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Industry crisis extends to benefits

Finite risk deals facing scrutiny

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Probes transfer attention to finite risk

Investigators question legitimacy of some nontraditional products

By JOANNE WOJCIK

In the wake of investigations of insurance industry practices, regulators, rating agencies and even some industry executives have started questioning the use of finite risk products, esoteric reinsurance transactions used to help finance hard-to-place risks and protect reinsurers from endless losses.

And as probes by New York Attorney General Eliot Spitzer and others continue, some are starting to wonder whether other types of nontraditional risk financing products—such as captives, loss-portfolio transfers and some self-insurance programs—will also become suspect.

In the meantime, virtually everyone connected to the industry is bracing for the impact of this scrutiny on the insurance market overall.

It's a lack of understanding on the part of outsiders that is causing those inside the industry to question themselves, suggested Andrew Barile of Andrew Barile Consulting Corp. Inc. in Rancho Santa Fe, Calif. "We all bought loss-portfolio transfer agreements, and they were put to bed," Mr. Barile said. "But now, I guess what's happened is, Mr. Spitzer has shocked enough people, and when he actually has the proof of the bid rigging, the industry is getting confused and mixing up all kinds of negative things, and so, consequently, everybody's in an uproar looking at everything again."

Bermuda-based Platinum Underwriters Holdings Ltd. announced earlier this month it was canceling a finite risk reinsurance contract out of concern that it might be perceived as improper.

Since then, Platinum, Bermuda-based ACE Ltd. and Swiss Reinsurance Co. all have received subpoenas from the U.S. Securities and Exchange

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Benefits broker, insurers sued on charges of steering clients

By JUDY GREENWALD

SAN DIEGO—The legal assault on insurance industry companies widened last week as California Insurance Commissioner John Garamendi sued four insurers and a benefits brokerage, charging that the companies conspired in client-steering deals linked to secret override commissions.

In announcing his suit, filed Thursday in San Diego County Superior Court, Mr. Garamendi also said that he had reached a settlement with the brokerage, Universal Life Resources Inc., that requires the firm's cooperation in the ongoing investigation and bans it from engaging in illegal practices.

The suit names CIGNA Corp., MetLife Inc., Prudential Financial Inc. and UnumProvident Corp. as defendants and accuses them of violating state law by concealing "hundreds of millions of dollars" in "kickbacks," which the suit says insurers paid to ULR for steering clients to them.

New York Attorney General Eliot Spitzer

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PHOTO: AP PHOTO/GERALD HERBERT

'The more profound their claims of purity, the more heinous' the behavior hidden.

Eliot Spitzer, testifying last week at a Senate subcommittee hearing

Spitzer says antitrust probes needed

Federal oversight urged for insurance industry

By MARK A. HOFMANN

WASHINGTON—The controversy over insurance industry practices moved to Capitol Hill last week, with New York Attorney General Eliot Spitzer and others testifying in Congress on the need for greater federal and state antitrust scrutiny of insurers and brokers.

And Congress should go even further by examining whether insurers and brokers have sought to evade state regulation by moving operations offshore, Mr. Spitzer told the Senate Governmental Affairs Committee's Subcommittee on Financial Management, the Budget and International Security last week.

Mr. Spitzer, whose investigation ignited the current controversy over broker compensation and industry practices, blasted what he called "interlocking relationships" between brokers and insurers and called for a "fundamental inquiry" into the ethics of the insurance industry.

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International

LLOYD'S ORDERS INVESTIGATIONS

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Late News

UnumProvident settles claims-handling probes

UnumProvident Corp. said it expects to pay $127 million in a global settlement stemming from states' investigations of its claims-handling practices. As part of its settlement with insurance regulators, the disability insurer will pay a $15 million fine, change its claims-handling practices and reassess potentially hundreds of thousands of claims closed or denied since 1997. The settlement figure includes potential benefit adjustments related to the reassessment of claims. The settlement stems from market conduct examinations that allegedly uncovered several problems, including an inappropriate burden placed on claimants to justify benefit eligibility. UnumProvident notes that the examinations did not reveal any illegal activities.

HSA contribution limits to increase in 2005

The maximum annual contributions that can be made to health savings accounts linked to high-deductible health insurance plans will increase next year to $2,650, up from $2,600 in 2004, for single coverage and to $5,250, up from $5,150, for family coverage, the Treasury announced. In addition, the maximum out of pocket limit–which includes expenses that fall under the health insurance plan deductible and copayments–for 2005 will rise to $5,150 for single coverage from $5,000, and to $10,200 from $10,000 for family coverage.

Bid rigging, steering limited: Greenberg

Alleged misconduct related to broker compensation arrangements are likely confined to a few people working in the insurance industry, according to Maurice R. Greenberg, chairman and chief executive officer of American International Group Inc. "There's been an apparent breach of ethics

Mr. Greenberg

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Sides awaiting verdict on occurrence wording

By DOUGLAS McLEOD

NEW YORK—A federal jury last week began weighing whether nine insurers that wrote $1.13 billion of the World Trade Center's property insurance coverage are liable for one policy limit or two.

Lawyers for the insurers and WTC leaseholder Silverstein Properties Inc. wrapped up their cases Nov. 15 after four weeks of trial that saw testimony from insurance and engineering experts, insurance company underwriters and executives of Willis Group Holdings Ltd., Silverstein's broker.

Silverstein contends that the two plane crashes that led to separate collapses of the WTC towers on Sept. 11, 2001, are two occurrences under the various policy forms the nine insurers bound themselves to in the weeks before the terrorist attack.

"Beyond all question, beyond all doubt, beyond all contest, one single force did not bring down the

twin towers," Silverstein lawyer Bernard Nussbaum told jurors. "If only one plane struck one tower and that tower collapsed, the other tower would still be standing."

Insurers argue, though, that the parties intended the WTC program to have a broad, aggregating definition of "occurrence" that would combine similar losses as a single event to limit Silverstein's deductibles. They noted that 15 other WTC insurers—representing $2.42 billion, or two-thirds, of the program's $3.55 billion limit—have previously been found liable for only one policy limit under the terms of a Willis form they agreed to, known as Wilprop.

"Ask yourself as a matter of common sense…why anyone would have this program being one occurrence for two-thirds of the coverage and two occurrences for the other third," said Paul Koepff, a lawyer with O'Melveny & Myers, representing Zurich American Insurance Co.

"This was a consistent single insurance program with a consistent meaning of occurrence, and the at-

See WTC/page 21

Big client drops Marsh; MMC ousts board insiders

By DOUGLAS McLEOD

LINCOLNSHIRE, Ill.—Consumer products giant Fortune Brands Inc. is dropping broker Marsh Inc. in the wake of New York Attorney General Eliot Spitzer's fraud and antitrust lawsuit against the broker.

Fortune Brands—which reported $6.21 billion in 2003 sales of home and office products, wine and spirits and other products—will switch to Marsh competitor Willis Group Holdings Ltd. for all policies renewing Jan. 1, 2005, a Fortune Brands spokesman said. Brokerage responsibility for additional 2005 renewals after Jan. 1 is still to be decided, the spokesman said.

The company's decision was "a result of our concerns about Marsh's alleged conduct" as outlined in Mr. Spitzer's Oct. 14 lawsuit

and followed Fortune Brands' own investigation of its placements, the spokesman added.

Mr. Spitzer cited Lincolnshire, Ill.-based Fortune Brands as a victim of alleged bid rigging in his complaint against Marsh. According to the suit, Marsh directed underwriters at ACE Ltd. to raise their quote on excess liability coverage for Fortune Brands to keep it from competing with a unit of American International Group Inc.

"Original quote $990,000," an ACE assistant vp later explained in an internal e-mail cited in the complaint. "We were more competitive than AIG in price and terms. (Marsh) requested we increase premium to $1.1 million to be less competitive, so AIG does not (lose) the business," the e-mail states.

Mr. Spitzer has charged that insurers intentionally produced inflated quotes and lost business in the alleged Marsh bid rigging, knowing that they would later win other accounts from the broker.

Meanwhile, last week five members of Marsh & McLennan Cos. Inc.'s board of directors who are also officers of the company resigned from the board. The resignations leave MMC with a board consisting of 10 outside directors and Michael G. Cherkasky, the company's recently appointed president and chief executive officer, MMC

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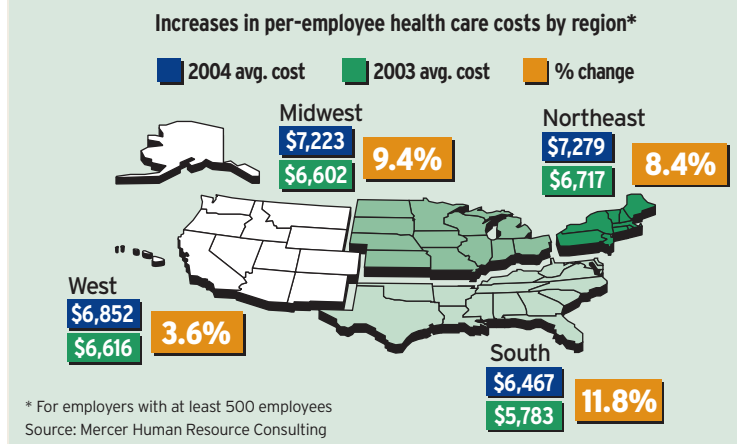
REGIONAL VARIATIONS



7.5% hike lowest in five years

Group health care cost increases fall to single digits

By RUPAL PAREKH

Group health care plan cost increases are slowing dramatically, with the rate of increase in 2004 the lowest in five years.

This year, group health costs rose by an average of 7.5%, to $6,679 per employee, according to a national survey of more than 3,000 employers released today by Mercer Human Resource Consulting in New York.

The 2004 cost increase is the lowest since 1999—when costs increased an average of 7.1%—and breaks a three-year run of double-digit cost increases. Cost increases peaked in 2002, when they climbed by an average of 14.7%, while they rose 10.1% in 2003.

Total health plan costs for large employers—those with at least 500 employees—climbed 9% this year, averaging $6,918 per employee; that's down from 2003's 10.2% increase. Group health plan costs for smaller employers increased just 5.5% this year, averaging $6,359 per employee—a significant drop from last year's 9.7% increase.

In calculating total health care costs, the Mercer survey included employer and employee contributions for medical, dental, prescription drug, vision and hearing care and mental health coverage.

The easing of cost increases, which was much greater than employers had earlier predicted, is the result of several factors coming together, said Blaine Bos, a Mercer consultant in Minneapolis who is one of the authors of the survey.

For example, smaller fully insured employers benefited from a point in the underwriting cycle that saw both nonprofit and for-profit health insurance carriers cut back premium increases compared to prior years.

Additionally, plan design changes implemented by employers, especially in the form of greater cost-shifting to employees, reduced the use of services among the employees of small

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Inside Business Insurance

Cover photo: New York Attorney General Eliot Spitzer, left, is joined by his Connecticut counterpart, Richard Blumenthal, and insurance commissioners Gregory Serio and John Garamendi.
AP Photo/Gerald Herbert

Online

- The **Datebook** department lists upcoming industry events as well as information on *Business Insurance*'s award competitions.
- Searchable **directories** provide access to all the listings of industry vendors found in *BI*'s Market Sourcebook.
- New **Opinion Poll** for readers: Which risk management issue would you like Congress to address first when it returns in January?

Departments

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Two Zurich execs plead guilty to bid rigging

By DOUGLAS McLEOD

NEW YORK—Two Zurich American Insurance Co. underwriters have pleaded guilty to criminal charges that they helped Marsh & McLennan Cos. Inc. rig bids on client insurance placements.

John Keenan and Edward Coughlin, underwriters with a New York-based excess casualty unit of Zurich, last week pleaded guilty to misdemeanor violations of the Donnelly Act, a New York state law prohibiting restraint of trade and anti-competitive practices, according to New York Attorney General Eliot Spitzer's office.

The two men admitted providing Marsh's Global Broking unit with premium quotes that were designed to lose, allowing Marsh to award the business to a "winner" it chose, Mr. Spitzer's office said. Mr. Spitzer charged in a lawsuit last month that Marsh pressured insurers to provide inflated quotes to create the appearance of competition, and that insurers went along with the alleged scheme knowing that they would win a share of Marsh's business.

In Mr. Coughlin's case, a Marsh broker sought an inflated quote and Mr. Coughlin at first refused, saying it was a waste of time, according to his lawyer, Lewis S. Wiener, with Sutherland, Asbill & Brennan in Washington. The Marsh broker then threatened that Zurich would lose future Marsh placements, and Mr. Coughlin agreed to provide the quote, Mr. Wiener said.

According to the criminal complaint against Mr. Coughlin, Marsh broker Nicole Michaels e-mailed him in February 2003 asking him to provide an inflated quote—known as a "B quote"—on a particular risk and supplying a quote already submitted by an American International Group Inc. unit. Attached to the e-mail was a string of earlier e-mails between Ms. Michaels and another Marsh broker, Edward Keane, in which Mr. Keane said that AIG's bid was $450,000, a bid from another insurer was $265,000 and that Ms. Michaels should "have Zurich come in anywhere in between," according to the complaint.

Ms. Michaels and Mr. Keane, both New York-based Marsh employees, could not be reached. Neither is charged in the complaints against the Zurich underwriters. A Marsh spokeswoman declined to comment. "Mr. Coughlin is glad to put this behind him," Mr. Wiener said of the guilty plea. "He intends to fully cooperate with the attorney general."

Mr. Keenan's lawyer, Preston Burton, with Caplin & Drysdale in Washington, declined to comment.

Mr. Spitzer has already obtained guilty pleas from two underwriting officials at an AIG subsidiary and one underwriter at Bermuda-based ACE Ltd.

Marsh, ACE and Zurich had announced the firing or suspension of several employees in the wake of Mr. Spitzer's Oct. 14 fraud and antitrust complaint against Marsh.

PBGC deficit reaches record $23.3 billion; more losses expected

Congressional action a must: Belt

By JERRY GEISEL

WASHINGTON—The financial condition of the Pension Benefit Guaranty Corp. continues to slide, with the agency last week reporting a record $23.3 billion deficit for its most recent fiscal year.

In 2004, the PBGC assumed $12.1 billion in losses from the actual or probable terminations of underfunded pension plans. That helped to more than double its 2003 deficit and to produce the largest deficit in the agency's more than 30-year history.

And more big losses appear likely. As of Sept. 30, the close of the PBGC's fiscal year, the agency said it faced a "reasonably possible" exposure of $96 billion, which represents the amount of unfunded benefits in plans sponsored by employers with a below-investment grade rating.

Some of that exposure is concentrated in the financially distressed airline industry.

For example, US Airways Group Inc. is seeking bankruptcy court permission to terminate pension plans covering machinists and flight attendants. If those plans are terminated, the PBGC would be saddled with a $2.1 billion loss. In addition, United Airlines, has said that it intends to terminate its pension plans early next year. The folding of United's plans would cost the PBGC more than $6.4 billion, which would be the agency's largest single loss by far. It isn't know whether the PBGC has recorded US Airways and United's plans as probable losses, as the agency does not publicly identify companies in the probable-loss category.

As its losses mount, the PBGC's premium income, a source of revenue it uses to help pay the pension benefits the agency guarantees, is likely to decline as more employers freeze their defined benefit plans and move to defined contribution plans. In the past year alone, such major companies as Aon Corp., NCR Corp. and Sears, Roebuck & Co. have frozen their defined benefit plans.

Amid the financial deterioration of the PBGC, Rep. John Boehner, R-Ohio, who chairs the House Education and the Workforce Committee, has pledged to produce a legislative reform package to help avert the a future PBGC default on its obligations.

Congressional action is a must, says PBGC Executive Director Bradley Belt. "It is imperative that Congress act expeditiously so that the problem doesn't spiral out of control," Mr. Belt said in a statement.

Additionally, Mr. Belt says, the administration intends to submit a comprehensive proposal that strengthens the funding rules, rationalizes premiums, enhances transparency and provides new tools to protect the insurance fund.

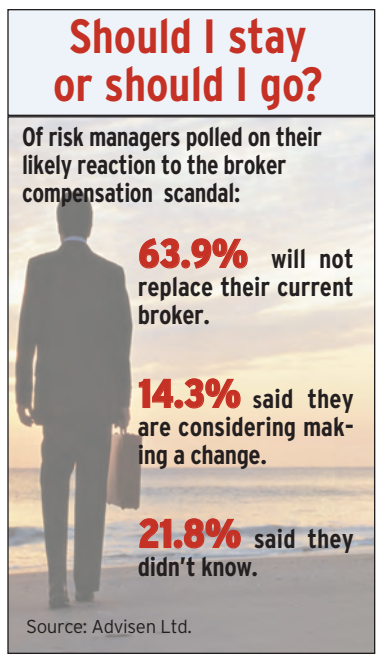
Most buyers sticking with brokers despite concerns about practices

By DOUGLAS MCLEOD

Most risk managers believe that their brokers do not fully disclose all of the compensation they earn on client accounts and are concerned that their brokers may have participated in the kind of anti-competitive practices being investigated by New York Attorney General Eliot Spitzer.

At the same time, relatively few are planning to change brokers, a survey by New York-based consultant Advisen Ltd. has found.

Of 684 respondents to an e-mail survey taken Nov. 10-12, large majorities said that they were familiar with Mr. Spitzer's Oct. 14 fraud and antitrust lawsuit against Marsh & McLennan Cos. Inc. and that they viewed contingent commissions as a conflict of interest.



Nearly 57% of respondents expressed concern that their brokers were not disclosing all sources of income to clients, Advisen found. A slightly smaller number, 52.6%, said they were worried that their brokers may have engaged in anti-competitive practices related to contingent commissions, while 40.9% expressed concerns that their brokers may have committed fraud related to the commissions, the survey found.

Most risk managers reported that they have discussed the contingent commission controversy with senior management, but only about 5% said that senior managers had asked them to put their companies' brokerage services out to bid. About 63.9% of those responding said they are not considering replacing

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Some hospitals leap backward in annual patient safety survey

By JOANNE WOJCIK

Though more hospitals are participating in the Leapfrog Group's annual survey of patient safety practices, the findings are still pretty grim.

In some cases, the "leaps" that the organization had hoped to induce have actually been steps backward, based on the findings of the 2004 Leapfrog Hospital Quality and Safety Survey released last week.

Founded in 2000 by the Business Roundtable, a Washington-based group of Fortune 500 top executives, the Leapfrog Group's stated mission is to trigger giant "leaps" forward in the safety, quality and affordability of health care by supporting informed purchasing decisions and promoting high-value health care through incentives and rewards.

The organization began assembling data in 2001 and released its first report in 2002. Using Ann Arbor, Mich.-based health care information company Medstat to assemble and analyze the data, the Leapfrog Group has released its findings every year since.

But it has been difficult, if not impossible, to make year-to-year comparisons of the survey findings because sometimes hospitals that participate one year do not the next, according to Geoff Schick, regional manager of health care at DaimlerChrysler in Kenosha, Wis., and a Leapfrog member.

"Unfortunately, because it is voluntary in nature—especially on a national scale—it would be very difficult to say for sure if there was an increase from year to year because some hospitals that reported last year may have chosen not to report this year and vice versa," Mr. Schick said.

Furthermore, the questions asked in the survey are refined each year in an effort to provide more-meaningful information to health care payers and consumers, said Suzanne Delbanco, Leapfrog's chief executive officer.

"Every year, when we field the survey, we do change the questions, and we update them to be in line with what recent research suggests," Ms. Delbanco said.

"For example, in the first year to measure evidence-based hospital referrals, Leapfrog asked how many of a list of specific procedures they performed annually. The next version of the survey also asked about volume, but it also asked about outcomes data for some of the procedures, as well as adherence to cer-

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Mercer: Group health plans' cost increases hit five-year low

Continued from page 3

and large firms, Mercer said. As their exposure to much greater out-of-pocket costs has increased, employees have become more judicious in their use of health care services, according to Mr. Bos.

Also contributing to a decrease in health care inflation was the migration of employees out of point-of-service plans and into preferred provider organizations, which tend to be less costly, especially for larger employers.

Among large companies, 55% of employees were enrolled in PPOs this year, up from 51% in 2003, while enrollment in POS plans dropped to 11% from 14%. This enrollment trend, in turn, is swaying large employers' plan offerings. In 2004, 86% offered PPOs to employees, compared to 84% last year and 75% five years ago. Simultaneously, large employers are moving away from HMOs, with 46% offering them in 2004, compared with 49% in 2003 and 51% in 2000.

The cost-shifting trend shows no sign of decelerating, as just over one-fifth of the surveyed employers said they intend next year to shift more costs for health benefits onto their employees through higher deductibles, copayments or out-of-pocket maximums.

Furthermore, many more employers are expected to embrace consumer-driven plans in the next two years. While just 4% of large employers said they offered a consumer-driven plan this year, 14% said they are likely to offer one in 2005, and 26% said they are likely to offer a consumer-driven option in 2006.

The cost-shifting trend shows no sign of decelerating, as just over one-fifth of the surveyed employers said they intend next year to shift more costs for health benefits onto their employees.

"We're going to see geometric growth, an uptick that is faster than year-over-year straight-line growth for CDHPs in the next three or four years," Mr. Bos predicted.

Such arrangements feature a high-deductible health insurance plan linked to an account—funded by employers and/or employees—that covers only a portion of the deductible. With employees more directly exposed to costs through the high deductible and being able to roll over account balances at the end of the year, the plans give employees a strong financial incentive to use services carefully, CDHP proponents say.

Investing in disease management programs for chronic illnesses is also becoming increasingly popular among larger employers—the two most common plans are for diabetes and heart disease/hypertension. That's with good reason; the programs are paying off. This year was the first in which a sizable number of respondents, 31%, said they saw a return on their investment.

Said Mr. Bos of long-term cost-management strategies, "We knew that they had a positive impact on quality of life and quality of care, but now we know that they are having a positive impact on financials as well."

When asked to predict their group health costs for 2005, employers said they expected inflation to continue to ease, estimating that cost would increase overall by 6.6% following plan and/or design changes.

"I think that's a very reasonable figure," said Mr. Bos, because the majority of companies at this point have already transacted their renewals process or selected new vendors. "But the question becomes, how long is this sustainable?"

Other findings in the survey include:

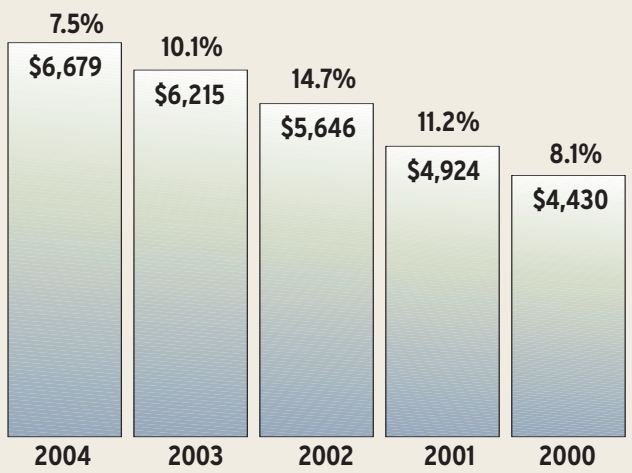
- Forty-two percent of large employers based in the Northeast and 38% of employers in the West extend same-sex domestic partner benefits to their employees. By contrast, just 14% of employers in the Midwest and 10% of employers in the South extend domestic partner benefits.
- A growing number of large employers are implementing "spousal charges." In 2004, 7% had adopted special provisions that either denied or attached surcharges to health insurance premiums for the spouses of employees who could obtain coverage elsewhere, and another 8% of large employers plan to add such provisions in 2005.
- Nearly all—97%—of respondents believe that the U.S. health care system is "in need of significant reform," though they are divided about who should lead the changes.

Forty-six percent say that the private sector—employers, consumers and the health care industry—should initiate the reforms, while 36% say the federal government should enact reforms to address problems in the system. In addition, 14% favor a federally financed system, such as Medicare, that would cover all Americans.

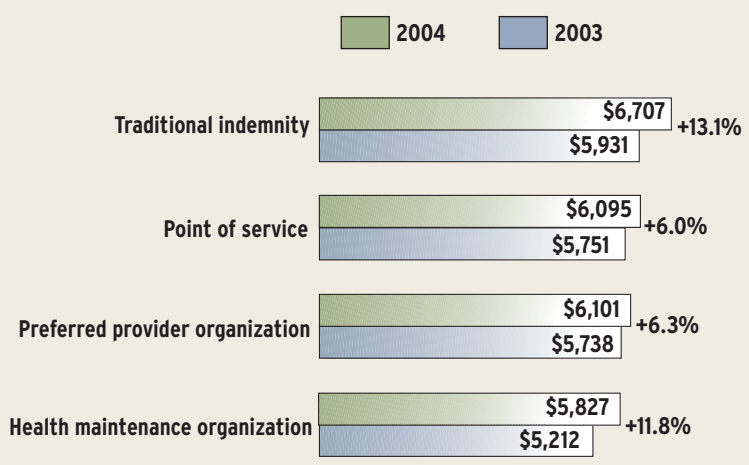
Copies of the National Survey of Employer-Sponsored Health Plans 2004 will be available in early March from Tara Lewis, Mercer Human Resource Consulting, 1166 Ave. of the Americas, 28th Floor, New York, N.Y. 10036; 212-345-2451, or from http://MercerHR.com/ushealthplansurvey. The cost is $500 per copy.

COSTS AT A GLANCE

Annual increases in average total health care costs per employee



Medical costs per employee by plan type



Source: Mercer Human Resource Consulting

Paul Winston

Spitzer takes aim at two-car target

New York—New York Attorney General Eliot Spitzer is expanding his assault on dishonest and uncompetitive practices in the insurance industry with a cease-and-desist order filed against an Illinois family who for years have marketed their garage as an offshore domicile.

The garage, which was named Winstonia, was promoted as a legitimate business location where companies, including insurers, could be free to engage in various money-making schemes free from regulatory oversight and the constraints of corporate governance requirements.

Mr. Spitzer, whose investigation is continuing, said that it appears the promoters of Winstonia defrauded prospective clients, solicited kickbacks and encouraged a climate of stupid and unethical business practices.

Paul Winston

"This garage not only was onshore and subject to U.S. laws and regulations, contrary to claims in its marketing materials, but also was small, drafty and poorly lit. Plus there were a few large spots of motor oil on the floor," Mr. Spitzer said at a press conference publicizing his investigation. "Hardly the luxurious and sophisticated business center it was promoted to be."

As for the allegation of kickbacks, Mr. Spitzer said that Winstonia schemed to charge companies exorbitant fees to be licensed in the bogus domicile and offered business advisers a cut of the income in exchange for steering their clients to it.

"Thankfully, no businesses were hoodwinked by Winstonia's false claims, but not for lack of trying," the New York attorney general said.

Asked why New York's top law enforcement officer was going after an ill-conceived business scheme in Illinois, Mr. Spitzer replied: "Somebody needs to grab the headlines. If Illinois officials are not up to the task, I'm willing and able."

Winstonia first burst on the scene in 1999 and, in chameleon-like fashion, has repeatedly changed its strategy in an effort to lure feeble-minded business owners to pay it huge sums to relocate there for no tangible advantage.

Winstonia was first marketed as an alternative to the many new captive insurance domiciles cropping up around the globe. While most captive insurers continued to bypass Winstonia in favor of more-established domiciles, like Mauritius, Winstonia did receive expressions of early interest. However, pledges by one individual to relocate Pitcairn Island captives never materialized.

A year later, Winstonia tried to capture some of the tens of millions of dollars in Nigerian government assets looking for an honest businessperson to provide a safe investment haven, as described in numerous heartbreaking faxes and e-mails.

When that effort failed, Winstonia promoted itself as an expert in diversified investment strategies. This move was spurred by the box office revenue bonds that several insurers issued on Hollywood films, with returns as disastrous as the box office receipts. If people were willing to throw their money away on insuring Barbra Streisand movies, Winstonia officials reasoned, why not try to take a cut?

In 2002, in the wake of a growing tide of business scandals and tougher scrutiny of business dealings and accounting practices, Winstonia smelled a new opportunity: A business locale that would look the other way, if it looked anywhere at all.

A brochure describing the new strategy stated: "Winstonia would offer embattled managements a refuge from the now-hostile climate in the U.S. marketplace. When even President Bush starts blasting corporations for their behavior, it's time to look for a more-receptive environment in which to practice New Capitalism."

None of these incarnations attracted any interest—let alone the hoped-for fees—from businesses, but neither did the bogus domicile's shameless promotions attract regulatory and law enforcement scrutiny—until now.

Mr. Spitzer has said he will not negotiate with the shadowy mastermind behind the Winstonia schemes. Asked if that meant the shadowy mastermind was uncooperative, he said: "No, it's because he's delusional if he thought these bizarre crackpot plans would actually work."

By the time his investigation is finished, Mr. Spitzer said, "They won't even be able to park a tricycle in this garage."

A man who described himself as a low-level functionary of the domicile answered calls to Winstonia.

"We don't think we did anything wrong, since no one took us up on our offers anyway," he said. But the spokesman added that Winstonia would halt efforts to promote itself while it explores more-legitimate business models. "Besides, we need a place to park the cars," he said.

Editorial Director Paul Winston's commentary appears fortnightly. Mr. Winston, who disclaims any resemblance to the potentate of Winstonia, can be reached at pwinston@businessinsurance.com.

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Editorial

A hearing, but who heard?

THE BROKER COMPENSATION crisis deserves serious federal scrutiny. Unfortunately, a hearing on the matter held by a Senate subcommittee last week fell well short of that goal.

In fact, the events at the Senate Committee on Governmental Affairs' Subcommittee on Financial Management, the Budget and International Security, could be better described as a sideshow rather than the main event. Summoned by its lame-duck chairman during a lame-duck session, the hearing on brokerage practices generated a lot of finger-pointing and rhetoric but added little to the understanding of the issue.

Part of the problem was the venue—the subcommittee in question has only tenuous jurisdiction over the issue, if it has any meaningful jurisdiction at all. While Chairman Peter Fitzgerald, R-Ill., obviously enjoyed presiding over the hearing—for the last time, since he chose not to seek re-election—few of his colleagues shared his enthusiasm. Only two of the subcommittee's 12 other members bothered to show up during the more than three hours of testimony, and they didn't stay long. None of the panel's Republicans appeared other than Sen. Fitzgerald, perhaps indicating the degree of seriousness with which they took the event.

And the issues raised by New York Attorney General Eliot Spitzer's allegations of widespread wrongdoing among brokers and insurers are nothing if not serious. The insurance industry is squirming under a legal microscope unlike any it has had to contend with before. Bid rigging is illegal. Self-dealing is unacceptable. The way in which some commissions are earned is questionable, to say the least.

Serious issues deserve serious questions. A one-man hearing isn't enough to cover the ground that needs to be covered. We can but hope that the committees that actually have power over insurance and expertise in same—the House Financial Services Committee and the Senate Banking, Housing and Urban Affairs Committee—waste no time after the new Congress convenes to conduct a meaningful investigation into the situation.

That's the only way for Congress to uncover what went wrong, sort out how it went wrong and determine how it should be prevented from ever happening again. A sideshow won't suffice.

Work to preserve ART

IF THERE EVER were a time for the insurance industry and risk managers to unite in defense of alternative risk transfer arrangements, it would be now.

As we report on page 1, investigations of industry commission practices have been accompanied by increased scrutiny of the ART market. Finite risk products, in particular, are drawing the attention of not just New York Attorney General Eliot Spitzer but also securities regulators.

Finite risk insurance and reinsurance products, which have become increasingly complex ways to cap liabilities and smooth balance sheets, are being criticized as loans masquerading as risk transfer.

There is nothing wrong with complex financial arrangements, per se, but things that are difficult to understand and lack transparency are easy targets for suspicion. Public skepticism of corporate intentions has grown exponentially since the fall of Enron Corp., WorldCom Inc. and other companies. And the insurance industry is now under a microscope.

Here's where it gets more troubling: Some believe the probes may eventually extend to other forms of nontraditional risk transfer, including captives.

After decades of operating experience and thousands of formations, captives have become a widely used tool for self-insurance and access to reinsurance markets. In fact, it's hard to find a major U.S. public corporation that has never used or explored using a captive. So why should risk managers worry? Ask brokers.

Until recently, most of the world's largest brokers accepted contingent compensation for placing coverage. Even as they insisted the longtime practice was not a conflict of interest, most of those brokers have stopped accepting such commissions. Under the harsh glare of the Spitzer probe, they decided they couldn't mount a strong enough defense.

Hoping that investigators will see finite risk products as legitimate isn't enough. The industry must make that case and voluntarily increase the transparency of complex transactions. If risk managers and ceding insurers don't want to see valuable ART tools taken away, they should speak up.

Schillerstrom

Letters to the Editor

Damage caps won't help reduce med mal rates

To the editor: According to Mark A. Hofmann's article "Tort Reformers Encouraged by Election Outcome," tort reform advocates say the recent elections will enhance their efforts in the next Congress. Those tort reformers who claim that placing a cap on pain and suffering in medical malpractice lawsuits will ensure lower insurance premiums for doctors should do their homework. The experience of three states where tort reform has been enacted proves that tort reform is not the answer.

Texans amended the state constitution to place a cap on medical malpractice liability awards for pain and suffering. GE Medical Protective, the nation's largest provider of medical malpractice insurance, has admitted in a filing that a $250,000 cap on damage awards for victims of malpractice will not lower physicians' premiums.

According to the filing, in which the insurer requested a 19% hike for doctors' insurance, "Non-economic damages are a small percentage of total losses paid. Capping non-economic damages will show loss savings of 1%," which contradicts a March 2004 report in which GE Medical Protective stated that capping non-economic damages is a "critical element (of reform) because in recent years we have seen non-economic damages spiraling out of control."

In 1975, California enacted the Medical Injury Compensation Reform Act, but only after insurance reform was enacted did malpractice insurance rates drop, a drop for which tort reform is erroneously given credit.

In 1986, after insurers and doctors lobbied for and Florida lawmakers enacted a cap on non-economic damages for medical malpractice claims, insurers Aetna and St. Paul increased doctors' premiums. The companies argued that, despite earlier promises, malpractice caps do not actually lead to savings for doctors.

I hope that Congress doesn't place a cap on awards for pain and suffering that will benefit no one but insurers and bad doctors and will deny medical malpractice victims a basic constitutional right.

Jane Marshall
Clarksville, Tenn.

Online Opinion Polls

Each week, Business Insurance posts a poll question about industry events on www.businessinsurance.com. Visit the BI Web site to cast your vote in the weekly online polls and to view the results of previous questions.

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Preventing adverse selection of health plans

By Rob Corrigan

As most benefits managers know, high-deductible health plans, or HDHPs, can be a boon to both employers and employees. For employers, the appeal of an HDHP is obvious. When paired with a health savings account or health reimbursement account, an HDHP permits significant cost savings for companies while making employees more conscious of their health care spending, a critical element in long-term cost management.

These plans benefit employees as well. An HSA allows an employee to receive valuable tax savings, pay less for health insurance, invest money and gradually accumulate pretax savings in an account from which he or she can withdraw tax-free funds to pay for health expenses later on. But in order for an employee to take advantage of an HSA, he or she must be enrolled in a plan with a deductible of at least $1,000 for single coverage and not be covered under any other health plan.

Unfortunately, if the HDHP is not properly designed, adverse selection will proliferate, transforming a boon into a burden. So how can benefits managers ensure that their plans are designed to neutralize adverse selection?

To answer this question, one must first identify the typical employee who is drawn to an HDHP. These employees generally earn more than $50,000 per year and have predictable health care costs. They select HDHPs over traditional plans because they can afford to fully fund the health savings accounts and cover their out-of-pocket expenses. Because many of them regard themselves as healthy, they don't anticipate incurring substantial health care expenses and are attracted to plans that offer lower premiums and richer preventive care benefits.

While healthier employees have a greater tendency to opt for HDHPs, the chronically ill are more likely to remain in lower-deductible health plans, creating the adverse selection that can destabilize employers' traditional plans and significantly increase health care costs for everyone.

It's a complex problem with a surprisingly simple solution. Instead of trying to make HDHPs more attractive to a broader group of employees, a benefits manager should create a plan design in which the employer is immune to adverse selection because its net cost is the same whether employees choose the HDHP or a traditional, lower-deductible offering. (The net cost to the employer is defined as annual network charges minus the employees' out-of-pocket costs and monthly contributions.)

This approach equalizes the contributions and out-of-pocket costs between HDHPs and traditional health plans, thereby neutralizing plan cost differentials and reducing adverse selection. Achieving it is as simple as one, two, three.

- Rule No. 1: Don't contribute more to an HSA or HRA than your low-cost members currently cost you. If an employer chooses to make a contribution to its employees' HSAs or HRAs, then that contribution must be less than or equal to the average actual paid claim per employee per month of those employees in the traditional low-deductible plan.

For example, a client wanted to add an HDHP and an HSA alongside a traditional lower-deductible health plan. The company settled on a $1,000 deductible for the HDHP. To determine the appropriate HSA subsidy, we analyzed all paid claims for employees whose total claims costs were less than $1,000 annually. We determined the average annual cost per employee for this low-cost segment was $225. The company was advised to contribute less than $225 into an HSA; otherwise, it would cost more if those people switched to the new plan.

- Rule No. 2: Set the out-of-pocket maximums so that all high-cost members pay the same. Companies must ensure that all employees with high-cost health incidents incur the same minimum network charges before they reach their out-of-pocket maximum.

For example, if an employee is enrolled in a $100 deductible plan with 75% co-insurance and a $5,000 out-of-pocket maximum, he or she would have to incur $20,100 in network charges in order to reach the out-of-pocket limit ($15,000 paid by the employer and $5,100 by the employee). When considering the addition of an HDHP with a $1,000 deductible and 80% co-insurance, the company must set the out-of-pocket limit at $5,000. This is the point at which this same employee would have also accumulated $21,000 in network charges ($16,000 paid by the employer and $5,000 by the employee). In this scenario, an employee who reaches the out-of-pocket maximum will cost the company the same regardless of the plan he or she selected.

- Rule No. 3: Set the employee contribution based on the average out-of-pocket costs for members in the middle. The idea here is simple—you want your employees' contributions to offset their out-of-pocket costs so that when they evaluate both HDHPs and traditional plans, they see that both plans cost them the same. As a result, more employees will realize the true benefits associated with HDHPs, such as pretax savings and rollover, thereby limiting adverse selection.

These three steps are a fail-safe way for companies to realize the promise of HDHPs and facilitate the inevitable—and critically important—move toward consumer-driven health care. Our experience demonstrates that out-of-pocket costs can be the same for all employees in any plan, except for low-cost employees who may do better by enrolling in the HDHP option.

Rob Corrigan is director-product management for First Health Group Corp., an employee benefits provider in Downers Grove, Ill.

Written agreements help all work together

By Barbara A. Devine

Sam Walton, founder of Wal-Mart Stores Inc., summed up the success of his business by saying, "We're all working together; that's the secret."

This is a powerful yet deceptively simple statement. What does working together really mean in the insurance and risk management industry? It's much more than two parties in a service relationship simply executing processes. That's just working. Working together requires a different kind of relationship, a true partnership.

In this type of relationship, both parties are committed to not only individual but also mutual success. There is a dedication to continually evaluating the quality of the partnership and identifying ways to improve it. Through this process, the team works together to drive increasingly higher levels of effectiveness and productivity. That's the secret of success.

How can you begin working together with your service providers? It starts with creating a service agreement that clearly describes the services to be provided as well as all forms of compensation related to the agreement. Though market service agreements will likely not exist in the future—at least in their current form—it is critical that your service provider offers full disclosure of all its sources of compensation. Without a foundation of trust, there is little upon which to build a meaningful relationship.

Once the service agreement has been formalized, a separate performance expectations document should be developed. This is as important as the service agreement, perhaps even more so. It is made up not of the kinds of expectations typically covered in service agreements—the top-level mechanics surrounding payment terms, confidentiality and the like—but of the nuances of relationships that ultimately drive success, such as communication and reliability. There isn't a right or wrong way to approach this process, but there are tools available that offer suggestions and guidance.

The Risk & Insurance Management Society Inc. provides tools specifically designed for use by the insurance and risk management industry: Guidelines for Performance Expectations, the Broker and Risk Manager Partnership Tool and the Underwriter and Risk Manager Partnership Tool. RIMS developed the tools as part of its Quality Improvement Process for the Risk Management and Commercial Insurance Industry, and they may be found at *www.rims.org*. The site contains a summary document describing the three components of the Quality Improvement Process, which are guidelines for performance expectations, learning resources and performance measurement.

The guidelines suggest potential categories and wording for both the performance elements and the associated metrics against which performance will be measured. These can serve as a springboard for other ideas outside of the guidelines. Each service relationship is unique; each demands an individualized approach. The key is to ensure that the performance expectations document captures all of the critical performance elements and that appropriate metrics have been identified for each. Given the current environment, one element that should be considered is a requirement that the service provider issue an annual accounting of all compensation received as a result of the partnership.

The next step is to determine collaboratively the frequency with which performance will be measured. Again, each relationship is unique, so there isn't a predefined interval that is right for all partnerships. The frequency will depend on the type of service being provided, the business cycles of both parties and the like. Enough time, though, must be allowed to pass between measurements so that the impact of future improvement initiatives can be accurately assessed.

Finally, while the actions in the previous steps form the foundation for the partnership and offer many benefits—increased communication, improved understanding and the development of a shared vision among them—the full value of establishing performance expectations is realized only when performance is measured against them.

Assigning a sliding point scale to each metric is ideal, rather than using a yes/no evaluation method. The value of a point scale is threefold:

- Performance against the metrics can be quantitatively measured, whether individually, by category or in the aggregate.
- Performance-based compensation (to or from the broker, depending on scores) can then be linked to the aggregate score.
- Scores can be tracked and trends examined over time. The use of performance-based compensation is extremely beneficial because it adds a measure of importance to the expectations and provides a tangible incentive for optimal performance and a tangible deterrent for lower-than-expected performance.

The assignment of a sliding point scale makes it possible to track scores over time. This is vital to the success of the partnership, because it provides a means of continual improvement. Statistical analysis can be applied to the data, and categories with lower-trending scores can be identified. The partners can then collaboratively develop quality improvement initiatives to target those areas of weakness. The success of such initiatives will be apparent over time, and with each cycle of measurement/quality improvement, performance can be driven to increasingly higher levels.

In a time of government investigations centered on the need for full disclosure, risk managers and service providers alike can benefit tremendously from having service agreements and performance expectations documents that clearly evidence relationships built and sustained by honest, ethical partnerships. And, in a time when we're all looking for ways to demonstrate value to upper management, what better way could there be than to provide the tangible evidence of continual quality improvement that results from implementing performance expectations with service partners?

Barbara A. Devine is manager-risk management and contract administration for TAP Pharmaceutical Products Inc. in Lake Forest, Ill.

DIC clause helps strengthen D&O coverage

By A. Quentin "Skip" Orza II

Perspectives

Without a doubt, having a good directors and officers liability program in place is a critical task for risk managers. Especially with publicly traded companies, risk managers must ensure that their directors and officers are sufficiently indemnified should they be named in a lawsuit. On top of addressing obvious fiscal concerns, companies want the very best individuals to serve as directors and officers. Having a thorough and comprehensive D&O program may be the ultimate factor in attracting a prestigious individual to serve on a company's board.

In today's business climate, directors and officers can easily find themselves without D&O coverage. When insurers first began writing D&O coverage, it was generally for the benefit of the individual directors and officers. As D&O evolved, extending coverage to the corporate entity became the norm. This tactic often left the individual directors and officers exposed, as huge settlements naming the entity consumed all of the policy's limits.

Additionally, over the last few years, we have witnessed an epidemic of corporate and financial fraud cases. The cases of Enron Corp., WorldCom Inc. and Tyco International Ltd., among others, have lead to significant D&O litigation, not only casting a disparaging light on corporate executives and board members everywhere but directly leading to the increased scrutiny of America's boardrooms, manifested in the creation of the Sarbanes-Oxley Act. In the end, these cases often leave the assets of the individual directors and officers exposed, as policy limits are consumed by litigation.

In addition, risk managers may inadvertently overlook an exclusion or policy coverage term. Woe to the risk manager who has placed D&O coverage only to find that a claim has been denied due to an exclusion in the policy. The result is a "perfect storm" of conditions barely navigable by even the most savvy risk managers. However, risk managers should consider a new alternative when placing their company's D&O coverage—a Clause 1/difference in conditions liability policy. This coverage may be perfect for the risk manager desiring the most comprehensive D&O program at the most reasonable price.

One key benefit of the Clause 1/DIC policy is a liability limit that exists solely for the benefit of the individual directors and officers. A claim involving the entity cannot erode the limit.

Another key provision of the Clause 1/DIC policy requires the policy to respond in cases in which the corporate entity cannot or will not indemnify. Does state law prevent the corporation from indemnifying? The policy would be there to respond. What if the corporate entity finds itself in financial dire straits? Or what if the corporation simply refuses to indemnify due to an acquisition, merger or some other type of change in control? The Clause 1/DIC policy exists to indemnify the directors and officers when there may be no corporate assets to do so.

Finally, what if the risk manager overlooks something in the standard D&O contract? As an excess policy, the Clause 1/DIC policy drops down and fills gaps—hence the DIC provision—should the D&O carriers deny coverage for any reason. Also, the Clause 1/DIC policy will often provide coverage should one of the primary D&O carriers become insolvent.

Indeed, the Clause 1/DIC policy is an option that risk managers should not ignore. Often, Clause 1/DIC policies cost less than traditional full-entity D&O because no entity securities coverage is included. Add to all of this some new features coming into the marketplace such as provisions covering fines levied under Section 308 of the Sarbanes-Oxley Act and the ability to write the coverage as primary or excess.

The result is a new product based on an old idea, one that may help round out any D&O placement. Quite a few insurers, both domestic and Bermuda-based, now are offering Clause 1/DIC policies. The premiums and coverage features vary, but a good insurance broker can help navigate the maze of price and forms. The Clause 1/DIC form does have its drawbacks: it may have onerous exclusions; it provides no coverage for the entity; and, in a highly competitive market for good D&O accounts, its coverage rates may be such that a policy for all three insuring clauses costs roughly the same as the preceding underlying layers. Regardless, the Clause 1/DIC form is an alternative worth considering.

A. Quentin "Skip" Orza II is vp of RLI Insurance Co.'s executive products group in Summit, N.J.

Commentary

When appearance really matters

Even if you buy into only a fraction of the accusations that New York Attorney General Eliot Spitzer has leveled against the insurance industry, his investigation and some of the reaction to it underscore problems beyond the alleged contingency commission hijinks that Mr. Spitzer intends to crush.

The reaction by some suggests that the concept of avoiding the appearance of impropriety is held in as high a regard as making an underwriting profit was during the bull market of the 1990s.

Throughout his 31-page lawsuit against Marsh & McLennan Cos. Inc. and its Marsh Inc. retail brokerage unit, Mr. Spitzer charges that the defendants illegally maximized profits by fashioning a business model in which they steered clients only to insurers that paid the defendants contingency commissions. The steering process involved rigging bids so clients would select the insurers that the defendants wanted to win the business, Mr. Spitzer charges.

Dave Lenckus

The lawsuit—which rests heavily on information gathered from e-mails sent by individuals that participated in the alleged scheme—and recent guilty pleas in the case do not suggest that any broker or underwriter stumbled into these arrangements unaware of the antitrust and fiduciary laws that Mr. Spitzer says were trampled along the way.

Yet, privately, some brokerage and insurer executives say they suspect that is exactly what happened. As a result, they say, Mr. Spitzer's investigation unfairly will create bad fallout for some good people.

How could such inadvertent illegal business practices occur?

The explanation: Consider a broker and an underwriter caught up in a hard market that generates an overwhelming workload for each. The broker needs one more bid to finish marketing an account for which he already has hammered out a sweet deal. The broker calls an underwriter for that last quote. The equally swamped underwriter, who is turning away some buyers, dashes off a high quote for an account he has no interest in snaring.

While that scenario seems plausible and does not quite sink to the level of deceit and fraud that Mr. Spitzer outlines in his lawsuit, it still does not pass the "appearance of impropriety" test.

A more troubling thought, though, is the suggestion that there are understandable circumstances in which a buyer's best interests may be supplanted for the sake of getting the deal done. Entertaining such a notion can lead only to more legal problems like the ones the industry faces.

Another discouraging reaction by some in the industry demonstrates that they either do not understand or just flatly reject the underpinnings of the "appearance of impropriety" test. The test applies to legal activities that could raise some legal or ethical concerns among reasonable observers.

Several of the world's largest brokers now have abandoned contingent commissions, a legal source of income absent bid rigging and client steering. Yet many other brokerages are hanging onto this maligned source of income.

Contingent commissions that a brokerage—as opposed to an agency—receives based on the volume of business directed to a particular insurer have no place in the industry. Nothing in that kind of arrangement even hints that the brokerage has its clients' best interests in mind.

Profit-based commissions seem much more reasonable and even could be beneficial for buyers that retain brokers that provide sharp loss-control services. But considering the allegations in Mr. Spitzer's lawsuit, could or should buyers feel 100% confident about how their accounts were marketed by a brokerage with even a transparent profit-based contingency commission arrangement with an insurer?

Certainly, some insurance buyers may feel comfortable with such an arrangement, but that does not make it any less potentially dicey.

Mr. Spitzer's investigation—and, particularly, his lawsuit—also should serve as a wake-up call to all of Corporate America about e-mail content.

For years, legal experts have warned risk managers to educate everyone within their organizations never to write anything in an e-mail that they would be uncomfortable sharing publicly. E-mails are discoverable during legal proceedings, and deleted e-mails generally are recoverable, the experts have stressed.

Yet, an industry built on managing risk was tripped up in large part by e-mail after e-mail that fueled Mr. Spitzer's investigation.

I'm not suggesting either that risk managers provide guidance on how to hide illegal activities or that Mr. Spitzer has proved his case. But Mr. Spitzer's lawsuit does show that e-mails also should pass the "appearance of impropriety" test.

Dave Lenckus can be reached at dlenckus@businessinsurance.com.

Comings & Goings

Mr. Silverstein

Mr. Davis

Mr. Darr

Mr. Ernoult

Mr. Blyfield

Brokers:

Atlanta-based Beecher Carlson Holdings Inc. has made several senior-level appointments:

Eric Silverstein has been named managing director, casualty marketing. Previously, Mr. Silverstein was regional managing director for Aon Corp.'s marketing operations in the Southeast.

B. Scott Davis has been named managing director in the Nashville, Tenn., office. Before joining Beecher Carlson, Mr. Davis was a senior vp and team leader for Willis Group Holdings Inc.

Bradley Darr has been named senior vp in the Nashville office. Previously, Mr. Darr was senior vp at Lockton Insurance Cos.

London-based Heath Lambert Group Ltd. has named **Tom Ernoult** managing director of its regional network in the United Kingdom. Previously, Mr. Ernoult was managing director and chief operating officer of the corporate client practice and middle-market business at Marsh UK.

Tony Blyfield has been named chairman of the combined professions and corporate risk solutions divisions of London-based Alexander Forbes Risk Services Ltd. Previously, Mr. Blyfield was managing director of Alexander Forbes Professions.

London-based Glencairn Ltd. has appointed **Kevin Hogan** chief operating officer. Before joining Glencairn, Mr. Hogan was an executive director at Aon Corp.

Acordia Inc. has named **Gary J. Tully** managing director for Acordia of New Jersey in Morristown. Previously, Mr. Tully was president of Kemper Financial Insurance Solutions.

Reinsurance:

Guy Carpenter & Co. Inc. has named **George Carrington** senior vp in the company's U.K. casualty specialty practice in London. Before joining Guy Carpenter, Mr. Carrington was an active underwriter at SVB Syndicates Ltd. at Lloyd's of London.

Benfield Inc. has named **Paul Surdel** team leader of its U.S. casualty facultative solutions group in Westport, Conn. Previously, Mr. Surdel was a managing director at Guy Carpenter.

New York-based Willis Re has named **James Kent** executive vp. Before joining Willis, Mr. Kent was vp in Aon's Bermuda office.

Insurers:

Damien Dawson has been named underwriting director of Amlin Credit, a specialty trade credit insurer of Amlin P.L.C. Before joining the London-based company, Mr. Dawson was assistant director, strategic accounts, for Marsh Ltd.

Other providers:

Michael P. Shine has been named president of Premier Healthcare Exchange. Before joining the Summit, N.J.-based claims management company, Mr. Shine was senior vp at Performax.

Arun Chanana has joined NIF Risk Management in Murray Hill, N.J., as senior vp of Professional Liability Risk Solutions. Previously, Mr. Chanana was a vp at American Re-Insurance Co.

Business Insurance would like to report on senior-level changes at commercial insurance companies and service providers.

Please send news of recently promoted, hired or appointed senior-level executives to: Joe Walker, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; jwalker@crain.com.

Photos should be sent to: Kathy Barnes, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; kbarnes@crain.com.

Lloyd's calls for all managing agents to probe for anti-competitive practices

London responds to industry charges

By PETA MILLER

LONDON—Lloyd's of London has instructed all businesses at Lloyd's to conduct internal reviews to investigate whether there is any evidence of bid rigging or price fixing in the wake of New York Attorney General Eliot Spitzer's probe into insurance industry practices.

Last week, Lloyd's announced that it expected all 45 managing agents at Lloyd's to ensure that they and their staff have not engaged in anti-competitive practices.

Lloyd's is calling for the probe as the active supervisor of the market; it is not a regulatory action stemming from instructions of the Financial Services Authority, a Lloyd's spokesman stressed.

One brokerage practice that is being investigated by Mr. Spitzer is common in the London market, according to a legal expert.

Reinsurance tie-ins, or packaging, are a common and legal practice in the London market, said Kenneth Underhill, a partner at the London-based law firm of Reynolds Porter Chamberlain at a seminar the firm sponsored last week.

Mr. Underhill, who worked at a London market brokerage in the 1990s, said London market brokers commonly place insurance coverage with insurers on the con-

See LONDON/next page

PHOTO: COURTESY OF LLOYD'S OF LONDON

Lloyd's of London said last week that it expects all its managing agents to conduct internal reviews for evidence of bid rigging or price fixing.

PHOTO: AFP

Firefighters sprayed water on the Chilean tanker Vicuña following two explosions in Paranagua, Brazil, on Nov. 15.

PHOTO: REUTERS

South Korean freighter Marine Osaka slammed into a breakwater off Otaru, Japan, during stormy weather on Nov. 13.

Marine losses mount with sinking of two ships

By PETA MILLER

Two deadly shipping losses over the past week will likely cause more than $20 million in insured losses.

Last Monday, Vicuña, a Chile-registered 11,636 gross tons tanker, exploded while unloading 3.7 million gallons of methanol in Paranagua, Brazil. Two explosions blew the vessel apart and killed two crew members.

Two other crew members were still missing and the vessel, in three pieces, was resting on the bottom of the port late last week. The cause of the explosions has not yet been determined.

The tanker, which is owned by Sociedad Naviera Ultragas Ltda. in Santiago, Chile, is valued at $14.5 million on a hull and machinery policy led by Gard Marine & Energy A.S. in Bergen, Norway.

Third-party liability coverage is provided by the London-based Britannia Steamship Insurance Assn. Ltd.

On Nov. 13, the South Korea-registered 5,500 gross tons freighter Marine Osaka slammed into a breakwater in stormy weather off Otaru, Japan, and sank, killing seven crew members. The freighter, whose ownership has not yet been publicized, was unladen and anchored at the time of the accident.

The hull is valued at up to $5 million and is likely covered in the South Korea insurance market, sources say.

The third-party liability coverage is provided by the Japan Ship Owners' Mutual Protection & Indemnity Assn. in Tokyo.

Negatives seen in pension plan shifting

Panel cites 'massive transfer' of risk to employees, recruitment troubles

By SARAH VEYSEY

LONDON—As more U.K. more employers consider closing their defined benefit pension plans to new members, they must explore both the advantages and perils of such moves, according to panelists at a pensions conference.

Recent years have seen a big shift from defined benefit plans—often known as final-salary plans in the United Kingdom—to defined contribution plans, said Colin Singer, a senior partner at Watson Wyatt Worldwide in London.

Mr. Singer cited a National Assn. of Pension Funds survey that found that 10% of private-sector defined benefit plan sponsors closed their plans to new entrants during 2004, while 26% of employers questioned in a similar study in 2003 had closed their defined benefit plans to new entrants (see story, page 20).

He also said that recent studies by Watson Wyatt showed that about 40% of open private-sector pension plans are defined benefit arrangements, while 50% are defined contribution and the remaining 10% are so-called pension hybrids.

And the shift to defined contribution is bringing with it a "massive transfer" of the investment risk from the employer to the individual, Mr. Singer said last week at the NAPF's conference in London.

Although the desire to shed such risk—and the associated costs—has been a major factor in companies' decisions to close defined benefit plans, there are downsides to such moves, Mr. Singer said.

For example, companies offering only defined contribution plans to new employees may have trouble recruiting middle-aged workers currently in defined benefit plans. In addition, even some younger workers may be concerned that a defined contribution plan might not provide adequate income at retirement, he said.

There are other options for employers that want to reduce their risk or costs while continuing to offer defined benefit plans, he said. For example, plan sponsors could invest fund assets in less-risky instruments, such as bonds, rather than largely in equities, he said.

Pension plans that provide members with a career-average payment on retirement are another alternative, among others, he said. Under such a plan, the retiree receives a pension payout based on his or her average—rather than final—salary. Such a plan can reduce an employer's pension liability while still guaranteeing employees a generous pension on retirement, Mr. Singer said.

Another panelist discussed his

See NAPF/page 20

World Updates

Euclidian shuts syndicate after funding delay

Euclidian Underwriting Ltd. is running off multiline Lloyd's of London syndicate 1243. The syndicate had 2004 capacity of £251.7 million ($449.0 million). Euclidian is owned by Capital Insurance Holdings P.L.C., which formed earlier this year and hoped to consolidate other small Lloyd's companies into a single publicly traded entity. CIH planned to raise £125 million ($232.5 million) from institutional investors to help capitalize Euclidian's syndicate. The previous capital provider, Berkshire Hathaway Inc., had pledged to take a 25% stake when CIH listed. Those plans were postponed due to lack of support from U.K. investors (*BI*, Aug. 2; July 19).

U.K. to investigate pension complaints

The United Kingdom's parliamentary ombudsman will investigate complaints that the government did not sufficiently warn occupational pension plan members of the risk of employer insolvency. Ombudsman Ann Abraham, who will investigate the Department for Work and Pensions, the Occupational Pensions Regulatory Authority, the National Insurance Contributions Office and the Treasury, said she had received about 100 complaints from plan members, trustees and former employees of insolvent companies that terminated their pension plans.

Despite hurricanes, ZFS profits rise 35%

Zurich Financial Services Group's net income rose 35%, to $1.90 billion, for the first nine months of 2004, despite a $400 million loss from recent hurricanes. A spokeswoman for Switzerland-based ZFS said the improvement stemmed in part from better expense and claims management and more selective underwriting. ZFS's gross written premiums for the nine-month period grew 3%, to $37.58 billion. ZFS said it restated 2003 figures to comply with International Financial Reporting Standards.

Tokio Marine retooling London operations

Tokio Marine & Nichido Fire Insurance Co. Ltd. will restructure its London-based operation to write international risks. The London unit, European Nichido Insurance Co. Ltd., is capitalized with £20 million ($37.1 million) and writes mainly Japanese property risks. Under plans announced last Thursday, the entity will be renamed Tokio Marine Global Ltd. and will have £125 million ($232.1 million) in capital to write direct and facultative reinsurance for large-scale property and engineering risks in 2005.

London: Lloyd's calls for internal review by all agents

Continued from previous page

dition that they are also contracted to place the reinsurance coverage for the insurer.

The practice is not illegal, but it does raise questions as to whether brokers involved in such deals are acting in the best interests of their clients, he said.

The problem with packaging is that the broker ends up in a dual role, with duties both to its client and to the insurer, Mr. Underhill said.

"We recommend that commissions be disclosed to the assured," he said.

The action by Lloyd's was one of several responses in London last week to the contingent commission scandal that has engulfed the industry over the past month.

While Mr. Spitzer's lawsuit against Marsh Inc. charging that the broker engaged in bid rigging and fraudulent use of contingent commissions arrangements has focused on activities in the United States, the allegations have also caused concern in London, which also is a broker-dominated market.

Earlier this month, the London-based Assn. of Insurance & Risk Managers released findings from a recent poll that revealed that two-thirds of U.K. risk managers surveyed believe that the use of contingent commissions "always creates a conflict of interest" for brokers.

In addition, while 99% of respondents said they consider full disclosure of broker compensation important, only 54% said they are satisfied with the amount of disclosure they receive, the survey noted.

According to a poll released earlier this month by AIRMIC, two-thirds of U.K. risk managers believe the use of contingent commissions 'always creates a conflict of interest' for brokers.

Last week, the British Insurance Brokers' Assn. lashed out at criticism of U.K. brokers, saying that it is unfairly damaging the U.K. market.

There exists no evidence to support fears that brokers in the United Kingdom have participated in the alleged fraudulent activities outlined in Mr. Spitzer's suit against Marsh, BIBA said in a statement.

The London-based brokerage organization said it was disappointed that AIRMIC members had made calls to investigate the practice of contingent commissions, the statement added.

"AIRMIC members are senior players within the insurance sector and are fully aware of market practice," BIBA Chief Executive Eric Galbraith said.

"Almost all of them operate on a fee basis, and it is inconceivable that they do not fully understand their relationship with brokers," Mr. Galbraith added.

In response, AIRMIC said it will be meeting with BIBA later this month to talk about working together toward a transparent market.

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LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

IN RE PETITION OF
GARETH HOWARD HUGHES AND PAUL CLARKE,
AS JOINT PROVISIONAL LIQUIDATORS OF
OCEAN MARINE MUTUAL INSURANCE ASSOCIATION LIMITED,
CASE NO. 99-B-42545 (BRL)

NOTICE IS HEREBY GIVEN THAT ON NOVEMBER 10, 2004, THE BANKRUPTCY COURT ENTERED AN ORDER (THE "ORDER") CONTINUING THE PRELIMINARY INJUNCTION ORDER PURSUANT TO 11 U.S.C. § 304 ORIGINALLY ENTERED IN THIS CASE ON MAY 5, 1999. THE ORDER SHALL REMAIN IN EFFECT PENDING A HEARING TO CONSIDER WHETHER IT SHALL BE CONTINUED, WHICH HEARING IS SCHEDULED TO BE HELD ON MAY 18, 2005 AT 10:00 A.M. (THE "RETURN DATE") BEFORE THE HONORABLE BURTON R. LIFLAND, IN ROOM 623 OF THE ALEXANDER HAMILTON CUSTOM HOUSE, ONE BOWLING GREEN, NEW YORK, NEW YORK. ALL PAPERS SUBMITTED FOR THE PURPOSE OF OPPOSING CONTINUATION OF THE ORDER AFTER THE RETURN DATE SHALL BE FILED WITH THE COURT, WITH A COPY TO THE CHAMBERS OF THE HONORABLE BURTON R. LIFLAND AND SERVED ON COUNSEL FOR THE PETITIONERS LISTED BELOW, SO AS TO BE RECEIVED AT LEAST FOURTEEN (14) DAYS PRIOR TO THE RETURN DATE. ANY PERSON WISHING TO OBTAIN A COPY OF THE ORDER SHOULD CONTACT COUNSEL TO THE PETITIONERS.

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REQUEST FOR PROPOSALS

LEGAL NOTICE
CITY OF NAPERVILLE
REQUEST FOR PROPOSALS
RFP 05-095
Workers' Compensation Excess Insurance Coverage

The City of Naperville, Illinois is requesting proposals for conventional excess workers' compensation insurance coverage for the upcoming year, beginning March 1, 2005.

Requests for market assignments are to be received no later than December 15th, and will be on a first-received, first-granted basis. Proposals must be received at the City of Naperville, Purchasing Division, 400 South Eagle Street, Naperville, Illinois 60540 by **3:00 p.m., local time, on January 14, 2005.**

Those desiring to submit proposals may obtain copies of the specifications between the hours of 8:00 A.M. and 5:00 P.M., Monday through Friday, in the Purchasing Division, at the above address, or download the document via the City's website: **www.naperville.il.us.**

The City reserves the right to reject any or all proposals.

REQUEST FOR PROPOSALS

Auditor For Captive Insurer

The City of New York ("the City") has formed a captive insurance company ("the Captive") that will cover certain liabilities of the City and its private contractors and subcontractors arising from their post – September 11, 2001 debris removal activities at the World Trade Center site. The Captive is to be licensed in the State of New York, and capitalized through a grant from the Federal Government of slightly less than $ 1 billion. In connection with this effort, the Captive is seeking proposals for an Auditor from qualified professional firms. However, since the Captive will be an independent entity it alone (not the City) will select the Auditor. In addition to other prerequisite qualifications for consideration, each candidate must affirm that it, both corporate and individual, presently satisfies all licensing and certification requirements necessary to conduct business in the State of New York with regard to the scope of services required, and have experience with at least four other captive insurance companies. This experience must include currently serving as auditor to a minimum of two (2) US domiciled single parent or group captive insurers with assets over $50,000,000. Potentially qualified applicants may request an RFP by emailing **William.J.Kelly@us.pwc.com.** The deadline for completed proposals (unless extended or changed pursuant to the RFP) is December 3, 2004.

NAPF: Risks in shift to defined benefits

Continued from page 17

company's experience in shifting to a defined contribution approach.

Mervyn Walker, director of U.K. airports for London-based British Airways P.L.C. and a trustee of the company's two defined benefit pension plans, said that rising funding deficits—and, thus, contributions—had prompted the airline to close its plans to new entrants and replace them with a defined contribution plan.

British Airways' staff is highly unionized, and union representatives feel that addressing pension funding difficulties is 'the company's problem.'

Mervyn Walker
British Airways P.L.C.

As a result of the funding deficits, the airline has had to greatly increase its contributions to the defined benefit plans, Mr. Walker noted.

Competitive pressure also played a role. Many of the company's rivals in the U.K. airline industry had already made the switch from defined benefit to defined contribution pensions, while some of its U.S. competitors had filed for bankruptcy in part because of pension funding holes, he explained.

In addition to putting new employees into a defined contribution plan, BA is considering making changes to the accrual and contribution rates applicable to its defined benefit plans, Mr. Walker said. To this end, the company has been involved in discussions with employees, he said, acknowledging that these discussions have been "very, very hard."

BA's staff is highly unionized, Mr. Walker explained, and union representatives feel that addressing pension funding difficulties is "the company's problem."

But Mr. Walker said that the company is making efforts to improve communication with its staff and is hopeful it will be able to persuade employees to share some of the pension burden the airline faces.

Michaela Berry, a partner at the London-based law firm of Sackers & Partners, also took part in the panel discussion, which was chaired by Terry Faulkner, chairman of the NAPF and group pensions and benefits manager of London-based Rexam P.L.C.

Employers foresee funding problems for DB pensions

Although the rate of closure of defined benefit pension plans to new members in the United Kingdom slowed in 2004, most employers operating such plans foresee funding difficulties, according to a recent survey.

A National Assn. of Pension Funds survey of 412 of its members found that 10% of private sector defined benefit pension plans were closed to new entrants during 2004, down from 26% in a similar survey in 2003.

Of those respondents that closed their pension plans to new entrants during 2004, 90% said that "containment of liability/risk to employer" was a principal reason for closure, compared with 40% of those who closed plans in 2003. In addition, 57% of respondents in 2004 cited the size of the plan deficit or falling fund value as a main reason for the decision, compared with only 9% in 2003.

Of those companies still operating a defined benefit plan, 79%—or 131 employers—said they expect funding difficulties with at least one of their plans. Of those, 13% predicted difficulties would be severe, while 57% said they would be moderate and 28% expect slight difficulties.

In addition, most of the employers that expect funding difficulties said they are taking or exploring steps to address those concerns.

Nearly three-quarters—71%—said they had increased or are increasing their contributions to their plans, while 19% said they are considering doing so. In addition, 41% said they are increasing employee contributions, and 27% said they may do so.

More than half said they would close the defined benefit plan to new members, while 10% may do so. And 41% said they were opening a defined contribution plan, while 9% are exploring that option.

In addition, 21% percent of respondents said they are reducing future benefit accruals, and 26% said they were considering doing so.

—By Sarah Veysey

Leapfrog: A step backwards

Continued from page 4

tain protocols," she said.

"So to compare how hospitals performed just on volume vs. how they compared based on three different criteria is a little bit of apples to oranges," Ms. Delbanco concluded.

Regardless of whether the findings gauge whether hospital quality is improving, both Mr. Schick and Ms. Delbanco insist the survey still serves a useful purpose in arming patients with information on how well their area hospitals are performing today, enabling them to make better health care purchasing decisions.

"We think that awareness is being raised within the provider organizations that employers and purchasers are looking for these answers (and) want to see how they're progressing," Mr. Schick said.

As far as achieving the goal of improving patient safety, though, "we haven't exactly seen a huge upswing in hospitals that are satisfying the requirements," he acknowledged.

But there are some signs of improvement, said Ms. Delbanco.

"When Leapfrog got started, in our first year of doing the survey in 2001, we were finding about 2% to 3% of hospitals in the regions who were reporting having fully implemented computerized physician order entry. Now it's about 6%, which is obviously…an increase, but a paltry one at that," she acknowledged. "I think we can conclude that things are going in the right direction."

The 6% figure Ms. Delbanco cited, though, refers only to the hospitals initially targeted by Leapfrog for study. When all of the hospitals that participated—both those that were asked and those that volunteered—are counted, just 4.4% meet the CPOE standard.

While some hospitals may be implementing safety measures to reduce medical errors, many still have a long way to go, the survey shows.

For example, seven in 10 hospitals do not yet have explicit protocols to ensure adequate nursing staff or policies to check with patients to make sure they understand the risks of the procedures they are undergoing, according to the survey.

In addition, only 3% of the hospitals surveyed met the volume and outcomes standard for abdominal aortic aneurysm repair, down from 16.2% in 2003. In 2002, 21% of the hospitals participating in the survey met this standard. Ms. Delbanco could offer no explanation for such a significant reduction. "We probably will analyze the findings at some point," she said, "but the first thing we try to do is to gather the information and make it available."

'We think that awareness is being raised within the provider organizations that employers and purchasers are looking for these answers (and) want to see how they're progressing.'

Geoff Schick
DaimlerChrysler Corp.

There has also been a reduction in the percentage of hospitals with neonatal intensive care units that met Leapfrog's specification for certain high-risk pregnancies, down to 31.6% this year from 36.9% in 2003. In 2002, 23% met the standard.

Leapfrog collects data on how well hospitals are implementing the four safety improvements that the organization says would have the greatest impact on improving patient safety. Three of those are computerized physician order entry, intensive care unit staffing with intensive care specialists and evidence-based hospital referral. For the fourth, this year Leapfrog surveyed for measures that cover all 30 of the safety practices endorsed by the National Quality Forum—up from 27 in previous years.

Among the practices endorsed by the NQF, a Washington-based public/private nonprofit group, are procedures for preventing malnutrition in patients, which six in 10 hospitals reported lacking; procedures to prevent bed sores, which five in 10 said they do not have; and policies requiring workers to wash their hands with disinfectant before and after seeing patients, which four in 10 hospitals lack, the survey found.

Health care experts estimate that more than 65,000 lives would be saved each year and more than 907,000 serious medication errors would be prevented if all nonrural hospitals in the United States implemented just the first three Leapfrog safety improvements.

"That's part of what Leapfrog is all about, to highlight that there are practices we know are associated with safer, higher-quality care and they're not practiced everywhere. And so, let's help consumers understand which hospitals have them in place and which ones don't and let them make an informed decision about where to get their treatment," Ms. Delbanco said.

This year's Leapfrog survey did have some bright spots:

- Eight in 10 hospitals have implemented procedures to prevent operating on the wrong part of the body, and seven in 10 hospitals now require pharmacists to review all medication orders before dispensing prescription drugs to patients, the survey found.
- 13.2% met the standard for coronary artery bypass graft surgery, up from 12.1% in 2003 and 12% in 2002.
- 16.7% met the standard for pancreatic cancer resection, up from 14.3% in 2003. This item was not measured in 2002.
- 10.5% met the standard for esophageal cancer surgery, up from 8.1% in 2003, but down from 12% in 2002.
- 38.6% have fully implemented at least one of the four Leapfrog safety practices. Last year, 32.0% of hospitals met a least one Leapfrog criterion. In 2002, 41.2% of the targeted hospitals fully implemented at least one Leapfrog criterion.
- Survey participation in 2004 increased to 1,019 hospitals, up from 1,012 hospitals in 2003. In 2002, Leapfrog collected data from just 637 hospitals it had targeted in 23 urban regions.

For more information about the Leapfrog Group and to find out how participating hospitals performed, visit *www.leapfroggroup.com.*

Survey: Most to stay with broker

Continued from page 4

their current brokers, while 14.3% said they are considering it and 21.8% said they don't know.

If they were going to replace their brokers, 44.6% of respondents said it would be for service-related reasons, 15.1% for price and coverage reasons, and only 11.1% because their broker has been tainted by the controversy, Advisen reported.

Risk managers also expressed little confidence that they could get enough information about other brokers' possible involvement in client steering and bid rigging to make an informed decision about whether they should switch firms, the survey found. Almost 34% said they could get the information they need, while 34.4% said they couldn't and 31.7% said they don't know.

Respondents were split on the impact of the compensation controversy.

About 45%, for example, predicted that the controversy would have no effect on the quality of brokerage services they receive, while 29% said service quality would increase and 25.6% said it would decrease.

About 46.6% also said the turmoil would have no impact on their companies' total cost of risk, while 33.8% said their costs would increase and 19.6% said they would decline.

Large majorities, meanwhile, were in favor of greater transparency in the brokerage process. Seventy-four percent agreed that commercial insurance transactions should be standardized and transparent, while 67.9% said they need more information about prices and terms being negotiated in the marketplace.

The survey's respondents represented companies ranging in size from less than $100 million in revenues to more than $5 billion, with 25% in the $1 billion to $5 billion category and about 27% in the less-than-$100 million category.

ULR: Benefits brokerage sued

Continued from page 1

had sued Universal Life Resources on Nov. 12, charging the life and disability broker with steering business to insurers paying it secret override commissions, but his suit, while mentioning MetLife, Prudential and UnumProvident, did not name any insurers as defendants (*BI*, Nov. 15).

Mr. Garamendi said at a press conference announcing the suit that he met with Mr. Spitzer on Nov. 15 and that the litigation and agreement with ULR was a planned "East Coast-West Coast knockout punch."

A spokesman for Mr. Spitzer's office said the California lawsuit has "no impact whatsoever" on the New York attorney general's own litigation against ULR but declined to comment further.

The California insurance department filed the suit in conjunction with plaintiff attorney John J. Stoia Jr. of San Diego-based Lerach, Coughlin, Stoia, Geller, Rudman & Robbins. Mr. Stoia's firm had already filed several suits in connection with ULR, which are still pending.

In announcing the suit, Mr. Garamendi said the allegations represent a "very sad and sordid chapter in the history of the insurance industry" that will continue to unfold "in the months and years ahead."

Mr. Garamendi's suit charges that ULR steered its clients to the insurers in return for contingent commissions and that insurers included in their rates ULR's "communication fees" that were actually a "pretext for undisclosed commissions and kickbacks."

According to the suit, ULR charged communication fees that were typically $10 to $20 per employee, claiming it prepares brochures for distribution to employees, even though the cost to produce such materials was "a few dollars at most." As a result, ULR clients "have unwittingly paid millions of dollars in communication fees for such negligible or nonexistent services," the suit charges.

The commissioner's suit also alleged that the defendants were involved in "tying," where the placement of ULR's clients with the insurers hinged upon the promise of other clients or insurance business; and that the insurers sent existing clients with whom they had direct contracts—those with no broker involvement—to ULR in return for the brokerage steering its clients to the insurers.

The charges are a 'very sad and sordid chapter in the history of the insurance industry.'
John Garamendi

The suit also charges the insurers with undisclosed remuneration to URL in the form of lavish gifts, travel, and loans, including CIGNA Corp.-sponsored trips for ULR owner Douglas P. Cox to "premier vacation destinations."

ULR steered more than 90% of its business to the insurer defendants, with MetLife alone receiving about 50% of the total, the lawsuit charges.

The suit states that some of the largest corporations in California are ULR clients, including Warner Bros. Entertainment Inc., Northrop Grumman Corp., Pacific Gas & Electric Co., Amdahl Corp. and Sun Microsystems.

The California commissioner's settlement with ULR requires the firm's cooperation in the ongoing investigation and requires it to "act in a manner consistent with the legal duties imposed on brokers and agents under California law." ULR makes no admission of liability in the proposed consent decree and permanent injunction.

Once the court approves the agreement, the insurance department's claims against the firm will be dismissed, the agreement states.

CIGNA attorney Paul Salvaty, with O'Melveny & Myers L.L.P. in Los Angeles, said last week that while he had not yet seen the complaint, "we don't know how Commissioner Garamendi could make a deal with ULR, given Attorney General Spitzer's allegations against the company, and before Commissioner Garamendi has completed his own investigation and learned the facts."

"We don't believe CIGNA violated any laws or regulations," he added.

Other defendants had no comment or could not be reached.

During his press conference, Mr. Garamendi said that although contingent commissions have been used for 40 years, their use has changed over the last five to eight years.

The system "changed from one of contingent commissions paid for real services rendered" to their being used to induce brokers to place business with particular insurers, "thereby breaking the fiduciary responsibility that a broker has, as well as the responsibility of the insurance company for fair and open dealing," he said.

Of ULR's $25.3 million in 2003 revenues, $11.5 million came from overrides and $5.6 million from communications fees, according to Mr. Spitzer's suit.

Observers say that generally, if a benefits broker accepts contingent commissions at all, they typically account for only a small percentage of total revenue and are reported by the insurers.

Rodney Clark, director of financial services for Standard & Poor's Corp. in New York, said that contingent commissions or volume-based bonuses account for an average of only about 10% of group life and health insurers' commission expense. "But a company who's doing business with 200 different brokers may have only 40 that are qualifying for the bonus," said Mr. Clark.

Furthermore, "I'm not sure they all take quite the form of the ones that you saw in the URL complaint," such as additional fees for communications that were more than the insurers would have charged themselves and "manipulation of the bidding process."

"Were those practices widespread? I think it would be far too early to answer that question," said Mr. Clark.

The question is whether these arrangements influence behavior "in ways that are detrimental to the end customer, and our presumption right now is that most of the industry right now is acting ethically, but there's a lot out here that we don't know," the S&P analyst pointed out.

"I think we're all in the early stages of the learning curve, trying to figure it out," said Peter Patrino, senior director at Fitch Ratings in Chicago. "A lot of brokers are privately held organizations," he said. "Most of them are not too big, and some of them are part of larger organizations, so really getting the financial statements of all of them to really try to decipher what's generating revenue is not a real easy task," said Mr. Patrino.

"I think a lot of what these investigations are doing are uncovering things that might have been difficult to uncover otherwise, and I think any time you get into what revenue is generated by price rigging…that gets real complicated," he said.

Tim Easterwood, president of Troy, Mich.-based Voluntary Benefits Solutions L.L.C., a consultant and broker, said his company has never accepted contingent commissions. However, "it wouldn't surprise me if this was prevalent in the industry, because it's easy money," he said.

Tom McGraw, president of Troy, Mich.-based McGraw Wentworth, an employee benefits brokerage and consulting firm, said contingent commissions represent only 4% to 5% of his company's total revenue and that insurers reveal this information in their disclosure statements.

He also said it is unusual for brokers to steer business to particular insurers, given the competitive nature of the business. "We don't have that much control with any of our clients that we can rig bids, or steer to just a couple of carriers, and I think most brokers are that way," he said. "We're constantly shopping for the lowest net cost for the client because that's how we keep the client."

Fran Pullano, of Mumford, N.Y.-based Pullano & Co., a brokerage and consulting firm, said she encountered a situation a couple of years ago "where we suspected that there was essentially a collusion between the insurance carrier and a preferred broker, and we were surprised, because we hadn't seen it before."

WTC: Silverstein awaiting verdict on claim recovery

Continued from page 3

tack on the World Trade Center was one occurrence for all," argued Michael H. Barr, a lawyer with Sonnenschein, Nath & Rosenthal. The firm is representing Royal Indemnity Co.

The legal battle over the World Trade Center property program, launched by lead insurer Swiss Reinsurance Co. in 2001, grew from the fact that no final policy had been issued at the time of the attack, even though Willis had placed the coverage nearly two months before, in time for the closing of Silverstein's 99-year lease on the complex.

In the first phase of the case, a jury decided earlier this year that 10 insurers had bound coverage on the Wilprop form, which a federal court had already ruled would treat the WTC loss as a single occurrence (BI, May 3). Five other insurers had earlier won court rulings that they were also bound on Wilprop or had settled with Silverstein on a one-occurrence basis.

The nine insurers in the second phase did not agree to the Wilprop form and instead signed binders referencing a variety of forms that included differing definitions of occurrence or no definition at all. One insurer—Allianz A.G. Holding of Germany—issued actual policies before the terrorist attack that included the insurer's own occurrence definition.

The only issue before jurors in the second phase is whether each insurer's form should treat the loss as one occurrence or two.

Silverstein, which bore the burden of proving its two-occurrence theory, drew on testimony of expert witnesses, Willis brokers and others.

Jeffrey G. McKinley, a consultant and former Alexander & Alexander Inc. and Aon Corp. broker, testified that the "fixed and well-established" meaning of occurrence in the insurance industry is a direct physical loss. This, Silverstein argued, meant that each aircraft striking each building was a separate occurrence.

Mr. Nussbaum, a partner with Wachtell, Lipton, Rosen & Katz, also cited two cases in which certain insurers involved in the litigation treated series of similar losses as separate events.

In one California case, an arsonist set fire to four courthouses, three of them on the same day. Travelers Property Casualty Corp.—which had no occurrence definition in either the policy covering the California buildings or in its WTC policy—treated the fires as separate occurrences, Mr. Nussbaum noted.

In a separate case in Shreveport, La., Industrial Risk Insurers likewise treated a series of rainstorms that damaged a Harrah's Entertainment Inc. casino as separate events under the same IRI policy form it used for the WTC risk.

"Insurance companies write their policies to treat each direct physical impact—each fire in the California matter, each rainstorm in the Louisiana matter—as a separate occurrence. That is what they intend," Mr. Nussbaum told jurors.

He also rebutted the argument that the nine so-called "phase two" insurance companies should not be hit with a double loss when the 15 "phase one" insurers are paying only a single loss.

"Why didn't we get concurrency during the binder period? Because these nine insurers used their own forms during the binder period. They got what they wanted," he said.

The insurers, meanwhile, dismissed Mr. McKinley as a "universe of one" on the occurrence issue and called his opinion on industry practice "novel."

All of the insurers on the WTC program either did have or intended to have an aggregating definition of occurrence that would be the functional equivalent of the Wilprop form's definition, lawyers for the nine companies argued.

In negotiations with Travelers, for example, Willis brokers noted several dozen differences between the Travelers form the insurer wanted to use and the Wilprop form, but they never brought up the absence of an occurrence definition. The reason was that both sides assumed the Wilprop definition would apply, said Harvey Kurzweil, a lawyer with Dewey Ballantine, representing Travelers.

The forms of Allianz, IRI and Zurich defined occurrence as losses—or in Allianz's and IRI's case, "series of losses"—arising out of one "event." While Silverstein argued that the undefined term "event" means the same thing as "occurrence," lawyers for the insurers contended that the definition is broader and clearly intends to aggregate similar losses.

The event in the World Trade Center case was a single, coordinated terrorist attack on the complex, not the separate crashes into the two towers, contended John B. Massopust, a lawyer for Allianz with Zelle, Hoffman, Voelbel, Mason & Gette.

Allianz, meanwhile, also argued that the loss should be treated as one occurrence under a 72-hour clause in its policies that aggregates losses from various perils including "vandalism and malicious mischief," which brokers understood to include terrorism.

Mr. Nussbaum, however, disputed that Willis brokers ever understood terrorism to be covered under the vandalism provision.

Hearing: Federal oversight urged

Continued from page 1

"The more profound their claims of purity, the more heinous" the behavior hidden, he said.

Risk managers came under fire at the hearing, too, from New York Insurance Superintendent Gregory Serio. "Not only have they been mute, they are still mute on this issue," he said.

The hearing was an unusual one, called during a lame-duck session

'When I hear the words "heinous" and "cartel" being used over and over again, it was instructive as to the depth of hostility that is aimed at our industry.'

Joel Wood
Council of Insurance Agents & Brokers

by a lame-duck senator. In fact, for all but a few minutes of the more than three-hour hearing, the only subcommittee member present was Chairman Peter Fitzgerald, R-Ill. Two Democrats on the 13-member subcommittee made brief appearances at the hearing, but no Republicans attended other than Sen. Fitzgerald, who did not seek re-election to a second term.

"It is not a committee of jurisdiction, chaired by a lame-duck senator who wanted to grab the headlines of the day, and it was poorly attended by senators," said Joel Wood, senior vp-government affairs for the Council of Insurance Agents & Brokers in Washington.

"In that sense, it doesn't demonstrate any specific legislative threat whatsoever," Mr. Wood said. "On the other hand, the vitriol in the room was extraordinary—when I hear the words 'heinous' and 'cartel' being used over and over again, it was instructive as to the depth of hostility that is aimed at our industry and the reputation issue. It's very difficult to have a 30-second response in defense of our members when the allegations are made in such a sweeping and callous way."

Jurisdiction or no jurisdiction, critics of the broker compensation system found it a forum to their liking.

"I welcome the idea of changing federal antitrust laws," Connecticut Attorney General Richard Blumenthal told the panel. Despite the McCarran-Ferguson Act's grant of limited federal antitrust immunity to insurers, both the federal government and the states should ratchet up their antitrust enforcement to rein in abusive practices such as bid rigging between brokers and insurers, Mr. Blumenthal said. But the attorney general made clear he does not favor changing McCarran-Ferguson—a 1945 law that grants states rather than the federal government the right to regulate insurance—in ways that would strip states of the right to protect consumers.

"Federalizing the problem may not be a solution," Mr. Blumenthal said.

Mr. Spitzer, who has charged New York-based Marsh & McLennan Cos. Inc. with fraudulent self-dealing in its collection of contingent commissions, also testified and called for an examination of how antitrust laws apply to insurers and brokers.

Sen. Fitzgerald made clear that he shared that concern even before Mr. Spitzer testified. While noting that state regulation of insurance "has worked well for many purposes," Sen. Fitzgerald noted that "state regulation purporting to govern global conduct may not always perfectly detect the abuses of daunting market power. I believe it is time for Congress to revisit the antitrust exemption of the McCarran-Ferguson Act, and to make clear that vigorous federal antitrust enforcement can and will reach the kind of anticompetitive conduct on the part of insurance brokers alleged" by Mr. Spitzer.

Mr. Spitzer, who also has sued San Diego-based Universal Life Resources Inc. for alleged self-dealing

Both the federal government and the states should ratchet up their antitrust enforcement to rein in abusive practices, but 'federalizing the problem may not be a solution.'

Richard Blumenthal
Connecticut attorney general

in its handling of employee benefits business (*BI,* Nov. 15), made clear that his probe was far from over and told the subcommittee that "there will be more criminal pleas." A few hours later, two executives of Zurich-American Insurance Co. pleaded guilty to charges that they had helped Marsh rig bids on client insurance placements (see story, page 4).

In addition, Mr. Spitzer said that Congress needs to look at what he called a "massive" insurance capital outflow to Bermuda and other offshore domiciles. He elaborated on the point in his written testimony, saying that many offshore facilities are "either owned in part or operated by the brokers themselves." In his written testimony, Mr. Spitzer notes that "Marsh helped to create the Bermuda-based ACE Ltd., XL Capital Ltd., Mid Ocean Re and AXIS, while Aon has sponsored LaSalle Re and Endurance. This sets the stage for conflicts of interest, steering and self-dealing in insurance and reinsurance markets that we are just beginning to understand. And this is not to mention the numerous and profound tax implications of permitting U.S. insurers to accrue investment earnings in favorable offshore havens."

After hearing Mr. Spitzer's assessment, the general counsel of a captive management and consulting firm disputed its thrust.

"By and large, I'm not an offshore fan," said Jon Harkavy, vp and general counsel of Risk Services L.L.C. in Arlington, Va. The captive community's greatest fear "is this all going to be broad-brushed into some kind of grand federal regulatory scheme that will be bad for captives," he said.

Julie Rochman, a senior vp at the American Insurance Assn. in Washington, noted that insurers do not enjoy a blanket antitrust exemption under federal law.

"The McCarran-Ferguson antitrust exemption is very limited," she said. "All sorts of things were ascribed to McCarran at the hearing. Most importantly, we need to separate the facts from rhetoric. McCarran did not prevent Attorney General Spitzer or anyone else from bringing charges against people they thought had done something illegal. Our long-held policy position at the AIA has been, in exchange for a well-crafted national charter, we would be willing to talk about doing away with McCarran for those companies operating on a national charter."

Sen. Fitzgerald, responding to Mr. Serio's criticism that risk managers have been silent on the issue, asked, "So they were embarrassed they were snookered?"

Janice Ochenkowski, the Risk & Insurance Management Society Inc.'s vp-external affairs, said after the hearing that "RIMS has heard from its membership regarding the Spitzer allegations, and the most prevalent response has been shock, not embarrassment.

"The allegations of wrongdoing by some brokers and some insurers in Attorney General Spitzer's complaint are shocking to all of us. RIMS, through its president, Nancy Chambers, issued a statement Oct. 22 regarding this on behalf of RIMS and its members," Ms. Ochenkowski said after she had testified at the hearing. Ms. Ochenkowski is also senior vp-risk management for Chicago-based international real estate firm Jones Lang LaSalle.

Ms. Chambers' statement in part read that RIMS members were gathering "the facts of the allegations, and then will analyze and assess the impact to their firms. This process may take some time, because investigations within the industry and from outside regulatory and enforcement organizations continue."

Marsh: Client walks

Continued from page 3

announced.

Board members stepping down are: MMC Vice Chairman Mathis Cabiallavetta; Peter Coster, president of MMC's Mercer Inc. benefits consulting unit; Charles A. Davis, MMC vice chairman and chairman and CEO of MMC Capital Inc.; Ray J. Groves, former chairman and CEO of MMC's Marsh Inc. brokerage unit and now a senior adviser to Marsh; and A.J.C. Smith, chairman of Putnam Investments Inc. and former chairman of MMC.

"This step is in keeping with the company's commitment to adhering to corporate governance best practices," said Robert Erburu, MMC's lead outside director, in a statement.

MMC meanwhile named Peter J. Beshar, a former partner with the law firm of Gibson, Dunn & Crutcher, as its new senior vp and general counsel.

MMC also announced that the company is deferring a decision on its first-quarter 2005 stock dividend pending the outcome of an internal review of its business model and "ongoing regulatory matters."

New York Attorney General Eliot Spitzer sued MMC last month, charging the broker with steering clients to insurers paying Marsh the highest contingent commissions and rigging bids on client programs.

The board shakeup follows several executive changes, including the resignations of former MMC Chairman and CEO Jeffrey Greenberg; Roger E. Egan, former Marsh president and chief operating officer; Christopher Treanor, chairman and CEO of Marsh's Global Placement unit; and William Rosoff, MMC senior vp and general counsel.

Worker sentenced for HIPAA violation

By MARK TAYLOR

SEATTLE—The sentencing this month of the first person convicted of violating the Health Insurance Portability and Accountability Act isn't likely to deter similar misconduct, health lawyers said, but it offers government prosecutors another weapon with which to punish violators and shows that the previously untested law works.

A Seattle judge ordered an ex-laboratory technician and phlebotomist to serve 16 months in prison and pay $9,000 in restitution in the first criminal conviction under HIPAA's privacy provisions, U.S. Attorney John McKay said.

U.S. District Judge Ricardo Martinez sentenced Richard Gibson, 42, for violating the 1996 law that prohibits the wrongful disclosure of individually identifiable healthcare information for financial gain. HIPAA's healthcare privacy provisions took effect in April 2003.

The Seattle Cancer Care Alliance, a collaboration among the University of Washington Medical Center, Fred Hutchinson Cancer Research Center, and Children's Hospital and Regional Medical Center, employed Mr. Gibson from November 2001 until he was fired in February 2003. He pleaded guilty in August to stealing cancer patient Eric Drew's personal identification information to obtain credit cards and charging more than $9,000

"After this, I don't leap to the conclusion that providers will be more susceptible to criminal prosecution for routine disclosures of personal health information because of the acts of their employees," said Mark Lutes, a lawyer at Epstein Becker & Green in Washington. "The more appropriate question is did the hospital or other provider apply the proper technical safeguards? How did the HIPAA-covered entity analyze its risk of the threat of identity theft?"

An American Hospital Assn. spokesman said the incident wasn't just a HIPAA violation "but a serious crime compounded only by the vulnerability of the patient. That activity is so extreme. I don't know whether the law will have much of a deterrent effect on people who do that. But it shows that when these things do occur, the government will deal with them swiftly."

He said the most common violations are unintentional invasions of patient privacy.

Bruce Fried, a lawyer with the Washington office of Sonnenschein Nath & Rosenthal, said Mr. Gibson's actions are "the exact kind of behavior HIPAA was intended to go after. It also reminds us that greed and stupidity are alive and well, and that greedy, stupid people will continue their schemes, even if a well-intentioned law is aimed at deterring them."

Mark Taylor is a reporter for Modern Healthcare, a sister publication of Business Insurance.

ADVERTISER INDEX

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Late News

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on the part of what seems to be a small group of individuals," Mr. Greenberg said at a conference last week. Mr. Greenberg said the industry needs to thoroughly review all its practices and called for increased transparency of compensation arrangements.

Proposal would expand 403(b) plan document rule

All 403(b) savings plans, including those funded solely through salary deferral, will be required to provide participants with plan documents under proposed rules issued jointly by the Internal Revenue Service and the Treasury Department. Currently, the plan document requirement applies only to 403(b) arrangements to which employers contribute. The proposed rules, though, do not specify how thorough plan documents must be.

Hartford securitizes cat reinsurance

The Hartford Financial Services Group Inc. has purchased $247.5 million of collateralized property

catastrophe reinsurance from a Cayman Islands reinsurer. The multiyear coverage was financed by Foundation Re Ltd. through the issuance of risk-linked securities. It provides $180 million in reinsurance for losses from hurricanes in the Northeast and Gulf Coast regions of the United States. In addition, $67.5 million in coverage is in place for losses resulting from U.S. earthquakes or hurricanes in the year following a major quake or hurricane.

California commissioner urges 2.2% comp rate cut

Insurance Commissioner John Garamendi last week recommended that California's workers compensation insurers reduce pure premium rates by 2.2% for policies that become effective Jan. 1. The commissioner's recommended rate decrease ignores the advice of the Workers' Compensation Insurance Rating Bureau, which suggested a 3.5% increase. Mr. Garamendi has no regulatory authority over workers compensation rates and only can recommend rate adjustments.

Mr. Garamendi

Grace seeks cap on asbestos liabilities

W.R. Grace & Co. has filed a reorganization plan that would include a $1.61 billion maximum aggregate payment for its asbestos-related liabilities. Grace filed the plan in U.S. Bankruptcy Court in Delaware in connection with its Chapter 11 reorganization. The manufacturer said that the payments should be sufficient to fund $2 billion in claims costs over time. A trust established by the plan would pay personal injury and property damage claims against Grace. The plan does not yet have creditor approval.

CalPERS seeks greater disclosure of execs' pay

The California Public Employees' Retirement System has formally adopted a three-year plan to rein in large executive compensation packages that includes advocating increased disclosure of compensation arrangements. Among other things, CalPERS will urge the Securities and Exchange Commission to ensure that publicly traded companies provide investors with greater transparency of compensation packages and orchestrate shareholder campaigns against companies that fail to incorporate its recommendations. CalPERS' decision to address executive compensation packages stems from a number of reports of large payouts to company executives, including those related to the proposed merger of Anthem Inc. and WellPoint Health Networks Inc.

Briefly noted

Hilb Rogal & Hobbs Co. will acquire Smith, Bell & Thompson Inc., a Burlington, Vt.-based managing general underwriter that generated more than $13.5 million of revenue last year. Terms of the transaction, which is expected to be completed by Dec. 1, were not disclosed....Florida's Department of Financial Services, the Office of Insurance Regulation and the state attorney general have **subpoenaed 11 insurance companies** as part of an investigation of broker compensation arrangements. The 11 insurers are: National Union Fire Insurance Co. of Pittsburgh, Pa.; American International Specialty Lines Insurance Co.; Lexington Insurance Co.; Continental Casualty Co.; Scottsdale Insurance Co.; Federal Insurance Co.; ACE American Insurance Co.; Zurich American Insurance Co.; St. Paul Fire & Marine Insurance Co.; State Farm Florida Insurance Co.; and Twin City Fire Insurance Co....Karl Wittmann has been elected chairman of the board of directors of the New York-based **International Insurance Society Inc.** Mr. Wittmann, a member of the executive board of Munich Reinsurance Co., succeeds Douglas Leatherdale, the retired former chief executive officer of The St. Paul Cos. Inc., who had been chairman of the society since 2001.

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NAIC proposes broker pay disclosure rules

By MEG FLETCHER

KANSAS CITY, Mo.—The National Assn. of Insurance Commissioners is proposing commission disclosure rules for insurance brokers that would include requiring brokers to obtain buyers' written consent for commission arrangements prior to coverage transactions.

The NAIC last week released a one-page document containing proposed amendments to its current Producer Licensing Model Act. The organization is inviting comment on its proposals, which will be the subject of a Dec. 4 public hearing.

The NAIC is proposing "a two-part framework" for disclosures; one set of rules applies to transactions in which a broker receives compensation from the buyer and insurer, while the other applies to some other types of transactions, said NAIC President Diane Koken.

Ms. Koken, the Pennsylvania insurance commissioner, also chairs the NAIC's newly formed Executive Task Force on Broker Activities. The NAIC formed that group as part of its response to the brokerage compensation scandal sparked by New York Attorney General Eliot Spitzer's fraud and antitrust lawsuit against Marsh & McLennan Cos. Inc.

Under the proposed rules, an insurance broker must refuse compensation from any insurer unless the broker meets buyer notification requirements. Specifically, the broker must fully disclose any compensation arrangements—including those for profit- or volume-linked contingent commissions—as well as the method for calculating such compensation. If the amount of contingent commission is not known, the broker is required to disclose "a reasonable estimate" of the amount and explain the method of calculation. In addition, the broker must obtain the buyer's written consent before the broker can receive such compensation payments.

The only exception to those requirements is a situation in which the buyer pays only "a nominal fee," according to the NAIC document.

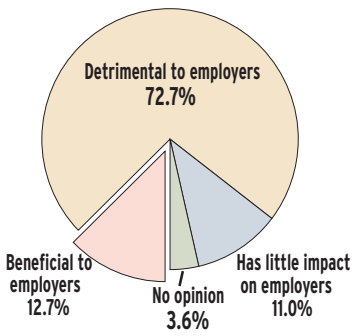
In addition, the NAIC proposes that all insurance brokers disclose details about insurer compensation, where applicable. Specifically, a broker must state that it will receive compensation from the insurer and that the compensation "may differ depending upon the product and insurer." In addition, the broker must disclose that it "may receive additional compensation from the insurer based upon other factors, such a premium volume placed with a particular insurer and loss or claims experience," according to the proposal.

The NAIC's Dec. 4 hearing will be held from 3 p.m. to 5 p.m. at the New Orleans Marriott Hotel, during the organization's winter national meeting. The deadline for written comments and for speaker registration is Dec. 1. Contact Tim Mullen at *tumullen@naic.org* for additional details.

Online Poll

[11/15-11/19]

Will employers benefit from the wave of mergers in the managed care industry?



BI Stock Index

[11/15 - 11/19]

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**	2226.03	-0.64
Dow Jones	10456.90	-0.78
S&P 500	1170.34	-1.17

Largest gains

ESG Re Ltd.	16.67%
Unum Corp.	14.13%
Clark Inc.	11.87%
PMA Capital Corp.	9.45%
Fairfax Financial Holdings	6.62%

Largest losses

Baldwin & Lyons Inc.	-6.49%
Vesta Insurance Co.	-5.74%
IPC Holdings Ltd.	-4.89%
Brown & Brown	-4.46%
Navigators Group	-4.18%

Weekly change by market segment

Brokers	0.63%
Insurers/Reinsurers	0.73%
Managed Care Organizations	0.71%

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

Finite risk: Use of products to cap liabilities questioned

Continued from page 1

Commission for documents relating to "certain nontraditional, or loss mitigation, insurance products." Platinum said it expects to receive a similar request from Mr. Spitzer's office. ACE and Swiss Re already have. All three said they are cooperating with the investigations. New York-based American International Group Inc. recently said it is in settlement talks to resolve a federal grand jury's investigation into a retroactive coverage transaction involving cell phone distributor Brightpoint Inc. of Plainfield, Ind.

"Maybe the bar hasn't changed, but the perception is that the bar could change," said Steven Bolland, president of New York-based reinsurance intermediary Gill & Roeser.

"All of these transactions go for a significant number of years. If the bar changes and if you have to unwind them, then suddenly it gets significant. If you're worried about it, maybe terminate and redo," Mr. Bolland said. But "if you've done things properly, there shouldn't be any issue," he said. "Most responsible reinsurers don't want to have their contracts unwound, so they wouldn't sell a product that would come under scrutiny."

The rating agencies, though, say they've always been skeptical of finite risk and have stepped up their scrutiny of such deals since the collapses of Australia's HIH Insurance Ltd., Long Grove, Ill.-based Kemper Insurance Cos. and other insurers.

Fitch Ratings "has been very vocal in the past about our reservations with finite risk reinsurance. Our analytical practice has generally been to reverse the impact of these arrangements when conducting our reviews of the buys of these products," said Michael Barry, an analyst in Fitch's North American Insurance Group who hosted a Nov. 17 teleconference addressing the issue.

In an Oct. 29 report, Fitch predicted finite risk reinsurance could be the next target in the widening investigations.

An end to finite deals?

Fitch warns of three possible outcomes: investigators may find illegal activities to which they would react, there may be a more stringent application of accounting guidance or even rule changes or the investigations may taint the product line and make it less attractive in the future.

It is this last scenario that has put many people connected to the insurance industry on guard.

"It is a very valid, useful form of coverage, and it would be a terrible shame if people's perception is that it's somehow crooked. There have obviously been some deals that haven't met the standards. But as long as the standards (are met) and everybody understands that, it's a terrific tool available to the market," said Mr. Bolland.

"I'm not saying all finite reinsurance goes away," said Steve Dreyer, a managing partner at Standard & Poor's Corp. in New York. "But there is going to be some carve-out of these activities that's going to be deemed to be improper, and I'm sure eventually the industry will adapt or maybe the capital markets or somebody will develop something to take its place. Maybe the banks will come in. But for at least some period of time, I would expect more volatility."

Complexity complications

A major contributor to the problem is the esoteric nature of finite risk contracts, industry experts say.

The first finite risk contracts were fairly cut and dried, used primarily by reinsurers to cap their exposure to long-tail liabilities, hence the term "finite," explained Mr. Barile.

Over time, though, they evolved and are now used to extend the reporting of losses over longer periods, as with spread loss contracts; to transfer books of business that are in runoff, as with loss-portfolio transfers; or to cover losses that have already occurred, as with retroactive reinsurance agreements.

In some instances, commercial insurance buyers themselves are bypassing primary insurers and using finite risk to finance captives and self-insurance programs.

"A finite policy for a captive is an alternative to borrowing from a bank, issuing stock or assessing members to put more capital into the company," explained Dan Malloy, executive vp in Benfield Inc.'s alternative risk solutions group in New York.

Finite coverage is also used to finance loss-portfolio transfers when a captive has decided to cease writing a line of business, he added.

When faced with runoff situations, "managements are very interested in looking for adverse development cover or loss-portfolio transfer where the day-to-day handling of those claims is taken over by a third party," he said. "They want to be able to say to their shareholders across a wide range of outcomes that they have finality."

Risk transfer concerns

As insurers, reinsurers and insurance buyers found creative uses for finite risk, the amount of actual risk transfer in some of the contracts diminished, which is what is causing such a stir, some observers say.

"Why are these products there? Because the industry developed them to get around the restrictions on the simple products," said Mr. Dreyer. "For example, a time-and-distance arrangement, which is effectively a loan, may incorporate some low-probability risk transfer to meet regulatory scrutiny" and be booked as reinsurance, he said.

Retroactive reinsurance is even more suspect, according to Bob Partridge, who is also a managing director at S&P in New York.

"You could certainly write a retroactive policy that includes risk transfer. You don't know if there is the significant event of adverse development. The losses keep going. But if it is a closed amount, then it becomes much, much more suspect," Mr. Partridge said.

A finite risk contract must contain two elements in order to be viewed as true reinsurance, said Don Thorp, senior director at Fitch Ratings, during the teleconference.

'It is a very valid, useful form of coverage, and it would be a terrible shame if people's perception is that it's somehow crooked.'

Steven Bolland
Gill & Roeser

First, there must be "a significant amount" of risk transfer. The industry has adopted "the 10/10 rule" as the standard, meaning that there must be at least a 10% probability of a 10% economic loss of premium, he explained.

Second, it must be "reasonably possible" that the reinsurer will assume some loss, "and that means 'not remote,'" Mr. Thorp said.

"If the contract has no apparent risk transfer, it is not accounted for as reinsurance and there is no change to written or earned premiums or incurred losses," he said.

If it does pass the accounting test, though, then how it is accounted for depends on whether it is prospective or retroactive.

"Prospective is accounted for in the same manner as other insurance or reinsurance," Mr. Thorp explained. "But with retroactive, there are some differences—the cedent does not change reported written premium, earned premium or incurred losses and the gain recognized is segregated in a special surplus account."

"There's a fairly clear road map in place since 1993 which lays out how you should account for transactions that you enter into to determine whether it's reinsurance or not—FAS 113," said Benfield's Mr. Malloy, referring to the accounting standard promulgated by the Financial Accounting Standards Board to address finite risk transactions.

"If transactions are structured correctly and accounted for correctly and exposed correctly, structured reinsurance, finite reinsurance is a very viable and positive alternative," he said.

However, "if transactions are being misrepresented through people looking to mischaracterize what they were doing, then I think that stakeholders—the shareholders, the regulators, the rating agencies—have a bona fide issue," Mr. Malloy said.

Some observers say that many finite risks deals made several years ago that met the muster of auditors and regulators and rating agencies at the time are being targeted now because of the perception created by the fall of Enron Corp. and other companies that corporate corruption is widespread.

"As an industry, we need to take lessons from Enron," said Elliott M. Kroll, a partner in the reinsurance practice of law firm Herrick, Feinstein L.L.P. in New York. The key lesson is, Mr. Kroll said, that it doesn't matter any more whether a deal complies with generally accepted accounting practices or statutory accounting rules. "What matters is, is it deceptive?" he said.

"It's incumbent upon the audit committee to look to management and ask them, 'Do we have any of these transactions? Has anyone gotten an independent opinion as to disclosure and deception?' Maybe they'll unwind the deal, or maybe it can be salvaged with additional disclosures," he said.

"There's no such thing as a free lunch. You're trying to get some balance-sheet relief. There's nothing in and of itself wrong with off-balance sheet (transactions). The question to ask is, 'Is the accounting treatment deceptive, and is it disclosed?'" Mr. Kroll said.

And even though the finite risk accounting issue was seemingly addressed with FAS 113 in 1993, "product structures were much simpler in nature, much more straightforward and there were rules and regulations put around those product structures. The old time-and-distance policies were simply doing a discount," said Mr. Partridge of S&P.

Since then, "the world has evolved. Risk management has gotten much more sophisticated in the industry; the levels of risk being covered are handled in a much more sophisticated way. And it's those nuances that are now being called into question," he said. "The products have changed, and the nature of this risk transfer has changed."

"The whole thing comes under this rubric that all of these industry practices that we all would agree are legal and many of us would argue are ethical, but the appropriateness is being called into question," said S&P's Mr. Dreyer.

"Mr. Spitzer said he views the whole island of Bermuda and other offshore venues skeptically, and I think that anything they're involved in will be perceived as being behind some sort of veil of secrecy and, therefore, suspect," he said.

"Let's face it, there's a lot of opaqueness in the transactions in this entire industry, and that applies to personal lines, commercial lines, life insurance, property/casualty, everywhere," Mr. Dreyer said.

"This is the thing that worries us. If something complex and/or offshore makes it bad, then this industry in for a heap of trouble, because they have a lot of both," said Mr. Dreyer. "And that is the primary reason we have a negative outlook on the sector from a credit ratings perspective. We just don't know where the bottom of this stuff is."

What is 'finite risk'?

Because of its complexity and the uniqueness of each transaction, "finite risk insurance" has no simple, single definition, insurance experts say.

According to Fitch Ratings, the concept originated at Lloyd's of London in the 1960s with "rollover" coverage purchased by syndicates. This coverage was canceled when a claim was made, and premiums paid—plus interest—were returned to the syndicate. If no claims were made, however, the premiums were rolled over in an interest-bearing account.

These policies, which Lloyd's has since banned, were followed by "time-and-distance" policies, Fitch said. In these transactions, premiums are equivalent to the net present value of claims, plus a fee, while the reinsurance recoverable is equal to gross claims. The difference is treated as a profit on ceding companies' income statements.

Time-and-distance policies are no longer used, however, because Financial Accounting Standard 60, issued in 1982 and now part of FAS 113, does not allow them to be accounted for as reinsurance transactions.

Many permutations of these early finite risk contracts cropped up to cover hard-to-place risks or to provide balance sheet relief to cedents with huge liabilities, such as asbestos and other environmental exposures.

Finite risk insurance products can be prospective or retroactive.

Examples of prospective finite risk products include:

- Spread-loss contracts. Similar to time-and-distance policies, these allow a cedent to spread a loss across multiple time periods.
- Aggregate stop-loss contracts. The transactions, which provide the cedent with coverage above an attachment point in a given period, cover all lines of business. Usually, a cedent transfers the losses when they're incurred, and the reinsurance reimburses it when the losses are paid.
- Finite risk quota-share treaties. Similar to traditional quota-shares, except that losses may be capped at a fixed dollar amount or at a fixed loss ratio.

Retroactive products include:

- Loss-portfolio transfers. The reinsurer assumes responsibility for all loss reserves for a line of coverage or book of business.
- Adverse loss development coverage. Similar to loss-portfolio transfers, except the reinsurer only assumes responsibility for any adverse loss reserve development beyond existing reserves.

Because finite risk transactions are usually treated like traditional reinsurance on financial statements, it is hard to determine how much of this coverage is in place in the United States, experts say. In addition, traditional reinsurers also often sell finite risk.

Finally, the Reinsurance Assn. of America does not keep track of reinsurance writings by line of business.

—By Joanne Wojcik