to the point where we won't buy insurance because everything will be uninsurable."

Christopher M. Treanor, managing director of North American Global Broking at Marsh Inc. in New York, said that as a broker, he has a role as a buyer's advocate.

"As an advocate, our role fundamentally is to understand the needs of the customer," he said. As such, it's disappointing to see "how big the chasm is" between what insurance companies view as the needs of the buyer and what buyers say their needs are.

"The customer base is crying for stability," Mr. Treanor said. "The insurance industry has to be about saying 'We can create products and services that will bring stability to your world.'"

"Interestingly enough, in the market cycle, we always turn to new products at the bottom of the cycle," the broker said, though part of creating a stable market should be stable innovation over time.

IRS: 401(k) contributions

Continued from page 3

tions—would not be able to contribute as much as the law allows, said Laura Philip, a vp in the Columbus, Ohio office of Aon Consulting. Currently, the maximum annual deferral to a 401(k) plan is \$11,000.

Alternatively, employers could allow all employees to contribute as much as they like, up to the \$11,000 maximum. Then, when the employer runs the final nondiscrimination test, it could refund, if necessary, a sufficient amount of contributions to highly compensated employees to bring down their average deferrals to pass the test.

That approach, too, has problems. For employers, refunds can be administratively messy and costly. "There is a fair amount of overhead, especially if refunds have to be provided to lots of people," said Buck's Mr. Koski.

In addition, employees, who had been counting on contributing a certain amount to their 401(k) plans, do not like to receive refunds. Refunds increase their taxable incomes and reduce the amount of retirement savings. If the refund is provided after employees have filed their tax return, they also will have to file amended returns.

To avoid the problems associated with refunds, employers can voluntarily give all rank-and-file employees an automatic contribution, such as a percentage of pay or a flat dollar amount—to boost those employees' average contributions to an amount sufficient to enable the 401(k) plan to pass the nondiscrimination tests with the employer refund-

ing contributions to the higher-paid.

But that approach can be expensive. That's why some employers having been using the bottoming-up approach. Through that technique, an employer will make contributions only for the very lowest-paid employees and just enough so the plan passes the nondiscrimination test.

Because the selected employees are very low-paid, even a small employer contribution will dramatically boost those employees' contribution rate—measured as a percentage of pay—and that of the entire group of low-paid employees. As a result, if an employer's aim is to avoid refunding contributions to higher-paid employees, bottoming up can cost a lot less than the employer making contributions to all non-highly paid employees.

But government officials say the arrangement may be abusive and not fit in with the congressional attitude of assuring that participation in 401(k) plans be broad and not skewed in favor of higher-paid employees.

"There may be a concern that, if the problem (passing nondiscrimination tests) is too easy and inexpensive to fix," employers will have less interest in promoting and explaining the plan to encourage broad participation, said Paul Strella, an attorney with William M. Mercer Inc. in Washington.

But Mr. Koski says bottoming up is a win-win situation, noting that contributions are made for the very lowest-paid employees, while the higher-paid ones will be more likely to make larger contributions to the plans.

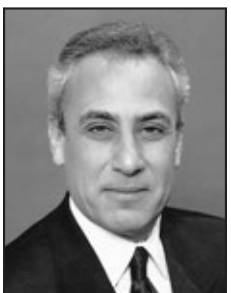
Comings & Goings



Mr. James



Mr. Glazer



Mr. Feldman

Buyers:

Henry D. James has been named director of the office of integrated risk management and insurance at Dartmouth College. He will be responsible for leading an integrated risk management program for the college, which is in Hanover, N.H. Previously, he was the associate director of risk management for Loma Linda University and Loma Linda University Medical School in Loma Linda, Calif.

Insurers:

Ivan J. Dolowich has joined the Financial Insurance Services division of Kemper Insurance Cos. as senior vp and senior claims counsel in Berkeley Heights, N.J. Mr. Dolowich previously served as se-

nior vp and claims counsel of CNA Global Specialty Lines, where he managed the company's directors and officers liability and fidelity claims operation.

Frank Lattal has been promoted to executive vp, general counsel and secretary of ACE Bermuda Insurance Ltd., a subsidiary of ACE Ltd. Mr. Lattal joined ACE in December 1998 as senior vp and claims counsel and was promoted in July 2000 to manage the entire ACE Bermuda claims department.

Andrew Doll has been promoted to chief actuary of General Casualty Insurance Cos. in Sun Prairie, Wis. Mr. Doll previously served as assistant vp in commercial lines.

Andy Bessette has been named senior vp and chief administrative

officer of the St. Paul Cos. Inc. Mr. Bessette comes to the St. Paul, Minn.-based insurer from Travelers Corp., where he was vp of corporate real estate and corporate services.

Excess/surplus lines:

James H. Levine has joined Dallas-based Summit Global Partners Inc. as president and chief executive officer of Vista Insurance Partners, a leading provider of specialized commercial insurers to independent agents throughout the southwestern United States. Mr. Levine previously was senior vp and manager of Swett & Crawford's operations in Florida.

Other suppliers:

Richard C. Glazer, who previously chaired Cozen O'Connor's National Subrogation and Recovery Group for 20 years, is undertaking expanded responsibilities in overall firm management as liaison of the firm's 17 offices.

Elliott R. Feldman, who served as director of national subrogation programs, has been named chairman of the National Subrogation and Recovery Group.

Peter Barr joined CompManagement Inc. as senior vp and will lead product development for the Greenwich, Conn.-based cost containment and medical management firm. He previously was president of GatesMcDonald Health Plus and MedProSolutions at GatesMcDonald & Co.

Premera: Health plan looks beyond price

Continued from page 3

with that physician for a particular case mix are 50% higher than those of providers in the same market treating a similar case mix. For hospitals, Premera uses a system that "allows you to compare the cost of different facilities on a severity-adjusted basis," said Mr. Ancell. This means hospitals could not blame a poor rating on the severity of their cases.

Premera's program "allows us to give members better choices about the products they select and understand the costs that underlay these choices," said Mr. Ancell.

This also helps providers understand what is driving their costs, he said. And this starts "a process of beginning to define what really is quality," said Mr. Ancell. He noted that Premera plans to adopt quality-based measures in the future.

Dorothy Graham, human resources manager for Bellevue, Wash.-based Puget Sound Energy, said that although both providers and patients may challenge the data that is developed, "I believe that the more data we collect about how treatment is delivered, whether it's by who delivers it or by the method of treatment...is really

a good thing."

Cara Lesser, director of site visits for the District of Columbia-based Center for Studying Health System Change, a policy research organization said, "Premera may very well be the model for other plans as they adopt these products."

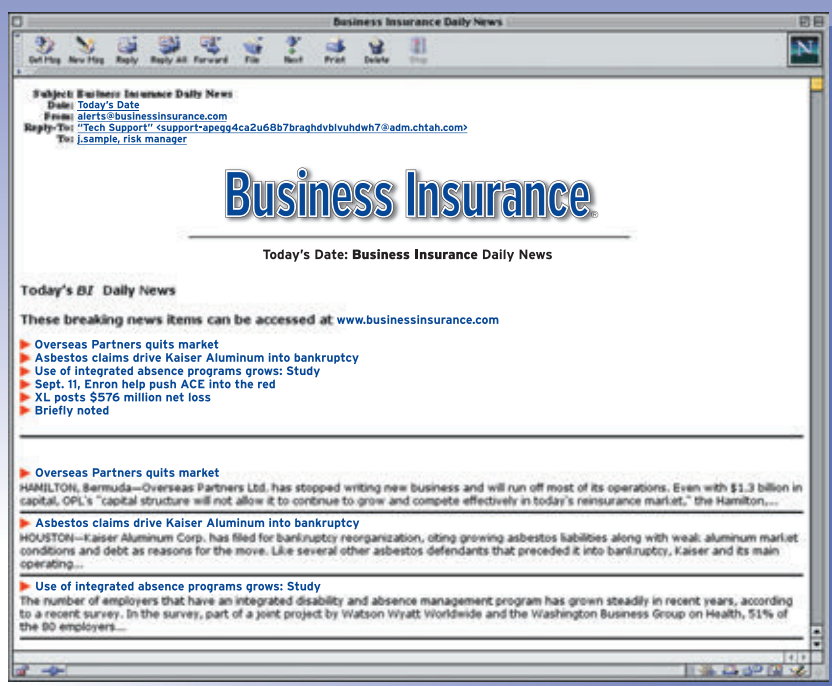
"They're bringing it to a different level" said Ken Drummer, senior consultant with Watson Wyatt Worldwide in San Francisco. "They're looking at the treatment plan and the overall cost effectiveness of treatment as opposed to simply looking at unit cost and units of service. It's evolutionary," he said.

The Premera approach is different, said Mikel Gray, a principal and actuary with William M. Mercer Inc. in Seattle. "I think, conceptually, other companies understand (efficiency) as a necessary component of future plan design, but I'm not sure they are ready to go with the analytical tools and products necessary to actually build that into a product."

Michael Rask, vp in Aon Consulting's health and welfare practice in Seattle, said, "I think employers are going to enjoy having a little more flexibility back in their hands."

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LTV: Plan terminations to cost PBGC

Continued from page 1

highest number of participants—51,000 Eastern Airlines participants—in a plan taken over by the agency.

Indeed, the 82,000 participants in LTV's plans are equivalent to about 15% of the total number of participants in the nearly 3,000 pension plans the PBGC has taken over during its history. The agency was created in 1974 as part of the Employee Retirement Income Security Act.

To handle the influx of LTV participants, the PBGC is adding 35 people to its Cleveland field office, doubling the previous staffing level. It also has created both a special section on its Web site that provides information on the LTV plans

and a toll-free number for participants.

The PBGC also is working with LTV, a one-time legal adversary, and the United Steelworkers of America union to ease the transfer of the plans for participants.

"We are working closely with both the company and the United Steelworkers of America to ensure a smooth transition," said PBGC Executive Director Steven Kandarian.

Although the termination of the LTV plans will be a huge financial hit to the PBGC, the loss by itself poses no threat to the PBGC's solvency. At the end of fiscal 2000, the PBGC enjoyed a record \$10 billion surplus, thanks to years of smaller-than-normal losses and healthy in-

vestment returns on the assets it manages.

"In the short term, its surplus will dip, but it will be at a point where

'We are working closely with both the company and the United Steelworkers of America to ensure a smooth transition.'

Steven Kandarian
PBGC

the agency is very healthy," said Nell Hennessy, a senior vp with Aon Consulting in Washington and a former PBGC deputy executive director and chief negotiator.

Even if the PBGC incurs more big losses, the size of its surplus should ensure that it won't need to hike the premiums it charges the employers whose plans the agency guarantees, Ms. Hennessy said.

The PBGC's sound financial condition is tied, at least in part, to its four-year legal battle with LTV.

In 1987, the PBGC took over

LTV's pension plans several months after the steelmaker had entered bankruptcy. LTV later set up new low-cost plans that provided participants the difference between what the old plans provided and the benefits guaranteed by the PBGC. In effect, at a relatively low cost, LTV transferred nearly \$2 billion in liabilities to the PBGC.

The PBGC warned that if LTV's move were permitted, other employers, saddled with big pension liabilities, would follow suit, dumping billions of dollars of liabilities on the agency. That, in turn, would force the PBGC to dramatically raise premiums, agency officials said at the time. And rather than pay the astronomical premiums, employers with well-funded plans would terminate their plans, crippling the agency's premium base, PBGC officials warned.

But the PBGC did not allow that scenario to occur: The agency returned the terminated plans to LTV, and, after a lengthy legal battle, the Supreme Court upheld the PBGC's move (see related story).

While the PBGC's battle with LTV in the 1980s did not prevent a second and final termination of the

plans and a big loss to the PBGC, some say the agency's actions made it much better able to afford that loss.

The publicity surrounding the LTV case was instrumental in spurring Congress to pass legislation that tightened pension funding rules, said Carol Connor Flowe, a partner with Arent, Fox, Kitner, Plotkin & Kahn P.L.L.C. in Washington and a former PBGC general counsel.

In addition, the Supreme Court's ruling that PBGC could return terminated plans when an employer established new plans, "probably deterred terminations that would have occurred and encouraged better funding than would have otherwise occurred," Ms. Flowe said.

In addition, the LTV case "caused corporate America to pay serious attention to the PBGC and to recognize the PBGC was not going to sit back and be a dumping ground" for pension liabilities that companies did not want to fund, she said.

On the other hand, Baruch Feller, a partner with Gibson, Dunn & Crutcher in Washington and a former PBGC associate general counsel, said it is conceivable that if the PBGC had allowed LTV to terminate its plans in the 1980s, the company might have been able to survive.

LTV Corp. timeline

The saga of LTV Corp.'s pension program spans more than 14 years and led to a landmark Supreme Court decision on the government's authority to reverse pension terminations.

July 1986: LTV Corp. files for bankruptcy.

January 1987: The Pension Benefit Guaranty Corp. terminates LTV's pension plans after the steelmaker says it can no longer afford to contribute to the plans. The PBGC assumes the plans' nearly \$2 billion in liabilities.

July 1987: A labor agreement between LTV and the United Steelworkers of America establishes a new, low-cost pension program to guarantee participants most of the difference between benefits promised by LTV and those guaranteed by the PBGC.

September 1987: The PBGC returns the terminated plans to LTV. PBGC Executive Director Kathleen P. Utgoff charges that the new LTV plans are an illegal continuation of the old plans, with benefits largely paid by the PBGC. The agency, Ms. Utgoff says, does not subsidize the benefits of ongoing plans. LTV immediately files action in court to stop the PBGC's move.

May 1989: The 2nd U.S. Circuit Court of Appeals upholds a district court ruling that PBGC cannot return the plans to LTV.

September 1989: The PBGC asks the U.S. Supreme Court to review the appellate ruling, warning that if the decision is allowed to stand, other companies will follow LTV's example by terminating underfunded plans, shifting the liabilities to the PBGC and then setting up new, lower-cost plans. Such actions would have a "crippling impact" on the PBGC's insurance program, the agency says.

June 1990: The Supreme Court rules that the Employee Retirement Income Security Act—the 1974 law that created

the PBGC—gives the agency the authority to restore terminated plans in situations where the PBGC has determined restoration is in line with its statutory duties. Those duties include ensuring the continuation of pension plans and keeping premiums as low as possible.

July 1992: LTV agrees, as part of a new contract with the United Steelworkers union, to boost pension benefits for certain retirees.

May 1993: LTV agrees to contribute, as part of a court-approved plan that clears the way for the company to emerge from bankruptcy, about \$1.6 billion in cash and securities to its three pension plans, whose unfunded liabilities now total about \$3.1 billion. The agreement requires the company to fund the remaining \$1.4 billion of the plans' liabilities over 28 years.

December 1998: The PBGC and LTV reach an agreement—replacing a 1993 pact—that will allow the company to follow a standard schedule in making contributions to its underfunded plans, rather than a complex schedule of fixed and variable payments. Since the 1993 agreement was reached, LTV has contributed \$2.8 billion to the plans, though the plans still have \$1.5 billion in unfunded benefits.

December 2000: LTV again files for bankruptcy amid a mounting crisis for much of the U.S. steel industry.

November 2001: LTV asks a bankruptcy court for permission to shut down its mills.

February 2002: The PBGC announces that it expects to take over the LTV pension plans, with a March 31 termination date. The agency's preliminary estimate is that the plans have more than \$2.0 billion in unfunded liabilities.

—By Jerry Geisel

K&K: Cutting ties with TIG

Continued from page 1

ness from general property and casualty to program business. It announced that it was considering a sale or restructuring of the company in 1998 amid a third-quarter 1998 loss of \$46.8 million. Toronto-based Fairfax Financial Holdings Ltd. bought the company at the end of 1998 for \$840 million (*BI*, Dec. 7, 1998).

Late last year, TIG received another blow when it lost its A- rating. Oldwick, N.J.-based A.M. Best Co. downgraded TIG's financial strength rating to B++, citing the company's protracted turnaround and limited flexibility in pricing and underwriting control. TIG maintains a significant concentration of business with a limited number of managing general agents, Best said.

Some brokers say that, with TIG's downgrade, it has been difficult to find excess coverage and that clients are requesting that their accounts be moved to a better-rated company.

"It's created a lot of work for everyone because we have to re-market accounts for our clients and make sure they are aware of those changes," said Paul Halloran, a vp specializing in entertainment for Near North Insurance Brokerage Inc. in Chicago, referring to TIG's downgrade. "Whether clients choose to move their accounts or not, they still need to have the option," he said.

Marc Blumencranz, executive vp of BWD Group L.L.C., a Jericho, N.Y.-based broker that specializes in professional sports, noted that he was "very concerned after TIG was downgraded, particularly with trying to secure excess liability insur-

ance over a B++ carrier."

"The sports marketplace is clearly sharing the tightening of the insurance market, just as the typical P/C customer is, but in some respects to a greater extent because there are fewer carriers that write sports business," he said.

In a statement, Fairfax said that

'The sports marketplace is clearly sharing the tightening of the insurance market, just as the typical P/C customer is, but in some respects to a greater extent because there are fewer carriers that write sports business.'

Marc Blumencranz
BWD Group L.L.C.

although it is "disappointed" by Best's downgrade, it believes "that various initiatives which are in the process should nevertheless allow TIG, with its statutory capital of approximately \$900 million, to substantially continue to write its desired business."

Best said TIG's downgrade reflects the rating agency's belief that TIG's turnaround will be protracted due to its operating platform, which limits flexibility in pricing and underwriting control.

In the third quarter of 2001, TIG took a \$309 million Canadian (\$194.4 million) charge to strengthen reserves for 2000 and prior accident years. That reserve strengthening contributed to the overall \$346 million Canadian loss (\$217.6 mil-

lion) Fairfax reported in 2001.

Matthew Coyle, a director with Standard & Poor's Corp. in New York, described TIG as "a work in progress" as it attempts to get its underwriting back in order and to an appropriate level.

"The main concern I have right now, in addition to earnings, is capital," Mr. Coyle said. TIG's risk-based capital levels are legally compliant, but they are approaching levels that warrant regulatory response, he said.

"Although it seems bleak and there are areas of concern, what gives me some confidence is the fact that (Fairfax) has contributed capital before" to TIG, Mr. Coyle said. "It's my belief it will do so in the future."

S&P lowered TIG's financial strength rating to BBB from BBB+ in the fourth quarter of 2001. The downgrade, which was tied to Fairfax in general, reflected the company's earnings problems and the charges taken to strengthen reserves, Mr. Coyle said.

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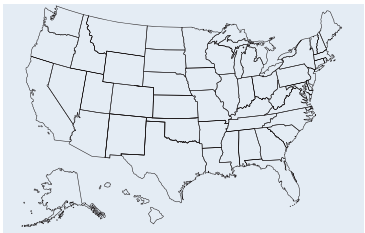
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FTR

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States working on 401(k) catch-up changes

States are rapidly moving ahead to amend their laws so that older employees can make "catch-up" contributions to 401(k) plans without the funds being subject to state taxes, according to the American Benefits Council. Tax codes in roughly 15 states still do not recognize pension law changes, such as those allowing catch-up contributions, that were included in the 2001 Economic Growth and Tax Relief Reconciliation Act. So far this year, the California and West Virginia senates have approved measures to bring their laws in line with EGTRRA, as have state houses in Idaho, Indiana and Iowa. Legislative committees have approved such measures in Arizona, Georgia and Hawaii, according to the Council.

CFO interest growing in strategic risk: Poll

Chief financial officers are increasingly interested in adopting an enterprisewide approach that uses risk management to support strategic company goals, according to an Aon Corp. survey. Although only 12% of companies surveyed have fully integrated risk management functions into a so-called "strategic risk management" program, 39% of companies expect to do so in three years, according to the survey. The preliminary survey results are based on responses from 416 financial executives and on 11 additional interviews. Companies' reasons for developing a strategic risk management program include the desire to better respond to various risks, enhance capital allocation, gain a competitive advantage, reduce earnings volatility and lower the cost of transferring risk, the survey found.

Princeton exiting med mal in Pennsylvania

Princeton Insurance Co. will not to renew medical malpractice liability

policies for policyholders in Pennsylvania, starting May 1. The move was made because of "dramatically higher costs associated with losses in the state," the company said in a statement. Princeton Insurance, based in Princeton, N.J., was among the largest medical malpractice underwriters in Pennsylvania in 2000, with net written premiums of \$15 million. To give health care providers some relief, both houses of the Pennsylvania Legislature have recently passed bills that would cap non-economic damages in medical malpractice suits. In addition, state Insurance Commissioner Diane Koken has asked private medical malpractice insurers to delay collecting a premium surcharge for four months.

Gannett changes 401(k) stock rules

Gannett Co. Inc. has amended its 401(k) pension plan to allow its employees to sell investments in company stock at any time. Before the rule change, employees could not sell shares of Gannett stock that the company had provided as a match to employees' 401(k) contributions until they had reached age 55. The move was made in light of the recent Enron Corp. debacle, said a spokeswoman for the McLean, Va.-based media company. "It heightened our sensitivity," she said. Many of Enron's 401(k) participants saw their retirement savings vanish when the company's stock tumbled last year. Restrictions in the 401(k) plan prevented those employees from selling their holdings in Enron stock.

Federal chartering bill draws insurers' fire

A proposal to permit the optional federal chartering of insurers is drawing a cool reception from the insurers it would regulate. The House Financial Services Committee's ranking minority member—Rep. John J. LaFalce, D-N.Y.—introduced the Insurance Industry Modernization and Consumer Protection Act shortly before Congress recessed on Feb. 15. Rep. LaFalce said that his 400-plus

page bill would provide a way to augment what he called an "inadequate" system of state-by-state regulation. But even the American Insurance Assn, which supports some form of federal insurance chartering, criticized the bill. In particular, the LaFalce proposal would allow states to continue regulating rates charged by nationally chartered insurers, an AIA spokesman pointed out. Insurer groups that have previously opposed federal chartering also criticized the bill.

Briefly noted

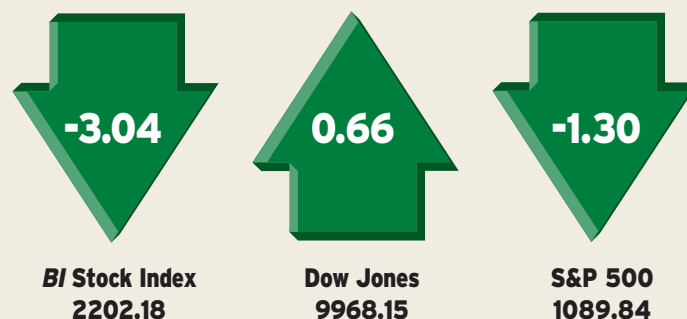
New Mexico's Legislature is sending Gov. Gary E. Johnson an insurance regulatory modernization bill that would permit the state insurance superintendent to **exempt commercial lines forms** from the approval process. The American

Insurance Assn. said the bill, S.B. 256, which the Legislature passed earlier this month but has not yet sent to the governor, would allow insurers to introduce innovative products more quickly. Gov. Johnson has not stated whether he supports the measure, a spokeswoman said.... **Wal-Mart Stores Inc.** must hire an independent third-party administrator to handle its workers compensation claims in the state of Washington and is barred from self-administering the claims for eight years, according to an agreement reached with the Washington Department of Labor and Industries. The agreement, which applies only to claims filed in Washington, follows the state's attempt to stop the Bentonville, Ark.-based retailer from self insuring because of employee complaints and several audits that showed it failed to open legitimate claims.

BI Stock Index [2/18 - 2/22]

Up-to-the-minute data for all 87 companies that comprise the *BI* Stock Index can be found at www.businessinsurance.com

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



Largest gains

Meadowbrook Insurance Group	15.64
NYMagic Inc.	11.11
Harleysville Group	7.69
Penn-America Group	4.09
RLI Corp.	4.00

Largest losses

Mutual Risk Mgmt. Ltd.	-58.00
Gainsco Inc.	-22.22
SCPIE Holdings Inc.	-20.76
ESG Re Ltd.	-9.38
Fremont General Corp.	-8.01

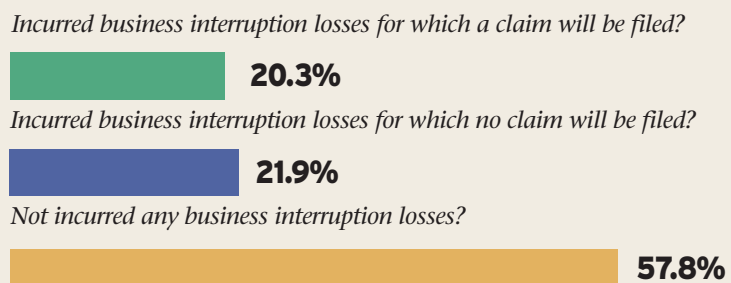
Weekly change by market segment

Brokers	-2.42
Insurers/Reinsurers	-2.73
Managed Care Organizations	0.47

Source: CNET Investor (investor.cnet.com)

Online Poll [2/18 - 2/22]

As a consequence of the Sept. 11 terrorist attacks and anthrax contaminations, has your organization:



Take part in our weekly poll at www.businessinsurance.com

MRM: Exploring all its options

Continued from page 1

about MRM's potential inability to collect on its reinsurance program are also plaguing the company, she said.

"They wrote a lot of program business in a very underpriced market, and their reinsurance recoverables ballooned. And the issue of getting paid under those recoverables could lead to a liquidity problem," Ms. Sharaf said.

Mr. Mulderig acknowledged that concerns over reinsurance recoverables are hurting MRM.

"The main problem has been that the company is very heavily leveraged in terms of reinsurance recoverables. Our business model was to retain very little," he said.

MRM's reinsurance recoverables now stand at \$2.5 billion, according to the company's 2001 results.

MRM also said that it still has three outstanding reinsurance arbitration disputes involving \$48.7 million in unreimbursed losses and \$14.6 million in unpaid reserves.

The company has settled two other arbitration disputes since December 2000. In addition, MRM commuted one of its reinsurance agreements and is negotiating to commute another because of a dispute over the agreement.

The disputes stemmed from the poor performance of the business that was reinsured, Mr. Mulderig said.

MRM also disclosed in its results that the size of its fourth-quarter loss, \$99.7 million, violated some of the covenants for bank debt and debenture holder agreements. MRM is seeking to negotiate a waiver of the violations.

Last April, XL led a \$112.5 million investment in MRM through a five-year debenture. The investment was part of a turnaround plan, which included shedding unprofitable business.

'There is value there. Someone will do something to keep them going in one form or another.'

Ira Zuckerman
Nutmeg Securities

Although, MRM is on track to cut its program book down from \$1 billion to between \$800 million and \$850 million, the turnaround plan was dealt a blow when the rating agencies announced their downgrades, Mr. Mulderig said.

Policyholders and brokers often refuse to place business with insurers that do not have at least an A-rating. Mr. Mulderig said it was too early to tell how much of MRM's business would likely be renewed elsewhere as a result of the downgrades.

However, he acknowledged that MRM was reviewing all of its strategic alternatives, including the possibility of seeking a buyer.

Under the debenture agreement with XL, the investors have the right to convert the debt into a 42% share of a holding company for MRM's rent-a-captive, captive management, brokerage and risk management services units. MRM's alternative risk business saw rapid growth in 2001, Mr. Mulderig said.

XL Chairman and Chief Executive Officer Brian O'Hara said that MRM "has a lot of value, still. They certainly have a problem now with their operations, the underwriting companies, with the downgrade.

But we're hopeful that they're going to find a way through it."

He said that XL has "made no plans" to change its investment in MRM.

MRM could find it difficult to continue in its current state, according to S&P.

"Mutual Risk's core corporate risk management and program business might no longer be viable as a going concern," an S&P statement said.

Another investment by XL or another company could be the best solution for MRM, said Ira Zuckerman, an analyst at Nutmeg Securities in Fairfield, Conn.

"There's value there, and somebody will do something to keep them going in some form or another....They need a friend with big pockets," he said.

Michael Bradford contributed to this story.