The perversity of insurance accounting: In defence of finite reinsurance

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The Centre for the Study of Financial Innovation is a non-profit think-tank, established in 1993 to look at future developments in the international financial field - particularly from the point of view of practitioners. Its goals include identifying new areas of business, flagging areas of danger and provoking a debate about key financial issues. The Centre has no ideological brief, beyond a belief in open and efficient markets.

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Although Shirley had previously written for the Centre a polemic on regulating insurance which struck a powerful chord with many in the City,\(^1\) I was initially a bit reluctant to take on the task of publishing Beglinger.\(^2\) The insurance and reinsurance industry is (as she makes clear) opaque and riddled with arcane practices that seem designed to intimidate the non-elect. But a couple of cups of cocoa, a cold compress on my head… And I started to get the message.

Just as regulators have great difficulty getting their minds round the peculiarities of the insurance industry, so do accountants – with equally perverse consequences.

What this paper does is point out something that is (probably) obvious to most insurance professionals, but which doesn’t easily percolate through the wall between insurance and the rest of the financial services industry. It is that insurance is so different that it needs different, indeed bespoke, accounting rules, just as much as it needs its own, bespoke, regulatory rules. The main reason (though there is much more to it) is that, while premiums are paid up front, claims can take years to emerge – and are subject to legal, political, even medical uncertainties in the meantime.

It is Shirley’s main contention that this mismatch – and the unwillingness of the accountants, actuaries and regulators to address it with accounting rules that are specific to insurance – has led the industry into its dangerous dependence on the so-called finite reinsurance contracts that New York State’s next Governor, Eliot Spitzer, has found so tough to swallow in the case of AIG.

The conventional wisdom today is that finite re is (at best) a dodgy bit of accounting legerdemain designed to pull the wool over the taxman’s eyes. At worst, it has blurred in most journalists’ minds into the wider world of offshore SPVs, impenetrable derivative deals and the kind of corporate shenanigans that brought down Enron, WorldCom \textit{et al.} For Shirley, the truth is a lot simpler. Finite re is a rational response to the irrational exigencies of an accounting and regulatory system that steadfastly refuses to acknowledge the “specialness” of insurance and that refuses to encourage the building up and retention of long-term reserves against what the industry knows are long-term liabilities.

\(^1\) “\textit{Regulation of the non-life insurance industry: Why is it so damn difficult?”} by Shirley Beglinger, CSFI. 2004.
One of Shirley’s most telling points is that “insurance…is a sophisticated industry which communicates like a moron”. It seems incapable of making a case to accountants, regulators or the press for the special treatment that she believes it self-evidently needs. And, pace her own arguments, that may well not change. But, in the UK and Europe at least, the regulators are themselves increasingly taking up the issues posed by insurance—and Shirley’s paper is addressed as much to them as to a lay or practitioner audience. Her clear preference would be for a thorough revamp of accounting rules, to promote greater long-term reserving. But, whether that is realistic may be open to question. As a result, she also looks at tort reform (particularly in the US), mutual insurance, greater use of captives, and pay-as-you-go insurance.

Whatever, something has to be done to stop the short-term orientation of accountants and regulators from undermining the viability of an industry that is so crucial to the global economy.

Andrew Hilton
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Introduction

The main point of this paper is *nihil novum sub sole*: there is nothing new under the sun. Finite reinsurance is a very relevant case in point. It has been around for a long time, and it has been used extensively. Absent fraudulent intent, nobody before Eliot Spitzer seems to have found anything objectionable about it.

On the contrary, finite reinsurance is a rational response to the irrational exigencies of accounting rules – which force insurance companies on both sides of the Atlantic to under-reserve, often to the extent of jeopardising their viability.

This is not to say that accounting rules set out to be irrational; merely that accounting rules which are perfectly sensible when applied to a widget-maker may be idiotic when applied to insurance. The reason is that a widget-maker has cash flows and accruals which can be accurately reflected within the 90 days that common usage inflicts on us as the standard accounting period. An insurer does not. To an insurer, cash flows and accruals tend to emerge over 90 weeks or 90 months. Therefore, short-term cash flows are no reflection of an insurer’s true business position; indeed, they can be woefully misleading. There is a heavy price to be paid for this. This paper gives a number of examples of how the short-term bias of accounting rules produces an inaccurate and unreliable reflection of an insurer’s financial position that is detrimental to all its stakeholders.

In an ideal world, the international bodies would write accounting rules exclusively for insurance. These would reflect the fact that accounting logic needs to be turned through 180 degrees, so that insurers are positively encouraged to set up reserves - and to hold them for the long term (90 months), rather than be forced to dissolve them to comply with accounting rules written for more ephemeral industries.

Of course, this would require accountants to define what is an insurer – life assurer? non-life insurer? reinsurer? bancassurer? Supermarket chain? Large manufacturer or service company with in-house captive insurance company? The reason is that they would have to decide which companies would be permitted to apply these special rules. This, say the accountants, is a slippery slope. If once we start writing specific rules for insurers, they insist, soon we’ll be writing separate rules for widget-makers and pizza purveyors. Therefore, insurers will just have to rub along as best they can – and, by and large, that is what the insurers have done. And that is why we are now faced with the finite reinsurance problem: finite re is a nifty piece of legerdemain, which can compensate (to some degree) for the craziness of current accounting rules.
Since insurers have proven incapable of standing up to the accountants’ bullying, maybe they should look elsewhere for help – perhaps to the actuaries.

If the actuaries would certify that bigger reserves must be created by the insurers (and held for longer), then surely even the accountants would back off. The money would then be left where it belongs – on the insurers’ balance sheets, against a rainy day. Unfortunately, the actuarial profession (in both the UK and US) is not exactly noted for the strength of its backbone, and, so far, it has shown no inclination to pick a fight with the accountants (or the press) on behalf of a much-reviled group like the insurers.

The final line of appeal then must be to the regulators - who currently happen to be reviewing capital adequacy rules for EU insurers.

However, the problem with turning to the regulators (whether national or international) is that they tend to have a wonky grasp of where their priorities ought to lie:

- The UK regulator (now the FSA), for instance, is very excitable on the subject of contract certainty – and is demanding that the insurance industry drop everything else and beaver away until it has achieved it. Unfortunately, there is no such thing as contract certainty – neither in banking nor in insurance. At best, there may be ‘satisfactory contract documentation’, but not ‘contract certainty’. So that is a huge waste of effort.
- Meanwhile, the EU regulator is concentrating on developing models to assess capital adequacy in insurance companies … over a one-year time horizon. Unfortunately, any model which assesses capital adequacy over less than a three year time horizon is falling into the same short-term trap as the accountants have already set.

As for the US regulators, all 50 of them, they seem to be in thrall to the accountants.

Insurers, therefore are left high and dry, attempting to shoehorn their business into a set of rules which don’t make sense for them. As long as this is the case, it is a good bet that finite reinsurance will be around as well – and it really needs a few words in its defence. Hence this Note.
A man with a mission…

Eliot Spitzer strikes again.

Not content with his campaign against the global insurance brokers, Mr Spitzer has launched a broad front attack on AIG – long recognised as the smartest firm in an admittedly not very smart industry. Not only was AIG (purportedly) a willing accomplice in schemes whereby some brokers engaged in anti-competitive practices designed to maximise their income to the detriment of their clients, AIG (Mr Spitzer assures us) also abused finite reinsurance contracts to pretty up its balance sheet in years when the company would otherwise have posted a less than stellar performance. Then there were the offshore reinsurance transactions which, perhaps, ought not to have been booked as transferring risk away from AIG. And finally there were some small (but perfectly formed) corporate vehicles kicking around the AIG empire whose main purpose (allegedly) was to enrich AIG executives at the expense of AIG shareholders…

AIG shareholders of course must be heartily sick of all this. Since Mr Spitzer launched his three-pronged attack, the stock price has dropped by 20-25%. At a stroke, Mr Spitzer has defended the interests of AIG shareholders to the tune of US$50 billion of their own money.

There’s an element of hypocrisy in all this. The general feeling seems to be that, if New Yorkers would just elect the pesky man as Governor, shareholders and stakeholders could sleep quietly in their beds at night, certain that no more electioneering raids would be made on their stockholdings. And on the job front, Marsh and Aon employees could once again roll up for work without the fear that Mr Spitzer’s crusade would render them redundant.

And yet (I am forced to concede) the messages from Planet Spitzer have merit. Worse, some of them are applicable on both side of the Atlantic. After all:

- price rigging is bad;
- cooking the books is bad;
- tilting the playing field in favour of some people (and to the detriment of others) is bad; and
- transparency is good.

At least in these areas, if not in the very specific area of finite re, most of us think that the Missionary Man is spot on. Indeed many of us believe that what he is doing may eventually bring about more effective regulation of the insurance industry – even if he himself doesn’t really understand how the insurance industry runs, and
what its real problems are. So, I would be grateful if you would not assume this Note is a broadside against everything Mr. Spitzer stands for.

Unfortunately, prospects for better regulation are all too often torpedoed by the supposed good guys – the Government, the judiciary, the accounting bodies, the tax man, the regulators, the insureds, the shareholders, the stock analysts, and/or the rating agencies.

All of them, all too often, seem bent on ensuring that insurance is badly regulated and badly run. That is certainly the case with accounting rules that force the industry down the derivatives (or finite re) route. Since this is a powerful (if malign) coalition, it is a brave soul who would stand up against it. Why bother? Why should anyone give a toss for better insurance regulation or better management?

Well, first and foremost, regulators (and their political masters) should give a toss. Not because managers are jolly good chaps who deserve unquestioned support, but because insurance is a crucial financial service in the Western economy, whose provision is predicated upon a steady supply of new capital. The ideal supplier of capital is the long-term shareholder, someone who buys the stock and holds it over at least one economic cycle. An ideal shareholder who has such confidence in management that he pockets his annual dividend, doesn’t bother to show up at the AGM and usually doesn’t vote his stock – but allows management to get on with the job of prudent stewardship.

Did such a creature ever exist? Oddly, yes. Lord Keynes, for instance, was chairman of the family-owned Provincial Insurance for many years; Britannic remained in family control into the late 1980s. But we hunted the last of them to extinction here in the UK a few years ago when the old-style Lloyd’s market imploded.

The Lloyd’s debacle has been widely discussed. Suffice it to describe the sad story as a catalogue of fraud, fake, fudging and incompetence. Nobody was ever sent to jail or even hauled before the beak as a result of the goings-on, but there are many who feel that that a wing of Wormwood Scrubs should have been set aside for those involved. Those Americans who followed the story snickered at our archaic English ways and leaned back in the knowledge that it could never happen in America. But it did.

The financial reinsurance arrangements Mr Spitzer appears to have identified (and excoriated) at AIG could be kissing cousins of the Time & Distance reinsurance policies so beloved of Lloyd’s during the 1980s and early 1990s. And they could have the same devastating impact on the ability of the industry to attract and retain capital.
Finite Reinsurance in the Stone Age – how it was done at Lloyd’s

For those (lucky) readers who have never encountered Time & Distance policies, here’s a potted history.

A Lloyd’s syndicate was (and is) an annual venture. This means that the capital providers – ‘Names’ – do not entrust their money to the syndicate as they would to a long-term investment manager. Instead, the understanding is that the syndicate will use their money as capital to back the underwriting of risks offered to Lloyd’s for insurance. An insurance contract is customarily entered into for 12 months, so it was generally reasonable to assume that at the end of the year, a syndicate would know how much profit it had made. In theory then, the syndicate could return the Names’ money, plus their share of the profit.

Lloyd’s being English, there were a lot of eccentric rules and practices surrounding the annual venture, which needn’t be explored here. One rule was very pragmatic, however. It specified that since the venture was only for one year, at the end of that year all liabilities (ie claims) had to be reserved in such a way that even if the Names never came back, there would be enough money in the pot to cover every single penny owed.

This placed the syndicate managers in a huge conflict of interest: most of their compensation for actually running the syndicate was in the form of profit-sharing. Thus, if the syndicate hadn’t made any money, they didn’t get paid. The easiest way around this would have been simply to under-reserve – ie to set aside less money than they prudently knew they would need to pay claims. But Lloyd’s trusted the managers, and the DTI (the soi-disant regulator at the time) fully expected the Lloyd’s governing body to boot them out if they didn’t obey at least this one rule. So under-reserving wasn’t really on (except if the syndicate manager was convinced no one was looking).

What they could do with impunity, however, was to take advantage of the time value of money.

Interest rates were high in the 1980s and 1990s. Unfortunately, in the UK, so were taxes – so the post-tax return on investment wasn’t that great. If, however, the syndicate manager totted up his syndicate’s claims, and then assumed (realistically)
that about 5-7 years would elapse before he actually had to fork over the cash, he could discount those claims by the prevailing rate of interest. If, in addition, he invested the claims reserves in an offshore vehicle – say in Bermuda or the Cayman Islands – he could also avoid UK tax, so he could use an even higher discount rate. If it subsequently turned out that he’d discounted a bit too much, he could always top up the investment fund from the following year Names’ money (this was referred to, quaintly, as ‘buying cover from the following year’). Thus, a zero (or even negative) result could be turned into an underwriting profit from which the syndicate manager could take his profit-share – often as high as 30%. No-one really knows how T&D policies came by their name, but the ‘Time’ element was almost certainly the time the syndicate manager expected to elapse before pay-out occurred. The ‘Distance’ presumably meant the distance between London and the wonderful tax and regulation-free sunny islands where the syndicate manager stashed the funds.

If the syndicate manager had been an asset manager, even the gentle SROs of the time (IMRO and LAUTRO) would have been up in arms at the cavalier mixing of separate investors’ funds. Lloyd’s, however, apparently had an exemption from precisely that regulation, so no outcry ensued.

Nevertheless, the accountants must have been turning a wilfully blind eye for T&D reinsurance arrangements to go on for as long as they did. They were not reinsurance in any sense, since no risk was transferred between insurer and reinsurer. At best they were an accounting dodge. At worst, they were a forerunner of what Mr Spitzer would have us believe went on at AIG.

Finite Reinsurance in the Space Age – how we do it now

“Gaming” the rules . . .

Finite re; T&D policies; rollover policies; structured reinsurance; etc. etc. These are all names for broadly the same thing – essentially, for “gaming” the perversities of the current (crazy) accounting rules as they apply to insurance. They are intended to achieve one or more perfectly sensible (indeed, generally desirable) goals:

- to take risk off the balance sheet of the insurer;
- to enable reserves to be set up over a number of business years;
- to make it possible to move assets and liabilities from the balance sheet to the profit and loss account (and back again); and/or
- to optimise an insurer’s tax liabilities.
Note the crucial phrase: ‘to take risk off the balance sheet.’ This does not mean ‘to take risk away from the insurer’ or ‘to make it go away entirely’. In the same way that SPVs and derivatives were fashionable back in the 1990s for making unwanted ‘stuff’ disappear from the balance sheet, finite re has been developed to make often crazy accounting rules work in an insurer’s favour instead of against the long-term view stakeholders might wish to take.

Back in the 1990s, SPVs and derivatives were the buzz-words which filled newspapers on both sides of the Atlantic. Then LTCM collapsed under the strain of leveraging US$5 billion of capital into a US$1.5 trillion portfolio. And suddenly the message was: ‘Derivatives = Drugs.’

The banking industry, however, had long since set SPVs and derivatives into the bedrock of its business model. Hence, the bankers rode to the rescue of LTCM. Then they cranked up their PR machines. Seven years later, derivatives are no longer a dirty word in banking, and no-one would dream of attempting to legislate them out of existence. Indeed, the debate now revolves around how to bring their manifest benefits to the wider retail public.

Not so (yet) with finite reinsurance, which has instead become a very dirty word.

Insurance as a whole is a sophisticated industry which communicates like a moron. No-one outside insurance understands it, and the industry makes no attempt whatever to make itself understood. Thus, it is effortlessly possible for everyone – the man in the street, the financial journalist and Mr Spitzer himself – to assume that insurers are basically crooks. They are not.

This paper attempts to redress the balance – at least as regards finite reinsurance.

Basic insurance and reinsurance concepts

In order to explain finite reinsurance, it is necessary to remind the reader of some of the fundamentals of plain old-fashioned insurance:

- **The premiums of the many pay for the losses of the few**: Thus, if an insurer covers the professional indemnity liability of (say) 100
solicitors each for a sum insured of £1 million per loss and in the annual aggregate, then he must take a view on how likely it is that one of those solicitors will make a mistake (resulting in a claim against the insurer), and how large the claim is likely to be when it happens. (A banker reviewing his loan portfolio would think of this as probability of default and loss given default.) Perhaps past experience has led the insurer to know that on average 10 of the solicitors will make an error, and that the average cost of those errors will be £400,000 – for a total claims cost of £4 million a year. In addition, the insurer knows that he needs to cover administration costs related to this portfolio of about £500,000 per annum, and he would like to generate an underwriting profit of (say) £1.5 million. So, now we have a simple calculation: Anticipated Claims Costs of £4 million plus admin expense of £500,000 plus target underwriting profit of £1.5 million = £6 million divided by 100 solicitors = an annual premium of £60,000 each. Thus, the premiums of the 100 solicitors pay for the losses of the 10 solicitors.

- **The past is not necessarily indicative of the future:** Past experience has led our insurer to make assumptions regarding both the number of claims likely to arise and their likely value. If either of those assumptions proves to be incorrect, the insurer could be in trouble. Let’s assume that 12 solicitors make a mistake, and that the average value of the claims turns out to be £500,000 instead of £400,000. Suddenly, the insurer’s claims cost has jumped by 50% to £6 million, and his underwriting profit has disappeared in a blotch of red ink. This risk – namely that underwriting will not produce the anticipated result – is called *underwriting risk*.

- **The wise insurer doesn’t just underwrite, he invests:** This statement is so obvious that it shouldn’t even need to be made. But it’s worth remembering that insurance is a huge generator of cash-flow. So instead of just letting premiums sit in his pocket for the customary 12 month duration of an insurance policy - an insurer invests the money, usually in the stock or bond market.

This means that even where his portfolio of solicitors’ professional indemnity policies has not performed as expected, our insurer is not necessarily daunted by the underwriting loss. After all, past experience tells him that he won’t actually have to shell out for another five years. This is not because the insurer is deliberately obstructive (although many of us would be inclined to believe so), but because of the way the tort system works.
Assume a solicitor, working in 1999, makes an error – say in a property conveyancing - and that he notifies his insurer immediately. He then waits for his client to notice the mistake.

The client doesn’t bother to look at the property documentation until the next year, when he wishes to carry out an extension – say in 2000. The client then comes back to the solicitor, who hums and haws and finally admits that the problem needs to be fixed. The solicitor then writes to his opposite number acting for the other side of the property deal. That solicitor needs to consult his client - who is off on a world cruise and won’t be back until Spring 2001. The cruiser eventually returns and the two sides trade stately correspondence during the next 6-7 months. The erroneous solicitor now decides to take a two month holiday. Around about Summer 2002, the other solicitor announces that his client doesn’t feel inclined to sort out the problem. The erroneous solicitor then takes him to court. For six months, the two solicitors battle it out in the courtroom. Court adjourns for Christmas 2002, and the problem is unresolved.

By Spring 2003, the original client is frothing at the mouth. Nothing short of court proceedings against the erroneous solicitor will satisfy him. So the client sues the erroneous solicitor. Stately lawyerly correspondence once again ensues, and the matter eventually comes before a judge in Autumn 2003. The judge recesses (and Christmases) … and hands down a judgment against the erroneous solicitor in early 2004. This the solicitor duly passes on to his insurer, who writes out the cheque – pretty much five years to the day after he first received notification. Five years previously, of course, the insurer had concluded (from past experience) that the loss would be £400,000, and would pay out at the end of five years. So the requisite funds had been carefully invested over that period to generate a tidy profit. So tidy in fact that it makes up to the insurer for the fact that he now has to pay out £500,000 per claim instead of the £400,000 he anticipated.

Now let’s assume that something changes … Say, for instance, that an administrative rule-change now allows junior circuit judges to hear cases valued up to £1 million (instead of the previous £100,000). Suddenly, our conveyancing case no longer needs to await the stately attention of a senior judge; the time needed for all of the above is compressed into two years and the claim is paid out in Spring 2001. The insurer had set aside the same £400,000, but he was only able to invest it for two years; so instead of growing to £500,000, it has only grown to (say) £440,000.
It is not unknown for claims pay-out patterns to change in this manner. This unforeseen speed-up in pay-out (and the resultant failure of invested reserves to have grown as needed) is called *timing risk*.

**Fortuity and insurability** – *in order for a risk to be insurable, the occurrence of the event needs to be fortuitous in both time and value*: That sounds like waffle, which is perhaps why this fundamental of non-life insurance is frequently forgotten - even by experienced insurance professionals. Broken down into its components, it makes a bit more sense.

The *OED* defines ‘fortuitous’ as ‘due to or characterised by chance; accidental, casual’. In other words, for a risk to be *insurable*, we cannot know *whether* something is going to happen, and, if it happens, *when* it is going to happen. And when it has happened, we cannot know *how much* it is going to cost. That said, in order to be insurable, the risk must be capable of a *monetary valuation* – if it cannot be objectively valued, it cannot be insured. In plain English: you cannot insure your house after you’ve burnt it down, because that event fails both the *whether* and the *when* test. Assuming that you’re not a good arsonist and your house is well built, the event will probably pass the *how much* test. Unfortunately for budding arsonists, all three tests must be passed.¹ *Insurability* is an important concept for later.

**Accumulations and catastrophes**: Common usage would see ‘accumulation’ either as the heaping up of something or (again the *OED*) as ‘the growth of capital by continued interest’. To an insurer, the word ‘accumulation’ means that several (or several hundred) policies in his portfolio can be affected by a single event or cause. Let’s imagine for example that our insurance company also has a thriving portfolio of retail insurance, particularly from a snooty area in West London where the company has an especially successful sales office. In one euphoric moment, it calculates that 40% of all households within a five mile radius of that sales office have both their homeowners’ and their vehicle policies with our insurance company.

Just as management is chilling the champagne to celebrate the great sales effort, a freak hailstorm strikes Chelsea. Traffic grinds to a halt, everyone runs for cover. Half an hour later, it’s all over and the sun comes out. Nobody has been seriously hurt, so everything is fine.

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¹ There are policies which place a value in advance on the event, eg a value on Marilyn Monroe’s legs, but they are a special case
quite. The hail has left about a hundred of those sinfully expensive Chelsea tractors looking as though they’ve been worked over with a sledge-hammer. Sky-lights have been broken, plate-glass windows smashed by bouncing hailstones … In short, several hundred of the insurer’s policies have been affected by a single event. In insurance-speak, this is a catastrophe.

This brings us to another important point. There are all sorts of mechanisms whereby an insurer can lay off risks which exceed his appetite or capital strength. But just as you can’t insure your house after it’s been set alight, so the insurer cannot lay off parts of his risk when the risks are already coming home to roost. In general, though (as we shall see) not always, he must arrange this protection – reinsurance – in advance.

There are many forms of reinsurance, but it suffices for now if we discuss two basic forms:

- **Proportional reinsurance:** There are many variations of this, but the simplest is the Quota Share Reinsurance Treaty. This is a contract between the reinsurer and the insurer (who for purposes of this contract mutates into ‘the cedant’), which states that the cedant will automatically share with the reinsurer a certain quota of the policies he insures (hence the name). So, for every policy our insurer issues, he will automatically (he has no choice in the matter, so cannot cherry-pick) cede to the reinsurer (say) 50% of his premium. The reinsurer agrees to accept that 50% automatically – again, no choice in the matter, no cherry-picking. In exchange, however, when a loss occurs, the reinsurer must pay 50% of any loss to the cedant.

Such contracts are usually concluded for 12 months. The other thing we need to know is that proportional treaties usually call for quarterly accounts to be rendered, and for cedant and reinsurer to settle up between them at the end of each quarter. Hence, there are cash-flow and accounting implications. Only in special (and pre-defined) circumstances may the cedant call upon the reinsurer to pay his share of a loss immediately, rather than wait for the next quarterly account.

- **XL reinsurance:** The other basic form of reinsurance is the Excess of Loss Treaty. In its most simple form, this is again a contract which stipulates that the cedant will purchase reinsurance from the reinsurer on an Excess of Loss (XL) basis – either per risk or per event – the risks to be affected or the event to occur during the 12 month life of the treaty. Note again that the insurer lays off the risk on a prospective basis – and
pays over the reinsurance premium before he knows whether he will need the cover.

In XL reinsurance, there are no simple percentages. Instead, the per risk XL treaty stipulates that the reinsurer will pay (for example) all loss affecting a risk in the insurer’s portfolio in excess of the insurer’s retention of (say) £250,000 and up to a limit of £500,000. In reinsurance parlance, this would be £250,000 in excess of (or xs) £250,000. In proper English, it means that if, for example, one of those fancy Chelsea homes has a fire, the resultant bill would be split between the cedant and the reinsurer as follows:

- The first £250,000 will be completely for the account of the cedant – he won’t receive a penny from the reinsurer.
- The next £250,000 will be completely for the account of the reinsurer – and he will be required to pay immediately (ie. no quarterly accounts nonsense).
- Any portion of a loss which exceeds £500,000 falls back upon the insurer – the reinsurer is not in the least concerned.

The per event XL (or Catastrophe XL) treaty does what it says on the box. If more than one risk – usually at least two or three risks (this is the generally accepted number) – in the insurer’s portfolio are affected by the same event or catastrophe, the reinsurer will pay all loss in excess of the cedant’s retention of (for example) £250,000 and up to a limit of (for example) £500,000. Again, in reinsurance parlance, this would be £250,000 xs £250,000 per event. In proper English, going back to our hailstorm example, it means the insurer keeps a running tab of all the bills he pays for his insureds to fix the damage done by the hailstorm. The cost of repairing the first 25 Chelsea tractors and the first 30 plate-glass windows tots up neatly to £250,000. The reinsurer offers a sympathetic smile but no cheque. However, it turns out that there are still 10 cars and 20 sky-lights that need fixing, for an aggregate cost of £150,000. The cedant has already used up his £250,000 retention, so now he holds out his hand, and the reinsurer duly hands over a cheque for £150,000.

In terms of cash-flows, it’s worth noting that most of the cash-flows in XL reinsurance occur at the beginning of the year (barring claims). In particular, the reinsurer calculates (and collects) his basic premium at the beginning of the year. However, recognising that the cedant’s portfolio of risks may grow during the course of the year, the reinsurer also reserves the right to collect a certain percentage of the annual premium at the end of the year – if the portfolio has indeed grown. XL treaties are usually on a losses-occurring or claims-made basis; again, this affects cash-flows.
Note a few key factors common to these and to all other permutations of reinsurance:

- In Anglo-Saxon countries, the contract is concluded at the beginning of the year, usually for 12 months. If the treaty is on an underwriting year basis, then risks (or policies, in good English) accepted by the insurer during those 12 months are protected by the treaty.

- Neither cedant nor reinsurer knows in advance what the risks and events will be, but they agree at the outset to share the financial outcome of the period.

- A shrewd insurer/cedant can use his proportional reinsurance arrangements to manage cash-flows – both in reality and in his quarterly reporting. As an example, let’s assume that the owners of those Chelsea tractors and plate glass windows pay their premiums on time (Mr and Mrs Middle-England tend to do so). Our insurer therefore has a pretty good idea of what money flows into his P&L statement. Those funds might theoretically flow straight through him to the reinsurer, but his treaty only calls for him to render accounts 90 days after the close of the quarter – and to pay over any balances due 90 days thereafter. (Astonishing as it may seem, many proportional treaties are indeed concluded on this basis.) Theoretically therefore, our insurer can get anywhere between six and nine months’ investment use out of inward-flowing premiums before he needs to pass them on to the reinsurer.

- By the same token, an insurer who is aggressively seeking to grow his portfolio can make inventive use of his non-proportional reinsurance arrangements. He knows that he only needs to pay a certain up-front premium at the beginning of the year, and that ‘buys’ the reinsurer for the coming 12 months. If the insurer grows his portfolio by cutting premiums, when it comes to the end of the year and he renders account, he may have been protecting a far larger portfolio than envisaged by the reinsurer, but the pool of premiums will not have grown commensurately – and therefore the reinsurer will not be receiving quite the price per policy he had envisaged.

Now, this is naughty, and there’s a cosy little thing called ‘Uberrima Fides’ – Utmost Good Faith – which is supposed to prevent the cedant from taking advantage of the reinsurer. Since most cedants are of course good chaps, they would never abuse their reinsurance in any way. However, over several hundred years, insurance has proven itself almost uniquely open to abuse by dishonest players, and reinsurance is merely another part of insurance. As a result, there are always a few crooks around.

Everyone accepts this. It is also accepted that their activities are not a justification for suggesting that insurance or reinsurance be legislated out of existence. Why then this witch-hunt against finite reinsurance? It too can be used and abused; but it generally serves an absolutely sensible commercial purpose.
How it works – a simple example of Finite Reinsurance

Let’s go back to our insurer of solicitors’ PI policies.

Because he’s been doing the business for a long time and has lots of claims data, our insurer has concluded that there is no risk of accumulation (see definition above) in this portfolio – therefore, no catastrophe risk and no need to waste good money buying reinsurance for the portfolio. Accordingly, he doesn’t.

Unfortunately, the solicitors have a bad year, and 20 of them notify claims under their policies. In each case, the insurer knows it would be prudent to reserve (say) £500,000. This would give him total claims reserves in this particular year for this particular portfolio of £10 million. Since our insurer is a fairly small company, he is very aware that the £10 million is going to look bad on his books at year-end. His loss ratio (the ratio of premiums written to claims paid and reserved) will sky-rocket; his shareholders will have a major sense of humour failure.

But wait. The claims won’t be paid out this year – or next. Our insurer knows it will take the various cases at least five years to wend their way through the court system. So rather than post the £10 million reserve in one huge result-bashing whack, he could build it up over (say) five years at £2 million per year. Hey presto, his first-year result is rescued.

Unfortunately, even though that might make sense from an economic point of view, it is not quite that easy. How does our insurer explain to his shareholders that he’s sticking an extra £2 million into reserves each year for five years when they know of no reason for such reserves? They will suspect him of cooking the books. The accountants – if they’re doing their job – will refuse to sign off on a first year reserve of £2 million when they can see perfectly clearly that the right number is £10 million. And even if our insurer manages to clear those two hurdles, then he’s produced £8 million of illusory profits… of which the tax man will want his cut.

Enter the finite reinsurer. Even though the days of T&D reinsurance are long gone, there are still lots of reinsurance companies capitalised and registered in Bermuda or the Bahamas. Lurid stories in the press notwithstanding, this doesn’t mean that they are unregulated – Bermuda in fact has quite a strict regulatory regime. But it does mean that our finite reinsurer doesn’t have to worry about the tax-man looking greedily over his shoulder.
The simplest structure imaginable ...

So our insurer pays the finite reinsurer a premium of (say) £7 million to take on the £10 million of claims. The difference between the premium paid and the reinsurance limit is accounted for by the fact that the reinsurer expects to invest the premium over the five years to pay-out. By the time he comes to pay, the reinsurer calculates that the £7 million will have grown to £11 million – giving him ample funds to pay out, as well as a nice little profit on the deal.

The insurer has removed £10 million of liabilities from his books, thus boosting net capital by £3 million (being the difference between the premium he paid and the liability disposed of). At the same time, he will have improved his underwriting profit by the same £3 million. Done and dusted; everybody happy.

Not quite. Strictly speaking, this deal transfers no underwriting risk between the two parties. The reinsurer knows in advance what his absolute maximum pay-out will be. If something changes – eg the junior judges we discussed before come on the scene - and payout speeds up faster than investments can grow, then and only then has the reinsurer accepted any risk. And that risk is only timing risk.

But, even if it isn’t perfect, this particular finite re deal does fulfil its purpose of moving numbers between the P&L and the balance sheet. Let’s work through a simple before-and-after comparison, using only the numbers relevant to the solicitors’ professional indemnity:

<table>
<thead>
<tr>
<th>Profit and Loss Statement before finite reinsurance transaction:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium income                                               £ 6,000,000 +</td>
</tr>
<tr>
<td>Administration expense                                       £ 500,000 -</td>
</tr>
<tr>
<td>Claims incurred (ie paid &amp; reserved)                         £ 10,000,000 -</td>
</tr>
<tr>
<td>Underwriting result                                          £ 4,500,000 -</td>
</tr>
</tbody>
</table>

Negative result drops straight from the P&L bottom line into the Balance Sheet as a **reduction** in net assets £ 4,500,000 -

<table>
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<td>Premium income                                               £ 6,000,000 +</td>
</tr>
<tr>
<td>Administration expense                                       £ 500,000 -</td>
</tr>
<tr>
<td>Reinsurance premium                                          £ 7,000,000 -</td>
</tr>
<tr>
<td>Underwriting result                                          £ 1,500,000 -</td>
</tr>
</tbody>
</table>
Negative result drops straight from the P&L bottom line into the Balance Sheet as a reduction in net assets £ 1,500,000 -

However, this is offset by a Reinsurance Recoverable on the asset side of the Balance Sheet £ 10,000,000 +

Therefore, net total assets are increased by £ 8,500,000 +

All of this looks very much like the sort of jiggery-pokery so beloved of investment bankers. Indeed, it is precisely that. There are as many permutations of finite reinsurance as there are of structured finance, and each transaction is tailored to exploit a specific accounting treatment or to handle a specific problem. Both sides know that the reinsurer is simply acting as a bank for the insurer. And the insurer knows perfectly well that, if he puts seven million in the bank, he still has to show the ten million liability, as well as the hit to earnings. Whether the deposit-holder is the bank or the reinsurer makes no odds: the liability and the earnings-hit still have to be shown.

Nevertheless, this transaction is actually rather clever. It reduces the loss in the P&L to a size which need not disturb analysts or shareholders. It expands the asset side of the balance sheet, which is always a good thing. And it does both without creating any kind of income upon which the tax-man can cast an acquisitive eyeball.

**Beggar at the feast...**

At this point the accountant steps in – as always, the beggar at the feast. This transaction, he announces, is not reinsurance. The way it should be shown is:

**Profit and Loss Statement after finite reinsurance transaction:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium income</td>
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</tr>
<tr>
<td>Underwriting result</td>
<td>£ 4,500,000 -</td>
</tr>
</tbody>
</table>

Negative result drops straight from the P&L bottom line into the Balance Sheet as a reduction in net assets £ 4,500,000 -
Deposit with reinsurer for investment purposes (ie remaining on the asset side of the Balance Sheet) £ 7,000,000 (neutral, as not moved)

Accrued investment gain – being £3 million spread over five years £ 600,000 +

Therefore, net total assets are decreased by £ 3,900,000 -

So, the accountant would have the insurer show the full hit to earnings, and an only slightly smaller reduction in total assets.

That’s not the idea at all, wails our insurer. If he’d arranged the damn reinsurance as a traditional reinsurance treaty, in advance, the accountant would now be looking pretty much at the post-finite re figures the insurer wants to show. And the accountant wouldn’t have a thing to quibble about. The accountant snorts. Yes, he says, but the insurer didn’t arrange a traditional reinsurance treaty. So he does have to quibble. Why doesn’t the insurer go back to his reinsurer and arrange a proper traditional reinsurance treaty?

Armed with this suggestion, our insurer trots back to his reinsurance company. Would it perhaps grant him a reinsurance treaty retroactive to the beginning of the financial year? Of course, there have been claims but nothing much to worry about – and no doubt that can be offset by the higher premium the reinsurer will charge him. The reinsurer gives him the sort of carefully worded response generally reserved for lunatics. The claims have happened. Their likely amount is known. Therefore this offer fails all three tests of insurability: whether, when and how much? In short: No.

So the insurer goes back to his accountant and complains bitterly about how unfairly he’s being treated. The accountant patiently explains the two main rules applicable to the type of accounting treatment desired by the insurer:

- in the US, it’s FASB Rule 113; and
- in the UK, it’s FRS 5.

The syntax and the spelling differ, but both rules specify that there must be a ‘significant’ transfer of both underwriting and timing risk in order for the transaction to be booked as reinsurance. ‘Significant’ is never defined clearly in either rule, but it is generally assumed that it would translate to mean that the Net Present Value of the payments the reinsurer is likely to make arising from this arrangement must be at least 10-20% greater than the Net Present Value of all cash flows to the reinsurer.
The simple structure becomes more complicated...

Long-faced, the insurer trudges back to his finite reinsurer – who assures him that ‘it’s not a problem, me old china’. The transaction just requires a little bit of restructuring, that’s all. Instead of structuring it as a 100% quota share reinsurance treaty, it’ll be structured as an excess of loss reinsurance treaty.

So, knowing there are £10 million of liabilities looming out there, let’s structure it so that the insurer keeps the first £2 million of liabilities (in reinsurance parlance, his retention is £2 million). The finite reinsurer then sells him a variation on the Excess of Loss Treaty – let’s call it an XL on Aggregate – for £10 million xs £2 million.

Hold on a sec. There is only (sic) £10 million of losses out there. If the insurer takes the first £2 million of those losses as his retention, the finite reinsurer only needs to sell him an XL on Aggregate for £8 million xs £2 million. Why does the finite reinsurer want to sell more cover than is necessary?

Well, first of all, the reinsurance premium might be smaller. Huh? The insurer is still ‘buying’ £10 million worth of cover, so why would the premium be smaller? Using complicated graphs and flow-charts, the reinsurer explains the following (actually, the finite reinsurer uses a lot of complicated actuarial science in this discussion, but the numbers below set out an approximate rule of thumb which is close enough to reality for the purposes of our example):

- Solicitors’ professional indemnity claims are composed of two elements:
  - The lion’s share is the actual amount of liquidated damages which is finally agreed as the monetary value of the solicitor’s error. This is usually about 80% of the total sum involved. And it is usually paid out towards or at the end of the five years we’ve discussed elsewhere.
  - The far smaller share of the claims – say 20% of the total – is legal and defence expenses, which the insurer customarily advances for the erroneous solicitor. Thus this 20% of the aggregate claims is usually paid out at an early stage in the proceedings, and tends to dribble out regularly during the five years.

- By taking an aggregate retention of £2 million, the insurer is essentially taking on the 20% of payments which will definitely dribble out first.
- By covering all the claims after that, up to £10 million, the reinsurer is assuming only that part of the claims which will pay out at the very end of the five years.
Therefore, whatever money he receives up front does not need to take account of the minor depletions which would otherwise arise as defence costs are paid out. So the reinsurer needs to charge a premium which will enable him to generate £8 million to pay out at the end of five years, plus of course something extra to allow for his profit on the deal.

DCF (Discounted Cash Flow) models are cranked up and spreadsheets run. An investment model is selected which will take in a large chunk of cash up front, produce no liquidity at all for five years – but then will turn in a lulu of a capital appreciation. The number at the bottom of the page is £4.5 million, which still includes £500,000 of profit for the reinsurer.

All right, but even assuming our head-scratching insurer is willing to buy the deal, no-one has yet explained to him why he needs to buy £10 million xs £2 million when both he and the reinsurer know that his claims are only going to add up to £10 million. Surely there isn’t any point in him buying £2 million of un-needed cover.

This is where the accounting rules come in – FRS 5 or FASB 113. They (sort of) specify that the NPV of the anticipated pay-out must be at least 10-20% greater than the NPV of all cash flows to the reinsurer. Put differently, if one discounts the value of claims by the prevailing interest rate over the period until anticipated pay-out, the amount of premium paid in respect of those claims today must still be 10-20% smaller than the discounted value of the claims. Only then will accounting practice accept that both timing risk and underwriting risk have been transferred.

Still our insurer scratches his head. So our finite reinsurer draws him a picture: the £4.5 million invested at a good interest rate, with no draw-downs of capital and all interest reinvested, can, thanks to clever investment, reliably be expected to grow to £8 million by the end of five years. And, of course, the finite reinsurer expects to pay out precisely £8 million at the end of five years. Therefore, the NPV of cash flows out will not exceed the net present value of cash flows in. Therefore the accountant will not agree to treat the transaction as reinsurance, but will demand that it be accounted for using deposit accounting – as in the Beggar at the Feast example above. Therefore, the finite reinsurer is offering a limit of £10 million, whose NPV is clearly greater than the NPV of inward cash flows. The accountant will have no excuse to quibble, but will book the transaction as reinsurance and not as a deposit.

The insurer cannot believe that his accountant will not recognise that he is buying £2 million more of cover than he needs. The reinsurer explains that there is a chance that the solicitors’ claims might be larger than £10 million – possibly even as large as £12 million. The insurer snorts. That chance is so small as to be identifiable only to an actuary, and then only with a magnifying glass.
... but balance sheet engineering becomes easy

It matters not, asserts the finite reinsurer. Accounting rules are written so that they address the *form* of a transaction rather than its *substance*. In *substance*, both the insurer and the reinsurer know that the insurer has bought only £8 million of effective cover, but the *form* says £10 million. And, under the letter of the rules, the accountant must look at the *form* — no matter what he suspects of the *substance*. This is a most curious reversal of the manner in which contracts are generally evaluated, but the insurer thinks it’s worth a punt and takes it down to the accountant — who waves the transaction through as reinsurance, with a happy smile.

So, now the numbers look as follows:

**Profit and Loss Statement after finite reinsurance transaction:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium income</td>
<td>£ 6,000,000 +</td>
</tr>
<tr>
<td>Administration expense</td>
<td>£ 500,000 -</td>
</tr>
<tr>
<td>Cost of reinsurance</td>
<td>£ 4,500,000 -</td>
</tr>
<tr>
<td>Claims incurred (ie paid &amp; reserved)</td>
<td>£ 2,000,000 -</td>
</tr>
<tr>
<td>Underwriting result</td>
<td>£ 1,000,000 -</td>
</tr>
</tbody>
</table>

Negative result drops straight from the P&L bottom line into the Balance Sheet as a *reduction* in net assets **£ 1,000,000 -**

However, this is offset by a Reinsurance Recoverable on the asset side of the Balance Sheet of **£ 8,000,000 +**

Therefore, net total assets are *increased* by **£ 7,000,000 +**

What a happy outcome – and again, the tax-man doesn’t see a penny of it. This is not to say that the transaction is *designed* to avoid tax, but tax optimisation is a serendipitous side-effect.

Oh, one other little thing: in order to pass the accounting tests, the ‘risk’ must be transferred outside the economic family, ie to an entity over which the insurer has no control. In other words, our insurer cannot simply set up an offshore subsidiary of his own in (say) the sunny Bahamas, shove the liabilities in there, chuck a bit of premium after and have done. In order for the serendipitous transaction to succeed, the
accounting rules require that the premiums and liabilities be passed on to an entity of which the insurer:

- owns less than 20%;
- does not exercise day-to-day management control; and
- does not control the composition of the board of directors.

If any one of these tests is failed, then the transaction must be brought back on to the balance sheet or consolidated. Then all the happy side effects go away and the insurer is exactly where he stood before.

It may be that the accounting rules are written with what was intended to be great care precisely because of the way Lloyd’s used T&D policies (see above) during the 1980s and early 1990s. Those T&D policies enabled syndicates to show a profit (like our insurer’s illusory £7 million increase in net assets above) while pushing their ever-burgeoning liabilities ahead of them like a beetle with a huge and growing dung-ball. Unfortunately, some time during the early 1990s, the dung-ball reached critical mass and exploded. The fall-out is still coming down all over the world.

Spitzer’s probe

The AIG investigation . . .

Mr Spitzer is rumoured to be looking hard at several such transactions, which appear on AIG’s books. The US $250 million deal with Gen Re captured most attention since Gen Re is part of Berkshire Hathaway – and Berkshire Hathaway equals Warren Buffett.

Far more interesting though is the series of deals allegedly concluded with offshore reinsurance vehicles which Mr Spitzer seemingly believes are controlled by AIG. In effect, AIG seems to have bought reinsurance from itself. Apparently, portfolios or years of account were closed out by the simple means of buying a Lloyd’s-style T&D policy from an offshore (non-US) entity. In other words, the dung-balls were shoved offshore and left to fester, while the AIG balance sheet apparently went from strength to shining strength.

AIG was doing what it had to do . . .

Along came Mr Spitzer, and suddenly these offshore vehicles must be fully consolidated. Since it has the strength to do this, AIG’s balance sheet will probably expand like the muscles of an Olympic weight-lifter. In contrast, if Lloyd’s had ever been forced to do the same, it would have sunk like a stone under the weight of the dung-balls.
Mr Spitzer professes himself puzzled as to why AIG entered into these dodgy deals, which he seems to think its management clearly knew were wrong – as, presumably, did Lloyd’s twenty years ago. Unlike Lloyd’s, however, Mr Spitzer feels that AIG had no need to indulge in such transactions because it was an otherwise extremely well-run company. But that’s the point exactly: well-run companies are run by rational people. When rational people are confronted by irrational rules, they rationally set out to turn those rules to a rational – constructive – purpose.

If the AIG example is being hammered here, it’s precisely because AIG is a well-run company, which one is inclined to believe was attempting to do the right and rational thing by its shareholders. And AIG is a perfect proxy for many other companies – both insurers and manufacturers – who see no other recourse than to game the rules.

AIG is far larger and stronger than Lloyd’s was: its balance sheet may lose its shine, but the onslaught is unlikely to cause meltdown.

What could cause meltdown though are those endangered, trusting AIG shareholders. Being American (and therefore protected by robust securities laws), they may well turn on AIG’s management en masse. And yet – if they were really after justice, and not just money – those enraged shareholders would be on the case of the Financial Accounting Standards Board, whose crime has been to create a body of accounting rules which forces companies and their accountants either:

- to bend the rules to find FASB-acceptable ways of creating the reserves they know are necessary; or
- to sign off on accounts which reflect short-term cash flows, but which they know do not accurately reflect their long-term prudential financial standing.

And here’s the daft bit: the manager who does the prudent thing is accused of accounting fraud, whereas the fellow who does what he knows must be tantamount to harm to long-term shareholders gets off scot-free. Surely, it is the accounting rules which need re-inventing, not the manager.
The implications for the insurance industry

Most of the implications of this are bad. Inevitably, while we wait for the accounting rules to be re-written (and don’t hold your breath), shareholders will change their investment strategy towards insurance stocks – not just AIG, but the entire sector.

It is already starting. Over the past two decades, the insurance and reinsurance industry has destroyed humungous amounts of capital – and it doesn’t seem to have changed its ways. In 2003, for instance, UBS published a study which suggested that the industry had successfully destroyed US $100 billion of capital during the 1997-2001 period. What is different now is that investors are less forgiving: the same UBS study shows that less than 30% of the US $100 billion has been replaced. And much of that new capital looks very different to traditional investment in the insurance industry. It seems to come with labels such as ‘Goldman Sachs Venture Capital’ and a business plan with ‘fast exit strategy’ blazoned across the top. Increasingly, the new breed of insurance investor is a hard-nosed speculator. He doesn’t buy management’s siren song that ‘this time it’s different’, that ‘we’ve learned from our mistakes’ or that ‘we’re only writing for profit now’. He doesn’t seek to understand insurance or insurers; he just takes a punt on the stock now and then.

The volatility in insurance stocks since 2001 says it all. Investment analysts now treat insurance stocks warily. At the best of times, it has always been difficult to get reliable information on insurance company performance. Now, it must seem worse. As a result of Mr Spitzer’s activities, AIG may well be forced to restate several quarters’ worth of numbers. Although this would actually affect only a small fraction of AIG’s worth, analysts around the world see this as confirmation of their mistrust of insurers in general. Even in ‘solid’ markets, they say, it’s easy to cast away good prospects if management goes astray. In short, you can’t trust them with your money. Therefore, buy cheap, watch for market events, and sell swiftly.

So the stable supply of capital which is the mainstay of the industry has headed for the exit – and all because of AIG’s finite reinsurance shenanigans. Right?

Well, yes and no. Yes, long-term capital has dried up. And, yes, AIG is being blamed. But the blame is largely unfair.

The court of public opinion is being primed to declare all finite re transactions (and others of their ilk) anathema and to cast them and their perpetrators into the outer darkness. But before we unleash the Inquisition, we should take a moment to examine why such transactions came into being. It just isn’t believable that some
insurer somewhere sat down and thought: ‘Steroids for the balance sheet. What a good idea.’

Leaving Lloyd’s and its T&D debacle aside, finite re didn’t start out as a conspiracy to defraud stakeholders. As I hope I have made clear, it began as the prudent manager’s response to the often counter-intuitive exigencies of IFRS and US GAAP. Both sets of rules demand that cash-flows be reflected exactly as they occur, and when they occur. Some leeway is granted for ‘foreseeable’ accruals – where ‘foreseeable’ is defined as ‘almost certain to occur during the next 6-8 quarters’. But that’s all. In general, that sounds perfectly sensible – until you apply the notion to an insurance company’s cash flows.

I want to examine this paradox in a bit more detail.

Perverse accounting incentives

Returning to our insurer of solicitors’ PI, let’s imagine that there is no friendly finite reinsurer, and that the whole dreadful year must play out in his very own P&L and balance sheet. Next, let’s imagine a time-line, with five years marked off from left to right. During Year 1, the insurer issues the policies and collects the premium – and the 20 unfortunate (or ‘bent and incompetent’) solicitors notify their claims to him.

At the end of Year 1, our insurer knows he ought to post a £10 million reserve across the portfolio. But if he does, he’s going to tip his underwriting result into the red. The analysts will hate him and the punters (formerly known as investors) will desert him in droves. Nevertheless, being a brave and slightly suicidal insurer, he decides to go ahead and stick up the reserve. His stock price duly tanks.

At the end of Year 2, the reserve has thrown off some unexpected investment gains, and his accountant suggests that the insurer has over-reserved. At the end of Year 3, there have been positive legal developments in several of the solicitors’ cases. The accountant is now rather forceful about taking down the reserve, because he doesn’t wish his own good name tarnished by accusations of cooking the books and diddling the tax man. Against his better judgment, the insurer therefore, reduces his reserve to £6 million and pays taxes on the resultant £4 million ‘underwriting profit’.

At the end of Year 4, the insurer’s natural pessimism is vindicated. Everything tanks, and the reserve needs to be increased back up to £10 million. Underwriting results for Year 4 drip red ink because that increased reserve must of course be financed
out of Year 4’s underwriting income. Our insurer complies with the accounting rules, and shows the flows as they occur. Underwriting results swing wildly yet again. Punters head for the exits. And then, of course, the wheel turns once more. By the end of Year 5, the claims have settled – substantially, for the £10 million the insurer first guesstimated.

At this point the accountant offers a damp handshake and a weak apology for insisting that the reserve be ‘corrected’, thereby causing the insurer to pay taxes unnecessarily. The tax man resoundingly does not offer to give back any of those taxes. Opportunistic punters have made money trading in and out of the stock. The insurer has acquired a reputation for fudging his numbers, diddling the tax man and generally not being on top of his business. And, all the while, the poor chap was only trying to do the right thing.

If the insurer had simply arranged the finite re contract discussed above, the accounting rules would have worked to his benefit. True, he would have paid over a large amount of money, which the reinsurer would have invested. And the claims reserves might still have gone up or down. But the accountant would now be looking at a reinsurance recoverable rather than at a dodgy reserve. He would have no reason to insist that the reinsurance recoverable should be reduced. The tax man has no immediate claim on anything that is labelled as a reinsurance recoverable. So a simple bit of hocus pocus could have made the insurer look prudent, reliable and on top of his business.

However the insurer would have been applying the letter of the accounting rules, rather than the spirit – and that carries its own risks. Indeed, the AIG experience suggests that Mr Spitzer and the NY State Inquisition would have an insurer apply both the spirit and the letter to his business dealings – with the letter prevailing where they conflict, and new rules frequently being applied retroactively.

This is a dangerous precedent. Imagine a case in which smoking was banned in all public places with immediate effect. Hooray. But now imagine that the same law had a codicil which says that anyone seen smoking in a public place over the past five years would be liable to a large fine. The mere whisper of the word ‘constitutional’ would blow the codicil into oblivion. Not so apparently with rules governing corporate conduct.

Beetles, dung-balls and dastardly doings at Lloyd’s 20 years ago notwithstanding, most finite re transactions are concluded for good commercial reasons. The foremost of these is the need to set money aside for uncertain outcomes – something that the prevailing tax code makes far more difficult than it should be.

The problem is that corporate shenanigans over the past few years have convinced too many people (and too many politicians) that such reserves are just ‘slush funds’,
that the people who set them aside are ‘creative’ accountants – and that the accountants who sign off on them are called ‘Arthur Andersen’.

But insurance is different. Really.

**Insurance is about the long-term, not the next accounting quarter**

Asbestos demonstrated unequivocally that insurance is all about uncertainty. In fact, it’s about *long-term* uncertainty. When the first wave of products liability judgments came down against manufacturers of asbestos in the early 1970s, underwriters thought they had hit Armageddon. Policies written 30 years before suddenly came lurching out of the crypt demanding huge payments. Some underwriters went broke, others just barely survived.

And then in the 1980s, just when the industry felt it was safe to go back into the water, the American plaintiffs’ bar found a way to come back for a second bite. It went after, not just manufacturers (whose insurance limits had long since disappeared), but after the landlords, the building industry, the machinery industry – after anyone in short who had ever used, touched, owned, manufactured or in any way allowed asbestos to come into contact with people, irrespective of whether those people were healthy, sick or dead of mesothelioma.

The American court system being what it is, a judge duly handed down a judgment which insisted that a company was liable if:

- it could be identified as having first exposed a claimant to asbestos;
- it could be connected to the claimant at the time he first manifested an asbestos-related disease; and/or
- it had employed the claimant at any time between his first exposure to asbestos and his manifestation of disease.

Oh, and the liability was joint (not several) between the companies and their insurers, which meant that if someone went bust under the weight of asbestos liabilities, the survivors were required to pick up the slack.

For the average insurer, this was insanity. The judgment made them parties to a contract they had never entered into. And, in many cases no doubt, it made them parties to a contract which they had specifically declined to enter into.
The definitive study on the evils of asbestos was published in 1927, so everyone in manufacturing or construction knew very well what they were getting into. Nevertheless, asbestos continued to be used in everything from car braking systems to fire retardant wall-hangings. Everyone knew that there was no question of whether harm would occur to humans, but only a question of when that harm would occur. Since one prefers not to think of insurers as total idiots, it is reasonable to assume that insurers of the time believed that asbestos was excluded from their policies by reason of its failure to pass all three tests of insurability. Once that assumption was made, it followed logically that there was no reason to expressly exclude asbestos from cover.

Thus, to an outsider, the strangeness – and possibly even the constitutionality under US law – of the asbestos judgment appears baffling. Imagine declining to invest your savings in a precipice bond – and then having a judge tell you that your savings were nevertheless going to be depleted by your rateable share of the value destroyed in the savings industry. Daft. No-one could possibly see it coming. No judge outside America would do it. At the same time, unfortunately, once such a judgement had been made, no judge inside America could completely reverse it without being lynched by widows, orphans and social justice activists. No-one can possibly know how many billions will flow out of the insurance industry into the pockets of the plaintiffs’ bar as a result of asbestos. Insurance companies just keep plugging billions of dollars into their reserves – and pray.

**Barbarians at the gate…**

Asbestos is the current high-profile worry in the insurance industry. Pharmaceutical products liability may be next.

These days, companies patent small chains of chemicals rather than particular pills. Those small chains, we are told, are then linked up with other small chains to produce medications – usually not just one medication but several. So, if a small chain of chemicals used in several medications suddenly turns out to be inimical, it will be extremely hard to quantify the resultant claims against the company and its insurers. Then there are electromagnetic fields, which can be produced by everything from high tension power cables to mobile phones. No doubt the plaintiffs’ bar will get to them in due course …

There is a school of thought which says that product liability for pharmaceutical companies (and possibly environmental impairment liability insurance for oil companies) is quite simply uninsurable. The mere whisper of this is enough to send
pharmaceutical companies flouncing off in a theatrical huff. If they can’t get insurance, they insist, then they’ll just have to stop inventing new drugs.

That’s as may be. But there is also a school of thought which believes that the actual and potential problems of asbestos, pharmaceuticals, telecoms and oil may actually force the insurance industry to rethink its approach – and to come up with new and radical solutions that could have wider applicability. It is worth highlighting a few possibilities:

1. **Mutual insurance:** The pharmaceuticals companies (or indeed any other manufacturing or service industry) could set up an insurer of their own, with each paying in his share of the capital in cash. They would jointly agree upon a standard policy wording which would be issued to each of them with no additions or subtractions. Each of them would then pay an annual premium to the mutual insurer. For pharmaceuticals companies, that premium might be calculated as (say) US$ 50 million for each drug or chemical complex which the company actually has in the development pipeline, US$100 million for each complex which reaches animal testing, US$150 million for each complex reaching clinical tests, US$250 million for each complex which receives FDA or comparable regulatory approval etc etc. Over and above this base premium, the mutual insurer would charge a percentage on turnover.

   This sounds plausible, but it has problems. First, each company’s annual premium spend would inevitably be huge, especially in view of the fact that the mutual would require each company to take an enormous deductible. Second, it is quite possible that the mutual insurer will nevertheless go bankrupt under the weight of class-action claims.

2. **Captive insurers:** The pharmaceuticals companies could each set up their own captive insurance company – essentially a corporate vehicle (similar to an SPV) which functions as an insurer to its parent. In other words, the captive underwrites the parent company’s risk, it issues insurance policies, collects premiums, handles claims and pays out losses. The old rule of thumb was that if a company spent more than US$2 million per annum on insurance, it was worthwhile to set up a captive. It could cut out the professional insurer, track the parent’s claims history and optimise its risk management practices; most importantly, it could access comparatively cheap reinsurance capacity. And here is the point: a captive is an insurance company. It can buy reinsurance, just like a real insurance company. It can set up reserves, just like a real insurance company. And when consolidation becomes a red-ink problem, it can enter the non-consolidated arrangements enjoyed by our fictitious PI insurer. This would enable pharmaceuticals manufacturers to establish
the reserves they know they need without getting their accountants excited or being slaughtered by the plaintiffs’ bar.

3. **Pay-as-you-go insurance**: This is probably the route least desired by manufacturers, since they profit from the fact that no insurer can ever hope to know the imponderables of their industry as well as they do themselves. Nevertheless, since insurance companies are reluctant to use one class of business to subsidise another, pay-as-you-go may have to happen. Under this approach, the traditional insurance company would become essentially a claims handler for the pharmaceutical companies. Each year’s premium would be the equivalent of the claims paid and reserved in the previous 12 months, plus (say) an additional 100% charge to cover those claims which come out of the woodwork with some delay. There doesn’t seem to be any point in suggesting that the premium could be used as a mechanism to spread claims over several years (as our PI insurer attempted to do), because there are so many claims out there, and they’re growing so fast that we would just be taking ourselves straight back to beetles and dung-balls.

4. **Tort reform**: The US Congress could rein in the plaintiffs’ bar. In the minefield between Federal law and States’ rights, this is easier said than done. But you’d think some fairly simple steps could be taken:

- Contingent fees are one of the most notoriously abused features of the US justice system. Any John Grisham reader is familiar with these no-win/no-fee arrangements. All too often, it means the person who really suffered the harm gets next to nothing while the attorney walks away with 90% of a million dollar settlement. So Congress could limit contingent fees to (say) 20% of any settlement received.
- Venue-shopping is another abuse. It occurs when an attorney shops around until he finds a State or County or judge likely to be sympathetic to his cause. Congress could require that the plaintiff or defendant must have been resident or had a principal place of business in that location for (say) at least six months. Not perfect, but an easy fix.
- When a plaintiff walks away with a judgment in his favour that has more digits than an international telephone number, that award has often been made by an excitable emotional jury. So Congress could require that judges make the award (instead of the jury), and do so no sooner than (say) three weeks after they have heard the case (judges are human too, just like the jury members).
Punitive and exemplary damages often make up 90% of those telephone number awards. They were originally intended to serve as a civil remedy for corporate behaviour which was amoral even if it wasn’t outright criminal. At some stage, they became part of the plaintiff’s ‘remuneration’ (and hence of his attorney’s). Since then, punitive awards have sky-rocketed. Congress could simply limit the amount to a (smaller) fixed percentage of the original award.

Needless to say, this is unlikely to happen; indeed, it is easier to conceive of water running uphill than of the US Congress (most of whose members are themselves attorneys) really and truly enacting any meaningful reform.

Absent such action, insurers should be setting up vast reserves. Irrespective of whether they know of exposure or simply fear there might be a claim out there somewhere, they would all dearly love to create huge reserves for the ghastly moment when the tide of asbestosis or pharmaceutical products liability reaches them. Such reserves would flow out of the annual profit and loss account and on to the asset side of the balance sheet. They could then be drawn down later when the need arises.

This would be prudent. Long term, it may even be the difference between bankruptcy and survival. But unless there are claims notified and unless the cash-flows out are foreseeable, the accountants would have a hissy fit. The notion that reserves should sit in the balance sheet for seven, 10 or even 30 years gives them (and the tax man) the howling heeby-jeebies.

Down with short-term accounting perversity!

Instead, the accountants and the tax man insist that reserves be established only when outward cash-flows are foreseeable. Thus, companies are permitted only to drip-feed their reserves. Admittedly it’s a several billion dollar drip-feed every year. But it’s never allowed to be so big as to wipe out profits – and therefore tax liabilities – entirely.

Hence the use of offshore reinsurance vehicles, finite reinsurance, captive insurers, structured solutions etc etc. Unfortunately, all such mechanisms are open to abuse –
as is demonstrated by the Lloyd’s story, by HIH in Australia, and now seemingly by AIG.

And the moral of the story is…? If the accounting rules create perverse incentives for the prudent manager, then surely it is the rules which require review rather than the manager.

From the viewpoint of a non-expert, the accountants will be the undertakers of the insurance industry. Not that they set out to bury it. But the insurance industry is part of a huge economic machine: a cog twiddled here turns a large wheel elsewhere – often without the cog-twiddler’s awareness and occasionally to the detriment of his intentions.

In Europe, accounting governance is determined these days by the IFRS (International Financial Reporting Standards) Board. In the US, FASB (Financial Accountings Standards Board) is the drafter and guardian of US GAAP (Generally Accepted Accounting Practices). Recognising the global nature of today’s companies, IFRS and FASB have been working for years on finding a meeting point between the two sets of rules. Unfortunately, the preferred meeting point (at least for FASB) seems to be not in the middle of the Atlantic, but just slightly Northeast of Staten Island – ie. somewhere in Manhattan.

Shifting the geographic centre of the accounting world to the US East Coast has meant that IFRS has largely abandoned the more principles-based accounting approach which served so well in the past – at least in the UK. In place of principles, the outside observer sees an ever greater flood of accounting rules. Being American, FASB likes rules (including, I hear, one particularly daft new one which requires that transactions carried out in currencies other than that of the balance sheet must be converted at the moment of the transaction rather than at the end of the quarter). Working with rules requires much less thought than working with principles. Rules are easy to comply with. But rules are also easy to bend. And rules can be circumvented. In short, unless operated in conjunction with principles, ‘rules are for fools’.

Plundering the coffers...

Specifically as relates to insurance, rules dictate when cash-flows must be recognised, when reserves may be established and when they must be dissolved – generally to the detriment of the long-term view required in insurance. Rules create a
mindless mechanistic approach which focuses on short-term profits, rather than on the long-term prudence for which this paper argues.

As far as the tax-man is concerned, once an accountant has deemed something to be profit, rather than a justified reserve, it becomes taxable. His need for cash tax revenues overrides any concern for the long-term financial viability of his tax source.

As a result, insurance companies put almost as much effort into managing their tax liabilities as they do into managing their underwriting liabilities. This is not because they’re trying to avoid taxes, but because the short-term accounting rules create wild swings in profitability. Wild swings in profitability, in turn, often lead to unjustifiably high tax bills. Tax apologists will point out that a high tax bill in a high profit year will be offset by a low tax bill in a low profit year. Tax experts will equally swiftly respond that a company with steady income pays steady taxes. Whereas intuitively the volatile and the steady tax bills should be more or less equal over the cycle, at least half a dozen of the world’s finest business schools have all published research which proves pretty conclusively that the tax man bites harder on the volatile earner.

And anyway, if the profits being taxed are accounting delusions, the tax bill is always too high.

Against this background, we really really need the regulator to ride to the rescue…

The Rescuers?

The Basel Committee on Banking Supervision recently brought out a new set of rules governing the amount of capital an internationally-active bank must hold relative to its assets and the risks in its portfolio. This replaces the rigid rules which previously applied (known as Basel 1) with a dynamic model which should more accurately reflect the real world (Basel 2). A major point in the new rules is that actuarial models may now be used to calculate the amount of risk in a bank’s business – and therefore how much capital it should be required to hold against that business. Since insurance is traditionally regarded as banking’s idiot brother, it is unsurprising that regulators insist that a large part of this model should be carried over to the insurance industry.

So, a new regulatory regime for insurance in the EU (colloquially known as Solvency II) should come into force around 2007, replacing the rigid, idiot-brother set of rules
which have hitherto applied. Like the banking model, the new insurance regime is supposed to fall into three ‘pillars’:

- **Pillar 1** is supposed to address *money* – how much capital a company should be required to set against the business transacted. This is to be calculated using a risk-based approach, and companies may be allowed eventually to use their own internal probabilistic models.

I may be missing a link somewhere, but I take this to mean that in the first instance, as the new regulations swing into force, all EU insurers will be required to base their capital calculation on the model currently being developed by the Comité Européenne d’Assurances. That committee has already ascertained that classical Value at Risk (VaR) models (as used by the banks to calculate the capital requirements for their trading books) cannot be applied to insurance companies which have an entirely different trading, investment and holding behaviour. Instead, they are looking at using something called Tail-VaR, which does seem to address the concern that insurance companies are long-term investors rather than day-traders. So that’s a Good Thing.

As a next step, the committee is evaluating various risk capital calculation models put forward by national regulators, with a view to building a consensus model that can serve Europe in the 21st century. Also good. But with few exceptions, the models put forward lead down the path of assessing capital adequacy on a one-year time horizon. Everything I know would indicate that capital adequacy should be assessed over a much longer time horizon – three, seven or even 10 years. Unfortunately, the longer time-scale would almost certainly result in a higher capital requirement, which would make just about everybody unhappy:

- shareholders, because the same premium income set against a higher capital requirement means that Return on Equity will sink;
- the tax-man, who would lose a lot of tax income while companies built up the necessary capital; and
- the hedge funds and stock analysts, who like ‘lean and mean’ balance sheets and lots of cash.

A few constituents would be happy however:

- insurance buyers – who would have some hope of their insurance company surviving the onslaught of
pharmaceutical products liability and EMF and actually being able to pay claims;
- bondholders – who would be reasonably certain of getting their money back;
- the rating agencies – more capital in the industry means more security for bond-holders, which in turn means ratings upgrades; and
- regulators – a greater capital cushion can only facilitate their task.

To date, the prudential desire to keep more money in the industry has been overwhelmed by the fiscal requirement. In the UK at least, HM Treasury appoints both the regulator and the tax-man. The need for tax income is perceived as more immediate than the financial stability of the insurance industry. In other words, the Chancellor needs to generate tax income now, and if that means allowing the goose that lays the golden eggs to sicken and die, then so be it.

- Pillar 2 would have national regulators assess the strength of management, as well as stress-testing “technical provisions” and assets.

The lion’s share of technical provisions are claims reserves. These are the first port of call when an insurer needs to pretty up his numbers for the annual report. So if a CFO’s numbers look wilted, all he has to do is under-reserve claims by a bit, and the P&L will magically gush cash. Even though this is fairly rare (see above), no national supervisor can possibly hope to catch this every time it happens. But I can suggest a two-pronged approach:

- Require teams of actuaries and claims specialists to audit the reserves of one of their rivals each year: When this idea was first advanced (by me), people howled that it couldn’t be done because of competition and confidentiality issues. Frankly, I’m sceptical. It sounds like a convenient excuse for not building a better mousetrap. Banks share all sorts of data about their clients – credit history, default history, mortgage history etc etc etc. So institutionalised is their cooperation that they can tell in advance what the likelihood of default is, what the probable loss given default will be, and even the amount of time they will need to complete recovery proceedings. Competition and confidentiality seemingly impose no barrier when it comes to ensuring the ongoing profitability of the banking industry. So if competition and confidentiality is genuinely such a concern
to the idiot brother industry, how does one explain the bankers’ nonchalance?

- National regulators could set up a clearing house: Each company could be required to deliver anonymised claims and underwriting information regarding its portfolio in each line of business. It could also be required to make available to the supervisor a team of claims specialists and actuaries for (say) 3-4 weeks each year. Those teams would peer review the anonymised reserves of their anonymous competitors. There would be no motivation to go overboard loading up the other guy with unnecessary claims reserves because whatever Team A did to Team B, Team B could theoretically do right back to them. Admittedly the clearing house concept has flaws. For instance, if any team sees AIG’s D&O portfolio (the largest in the world), it will be unmistakeably recognisable. But the clearing house would at least provide the fig-leaf of confidentiality.

Once this actuarial review becomes embedded in the true and fair statement of companies’ annual reports, those nightmare moments when reserves are inadequate and the tax man is knocking on the door should gradually disappear. And then at least part of the need for friendly finite reinsurers will quite simply go away.

- Pillar 3 is market disclosure. The concept is that companies should disclose information which would enable their stockholders to judge the risks. I’m sceptical. Most private investors barely even bother to read their household insurance policies. It seems unlikely that they’ll suddenly develop a burning interest in the risk landscape of their insurer. Institutional investors rely upon analysts – who are among the first to voice their lack of understanding and blatant distrust of the industry. Greater disclosure is not really going to change that. What might work though is for reinsurers to start demanding the type of information which would enable them to evaluate their cedants’ risk landscape, risk management and threat scenarios. As industry insiders, they are in a position to evaluate the information they receive. Over time, this information would lead reinsurers to create natural benchmarks for company risk management. Their own economic self-interest would lead them then to avoid doing business with those insurers who wind up at the wrong end of the scale.

This sort of work of course would really be meat and drink to the big five (or big six) professional reinsurers. An alert national regulator would
then notice the presence or absence of the professionals on an insurer’s reinsurance programme as a sort of early-warning system.

In exchange for this, regulators would need to strengthen the hand of the professional reinsurers. Under current market conditions, reinsurer requests for greater disclosure can easily be swept aside by cedants. It follows, therefore, that the regulator would need to require all reinsurance companies periodically to report on their evaluation of their ceding companies’ risk management. The form of that report would drive the type of information required to be delivered by cedants to reinsurers.

Two other concerns manifest themselves immediately: the reinsurer’s evaluation will always be driven by his own business interest – hence he will never be an entirely disinterested party. Secondly, ceteris paribus, nice guys among cedants might expect better evaluations than creeps. Not that their risk management is any better, but there’s always a ‘people’ factor. This is not a new idea, but it seemed to rattle quite a few cages when it was first advanced.

Conclusion

A great American statesman once commented that a government could only govern by the consent and with the cooperation of the governed. Regulation seems pretty similar, in that it works best and most effectively when regulators and regulatees agree that the direction of march is correct.

So far, there is no sign that the insurance industry has actually set out to make the perfectly legitimate argument that accounting rules for insurance need to be different. Until the industry manifests some sort of backbone, IASB and FASB are going to continue writing counter-intuitive rules in the firm conviction that they are doing the investing world a service.

Instead of fighting for more reasonable rules, the insurance industry at the moment appears to be flailing around, beset on all sides by conflicting demands – and thus lacking the time to think about its strategic long-term direction. It rubs along in a half-baked sort of way, apparently hoping that someone else will fix the accounting and regulatory machine before it grinds to a horrible halt.
The regulators equally seem to scrabble around, looking for sensible things they can do to fix the mess they’ve inherited. Solvency II should provide a marvellous opportunity for regulators to lead the way in creating a sustainable long-term framework which will work for all stakeholders. Perhaps this paper will serve to awaken all of them to the most urgent requirement of the new regulatory regime – to encourage captains of the insurance industry to band together with them to lobby for a sane accounting, tax and capital regime to stop the short-term idiocy which is draining cash and capital from the industry just as the need for both is becoming greater.
Shirley Beglinger started her career at Credit Suisse in Zurich as a fixed income trader, before moving into private banking. In 1984, she joined GAM Global Asset Management – now part of UBS – in fund management. She joined Swiss Re in 1988, and gathered ample experience in both insurance and reinsurance practice. Since 1995, she has specialised in all types of financial institutions underwriting. Shirley spearheaded Swiss Re’s efforts to gain recognition in the Basel 2 process for insurance as a mitigant of operational risk. She recently resigned her post as a managing director of Swiss Re, and is currently on sabbatical.
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