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TRIA bills' introduction renews hope

Backers hail actions of House, Senate

By MARK A. HOFMANN

WASHINGTON—Supporters of extending the Terrorism Risk Insurance Act by two years say they have renewed hopes, now that extension bills have been introduced in both chambers of Congress.

House Democrats' introduction last week of the Terrorism Insurance Backstop Extension Act came only a couple of weeks after Sens. Robert Bennett, R-Utah, and Christopher Dodd, D-Conn., introduced a similar bill in the Senate.

TRIA, which established a federal financial backstop for insurers covering losses from future catastrophic terrorist attacks, is slated to expire at the end of the year. Extension proponents—including risk managers and insurers—have argued that the backstop must be maintained to prevent market disruptions.

The House Democrats, all members of the Financial Services Committee, introduced H.R. 1153 on March 8.

"We need to act now to extend the program while we work on long-term solutions to protect American workers and our cities and towns against possible terrorist attacks," the bill's chief sponsor—Rep. Michael Capuano, D-Mass.—said in a statement.

Reps. Barney Frank, D-Mass., Paul Kanjorski, D-Pa., and Joe Crowley, D-N.Y., also sponsored the bill. Rep. Frank is the Financial Services Committee's ranking Democrat.

In addition to extending TRIA through the end of 2007, the bill would extend the backstop cover to group life policies as well as property/casualty insurance and would require that policies issued during the last year of the program retain the terrorism coverage backstop until

See **TRIA/page 19**

COMPENSATION CRISIS

Minnesota AG hints Willis violated consumer laws

By SALLY ROBERTS

With two of the three megabrokers having settled self-dealing charges over the collection of contingent commissions, prosecutors' focus may be shifting to Willis Group Holdings Ltd.

Although no charges have been filed against London-based Willis in connection with various state investigations into brokerage compensation practices, Minnesota Attorney General Mike Hatch said last week that he has a "reasonable basis" to believe that Willis may have engaged in fraud and deception in violation of Minnesota's consumer protection laws, court documents show.

Specifically, Mr. Hatch said he has evidence that suggests the world's third-largest brokerage may have steered clients to insurers paying it the most contingent commissions and that it may have engaged in fraud by using its wholesale brokerage unit, Stewart Smith Group, in order to "churn" additional commissions, the documents note. None of these commissions appear to have been disclosed to clients, Mr. Hatch said.

In a statement issued in response to Mr. Hatch's motion, Willis claims that the document "contains a number of inflammatory and inaccurate statements."

Mr. Hatch's claims, which were contained in a motion seeking to compel Willis and several of its sub-

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Demanding documents

- Minnesota Attorney General Mike Hatch is seeking to compel Willis to provide documents on its business practices and those of wholesale unit Stewart Smith, including the payment of contingent commissions.
- Mr. Hatch says he has "reasonable grounds" to believe Willis may have breached consumer protection laws.
- The attorney general calls Willis' response "lackluster," a statement Willis denies, saying he has refused requests to discuss the investigation's scope.

Charges spanned Aon operations

Suits say top execs, various units implicated

By DOUGLAS McLEOD

In mid-September of 2000, Aon Corp. Chairman Patrick G. Ryan met for dinner at the Four Seasons Hotel in Chicago with Chubb Corp. Chairman Dean R. O'Hare to talk over their companies' deteriorating relationship.

Mr. Ryan was pressing to have Aon's reinsurance subsidiary, Aon Re, take over placements for Chubb's newly acquired Executive Risk unit, according to the lawsuit New York Attorney General Eliot Spitzer filed against Aon earlier this month. Mr. O'Hare countered that Aon was not placing enough retail business with Chubb; Chubb officials had already complained that Aon never followed through on an earlier promise to boost retail placements in exchange for a casualty reinsurance assignment for Aon Re, the suit states.

After the dinner, Mr. O'Hare told his executives to "see what Aon can do for us," but those executives later recommended keeping the Executive Risk program with a rival intermediary, according to the suit.

Mr. Ryan then tracked down Mr. O'Hare, who was traveling in Brazil, to reargue his case. This time, Mr. O'Hare overruled his staff and ordered the program shifted to Aon Re, the suit claims.

Mr. Ryan "told Dean that Aon handling (reinsurance) is critically important to Aon and Chubb having positive relations," according to notes taken by a participant in a subsequent Chubb conference call and cited in the suit. "Ryan willing to put his personal credibility and friendship w/Dean on the line to make sure Chubb receive preferential treatment from Aon."

Spokesmen for Aon and Chubb declined to comment on the allegations. Mr. O'Hare, who retired from Chubb in 2002, could not be reached.

This episode is only one of many supporting charges of fraud and anti-competitive practices at Aon in

See **AON/page 18**

Late News

PHOTO: NY TIMES

A UAL plan for ground workers will be terminated.

PBGC takes over second United plan

The Pension Benefit Guaranty Corp. on Friday moved to terminate a United Airlines plan covering more than 36,000 active and retired ground employees, saddling the agency with one of its biggest losses. The plan has $1.2 billion in assets and $4.1 billion in benefit obligations. Of the $2.9 billion funding shortfall, the PBGC will guarantee $2.1 billion. Last year, the PBGC took over a United pilots' pension plan, which cost the agency $1.4 billion.

Sentencing postponed for Near North's Segal

The sentencing of convicted Near North National Group Inc. owner Michael Segal has been postponed from April 6 until June 29, under a motion approved last week by Judge Ruben Castillo of the U.S. District Court for the Northern District of Illinois. The delay was granted in part because of the complexity of the case, and partly due to a psychiatric evaluation finding that Mr. Segal suffers from attention-deficit disorder, a lawyer for Mr. Segal said. In June, Mr. Segal was found guilty by a federal jury of fraud and racketeering.

P/C renewal rates flat in February

The property/casualty market continued to soften in February, with average renewals coming in flat, according to Internet-based insurance exchange MarketScout. "This is the first time in over four years that renewals are being placed with a composite average of a 0% rate increase," Richard Kerr, chief executive officer of Dallas-based MarketScout, said in statement. The flat rate contrasts with a 9% increase in February 2004 and a 25% increase in the same month in 2003, according to MarketScout's analysis, which is

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International

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PBGC final ruling to ease paperwork for employers

By JERRY GEISEL

WASHINGTON—Employers with large underfunded pension plans soon will have to file electronically to the Pension Benefit Guaranty Corp. certain financial and actuarial information under a final PBGC rule.

In addition, another rule, which the PBGC is proposing and seeking comment on, would mandate electronic filing of PBGC premium-related information to the agency starting next year.

The final rule—significantly modified and improved, benefit experts say, from an earlier PBGC proposed rule—involves a decade-old law that requires employers whose pension plans are underfunded by at least $50 million to disclose to the PBGC certain pension plan actuarial and corporate financial information.

The requirement also applies if the Internal Revenue Service has imposed a lien of at least $1 million on the employer for missed required pension plan contributions or if the IRS has approved a pension plan funding waiver of at least $1 million and a portion of that waiver is outstanding.

Last December, the PBGC proposed that the information provided by employers be filed electronically—in many cases by April 2005—using the PBGC's Web-based software application.

While that filing deadline still stands, the PBGC made several changes that will ease the transition to electronic from paper-based filing.

The most significant change affects employers with dozens or even hundreds of small units that are part of the corporate "controlled group." The original proposal would have required affected employers to supply to the PBGC identification-related information on all members of the controlled group, regardless of the size of the entity.

In the final regulation, though, the PBGC said such information will not be required for very small controlled group members that are not a contributing sponsor to the underfunded pension plan. These so-called exempt entities, among other things, cannot have revenues greater than 5% of that of the controlled group and whose annual operating income can be no more than the greater of $5 million or 5% of the controlled group's income.

The PBGC will only seek information from the exempt entities when the information is "vital" to protecting the PBGC's insurance program.

Benefit experts welcome the change in the PBGC's position, saying that—in most cases—funds the PBGC could recover from small members of a controlled group would be tiny while the reporting burden on employers would have been significant.

"The PBGC was asking for something that could have been really burdensome for employers" and not necessarily relevant for the PBGC, said Sandy Wheeler, a director with the HR Services unit of PricewaterhouseCoopers L.L.P. in Washington.

Also changed from the proposed regulation was the requirement that corporate financial and plan actuarial information be filed electronically using the PBGC's web-based software application.

See PBGC/page 6

What final rule allows

- PBGC eases electronic filing requirements for large underfunded plans
- Information can be filed this year using commercial software programs
- Identifying information not automatically required for very small members of corporate controlled groups

California judge dismisses suit over reorganization of CIGNA

SAN FRANCISCO—In the latest development in a long legal battle, a California judge has dismissed insurers' lawsuit against the ACE Group of Cos. over CIGNA Corp.'s 1996 reorganization, citing a new statutory limitation on suits charging unfair business practices.

In 1996, CIGNA used a Pennsylvania law to split a subsidiary, Insurance Co. of North America, in two without policyholder approval. One piece retained the operation's ongoing profitable business and the name INA. The other assumed sole responsibility for most of INA's pre-1996 liabilities, including its long-tail asbestos and environmental liabilities. CIGNA then merged that piece into an existing licensed unit, Century Indemnity Co.

The Pennsylvania Supreme Court upheld CIGNA's reorganization in 1999. The same year, both INA's ongoing business and the separately capitalized runoff facility, Brandywine Holdings Ltd., were sold in a $3.5 billion deal to ACE Ltd.

American International Group Inc. units AICCO Inc. and Granite State Insurance Co. and Chubb Corp. unit Northwest Pacific Indemnity Co. filed suit in California state court later that year, claiming the reorganization violated California's unfair competition law.

Why suit was tossed

- Proposition 64 stipulates that lawsuits under California's unfair-competition law can be brought only by plaintiffs who have suffered harm as a result of allegedly unfair business practices.

In 2001, a California state appellate court overturned a lower court ruling and said a trial could proceed on the issue.

But in his March 4 decision, California Superior Court Judge James L. Warren dismissed the case, citing Proposition 64. The proposition, approved by California voters in November, stipulates that such lawsuits can be brought only by plaintiffs who have suffered harm as a result of allegedly unfair business practices.

"Plaintiffs do not claim to have suffered any injury themselves as a consequence of defendants' actions," said Judge Warren in his decision.

Judge Warren noted that although state appellate courts have differed over whether Proposition 64 should be applied to cases that were pending at the time of its introduction, he finds "persuasive" those decisions holding that it should apply to such suits.

An AIG spokesman said, "We are appealing, and we are hopeful that the decision will be overturned." A Chubb spokesman had no comment.

—By Judy Greenwald

Tort system not to blame for med mal rates: Study

By MARK A. HOFMANN

Increased medical malpractice insurance premiums in Texas did not spring from problems with that state's tort system, according to a study conducted by four law professors.

Instead, the study—"Stability, Not Crisis: Medical Malpractice Claim Outcomes In Texas, 1988-2002"—found that, adjusted for inflation, the number of claims above $25,000 in 1988 dollars remained roughly constant during the study period, while the number of claims below $25,000 dropped. During the period 2000-2002, there was an average of 4.6 paid claims per 100 practicing Texas physicians compared to 6.4 paid claims per 100 practicing physicians in 1990-1992.

But the authors found that during the period 1998-2003 alone, medical malpractice insurance rates increased by a weighted average of 135% for the state's three largest medical malpractice insurers.

The authors conclude that medical malpractice insurance price spikes could stem from a variety of factors. These include the general nature of insurance, which depends in part on investment income; catastrophe-driven stresses across broad insurance and reinsurance markets; and the long-tail nature of medical malpractice insurance.

The authors also say that "many malpractice insurers or undiversifed, single-line companies are sponsored by state and local medical societies....These member-owned insurers may feel pressure to estimate future losses on the low side, and then need to compensate for past un-

See TORT/page 6

Inside Business Insurance

Online

- The **Datebook** calendar lists upcoming industry seminars and meetings and allows you to add info about your own event.
- Searchable **directories** provide access to all the listings of industry vendors found in *BI*'s Market Sourcebook.
- New **Opinion Poll** for readers: Do you think employers not offering health care coverage should be required to pay a fee to the government to help subsidize coverage for the uninsured?

Departments

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Elect or appoint? Regulators' post debated

By MEG FLETCHER

Insurers and businesses will see no benefit from proposals in Connecticut and Maryland to change the post of insurance commissioner in those states to an elected post rather than an appointed one, several observers say.

Elected insurance regulators are more likely to take a narrow view of insurance regulation and base their decisions on popular appeal, they say.

States that already have elected commissioners would do better to follow the example of Oklahoma, which currently is considering a measure that would change its elected insurance commissioner office to an appointed post, they say.

But supporters of electing commissioners say that regulators who are selected by popular votes are more accountable than appointed commissioners are and likely to be more aggressive in enforcement actions.

The lack of uniformity about the "right way" to choose an insurance commissioner is reflected nationally. More than three-fourths of states require that their governors appoint the top insurance regulator, while a dozen states elect them.

There are potential advantages and disadvantages to each approach, according to Robert W. Klein, associate professor and director of the Center for Risk Management & Insurance Research at Georgia State University in Atlanta.

Most observers sympathetic to business interests, though, generally favor the stability and cohesion that they say comes with having governors appoint commissioners. Many are wary of elected commissioners because they must seek political support from individual voters, as well as campaign contributions from both industry groups and individuals.

Connecticut's proposal to change from appointing to electing its commissioner is garnering special attention.

That legislative proposal was inspired by hearing testimony from

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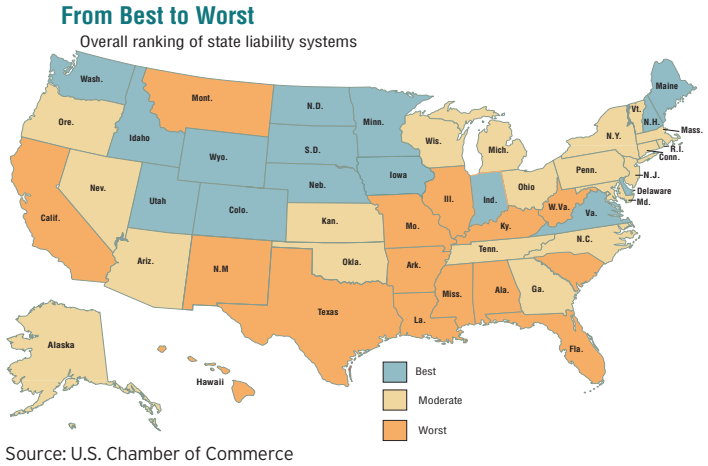
ELECTED REGULATORS

A dozen states have insurance commissioners who are elected:

- California
- Delaware
- Florida*
- Georgia
- Kansas
- Louisiana
- Mississippi
- North Carolina
- North Dakota
- Oklahoma
- Montana
- Washington

* Voters in Florida elect the state's chief financial officer.
Source: NAIC



Source: U.S. Chamber of Commerce

State tort system ranked 'poor to fair' by corporate lawyers

WASHINGTON—Three-fifths of the corporate attorneys surveyed for the U.S. Chamber of Commerce's Institute for Legal Reform gave the state-based tort system an overall ranking of "poor to fair," the ILR announced Tuesday.

While some states won praise as maintaining what the report called a "fair and reasonable litigation system," 60% of those surveyed ranked the overall system fair to poor, an increase from the 56% who did so in 2004, according to the report.

The finding in "The Harris Interactive 2005 State Liability Systems Study" was based on interviews with 1,437 senior corporate attorneys.

The corporate attorneys once again ranked Delaware at the top of their list, followed by Nebraska, North Dakota, Virginia and Iowa.

Mississippi once again received the worst ranking, followed by West Virginia, Alabama, Louisiana and Illinois.

The survey asked respondents to give each state a grade in each of the following areas: tort and contract litigation, treatment of class action suits, punitive damages, timeliness of summary judgment/ dismissal, discovery, scientific and technical evidence, judges' impartiality and competence, and juries' predictability and fairness.

The attorneys were asked to identify the most important issue that "state policymakers who care about economic development should focus on to improve the litigation environment in their state."

In 2005, 22% of the respondents cited tort reform, compared with 17% of the respondents in 2004.

Sixteen percent of this year's respondents named punitive damages as the most important issue, compared with 24% of respondents in 2003.

The complete survey is available at *www.instituteforlegalreform.org*.

—By Mark A. Hofmann

Errors & Omissions

• A chart accompanying a March 7 story on captives licensed in Hawaii listed incorrect information about the number of captives managed by Beecher Carlson/RiskCap (Hawaii). The company managed 34 captives at the end of 2004 and 27 at the end of 2003.

Mexico RIMS stresses fostering resiliency in companies, workers

By ROBERTO CENICEROS

MONTERREY, Mexico—Risk managers have a key role to play in building resiliency into their organizations and helping them grow their business by taking, and managing, increasing levels of risk, according to a technology company risk manager.

By working with operating units to help them prepare for adversity, risk managers can help other managers make operational decisions, said Christina S. Kite, senior director of global risk management at Cisco Systems Inc.

Through such an approach, risk managers can help develop opportunities at their companies rather than simply protect them from losses, she said.

Ms. Kite spoke to the 300 registrants at a conference hosted by the Mexico chapter of the Risk & Insurance Management Society Inc. in Monterrey, Mexico, earlier this month.

By embedding resiliency in their operations, Cisco's business managers can assume more risks when making business decisions, such as whether to enter or exit certain markets, Ms. Kite said. They can also recover faster after unforeseen events.

'Part of our role in risk management is helping those organizations that often only know their part of the overall business...help them see the business from an end-to-end perspective.'

Christina S. Kite
Cisco Systems Inc.

"Part of building resiliency into an organization is very similar to how we build resiliency into our own bodies," Ms. Kite said.

"We don't know what virus lurks around the corner. But how do we make sure we are strong physically and mentally, so that, whatever could hit us, we could quickly bounce back? And what do we need to do for prevention, so we don't get sick in the first place?"

San Jose, Calif.-based Cisco, with 34,000 employees worldwide, provides software, hardware and services for communications and Internet networking. Its employees must take on risks because they have to be willing to fail as well as succeed when developing new products for markets that demand quick responses, Ms. Kite noted. So, by helping employees assume more risk, risk management can be viewed as an opportunity for growth rather than an impediment

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HIH liquidator probing Gen Re deal

Berkshire units may face claims over reinsurance

By ELIZABETH FRY

SYDNEY, Australia—The liquidator of defunct Australian insurer HIH Insurance Ltd. may seek further compensation from units of Berkshire Hathaway Inc. for their alleged role in HIH's 2001 collapse.

HIH's liquidator—Tony McGrath of Sydney-based McGrath Nichol & Partners—confirmed that following the collapse of HIH and the resulting Royal Commission inquiry, he is still investigating a range of claims against various parties that may have contributed to the insurer's insolvency.

Mr. McGrath has contacted Berkshire units General Reinsurance Australia and Kolnische Ruckversicherungs-Gessellschaft, notifying them of "claims it intends to assert arising from insurance transactions" Gen Re Australia entered into with FAI Insurance Ltd., Berkshire revealed last week in its annual report.

The liquidator contends that "GRA and KR engaged in deceptive conduct that assisted FAI in improperly accounting for such transactions as reinsurance," Omaha, Neb.-based Berkshire notes.

HIH's 1999 takeover of FAI, which eventually became insolvent, has been cited as part of the reason for HIH's unraveling, and Gen Re Australia last year agreed to pay $27.2 million Australian ($19.9 million) to HIH's liquidator to settle charges that reinsurance contracts it wrote were designed to hide FAI's true financial condition.

A spokeswoman for McGrath, Nichol said the liquidator has not yet served any claims against the Berkshire subsidiaries, though he has filed papers with the Supreme Court of New South Wales. "Our preference is for mediation or an out-of-court settlement," she said.

According to William Thiele, General Re Corp.'s New York-based senior vp and operating manager for Asia Pacific, U.S. disclosure rules require Berkshire to note the HIH liquidator's actions. "The note to Berkshire Hathaway's financial statements is in accord with those rules," he said.

In its report, Berkshire notes that it cannot estimate the potential financial impact of the matter.

PBGC: Ruling mandates e-filing

Continued from page 3

Instead, for the first year, the required information will still have to be filed electronically, but the information can be presented using such widely available commercial programs as Microsoft Word and Excel or in an Adobe PDF file rather than they the PBGC's Web-based software.

Benefit experts say employers could not have changed their information gathering systems in time to adapt to the PBGC's Web-based system this year.

"It would have been an unmitigated disaster," said Ethan Kra, chief actuary for Mercer Human Resource Consulting in New York.

This is "needed flexibility," said Harold Ashner, a partner with the law firm of Keightley & Ashner L.L.P. in Washington and a former PBGC assistant general counsel. The delay will give the PBGC time to explore the feasibility of allowing multiple users to enter data for a filing, which, Mr. Ashner said, is a shortcoming of the PBGC's web-based system.

Still, there are concerns about the new filing system, including whether the PBGC has done enough to ensure adequate electronic security is in place to protect the information, some of which could be sensitive.

"This could be a potential target for hackers," said Kyle Brown, an attorney with Watson Wyatt Worldwide in Washington.

The PBGC says its Web-based software application uses the best available information security measures.

Meanwhile, under the proposed regulation, large pension plans—those with at least 500 participants—would be required, starting in 2006, to file electronically their PBGC premium-related information to the agency. The same requirement would be imposed on smaller pension plans starting in 2007. Currently, electronic filing is optional.

Observers doubt, after working through transitional issues, such a requirement would be difficult for plan sponsors.

"Once systems are put in place, it should not be any more difficult compared" to paper filing, Mr. Brown said.

The PBGC says it is now working with a vendor to enable employers to use private sector software to prepare premium filings.

Tort: Variety of causes

Continued from page 3

derpricing when assets are depleted."

The authors say that they "mean to deny neither the importance of insurance prices nor the desire of policyholders to address significant price increases." Rather, "our point, which has been largely neglected in the furious battle over malpractice liability, is that attempts to avoid crises in malpractice insurance prices should focus on insurance, not litigation."

The study, which will appear in the May issue of the Journal of Empirical Legal Studies but which was made available Thursday on the Internet, was based on 15 years of closed medical malpractice claim reports gathered by the Texas Department of Insurance.

The study was sponsored by the Center on Lawyers, Civil Justice and the Media at the University of Texas Law School and the University of Illinois School of Law.

The study can be accessed online at *http://ssrn.com/abstract=678601*.

Paul Winston

Industry proves it's not above fray

If hindsight is 20/20 vision, then it's probably safe to say that foresight is legally blind.

A few short years ago, as repeated corporate governance and fraud scandals rocked the corporate landscape, few industry analysts expected the insurance industry could be similarly tainted by the disclosure of shady practices and uncompetitive dealings. While the broader business world was reeling from charges of accounting fraud and deceptive practices at some of the world's biggest companies, including Enron, WorldCom, Tyco, Adelphia and others, many felt the insurance industry was above the fray.

I recently stumbled across evidence of this myopia in a 2002 *Business Insurance* article, "Insurers Unlikely as Source of Next Accounting Scandal."

Paul Winston

The 2002 article quoted analyst after analyst basically proclaiming the possibility of Enronesque shenanigans was extremely remote in insurance. At most they ventured, the industry might make some errors in reserving that could artificially inflate income.

Given the close scrutiny the insurance industry receives from regulators, analysts, rating agencies and auditors, "it would probably be less likely that something like what's happened with a WorldCom could actually get by all those different constituencies that are scrutinizing the industry," said one analyst.

"A lot of the other scandals, whether it's Enron or WorldCom or Tyco, are all about ways of changing or modifying your financial statement in ways that investors would not have expected or didn't think about, whereas in the property/casualty industry, investors know specifically how the managers can do it, so there's no mystery in what they can do," another analyst commented.

One observer specifically drew a contrast between acts of dishonesty at some companies and honest reserving errors in insurance.

In some of these other scandals, you "hear of blatant dishonesty that has happened. I guess the type of thing that might happen in the P/C industry might be better categorized as saying it could be a mis-estimation of what reserves should have been. That doesn't necessarily mean it was dishonest," he said.

And one industry executive suggested such scandals could never happen in an industry founded on trust.

"I would say the weight of history suggests the management, particularly of the large insurance companies, tend to have had 'above average' (marks) on the integrity scale," he said. "That's partly due to the nature of the business, because it is a business of trust. People are giving you money for uncertain returns, and so built into the business is a sense that insurance companies are going to be upright and make sure that the money is available to pay claims."

Unfortunately, much of that trust has vanished among customers of these companies, and in all likelihood among some of those analysts, too. You'll notice I withheld their names to protect the innocent, or should I say gullible? But then, we reported and printed that story, so I guess that also makes us guilty of being too trusting of what we were told.

I expect many buyers will be a little less trusting of their brokers and insurers, now. And that's a sorry basis for a business relationship. But after the deception and self-dealing, it's hard to blame anyone for being cynical. The brokers that have settled with Eliot Spitzer—Aon and Marsh—have pledged to redouble their commitments to ethical practices and honest dealings, but mere words no longer count for as much as they once did. Consider the words of Aon CEO Pat Ryan, in a Dec. 5 article in the Chicago Tribune:

"I'm very comfortable with our past behavior," Mr. Ryan said. "You can talk to 1,000 Aon brokers, and I would defy you to find one who would say they ever placed business" by steering their clients toward a favored insurance company solely so Aon would earn a bigger commission. "They just don't do it, and they don't get paid that way."

Mr. Spitzer's detailed complaint and Aon's own settlement agreement and apology clearly suggest differently. Marsh similarly dragged its feet and denied any wrongdoing, until it was forced to admit otherwise. How many other brokers are hoping no one shines a light on their dark practices? And how many insurers have benefited from the fact that Mr. Spitzer has focused so far on the intermediaries?

Given all that, why should buyers trust anything these companies *say*? Instead, they will have to prove themselves in what they *do* to regain the trust and loyalty of clients; that is, if it's not already too late.

Editorial Director Paul Winston's commentary appears fortnightly. He can be reached at pwinston@businessinsurance.com.

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Editorial

Brokers need to put clients first

FIRST MARSH, NOW AON. Misconduct at insurance brokers appears not to be so isolated after all.

As our coverage shows, state attorneys general aren't done with the largest brokers. Aon Corp. recently agreed to settle suits by three states on charges that it steered business and engaged in "clawbacks" linking retail and reinsurance placements. And now Minnesota is investigating Willis Group Holdings Ltd. on suspicion of similar improprieties.

When New York Attorney General Eliot Spitzer filed his bombshell lawsuit against Marsh & McLennan Cos. Inc. in October 2004 on charges of fraud and bid rigging, few in the industry—and at *Business Insurance*—believed that wrongdoing was widespread.

The egregious acts of which MMC was accused led to several guilty pleas and an exodus of high-ranking executives, including the company's chief executive, and an $850 million settlement. But the misconduct appeared to be confined to excess casualty business and rooted in Marsh's now-disbanded Global Broking system.

The recent suits against Aon, on the other hand, alleged that the brokerage steered business in many areas, both commercial and personal lines.

Bid rigging and antitrust violations may not have occurred, but clearly Aon put its own interest ahead of clients more than once. And the brokerage agreed to pay $190 million in restitution, plus another $38 million last week on other related litigation. Statements of "values" and "client focus" ring hollow alongside the allegations in the suits.

The current chief executive officers of MMC and Aon have apologized for improper actions that occurred but have studiously avoided admission of any wrongdoing. Willis has asserted its internal investigations have found nothing improper.

To say that misconduct at Aon, or at Willis, if any evidence emerges, paled in comparison to that at Marsh is to miss the point. The good name of the insurance brokerage business is at stake, and it had better take immediate action to prove clients really do come first.

Buyers aren't convinced, as last week's *BI* online poll suggests (see results, page 19). We asked readers if they plan to change their brokers in light of alleged improper practices. Virtually the same number said yes as said no, and a smaller percentage said they don't know.

If brokers want to stay in business, they must return their focus to the client.

Urgency needed on TRIA

EVERYONE LEARNS AT an early age that haste usually makes waste.

But that's not necessarily the case when it comes to reauthorizing the Terrorism Risk Insurance Act. The act, which provides a federal backstop for insurers paying losses from future catastrophic terrorist attacks, will expire on Dec. 31 if it is not extended. Insurers have already indicated that their appetite for writing terror coverage without the TRIA guarantee won't be great.

We think there should be a sense of urgency about extending the act and, fortunately, some lawmakers agree. A bipartisan group of senators introduced a two-year extension bill in the Senate last month, and last week a group of Democratic lawmakers introduced extension legislation in the House of Representatives as well.

We certainly would have preferred that a bipartisan bill be the first out of the gate in the House as well as in the Senate.

Still, we welcome any movement on reauthorization legislation this early in the session. After all, there is considerable support for a two-year TRIA extension on both sides of the aisle in both houses of Congress. This shouldn't be controversial.

And it's an issue of great importance to the national economy in general and to risk managers in particular. Without the federal backstop, terrorism coverage would be less available and less affordable, particularly in the central financial districts of major cities. Uncertainty over whether that coverage will be available on New Year's Day and thereafter could have a negative economic impact even before TRIA expires.

Extending TRIA as soon as possible is one of few situations in life in which haste, rather than making waste, may prevent economic opportunities from being lost unnecessarily.

Schillerstrom

Letters to the Editor

HUD's rule on ratings intended to protect

To the editor: I want to commend *Business Insurance* for its Feb. 28 coverage of Department of Housing and Urban Development's acceptance of Demotech Inc. Financial Stability Ratings of A or better for risk retention groups, captive insurance companies, regional insurance companies and risk-bearing entities seeking to qualify under the requirements of the Section 232 Program associated with long-term care facilities.

It is my understanding that HUD's concerns emanated from their duty to protect citizens and taxpayers from potential financial losses associated with assuming the financial burden incumbent in the Section 232 guarantees.

To mitigate the possibility of a Section 232 guarantee being triggered due to an insurance company being unable to honor a claim and the nursing home owner or operator declaring bankruptcy because they were effectively uninsured, HUD imposed its original criteria to protect citizens and taxpayers.

Once Demotech Inc. was able to demonstrate that the application of our Management Audit Process and assignment of a Financial Stability Rating to risk retention groups, captive insurance companies, regional insurance companies and risk-bearing entities would provide sufficient assurance of effective insurance coverage, we were accepted by HUD.

Our goal is to level the playing field for regional insurance companies. We are delighted to have been successful once more.

Joseph Petrelli
President
Demotech Inc.
Columbus, Ohio

Business Insurance* welcomes letters to the editor. The section is intended to be a forum for readers' opinions and comments. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Please send your letters to: Letters to the Editor, *Business Insurance*, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; fax: 312-280-3174; e-mail: *rcoccia@businessinsurance.com

How to motivate a nation of desk potatoes

Employers have an active role to play in their workers' fight against obesity

By Kenneth Mitchell

Much has been reported about obesity recently, but no one has concentrated on the employer's role. Because American workers spend more time at work today than at any other time in recent history, it makes perfect sense for employers to play an active role to reduce the obesity epidemic.

In a nutshell, America has become a workforce of desk potatoes. Manufacturing work that typically involves more manual labor is declining, while more-sedentary jobs that depend on technology are increasing. In addition, time-crunched workdays contribute to the rise of vending-machine junkies.

All this adds up to a weighty workforce that is unhealthy and a drain on a company's bottom line.

Nationwide, obesity costs employers $13 billion a year, according to the National Business Group on Health. And with two-thirds of Americans considered overweight or obese, there is a high likelihood they're also someone's employees.

Suffice to say, it's employers that assume the financial burden of these employees. Consider these staggering statistics:

- Employees with weight problems incur 36% higher annual health care costs, due in large part to other chronic health concerns associated with excessive weight.
- UnumProvident Corp., the leading disability insurer, reports a 10-fold increase in the incidence of disability claims attributed to obesity, showing an average annual cost of $51,023 per claimant.
- Obesity is associated with 39 million lost workdays per year.

This should be corporate America's wake-up call.

Even in his "Call to Action to Prevent and Decrease Overweight and Obesity" report, the U.S. surgeon general highlights the important role employers play in the fight against obesity. Employers are being asked to provide a corporate environment that encourages employees to achieve and maintain a healthy body weight.

Work and health are not independent issues—each influences the other. But how close is the interaction between work, productivity and employee health?

Recent research by Minneapolis-based Health Partners examined workers' health and lifestyles in a variety of occupations. The findings showed obesity had a significant and negative affect—poor health, increased health costs, excess absences and problematic workplace relationships. However, as physical fitness increased, so did the quantity and quality of work performed.

Similarly, a study by the University of Michigan examined the relationship between medical costs and weight. Research showed average annual medical costs were lowest for healthy-weight groups, whereas medical costs steadily increased as the body mass index increased—generally regardless of gender or age.

Therefore, employers have a vested interest in controlling weight and obesity-related health conditions, especially in today's economy, where health care costs consistently rise.

The workplace can be an extremely effective part of an overarching public health initiative aimed at obesity as large numbers of people can be reached at relatively low costs. And because most people spend the majority of their waking hours at the office, the worksite offers a built-in group support system of co-workers—a key component to successful weight management.

A company wellness program is a starting point for many organizations. Helping employees focus on healthy behaviors can lead to a reduction in illness and injury, not only for the employees but also for their families.

Benefits of a strong corporate wellness initiative can extend beyond the workplace. Employees who learn proper eating and exercise habits will transfer their behavior to their homes, where they will prepare healthier meals and be more active.

Employers are starting to look at the relationship between their employees' health and that of their business. Employers are also realizing the impact employee health and productivity have on the bottom line, as well as the importance of investing in programs to manage them. The following illustrates some best practices for employers:

- Provide healthy lunch and snack options. Office snack machines and corporate cafeteria menus should provide a variety of low-calorie, low-fat and/or low-carbohydrate choices.
- Offer weight-control classes and nutrition programs. Local hospitals, universities and weight-loss organizations make excellent partners, especially if businesses aren't large enough to devote internal resources.
- Encourage activity. Employers can promote the use of stairs and persuade employees to walk to co-workers' offices for discussions instead of e-mailing individuals who are around the corner.
- Partner with a fitness center. Adding a campus workout facility or partnering with a community center can provide an employer with significant savings in employee health care expenses.
- Provide employee assistance programs. An employee assistance program is an effective portal to private counseling or community-based weight management.
- Offer incentives. Some companies offer employees incentives to participate such as discounts on employee contributions to health care premiums or reduced costs associated with joining a fitness facility.

Collectively, the degree of interaction between work and health issues affects any organization's overall well-being. Employees are ultimately responsible for their own well-being, but employers, through a commitment to help fight obesity in the workplace, can see healthier employees, lower health costs and improved work.

Kenneth Mitchell is vp-corporate return-to-work program development for Chattanooga, Tenn.-based UnumProvident Corp.

Have a topic to address? Submit a *BI* Perspective

Business Insurance accepts articles from experts in commercial insurance, risk management and employee benefits management for publication in its Perspectives section.

The section is intended to be a forum for readers' opinions and the discussion of technical topics that do not lend themselves to news stories. Therefore, Perspectives articles should take a point of view, offer advice or explain a technical subject. They should not present case studies or promotional information.

All articles for the Perspectives page should address the concerns of the corporate buyer of insurance; i.e., the risk management or employee benefits manager. Material written to address only the concerns of brokers or underwriters is not appropriate.

To submit an article for the Perspectives section:

- Send a letter describing the topic you would like to address. Writers might want to suggest alternative topics. For each topic, briefly describe what you intend to say and accomplish in the Perspectives article.
- You will receive notification from *Business Insurance* accepting or declining your article idea.
- If accepted, we will respond with comments and request the full article, which generally should be 1,200 to 1,500 words in length.
- Each article is to be accompanied by a black-and-white photograph of the author and a brief biography.
- We will notify you of any questions we have about your article or any substantial editing we think is necessary.

Each author must assign the copyright on his or her article to *Business Insurance*.

Because of the volume of Perspective submissions we receive, we cannot guarantee the edition date on which an article will appear. For the same reason, we will not run more than one article in a calendar year from the same author.

To submit a Perspectives article query or find out more information, please send a note to *biweb@crain.com*.

Commentary

Have some funds with this idea

President George W. Bush's modest Social Security proposal has me thinking about ways to fix another system that's clearly broken: property/casualty reserving.

Take a look at the record. The St. Paul Travelers Cos. recently filled in a $1.01 billion hole in its asbestos and environmental liability reserves. Not long before, ACE Ltd. said it would charge a few hundred million against 2004 earnings for its own asbestos losses. Those moves follow reserve increases of several hundred million to several billion dollars over the last few years by a host of companies, from The Hartford Financial Services Group Inc., CNA Financial Corp. and Royal & SunAlliance Insurance Group P.L.C. to—oops—Travelers and ACE again.

Nobody's clairvoyant. No one can foretell the future. But come on. If these guys were William Tell, they'd have no grandchildren.

Douglas McLeod

Something needs to be done, and luckily President Bush has shown us the way. Here's my conservative proposal: Property/Casualty Private Reserves®.

Borrowing a page from segregated cell captives, P/C Private Reserves would allow a policyholder to divert a portion of its premium into a private account maintained by its insurer. The insurer would be relieved of any liabilities associated with the diverted portion of the business; any gain or loss would belong to the policyholder. This gives the policyholder a much bigger ownership stake in its underwriting results and dovetails nicely, I think, with the president's call for an ownership society.

Private Reserves could start out shifting, say, 10% of a policyholder's business into its account. This would work only on a prospective basis. Some policyholders, after all, might be a little antsy about taking ownership of decades of asbestos-exposed liability policies. It might also require some heavy new borrowing by insurers, who would be losing 10% of their premium volume while still having to fund prior years' losses and administer the new program.

Here's the beauty of Private Reserves, though.

It would also loosen the artificial constraints on free market investment choice that have hampered the property/ casualty industry's performance for years. Private Reserves account holders and insurers would no longer be tethered, as they have been historically, to investing in worthless IOUs like U.S. Treasury securities and AAA-rated corporate bonds. They would now be free to move into higher-yielding investments like frozen orange juice futures and South African rand forward contracts.

This simple change would have far-reaching effects. The tremendous gains in investment income would allow policyholders to build more-than-adequate reserves in their private accounts and would more than offset insurers' cost of borrowing.

But it wouldn't end there.

As enhanced earnings from short-selling zinc and funding nanotechnology research roll in, Private Reserves would likely expand to 25% or more of policyholders' insurance placements. As they pay off debt and prior years' losses, cash-rich insurers—unburdened by future liabilities that have been shifted to private accounts—would suddenly find themselves able to offer huge rate cuts to their clients.

Policyholders may actually see their Private Reserves accounts turn into profit centers. By some calculations—mainly those of my cousin, who is a Certified Public Accountant—the combination of double- or triple-digit investment gains and sharp premium reductions could mean that the accounts would not only reduce their owners' cost of risk to zero but could virtually print money.

The regulatory implications are also astounding. Insurers, of course, would be enjoying improved investment performance at the same time that they're shedding a significant portion of the liability on business they write. My proposal, therefore, calls for the elimination of burdensome risk-based capital rules—an unnecessary irritant in a free market—and an eventual reduction or elimination of minimum capital and surplus requirements.

If all of the advantages of Private Reserves weren't impressive enough, think of the branding possibilities. For example: "The St. Paul Travelers 2005 Private Reserve—The Premier Cru of Workers Compensation."

(Note to CFOs: Keep a managed portfolio of fine wine in mind as an investment option for your account.)

For anyone interested in following up on this proposal, I would be happy to discuss authorized use of the name for a reasonable royalty. And, of course, I'll be forwarding a contingent commission to the Republican National Committee.

Senior Editor Douglas McLeod can be reached at dmcleod@businessinsurance.com.

Products & Services

AIG unit introduces new benefit products

NEPTUNE, N.J.—AIG American General, the domestic life insurance operations of American International Group Inc., has launched a set of employee benefit products for small and midsize companies.

The program is marketed by AIG Employee Benefits and features group life, which includes spouse, domestic partner and children's coverage options; group accidental death and dismemberment, which is available bundled with a term life plan or on a stand-alone basis for groups of 10 or more insureds; and group dental, which allows employees to select a PPO or indemnity plan. Other program offerings include group vision and group short- and long-term disability.

Services offered with the program include online support, which allows employers and employees to view premium statements as well as access policy forms, product information and network provider listings; and a medical underwriting tracking system that provides employers with automated weekly status reports on coverage applications.

For more information, contact Cynthia Osofsky, senior vp-marketing and product development for AIG Employee Benefits, at 732-922-7035. More information also can be found on the company's Web site at *www.aigemployeebenefits.com*.

JLT offers coverage for privacy risks

LONDON—JLT Risk Solutions Ltd., in cooperation with Jardine Lloyd Thompson L.L.C., both units of Jardine Lloyd Thompson Group P.L.C., have introduced an insurance product for privacy and security risks marketed to U.S. financial and health care industries.

Enterprise Privacy Protection includes several insuring agreements. Those include third-party privacy suits, which deliver coverage for claims arising from an insured's breach of privacy under defined privacy regulations, such as the Gramm-Leach-Bliley Act, the Health Insurance Portability & Accountability Act and state privacy protection laws. Also included are network security, which covers legal liability and legal costs for claims due to computer attacks caused by security failures, including identity theft and client information theft; and regulatory fines and penalties, which provides defense of a regulatory action or complaint.

The coverage is offered through London and U.S. excess markets.

The normal maximum limit is $15 million, but London-based JLT Risk Solutions will consider limits of up to $25 million. Retention options are also available starting at $25,000, with a policy minimum premium of $25,000. The regulatory fines and penalties agreement has a sublimit of $500,000 with some co-insurance participation.

For more information, telephone Emily Freeman, senior vp of Jardine Lloyd Thompson L.L.C., in London at 44-207-528-4679 or in San Francisco at 415-835-1263. She can also be contacted via e-mail at *emily_freeman@jltgroup.com*.

CIGNA expands HSA offering

BLOOMFIELD, Conn.—CIGNA HealthCare has expanded its consumer-driven health savings account, CIGNA Choice Fund HSA.

The expansion extends the availability to employers with 51 to 200 employees. The plan previously was available only to employers with more than 200 employees. The program offers savings accounts with tax advantages, a high-deductible health plan and financial management services from New York-based JPMorgan Chase & Co.

The Bloomfield, Conn.-based company's CIGNA Choice Fund HSA is now available to employers in Connecticut, Maine, New Hampshire, New Jersey, New York, North Carolina, South Carolina, Tennessee and Vermont. It is available for plans that take effect on or after May 1, excluding those in New Jersey and New York. The HSA expansion in New Jersey and New York will be for plans with effective dates of June 1.

To learn more, visit CIGNA's Web site at *www.cigna.com*.

IFEBP publishes book on benefit issues

BROOKFIELD, Wis.—The International Foundation of Employee Benefit Plans has published a book focusing on multiemployer benefit issues.

The Brookfield, Wis.-based IFEBP's "Employee Benefit Issues—The Multiemployer Perspective, Volume 46" is a compilation of session presentations that took place at the 50th Annual Employee Benefits Conference, which was held Nov. 30-Dec. 1, 2004, in New Orleans. It consists of more than 30 chapters that present instructional advice for trustees and other benefit plan fiduciaries. The book also discusses other topics that relate to multiemployer, corporate, public-sector and Canadian benefit plans. Some of the topics include fiduciary responsibility, which provides information on reviewing a fund's insurance needs and developing a fraud policy; health care issues, which consists of chronic disease management in a Taft-Hartley indemnity plan; and pension issues, which discusses withdrawal liability, including Social Security and Medicare finances.

To obtain a copy of the book, contact the IFEBP's Publications Department at 888-334-3327, option 4, or at *books@ifebp.org*. More information can also be found at *www.ifebp.org/bookstore*.

Court limits reinsurance recoveries on Valdez

By SARAH VEYSEY

LONDON—The Court of Appeal in London has upheld a 2004 High Court decision that will limit the amount of reinsurance and retrocessional recoverables on claims that insurers have already paid out for the 1989 Exxon Valdez oil tanker spill.

In the case of *D.G. King Syndicate 745 vs. Brandywine Reinsurance Co. (U.K.) Ltd.*, the appeals court ruled in favor of Brandywine, a runoff vehicle for policies written by CIGNA Reinsurance Co. (U.K.) Ltd., which was a reinsurer and retrocessionaire for the D.G. King Lloyd's of London syndicate—the liabilities of which were later assumed by runoff reinsurer Equitas Ltd.

The appeals court upheld the lower court's ruling that certain reinsurers were not liable to reimburse primary insurers who had paid out Exxon's claims under various sections of its insurance policy.

It ruled that claims made by Houston-based Exxon under the property damage and third-party liability sections of its general corporate excess insurance policy, underwritten by syndicates at Lloyd's, and paid by the insurers, were not covered by the policy and that reinsurers, therefore, were not liable to cover the claims.

PHOTO: AFP

Exxon paid about $2 billion to clean up oil spilled after the Exxon Valdez tanker ran aground in Alaska's Prince William Sound in 1989.

Exxon, now Exxon Mobil Corp., paid about $2 billion to clean up the 11 million gallons of crude oil that had fouled Prince William Sound in Alaska and killed wildlife.

After a court action in Texas in 1996, Exxon's primary insurers settled claims under the property damage section of the general corporate excess policy, and in 1997 they settled claims against the liability section of the policy for $480 million. Brandywine argued that the cost of these claims should not be recoverable from reinsurers.

Payments made under the marine section of the policy were not disputed by the reinsurers.

Wider implications

"The case has huge implications for the London Market Excess of Loss spiral, since many insurers have already paid Exxon Valdez reinsurance and retrocession claims as if they were liable for them," law firm Holman Fenwick & Willan, which represented Brandywine, said in a statement.

"The unscrambling and reimbursement of the invalid elements of these claims could prove very complicated," it added.

The so-called LMX spiral occurred in the 1980s as large losses hit London market insurers that had reinsured the risks with each other.

In a statement, Equitas, the runoff reinsurer for the pre-1993 longtail liabilities of Lloyd's syndicates, which was involved on both sides of the dispute, said it was pleased that the long-running case had been brought to an end.

"Following the Court of Appeal decision, we are currently looking at identifying the most expedient and commercially viable way of finally settling these claims trapped in the LMX spiral," the statement said.

Equitas noted that because it was involved on both sides of the dispute it would face no material impact from the court ruling.

U.K. liability market too fragile for NHS proposal

Government postpones plan to allow recovery of workplace injury costs

By CAROLYN ALDRED

LONDON—The U.K. government has postponed its plans to allow the country's National Health Service to recoup from employer's liability insurers the costs of treating workplace injuries.

The decision to call off the proposed April 1 start date for the program was made, in part, because of the continued "fragile" state of the employer's liability insurance market, according to a Department of Health statement.

Still, the plan has not been abandoned and will be in place by October 2006, the statement said.

The plan, which was first announced last September (*BI,* Sept. 27, 2004) would have extended the ability of the government-funded NHS to recover costs from insurers for treating patients beyond traffic accident victims to include workplace injuries, among other things.

At the time, Health Minister Rosie Winterton said: "It is unacceptable that taxpayers have to pay for the medical treatment of someone injured at work simply because employers fail to take adequate steps to protect their workforce."

After a consultation period, however, Ms. Winterton said earlier this month that: "One of the key messages to come out of our initial scrutiny was that high levels of concern remain about the insurance market's ability to cope with the new changes. After further discussions, I have decided that now is not the right time to introduce the expanded scheme."

However, the government remains "committed to the principle of 'polluter pays' that underpins" the plan, she said.

The Assn. of British Insurers welcomed the decision.

The plan "would have put more cost pressures on an already fragile liability insurance market. In particular, it would have put more pressure on many businesses who have already faced increases in the cost of their liability insurance," an ABI statement said.

The ABI estimates that the proposal would increase employer's liability costs by 5%.

U.K. employers have seen sharp increases in employer's liability premiums over the past three years, but the increases are moderating.

According to an ABI survey released last week, employer's liability premiums increased 7% in 2004.

And some employers are still seeing significant premium increases.

A survey of members of the Electrical Engineering Federation found that firms are facing an average 23% increase in premiums in 2005.

Fitch assigns q-ratings to 166 E.U. insurers

By SARAH VEYSEY

LONDON—Fitch Ratings Ltd. in London has published unsolicited public information ratings on 166 insurers in France, Germany and the United Kingdom.

The publication of the Quantitative Insurer Financial Strength ratings comes three months after insurers in Germany objected to the plan saying that Fitch had not provided sufficient information on its rating methodology.

Fitch had delayed publication of the ratings from the start of the year after the German insurer association, Gesamtverband der Deutschen Versicherungswirtschaft e.V., raised concerns.

In response to the GDV's concerns, Fitch, this week published detailed information on its methodology and a report outlining the concerns raised by the GDV and other insurer groups and detailed responses. The expanded methodology published by Fitch includes details on the assumptions it uses to make cost of equity and investment return calculations.

Michael Wolgast, chief economist for the Berlin-based GDV, said the association was pleased that Fitch is providing greater transparency about its methodology, that the rating agency is now making clear to users that the so-called "q-ratings" are unsolicited and that it is also making clear when companies have provided supplementary information to the rating agency.

Mr. Wolgast said that when Fitch first announced it would be publishing unsolicited q-ratings, the GDV had been concerned that this might make companies feel pressured to seek an interactive rating. That possible pressure, he said, would be eased by now that the q-ratings will be marked as unsolicited.

A list of the 166 insurers assigned "q-ratings" can be viewed at *www.fitchratings.com.*

Taking a 'Q'

Fitch's q-ratings are:

- "Point in time" ratings that are valid as of the insurer's balance sheet date
- Based on the same publicly available information that is typically available to brokers and financial advisors
- "Stand alone," in that they exclude parental/affiliate relationships
- Purely quantitative, as factors requiring subjective assessment are not considered

Source: Fitch Ratings

World Updates

Benfield to expand primary brokering

Benfield Group Ltd. plans to offer primary coverage brokerage services to marine, energy and power companies later this year, the London-based reinsurance broker announced. Large corporations have increasingly been seeking alternative primary brokers following the broker compensation scandal sparked by New York Attorney General Eliot Spitzer's investigation of the insurance industry, said Grahame Chilton, chief executive officer. The primary insurance brokering operations will be ringfenced from the company's reinsurance operations, he said.

Markel to open Madrid office

Markel International Insurance Co. Ltd., the London-based arm of Markel Corp., is opening an office in Madrid, Spain. Markel initially will focus on professional indemnity and directors and officers business, the company said in a statement, but will offer other coverages over time. The Madrid office will be headed by Esteban Manzano, formerly a senior director at Madrid-based wholesale broker Global & Partners, the statement said.

Amlin posts profits increase

Amlin P.L.C. reported pretax profits of £121.6 million ($233 million) for 2004, up slightly from the £120.3 million ($230.5 million) recorded in 2003. The company, which operates multiline syndicate 2001 at Lloyd's of London, said that losses from U.S. hurricanes and Japanese typhoons during 2004 totaled £74 million ($141.8 million). The syndicate's combined ratio for 2004 was 82%, a slight improvement from 83% in 2003, it announced. Gross written premiums increased less than 1% to £945.6 million ($1.8 billion) in 2004.

Briefly noted

David Gay has retired from his post as non-executive director of Cooper Gay (Holdings) Ltd. Mr. Gay founded the London-based broker in 1965 with Derek Cooper.... **Goshawk Insurance Holdings P.L.C.** posted a loss of $3.2 million for 2004, compared with a loss of $108.3 million in 2003. The London-based company said its 2004 loss resulted largely from net claims of $40 million from natural catastrophes in the third quarter.

Mexico: Fostering resiliency in companies, workers

Continued from page 4

to the development of new products or services.

One way risk managers can help develop resiliency and promote employee willingness to assume more risk is by facilitating business units' understanding of possible adverse outcomes through scenario planning, she said.

Often, business units consider "best case" or "most probable case" scenarios, Ms. Kite said, but they are less likely to run "worst-case" scenarios. Understanding those potential outcomes can help them determine mitigation and prevention measures. It can also help them grasp how much more risk they are capable of assuming.

"By running worst-case scenarios, they absolutely build up resiliency into an operation, a process or a building," Ms. Kite said.

Helping business units accomplish more by managing greater amounts of the risks they generate also motivates them to seek the risk management department's help in preventing potential problems, Ms. Kite said.

In order to build resiliency into the company, one of risk management's roles at Cisco is to help business units assume complete responsibility for managing the risks they generate. The company, though, does not believe in allocating risk costs to each unit, she said.

But risk management does seek to help each unit understand that, even though they may be willing to assume certain risks, they need to weigh the ramifications of their decision for other units throughout the company, "upstream and downstream," Ms. Kite said.

"Part of our role in risk management is helping those organizations that often only know their part of the overall business…help them see the business from an end-to-end perspective," Ms. Kite said. "That is one of the major roles that a risk management team can play."

Cisco Systems has learned that employees, and not just business systems, have to become resilient, Ms. Kite added.

"Part of building resiliency in at Cisco is that we want individuals, when they are faced with adversity, when things don't go 100% the way they thought they would… how do we make sure they are adaptable, flexible and agile?" Ms. Kite said.

One way to increase the resiliency of employees is to cross-train them in a variety of roles to help them "think on their feet" and escalate their decision-making abilities in emergencies, Ms. Kite said.

Cisco also provides crisis management training videos on an employee Intranet site, conducts crisis management drills and has a huge network of employee volunteers whom the company trains in crisis management, Ms. Kite said.

Overall, risk management should help a company grow faster and not just protect it from loss, Ms. Kite said. In that way, risk management contributes to shareholder value, she said.

Regulators: Businesses like appointed commissioners

Continued from page 4

Connecticut Attorney General Richard Blumenthal that was prompted by recent probes into allegedly deceptive insurance industry practices. With an elected commissioner, "enforcement will be more aggressive and accountable," Mr. Blumenthal said earlier this month.

The Hartford, Conn.-based Connecticut Business & Industry Assn. is "opposed to the measure," said counsel Bonnie Stewart. "Politicization of the position could be disastrous," Ms. Stewart said. "We need to be sure that we have a healthy and stable (insurance) environment."

Meanwhile, a spokesman for Delegate Herman L. Taylor Jr., D-Montgomery County, the lead sponsor of the Maryland bill, said switching to an elected commissioner would increase "accountability to people" and add "checks and balances" in the governor's cabinet.

Conversely, the bipartisan bill in Oklahoma to switch to an appointed commissioner should reduce "the opportunity for impropriety" that occurs when an elected insurance commissioner—like the impeached Carroll Fisher—tries to raise money from a regulated industry, said Oklahoma Rep. John Carey, D-Bryan County, a co-sponsor of the bill.

Pro and con

The lack of uniformity nationally in choosing state insurance commissioners reflects that "arguments can be made on both sides," said Carl Martincich, director of human resources and risk management for Love's Travel Stops & Country Stores Inc. The Oklahoma City-based company operates facilities in 26 states.

'An appointed commissioner would be better for business' because 'an elected commissioner has to constantly run for office.'

Jim Crockett
Denver Water

From the perspective of promoting business interests, "appointed commissioners are definitely better," said Robert H. Myers Jr., an attorney with Morris, Manning & Martin L.L.P. in Washington.

Having a commissioner on the governor's team facilitates the development of a good captive program and encourages legislative support, said Mr. Myers, who represents the National Risk Retention Assn.

"Generally, appointed commissioners tend to put insurance in a larger context," and that is good not only for the insurance market but also for business, said David Snyder, vp and assistant general counsel with the Washington-based American Insurance Assn. Also, there typically is less risk of marketplace issues—such as pricing and underwriting—becoming politicized with appointed commissioners, he said.

"An appointed commissioner would be better for business" because "an elected commissioner has to constantly run for office," said Jim Crockett, manager of risk and benefits for Denver Water. The governor has to appoint qualified individuals, though, and not "political cronies," he said.

"We know of no other industry…that has elected regulators," said a spokesman for the Des Plaines, Ill.-based Property Casualty Insurers Assn. of America.

"Those states with elected commissioners tend to have overregulated markets," especially in personal lines, because elected regulators want to win support from voters by showing that they are controlling rates, the PCI spokesman pointed out.

"Their livelihood depends on votes," Lance Ewing, vp-risk management for Las Vegas-based Caesars Entertainment Inc., said of elected commissioners.

Louisiana, though, is an exception, because the elected commissioner there has "campaigned aggressively for a more market-based approach to regulation," the PCI spokesman said.

Some observers say that elected commissioners have to show that they are qualified for the office and, once elected, they must show that they are responsive to voters' concerns.

But consumer advocate Bob Hunter both said he did not think that it mattered whether a commissioner was appointed or elected. That is especially true in the absence of campaign-financing reform, Mr. Hunter said.

Even appointed commissioners face "serious pressures" from state legislators, said Mr. Hunter, who previously served as Texas' appointed insurance commissioner. He is now director of insurance for the Consumer Federation of America.

Washington attorney and lobbyist James T. McIntyre agreed that the elected and appointed regulators can both be effective as their staffs are often professional regulators.

"I get a fair hearing before all departments regardless of whether they have appointed or elected commissioners," he said.

Feds subpoena MBIA over finite coverage

Bond insurer restates financials

By JUDY GREENWALD

ARMONK, N.Y.—MBIA Inc. said last week it has received a subpoena from the U.S. attorney's office in New York seeking information related to two financial reinsurance agreements with the former Zurich Reinsurance North America that it entered into in connection with bonds insured by its MBIA Insurance Corp. unit in 1998.

Earlier in the week, the financial guarantee insurer said it will restate its financial statements for 1998 and subsequent years to correct its accounting treatment of the agreements.

Armonk, N.Y.-based MBIA said the restatements are not expected to have a material effect on its financial position, nor on its AAA ratings.

According to MBIA, the two 1998 reinsurance agreements with Zurich Re, which was renamed Converium Reinsurance (North America) Inc. after a 2001 spinoff, consisted of a quota-share agreement and an excess-of-loss agreement involving $265 million of bonds issued by Allegheny Health, Education and Research Foundation and insured by MBIA.

Under the excess-of-loss agreement, Zurich Re reimbursed MBIA for $70 million of the $170 million loss that MBIA experienced on the bonds.

Under separate agreements to which MBIA was not a party, Zurich Re reinsured losses in excess of $13 million with AXA Re Finance S.A., a subsidiary of Paris-based AXA Re Group.

AXA Re contended it had an oral agreement with MBIA under which MBIA would replace AXA Re as a reinsurer to Zurich Re no later than October 2005. The reinsurer, now named Converium Re, was put into runoff by its Zug, Switzerland-based parent, Converium Holding A.G., last year shortly after the reinsurer was downgraded by rating agencies.

After an investigation, the audit committee of MBIA's board of directors said it appears likely there was such an agreement, which led to the decision to restate its financial statements.

MBIA now says that in light of this, it will change its accounting treatment of the $70 million.

The $70 million was originally recorded as an offset to the $170 million loss. MBIA says that the appropriate accounting treatment is to record the $70 million as a deposit, and to record the subsequent premium cessions under the quota-share agreement as a repayment of the deposit with imputed interest.

As a result of the restatement, MBIA will report net income of about $386 million for 1998, or $47 million less than the amount previously reported. In addition, net income will be reduced by about $6 million for 1999, $4 million for 2000, $3 million for 2001 and by a nominal amount for 2002, according to MBIA. Its earnings will increase by about $2 million for 2003 and by about $4 million for 2004.

MBIA said it also had excess-of-loss agreements with AXA Re and Munich Re related to Allegheny Health, as well as quota-share agreements. MBIA said it continues to believe its accounting for these agreements is appropriate.

In addition to the U.S. attorney's office subpoena, MBIA has previously reported that in November it received subpoenas from the Securities and Exchange Commission and New York Attorney General Eliot Spitzer's office related to nontraditional reinsurance arrangements, including the Allegheny Health reinsurance transaction.

COMPENSATION CRISIS

Willis: Minnesota seeks information on practices

Continued from page 1

sidiaries to provide additional information for Mr. Hatch's investigation into the company, mark the first time a state prosecutor has publicly said that Willis—like its two biggest rivals—may have engaged in improper compensation practices.

In late January, Marsh & McLennan Cos. Inc. agreed to pay $850 million to clients and to change its business practices to settle New York Attorney General Eliot Spitzer's allegations that Marsh Inc. rigged bids and steered clients to favored insurers to maximize contingent commissions (*BI*, Feb. 7).

Weeks later, Aon Corp. agreed to pay $190 million in restitution to jointly settle allegations from five agencies in three states—including Mr. Spitzer's office—that it steered clients to insurers and reinsurers paying the highest contingent commissions and linked insurance placements with reinsurance brokerage business (see story, page 1).

Neither Willis nor Mr. Spitzer's office would comment on whether negotiations are under way to resolve any investigations into Willis' compensation practices.

In the cases of Marsh and Aon, the settlement amounts resemble the $845 million and $169 million, respectively, they collected in 2003 contingent commissions. In 2003, Willis collected $70 million in contingent commissions, which the brokerage—along with Marsh and Aon and others—stopped accepting shortly after Mr. Spitzer sued MMC last October.

State probes

Willis has received requests for documents and information pertaining to its compensation practices from 19 states and the District of Columbia, according to U.S. Securities and Exchange Commission filings.

Minnesota Attorney General Mike Hatch, left, says he has reason to believe Willis steered business to its wholly owned wholesale unit, Stewart Smith Group, to produce additional commissions.

"We continue to cooperate with Mr. Spitzer and all other attorneys general and all governmental and regulatory authorities that have asked for information," a Willis spokesman said.

Minnesota's attorney general, however, says Willis has not been forthcoming with all information he has requested.

Willis has failed to provide "anything other than a lackluster response to the state's (civil investigative demand) and has withheld the vast majority of documents sought by the state," Mr. Hatch's motion states.

The motion, which was filed Tuesday in Ramsey County District Court in St. Paul, seeks to compel Willis, Willis North America Inc., Willis of Minnesota Inc. and Stewart Smith to provide information and documents as requested in the state's civil investigative demand, issued Dec. 15, 2004.

That order seeks documents and information relating to Willis' and Stewart Smith's business practices, including the payment to Willis of contingent commissions by insurers and the practice of brokering business originated by Willis through Stewart Smith, court papers say.

Willis quickly responded to Mr. Hatch's motion, saying in a statement that it has made "several attempts to discuss the scope of the Attorney General's request, which seeks extremely voluminous information on a global basis within a short timeframe.

"Mr. Hatch's office has consistently refused to engage in such a discussion. In every other state that has made similar requests for information, the regulatory or governmental agencies have been willing to discuss the terms of their requests. This is the first time any authority has ignored our requests for a dialogue or expressed dissatisfaction with Willis' cooperation," the statement adds.

Mr. Hatch said he needs further information and documents from Willis in order to proceed with his investigation, for which he said he has "reasonable grounds" to believe that Willis may have violated Minnesota laws.

'Reasonable grounds'

Internal documents from the brokerage, for example, show a key strategy within Willis to maximize premium volume flow to key insurers with the most attractive contingent commission agreements, Mr. Hatch states in his motion. Copies of several contracts between Willis and Minnesota clients show such contingent commissions have not been disclosed, the motion states.

In addition, Mr. Hatch says he has reason to believe Willis steered business to its wholly owned wholesale unit, Stewart Smith, in order to produce additional commissions.

Citing an internal memo, the motion asserts that Willis brokers were instructed to "maximize a new volume bonus arrangement with Stewart Smith by moving accounts to Stewart Smith that are written net of commission."

"The State has copies of contracts with Willis' clients where the practice of generating commissions for the company by running business through its wholly-owned wholesaler was not disclosed," court papers say.

Willis announced last month that it was selling Stewart Smith to Charlotte, N.C.-based American Wholesale Insurance Group for an undisclosed sum (*BI*, Feb. 21).

Willis maintains that the sale, expected to close later this month, is part of its overall strategy to focus on its core retail business and is not related to ongoing investigations.

Observers say that, in light of the Marsh and Aon settlements, it's not surprising that attention is now turning to Willis.

"It's logical to assume that there would be a progression down the line on the first three insurance brokers to be subpoenaed almost a year ago," said Donovan Fraser, an associate director with Standard & Poor's Corp. in New York and a Willis credit analyst. "Marsh, Aon and Willis…are the global brokers that have market clout, albeit Willis being a distant third to Marsh and Aon. However, it does make sense they would be next on the radar screen," he said.

S&P is maintaining its review of Willis' credit rating with a negative outlook and views the developments in Minnesota as part of the overall uncertainty surrounding the company, Mr. Fraser said.

"Willis is on the hot seat right now," said Donald Light, a senior analyst with Celent Communications.

"At this point, I'd say it's significant that they have not announced any establishment of a (settlement) reserve," Mr. Light said. "With that said, given the unattractive picture we've seen inside Marsh and the unattractive picture we've seen inside Aon, has Willis actually managed to avoid the same unattractiveness? I don't know."

MMC reveals other regulators investigating its businesses

By SALLY ROBERTS

NEW YORK—Marsh & McLennan Cos. last week revealed more investigations into its units' business practices and further clarified its plan to shed much of its small-commercial business.

In its annual report filed with the Securities and Exchange Commission, MMC reports that it recently received a subpoena from the Department of Labor seeking documents pertaining to services provided by MMC subsidiaries to employee benefit plans, including documents relating to how such subsidiaries have been compensated.

The subpoena also seeks information concerning market service agreements—also known as contingent commission agreements—and the solicitation of bids from insurers in connection with such services.

The company said that it is fully cooperating with all the investigations and examinations.

MMC recently settled for $850 million New York Attorney General Eliot Spitzer's suit alleging that the company's brokerage unit rigged bids to steer business to those insurers paying it the highest contingent commissions (*BI*, Feb. 7).

MMC also reported that its Mercer Investment Consulting Inc. unit has received requests for information from the SEC in connection with an examination of the practices, compensation arrangements and disclosures of consultants that provide services to sponsors of pension plans or other market participants.

In addition, MMC, Putnam Investments and Mercer Inc. have been advised by the Boston office of the SEC that it is conducting an informal investigation of how companies within MMC refer business to one another and receive compensation for such referrals, the company said.

Separately, Marsh elaborated on its new business model that calls for cutting business—mainly small accounts—that it deems unprofitable.

While Marsh will no longer service most stand-alone small-commercial accounts that require individual local service and have premiums below $50,000, it will continue to service the small-commercial market on a limited basis, explained John Chippindale, chief executive officer of Marsh's global Consumer & Small Commercial Division in New York.

For example, Marsh will continue to provide full brokerage services to small-commercial clients through its technology-driven service center in San Antonio, Mr. Chippindale said. The brokerage will transition some of its stand-alone small-commercial accounts to this service center, which handles businessowners policies business.

Marsh also will continue to service small-commercial clients within its program and affinity operations, Mr. Chippindale said.

AXIS stake for sale

Meanwhile, AXIS Capital Holdings Ltd. said that MMC unit Marsh & McLennan Risk Capital Holdings Ltd. has agreed to sell 3.7 million AXIS Capital's common shares in a block trade. Marsh Risk Capital, the founding investor of the Bermuda-based company, will receive all net proceeds from the sale, which represents about half of its current ownership of AXIS Capital's common shares. Marsh Risk Capital will retain approximately 3.7 million shares, AXIS Capital said in a statement.

Aon: Charges span operations

Continued from page 1

suits filed this month by Mr. Spitzer and the attorneys general of Connecticut and Illinois.

Citing e-mails and other documents, the suits allege a broad Aon corporate policy of steering business to insurers paying it the highest contingent commissions and of using retail insurance production to extract reinsurance brokerage business from insurers.

Aon brokers even manipulated pricing on client placements, according to Mr. Spitzer's suit, in one case allowing an insurer to raise its winning bid on a client's workers compensation program by almost 17.5% to repay an obligation the broker felt it owed the insurer on another client's program.

Aon settled the three actions earlier this month, agreeing to create a $190 million restitution fund for clients and to reform its business practices *(BI,* March 7). Last week, the broker also agreed to a $38 million settlement of class action litigation brought on behalf of its clients.

Announcing the March 4 settlement with state prosecutors, Mr. Ryan said, "While we do not agree with a number of the allegations in the complaints, the settlement permits us to look at the future."

Aon also asserted that its internal review of the charges found "no evidence" of bid-rigging or solicitation of fictitious quotes and that the suits themselves do not level antitrust charges related to tying, a specific antitrust offense under New York law.

No Aon employees have been charged criminally in the investigations, and Aon said it does not expect any to be charged. A spokesman for Mr. Spitzer's office declined to comment.

The Aon complaints do not include the most serious charge leveled against rival Marsh Inc.—demanding inflated quotes from certain insurers to rig bids in favor of others. The Aon suits also do not include antitrust charges. Such charges were included in Mr. Spitzer's complaint against Marsh.

Nevertheless, the complaints against Aon charge a much broader effort to maximize profits by stifling competition. While Mr. Spitzer's Marsh complaint focused only on its retail brokerage business, the charges against Aon encompass its retail brokerage, reinsurance, employee benefits consulting and even personal lines insurance arms.

And, while the Marsh complaint cites senior Marsh executives in the alleged schemes, the Aon complaints accuse the broker's top officers—Mr. Ryan and his second in command, Senior Executive Vp Michael D. O'Halleran—of direct involvement in alleged wrongdoing.

An Aon spokesman said that Mr. Ryan, Mr. O'Halleran and other Aon officials cited in the complaints would not comment on the charges. Aon officials mentioned in the suits either could not be reached or declined to comment.

Aon Risk Services

Following the lead of Marsh and its Global Broking unit, Aon Risk Services, the company's commercial retail operation, sought in 2001 to consolidate control over contingent commission agreements in a single unit, known as the Syndication Group.

The Syndication Group led a broad Aon effort to steer business to "premiere" or "partner" insurers paying the highest contingent commissions, resulting in higher premiums and less advantageous insuring conditions for Aon clients, prosecutors charge.

Negotiating an agreement with a unit of Royal & SunAllance Insurance Group P.L.C., the suits say, Carol Spurlock, Aon's managing director of commercial risk, wrote: "we are looking for a national agreement that would incent us to move the (workers comp) business…Let me further confirm our ability to (affect) placement behaviors. Our syndicators are evaluated on the percentage of their books that are with our 'premiere' markets. Each regional syndication director is held accountable as well. This is a measurable, compensated item that each syndicator is financially motivated to drive."

In an internal e-mail, another Aon official, Peter Trunfio, discussed Travelers Indemnity Co.'s insistence on holding down contingent commissions on renewal business, according to Illinois Attorney General Lisa Madigan's lawsuit.

"When I pointed out that a Travelers renewal at 12.5% is a new business opportunity (17.5%) to Chubb, I think they saw the fatal flaw in their strategy," he wrote. "For that kind of 'incentive,' I'd rather give the premium to Chubb."

The contingent commission agreements typically included premium volume targets that would trigger higher levels of commission for Aon, and internal e-mails show Aon officials steered business to make those goals, the suits say.

In December 2003, for example, Aon was close to meeting a premium target that would trigger additional commissions from CNA Financial Corp., and Ms. Spurlock exhorted Aon brokers and CNA officials to reach the goal, documents cited in Ms. Madigan's complaint show.

"Every little bit at this point," Ms. Spurlock wrote others at Aon. "I am obsessed with hitting this number."

Aon also punished insurers that displeased it by steering business away from them, Mr. Spitzer's suit alleges. When Hartford Financial Services Group Inc. dropped Aon as the broker of its directors and officers liability program in 2003 and offered to "make it up" by using Aon to broker some of its property coverage, top Aon officials were not satisfied, Mr. Spitzer's suit says.

"Let's also take some business from them," Mr. O'Halleran wrote in an e-mail to Robert Needle, managing principal of retail syndication. Mr. Needle responded by noting that Aon could steer business away from Hartford in lines where its contingent commission levels were less favorable than other insurers', according to the complaint.

Aon's pursuit of its own interests over those of its clients also led to inflated bids on client programs, Mr. Spitzer's suit charges.

In September 2003, Zurich American Insurance Co. bid $246,922—well below the expiring premium—for the workers comp business of Columbia, Md.-based real estate company Fieldstone Investment Corp., according to the New York attorney general's suit. Aon brokers, however, told Zurich it could raise its bid without losing the business, and Zurich responded with a successful $290,005 quote, the complaint says.

The reason for this, the suit charges, is that Zurich was unhappy with an unrelated Aon client's business, for which it had decided to buy additional excess-of-loss reinsurance at a cost of $18,000. The added premium charged to Fieldstone was aimed at making up that cost, the suit says.

"We allowed Zurich to get more money on this," an unidentified Aon employee reported to Ms. Spurlock in a document cited in the suit. "This is an example of Aon letting Zurich have more rate and premium when we could have held them at a cheaper price."

Fieldstone officials could not be reached.

Aon Re

Top Aon officials, meanwhile, also promised to steer retail business to several insurers in exchange for their use of Aon Re for reinsurance placements, the lawsuits charge.

In addition to Mr. Ryan's contacts with Chubb's Mr. O'Hare, Mr. Ryan as early as 1994 allegedly demanded reinsurance assignments from CNA in exchange for a promise to deliver two lines of retail business to the insurer, Mr. Spitzer's complaint charges, citing documents from rival intermediary Carvill America Inc.

Aon Re officials made similar demands of American International Group Inc. and Liberty Mutual Insurance Co., according to the complaint.

A number of insurers ultimately protested Aon Re's high brokerage commissions and threatened to shop their accounts, leading Mr. O'Halleran to negotiate what became known as "clawback" agreements, the suit says.

Under these confidential deals, Aon Re agreed to discount its commissions if an insurer agreed to write more Aon-produced retail business. Aon Re would then recapture the commissions based on the volume or profitability of the retail business.

Mr. O'Halleran negotiated one such agreement with Liberty Mutual, which had complained about Aon's reinsurance commissions and threatened to switch to another intermediary, according to Mr. Spitzer's complaint.

After the clawback arrangement was in place, an Aon Re property practice group official wrote in an internal e-mail that he would speak to the head of Aon's property retail department "about the reality of putting significant business into (Liberty Mutual) in order to trigger the partnership dividend," the suit notes.

A Liberty Mutual spokesman declined to comment on the complaint but said the insurer is cooperating with "all regulatory authorities."

Aon Re executed similar clawback agreements with RLI Insurance Co. and Travelers, according to the lawsuit.

Aon Consulting

The broker's employee benefits unit, Aon Consulting, also steered clients to insurers that served the broker's interests, forced "pay-to-play" arrangements on insurers and inflated bids on client accounts, prosecutors in Connecticut, Illinois and New York charge.

Aon Consulting made it clear to insurers that they would lose ground to competitors if they did not pay an adequate contingent commission, the suit filed by Connecticut Attorney General Richard Blumenthal charges.

Aon brokers also suggested a simple method for insurers to recoup the commission costs, Mr. Blumenthal alleged: pass them on to clients.

One executive of Aetna Inc. related the broker's advice: "Their comments: Load the rates for the additional comp and you'll start to get the business. If the comp is right, they will sell the rates," the suit says.

In a statement, Aetna noted that it is not named as a defendant in the suit and said, "we believe that our business practices in Connecticut are consistent with applicable law."

One Aon Consulting client damaged by the alleged schemes was Herkimer County, N.Y., which hired Aon to help place stop-loss coverage for its self-insured employee health care plan, according to Mr. Spitzer's complaint.

While Aon Consulting agreed to handle the job for a flat fee, it did not tell county officials that it was demanding a 15% "pay-to-play" commission from insurers as a condition of bidding on the program. Over five years, the broker collected $78,153 in undisclosed commissions, the suit alleges.

In 2001, Aon did not submit the program's lowest bid, from Blue Cross & Blue Shield, because the insurer did not add the 15% commission, according to the complaint. Herkimer officials later found out about the bid and demanded that Blue Cross be included. The insurer won the county's business, despite Aon Consulting having added its commission to the bid without disclosing it, the suit says.

Herkimer severed its relationship with Aon and sued the broker over its actions in 2003. Aon settled the suit last month for $450,000, said Robert J. Malone, Herkimer County attorney.

Another client damaged by the broker's alleged schemes was Yale University, which used Aon Consulting for its employee health, disability and other coverages. Like Herkimer County, Yale agreed to pay Aon an annual retainer: in the university's case, $18,650. Yale was not told, though, that one insurer Aon recommended—Anthem Blue Cross & Blue Shield—was paying it contingent commissions that totaled $1.2 million in 2003, the Connecticut attorney general charges.

Aon's agreements with Anthem, on the one hand, and Yale, on the other, outline the plan design, communication and claims services the broker is to provide, and is seeking compensation for from both entities, in virtually identical terms.

"The university," Mr. Blumenthal alleges, "was effectively being charged twice for the same service."

In August 2004, after Connecticut authorities questioned Aon's commission arrangements, the broker sent a letter to Yale saying, "We are in the process of updating our files and note that we have not sent you a disclosure statement within the last three years."

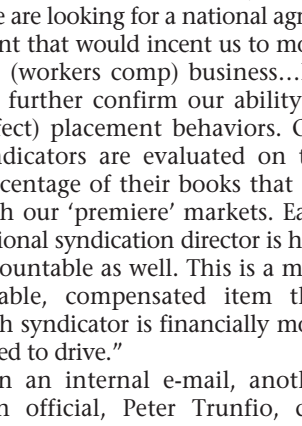
In fact, Aon had never sent Yale a disclosure statement regarding its compensation, the suit says.

Robert Schwartz, Yale's assistant vp for human resources, declined to comment.

An Anthem spokesperson could not be reached.

Spitzer's charges

PHOTO: GETTY



New York Attorney General Eliot Spitzer's suit charges that Aon:

- Steered business to insurers paying the highest contingent commissions
- Funneled retail business to insurers in exchange for their agreeing to use Aon's reinsurance brokerage services
- Negotiated confidential "clawbacks" to offset discounts on reinsurance placements

Late News

Continued from page 1
based on business placed through the portal.

Munich Re out of U.S. direct liability business

Munich Reinsurance Co. has stopped underwriting direct casualty and professional liability insurance for large U.S. corporations. A spokeswoman for the German reinsurer said Munich-American Risk Partners, a unit of its U.S. subsidiary, American Re, had stopped underwriting such business at the start of the year because it does not view the business as profitable in the long term and because it is volatile. Direct liability insurance for large U.S. corporations generated premium volume for the company of about $136 million last year, she added.

Rules give guidance on 'abandoned' 401(k) plans

Proposed Labor Department rules issued last week lay down procedures for financial institutions that hold assets of "abandoned" 401(k) plans to distribute plan assets to participants. Under the proposed rule, a qualified termination administrator—the entity that holds plan assets and is an eligible plan trustee—would have the authority to determine whether a plan has been abandoned, such as by an employer no longer in business. Such administrators would calculate benefits payable to participants, distribute benefits and file a summary termination report with the Labor Department.

Universal health care bill introduced in California

A California health insurance premium tax of 2.35% that now only applies to commercial insurers would be extended to nonprofit insurers under recently introduced universal health care coverage legislation. A.B. 1670 also would require all Californians to have coverage under a plan with a deductible no greater than $5,000. The state would, among other things, subsidize coverage of lower-income employees who work for small companies. California also would set up purchasing pools through which employers could purchase coverage. California's health coverage "play or pay" law was repealed last year.

Nebraska passes comp reforms

Insurers will be able to "file and use" workers compensation rates under a new law in Nebraska. The law, enacted last week, is intended to increase competition in the state's workers comp and personal lines markets, said Eric Dunning, counsel to the Department of Insurance. In addition, the measure, which takes effect in September, allows insurers the option of increasing or decreasing filed workers comp rates by as much as 40%.

GAO expects to release RRG analysis in June

The first comprehensive government analysis in more than 15 years of how well the federal Risk Retention Act is working should be released in early June, the director of the upcoming report says. For more than a year, the Government Accountability Office has been collecting information to determine the impact that risk retention groups have had on the availability and affordability of commercial liability insurance. Federal legislators felt a new analysis was needed because so much time has passed since the last report on RRGs, said Lawrence Cluff, the GAO's assistant director of financial markets and community investment.

Archdiocese, insurer settle over abuse claims

The Roman Catholic Archdiocese of Boston has reached a settlement with a former insurer, Lumbermens Mutual Casualty Co., over the insurer's denial of claims stemming from sexual abuse charges brought against the church, the archdiocese reported. Terms of the settlement were not disclosed. The dispute arose from Lumbermens' refusal to contribute to the $84.3 million sum that the Catholic church in Boston agreed to pay in late 2003 to settle more than 550 clergy abuse claims (*BI*, May 3, 2004).

NCOIL disclosure rules narrower than NAIC's

The National Conference of Insurance Legislators has adopted a producer compensation disclosure model act that is more lenient than one the National Assn. of Insurance Commissioners adopted in December. Under the NCOIL recommendations, formally adopted at the organization's recent spring meeting in Hilton Head, S.C., only producers that receive compensation from both the customer and the insurer or another third party will be required to disclose compensation for the initial placement of insurance. The NAIC's Producer Licensing Model Act requires disclosure not only when the insurer and customer both pay the producer, but also when someone "represents" the customer.

Briefly noted

American International Group Inc. has elected Stephen L. Hammerman to its board of directors. Mr. Hammerman, who is a former vice chairman of Merrill Lynch & Co., also has served as New York regional administrator for the Securities and Exchange Commission and an assistant United States attorney for the Southern District of New York, among other positions.... **Steven Kandarian**, former executive director of the Pension Benefit Guaranty Corp., will join MetLife Inc. in New York next month as chief investment officer.... Brokerage **Lockton Cos. Inc.** has formed a Washington office, headed by President Robert T. Connolly and Executive Vp and Chief Operating Officer Leonard J. Gemma, both formerly of Marsh Inc.

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TRIA: Extension legislation moves ahead

Continued from page 1
they expire. It would also require the Treasury Department to draft recommendations about long-term ways to deal with terrorism reinsurance.

Extension supporters hailed the introduction of the bill.

Janice Ochenkowski, vp-external affairs for the Risk & Insurance Management Society Inc., said in a statement that "both legislative chambers have now confirmed what RIMS has championed all along—the TRIA program is a necessary measure to provide effective and reasonable commercial insurance options against catastrophic terrorist attacks."

"It's indicative of the importance that's attached to this issue, especially considering how early this is in the 109th Congress," said David Winston, senior vp in the National Assn. of Mutual Insurance Cos.' Washington office. He said he hopes for "early action" on extension.

Julie Gackenbach, an assistant vp at the Property Casualty Insurers Assn. of America, called the move a "first step toward mitigating the negative effects TRIA's expiration would have on our nation's economy."

"It's a sign that Congress recognizes that, without a backstop, the economy and our markets will suffer," said Maria Berthoud, principal and vp at B&D Sagamore, a Washington lobbying firm that deals with insurance and financial services issues.

"Recognizing the public comments of Republican leadership... the introduction of a Democratic bill reflects a bipartisan desire to continue a public-private partnership dealing with terrorism risk," said Frank Nutter, president of the Reinsurance Assn. of America.

"If we can't agree on a long-term partnership and convince Congress and the business community that it serves their goals, then it seems that an extension with a mandate to agree on a long-term program is inevitable. Congress certainly has resisted the notion that TRIA could be extended indefinitely," said Mr. Nutter.

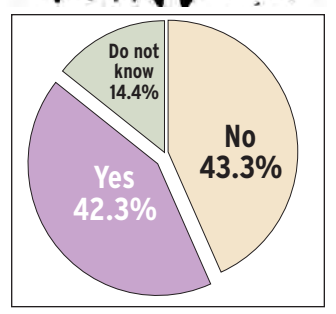
A spokesman for the American Insurance Assn.—which also praised the new bill—cited another sign of increased interest in TRIA reauthorization. He said that a group of AIA member company chief executive officers met with Treasury officials as well as lawmakers of both parties in both houses last week.

They urged their listeners to deal with the issue quickly and "were encouraged by what they heard at both Treasury and Congress," he said.

Online Poll

[3/7- 3/11]

Do you plan to change brokers in light of alleged improper practices by insurance intermediaries?



BI Stock Index

[3/7-3/11]

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

***BI* Stock Index**	
2484.35	-0.59
Dow Jones	
10774.36	-1.52
S&P 500	
1200.08	-1.80

Largest gains

Gainsco Inc.	16.43%
UNUM Corp.	2.72%
Vesta Insurance Co.	2.27%
Transatlantic Holdings	2.17%
Alleghany Corp.	1.94%

Largest losses

Argonaut Group	-7.94%
PMA Capital Corp.	-7.74%
Harleysville Group	-7.16%
Willis Group Holdings Ltd.	-5.40%
Marsh & McLennan Cos. Inc.	-4.94%

Weekly change by market segment

Brokers	-2.34%
Insurers/Reinsurers	-0.73%
Managed Care Organizations	-2.62%

Source: FinancialContent Inc. *(http://financialcontent.com)*