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UPDATES

Pension reform prospects brighten as House passes bill

WASHINGTON—Passage last Wednesday of comprehensive pension reform legislation by the House of Representatives by a 401-25 vote significantly increases the chances that a reform bill could be enacted this year.

"This is a huge momentum boost for the package," said James Delaplane, vp-retirement policy at the Assn. of Private Pension & Welfare Plans in Washington.

The bill, H.R. 1102, was introduced by Reps. Rob Portman, R-Ohio, and Ben Cardin, D-Md. It would, among other things,

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Aetna, ING deal to bring new focus

By JUDY GREENWALD

HARTFORD, Conn.—Aetna Inc.'s $7.7 billion deal to sell its financial services and international operations to ING Groep N.V. does not address problems the company still faces in its health care business.

Those problems include rising medical costs, which resulted in lower-than-expected second-quarter earnings, continued problems in its provider relationships, and the need to place an experienced health care executive at its helm, analysts say.

The deal with ING, unveiled last week after months of negotiations, is not expected to directly affect employers that do business with Aetna U.S. Healthcare, though the sale of Aetna's other operations could focus management's attention more closely on the health care business, analysts say.

Under the definitive agreement reached with ING, Aetna will sell its financial services and international businesses for about $5 billion in cash and the assumption of about $2.7 billion in debt.

Aetna will then spin off to its shareholders a new health insurance business, to be called Aetna Inc., that will include Aetna U.S. Healthcare, group insurance and large pension plans, as well as Aetna global benefits. It will continue to be headquartered in Hartford, Conn.

Aetna's current stockholders will receive one share in the new health company and about $35 per share in cash for each share they currently hold.

Aetna U.S. Healthcare reported $459.7 million in operating earnings in 1999. Its large-pension business is a discontinued operation that is basically in runoff mode,

See **Deal** *on page 22*

Snapshot of Aetna

1999 revenues of Aetna Inc.'s core operations. ING's purchase highlighted

Divisions	*In millions of dollars*
Aetna U.S. Healthcare:	**$20,888.0**
Aetna Financial Services:	**$1,530.4**
Aetna International*:	**$2,807.8**
Large pension plans:	**$1,171.8**

Source: Aetna Inc. * Excludes Aetna Global Benefits

PBGC clarifies intervention

Rules of engagement

By JERRY GEISEL

WASHINGTON—The Pension Benefit Guaranty Corp. will intervene in corporate transactions, such as mergers or spinoffs, only when they pose a significant risk of creating major losses for the agency.

The PBGC is releasing today a 10-page technical update that, for the first time clearly stipulates when it will contact employers seeking more information about a transaction. In addition, the update addresses the remedies the agency may seek if it believes the transaction could significantly increase the likelihood of it incurring losses.

The guidance has long been sought by employers, which have complained not only about the lack of written standards for intervention, but also that the PBGC has involved itself in transactions that posed no real threat to the federal agency's insurance program, which guarantees participants' basic pension benefits.

"In effect, the PBGC wasted its internal resources," said Mark Ugoretz, president of the ERISA Industry Committee, a Washington-based benefits lobbying group representing large employers.

The new guidance is a response to both of those concerns.

"Because we had not published clear guidance, there was uncertainty among employers as to what we were looking at. Now, the program will be a lot more transparent," said PBGC Executive Director David Strauss.

At the same time, he said, the PBGC's involvement will be tightly focused.

"Unless you are involved in a transaction that poses a risk of a long-run loss to the PBGC, which I interpret to mean a catastrophic loss, we are not going to be meddling in your transactions. This is a tool we intend to use most judiciously," the

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NEWSPAPER 01

Tobacco firms set strategy for appeal

By MICHAEL BRADFORD

MIAMI—Tobacco companies will stake much of their appeal of a nearly $145 billion punitive award on their argument that sick Florida smokers should not be treated as a class in litigation.

The industry was hit with the staggering judgment on July 14 when a Miami jury in the 2-year-old *Engle vs. R.J. Reynolds Tobacco Co. et al.* case ordered the defendants to pay that amount to the class of 500,000 to 700,000 sick Florida smokers. The state court jury already had awarded $12.7 million in compensatory damages to three representatives of the class after deciding the companies manufactured a defective product.

Defendants are R.J. Reynolds, Philip Morris Inc., Brown & Williamson Tobacco Corp., Lorillard Tobacco Co. and Liggett Group Inc.

Tobacco makers vowed to fight the award and pointed to Florida law barring judgments that would bankrupt a company. During the trial, the industry claimed a net worth of about $15 billion.

The tobacco industry denounced the award, calling it grossly excessive and in error. Tobacco company attorneys said they don't expect to pay anything, as they are confident of a successful appeal.

The industry also contends that if a judgment is upheld, separate trials would be needed to determine each plaintiff's award.

"We are confident it will be reversed on appeal," Dan Webb, an attorney for Philip Morris, said after the award was announced. He said the verdict "is in favor of no one and, ultimately, will have no impact on anyone."

Gordon Smith, an attorney for Brown & Williamson, said in a written statement that the defendants were subjected to "a kangaroo court setting, where fairness, justice and plain-old common sense have been thrown out in favor of emotion and prejudice."

He gave several reasons why Brown & Williamson believes the judgment was in error, including that certification of the class was inappropriate, as most courts have determined in tobacco cases. He said Circuit Court Judge Robert Kaye inappropriately allowed the jury to establish punitive damages for an unknown class before the members of the class presented their claims for compensatory damages.

The issue of whether smokers should be treated as a class will be at the heart of an appeal, said Daniel W. Donahue, senior vp and deputy general counsel for R.J. Reynolds.

See **Tobacco** *on page 20*

Sparking a fire?

Award may fuel tort reform

By MARK A. HOFMANN

A Florida state court jury's decision to hit the tobacco industry with a punitive damages award of nearly $145 billion may focus renewed attention on tort reform.

Tort reform advocates say there are signs that the huge award is causing the public to think again about possible abuses of the civil justice system. The verdict could act as a catalyst, they say, for renewed efforts to enact tort reforms—particularly regarding class actions and punitive damages—at both the state and federal levels.

The Miami jury that heard the case, *Engle vs. R.J. Reynolds Tobacco Co. et al.*, had previously awarded $12.7 million in compensatory damages to three representatives of a class consisting of hundreds of thousands of Florida smokers and former smokers, thus paving the way for the punitive damage award (*BI*, April 10). That compensatory award had followed the same jury's decision that the tobacco industry had produced a defective product (*BI*, July 12, 1999).

The tobacco companies already have announced their intention to appeal the verdict. Under Florida law, they will have to post a bond of up to $100 million to appeal the case.

Dismayed as they are at the jury's verdict, some tort reform advocates view it as a call to action.

"I think the whole question of class actions has moved right to the forefront of the agenda for civil justice reform at both the state and federal levels," said Sherman Joyce, president of the Washington-based American Tort Reform Assn. "I think is a resounding call for both procedural and substantive reform of punitive damages."

"I want to say that it will (result in reform), but there have been so many of these large punitive damage awards lately. Maybe there will be more push in states to do something, but in a national context, it always seems to get bogged down," said Glenn Lammi, chief counsel of the Washington Legal Foundation.

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UPDATES

Pension bill passes House

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gradually increase to $15,000 from the current $10,500 limit the maximum annual salary deferral an employee could make to a 401(k) plan.

Other provisions in the bill would allow employees age 50 and older to make an additional $5,000 in annual "catch-up" contributions to their 401(k) plans and allow employees moving back and forth between the for-profit and non-profit sectors to transfer funds from 401(k) to 403(b) plans and vice versa.

In addition, the pension measure would shorten, to three years from the current five years, the maximum amount of time in which employers' matching contributions to savings plans must be vested.

The measure also would allow employers to prove, through as yet undefined "facts and circumstances," that their pension plans do not discriminate in favor of highly paid employees. This approach would replace current rigid mathematical non-discrimination tests.

The bill now moves to the Senate, where the biggest question is whether there is enough time remaining in the session to consider the measure.

President Clinton opposes the legislation, under which he says too many benefits would go to higher-paid employees. But he stopped short of saying he would veto the measure.

Travelers buys more of Reliance

NEW YORK—In the ongoing piecemeal sale of Reliance Group Holdings Inc. units, Travelers Insurance Co. agreed last Friday to buy the renewal rights to an unspecified portion of Reliance's commercial middle-market business.

Financial terms were not disclosed, but the ultimate payment will depend on how many contracts Travelers successfully renews, a Reliance spokesman said.

The middle-market business was the largest unit remaining at Reliance and is the second chunk of business that Reliance has sold to Travelers. In May, Travelers completed its purchase of Reliance's surety business.

The news followed closely on last week's announcement by Leucadia National Corp. that it is pulling out of its proposed $300 million purchase of Reliance. Reliance said it would try to restructure the more than $500 million in debt that the troubled insurer has due this year and would attempt to sell more of its insurance units.

Reliance has also sold parts of its other businesses to other insurers. The Hartford Financial Services Group Inc. bought the financial services and excess and surplus lines business; Kemper Insurance Cos. bought renewal rights to Reliance's large-account casualty and construction wrap-up business; and Overseas Partners Ltd. bought its reinsurance unit.

The middle-market business makes up the largest part of Reliance Insurance Group, which overall recorded $693 million in net written premiums in 1999. The casualty business sold to Kemper was also part of Reliance Insurance Group, however, and the premiums have been significantly depleted further by non-renewals.

Sales of other Reliance businesses are also being negotiated, the spokesman said. The remaining businesses include: international; CyberComp, Reliance's online workers compensation business; property; accident and health; credit life and warranty; and personal auto.

Reliance, meanwhile, faces further deteriorating ratings. After the collapse of the Leucadia deal, Moody's Investors Service downgraded Reliance's financial strength rating to Ba3 from Ba2.

Frontier sells renewal rights

NEW YORK—Frontier Insurance Group Inc. has reached an agreement in principle to sell the renewal rights to certain casualty and surety business to Gulf Insurance Co., a surplus lines unit of Travelers Property Casualty Corp.

Included in the deal are renewal rights to Frontier's excess and surplus lines casualty business, general liability coverages for environmental contractors and consultants and various classes of surety bond business, said Mark H. Mishler, an executive vp for Rock Hill, N.Y.-based Frontier.

Mr. Mishler would not disclose the premium volume of the business being sold, and Gulf Insurance officials could not be reached. Other terms of the agreement were not disclosed.

The move is part of restructuring plan that has seen Frontier shed several operations. Also last week, the insurer announced the sale of its World Wide Web portal, OneStop.com, to SolutionsAmerica Inc., a Culver City, Calif.-based e-commerce company. As part of the deal, Frontier will receive 10% of the common stock of privately held SolutionsAmerica.

Suzanne R. Loughlin, a Frontier executive vp, said she could not give a valuation for the deal, but said Frontier is optimistic about recouping its roughly $13 million investment in OneStop.com.

Frontier also announced it has completed its $7.1 million sale of subsidiary Regency Insurance Co. to Tomoka Re Holdings Inc., a unit of Tower Hill Insurance Group.

Meanwhile, Frontier and several of its top officers have been named in a shareholder lawsuit charging that the company mis represented its performance in financial filings, inflating its stock price.

The lawsuit, filed last Wednesday in federal court in New York, seeks class-action status and alleges that Frontier made a variety

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IRS OKs automatic enrollment of workers into 403(b) plans

By JERRY GEISEL

WASHINGTON—Non-profit employers with 403(b) retirement savings plans now can automatically enroll their employees in the plans.

The Internal Revenue Service last week in Announcement 2000-60 gave the green light to automatic enrollment for 403(b) plans, which are offered by non-profit employers—principally colleges and universities and health care systems—and are similar to 401(k) plans offered by for-profit companies. In both types of plans, employees generally can make pretax contributions of up to $10,500 annually.

"This is a very positive step," said Chris Kellogg, a consultant in the Minneapolis office of Watson Wyatt Worldwide.

Under automatic enrollment plans, which the IRS approved for 401(k) plans about two years ago, employers can automatically enroll employees in the plans as long as the feature is explained to employees and employees have the opportunity to opt out. These programs are aimed at employees, typically recently hired and lower-paid employees, who make no decision on whether they want to enroll in 401(k) plans.

While only a small percentage of employers offer automatic enrollment programs for their 401(k) plans, that percentage has grown since the IRS first permitted the practice. A recent study by Hewitt Associates L.L.C. of nearly 500 employers found that 7% of them last year offered automatic enrollment, up from 4% in 1997.

And many benefit experts expect that the number of automatic enrollment programs for 401(k) plans will increase significantly in the next few years as employers—especially those without other retirement savings plans—look for new ways to get more employees to save for their retirement.

In the wake of last week's IRS announcement, employers with 403(b) plans also are likely to implement automatic enrollment programs, though perhaps not at the same rate as employers with 401(k) plans.

That is because one incentive that employers with 401(k) plans have to implement automatic enrollment—making it easier to pass a key non-discrimination test—is

See **403(b)** *on page 22*

Jury finds unit responsible for defective latex

Baxter faulted in glove suit

By MEG FLETCHER

McGAW PARK, Ill.—Allegiance Corp., a subsidiary of Baxter International Inc. that manufactures latex gloves, plans to appeal the first jury verdict ever rendered against it for making a defective latex product.

Manufacturers of latex products are concerned because Allegiance is one of the largest latex glove manufacturers and because hundreds of similar cases are pending against it and other makers of latex products (*BI*, Aug. 9, 1999).

McGaw Park, Ill.-based Allegiance, which Baxter formed in a 1996 spinoff, will seek to overturn the July 13 California state court jury verdict. That verdict requires the company to pay approximately $878,400, plus costs, to Christine McGinnis of Stockton, Calif., a former respiratory therapist, according to plaintiff's attorney Philip Harley of Kazan, McClain, Edises, Simon & Abrams in Oakland, Calif.

Specifically, the jury found that Baxter was responsible for manufacturing defective gloves that caused her to develop a disabling allergic reaction while working at St. Joseph Hospital, also in Stockton, during the 1990s. The plaintiff alleged that, until 1996, the company failed to use an effective washing system that would have removed, or greatly reduced, allergenic proteins found in the natural rubber used to make the gloves.

The jury in *McGinnis vs. Baxter Health Care* initially awarded the plaintiff nearly $1.13 million in compensatory damages but later reduced the company's liability according to a formula that factored in her 15% negligence and the 15% negligence of her hospital employer.

Ultimately, the jury asked that the manufacturer be solely responsible for the judgment, which was reduced to $878,400 plus costs, according to Mr. Harley. The hospital will not be required to contribute to the award, but the negligence finding

See **Latex** *on page 14*

Questionnaire deadline nears for directory of reinsurers

Business Insurance will publish its annual Directory of Worldwide Reinsurers in the Aug. 28 issue, which will also contain a Spotlight Report on international reinsurance.

The directory is published as an editorial service; there is no charge to be included.

To be listed, a company's 1999 net written reinsurance premium volume must exceed $100 million (including both property/casualty and life/heath premiums).

Companies must provide premiums written and capital and surplus figures for 1998 and 1999 to be listed.

If your company meets the requirements and has not received a questionnaire, please request one immediately by calling Directory Editor Kevin Edison at 312-649-5279.

Copies of the reinsurance company directory questionnaire also can be printed from the *BI* Web site at *www.businessinsurance.com.*

Completed questionnaires must be submitted by the extended deadline of Aug. 4.

INSIDE

- A Florida jury's recent award of nearly $145 billion in punitive damages in a class-action suit against the tobacco industry ought to breathe new life into the tort reform movement, this week's editorial says. **PAGE 8**

- In Perspectives, Gerald L. Maatman Jr., of the Chicago law firm Baker & McKenzie, says the Supreme Court's decision in *Reeves vs. Sanderson* makes it even more important for companies to carefully manage employment practices liability exposures. **PAGE 13**

- Closing arguments in the high-profile *Jaffray vs. Lloyd's* fraud case have ended, forcing Lloyd's to revisit one of the most difficult periods in its 312-year history. **PAGE 17**

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Comp costs rising

Total medical cost per injury

	1998 average	1997 average	Percent increase
Texas	$2,314	$2,122	9.0%
Alaska	2,282	1,738	31.3
California	2,062	1,903	3.9
Colorado	2,055	1,423	44.4

Source: Dallas/Fort Worth Chapter of RIMS

Comp medical costs as big as Texas

RIMS study finds state's workers comp medical costs highest in nation

BY SALLY ROBERTS

The Dallas/Fort Worth chapter of the Risk & Insurance Management Society Inc. has confirmed what it already believed: Employers in Texas pay some of the highest workers compensation medical costs in the country.

And not only are Texas employers paying more for treatment of the same types of injuries than most employers in other states, but workers comp medical costs in Texas and three other states also seem to be on the rise, according to findings from a recent national survey.

The Dallas/Fort Worth RIMS chapter set out in March to survey RIMS members nationwide about their companies' workers comp medical costs. The goal of the survey was to determine whether Texas' workers comp medical costs were in line with those elsewhere in the nation, and to give other RIMS members an idea as to where their state fell in the cost range (*BI*, March 6).

RIMS asked respondents to provide actual paid amounts, valued as of March 31, 2000, for medical expenses related to workers comp claims in 1997 and 1998. In all, 194,814 claims from 1997 and 178,540 claims from 1998 were collected and analyzed from more than 50 RIMS members in the retail, grocery, restaurant, hospital and package/cargo handling industries across the country. The RIMS chapter also surveyed members at airlines and in school districts, but the information they supplied was not sufficient to aid in the analysis.

The survey lists, by industry, the states whose average medical cost per workers comp claim is higher than the

See **Costs** *on page 12*

IIS 36th annual seminar

Laws should protect buyers

By GAVIN SOUTER

VANCOUVER, British Columbia—As regulation of the global insurance marketplace becomes more complicated, regulators throughout the world should work together to develop a realistic approach to protecting buyers, says the United Kingdom's financial services regulator.

Because insurance buyers differ in terms of sophistication, insurers need different kinds and degrees of regulatory oversight, said Sir Howard Davies, chairman of the Financial Services Authority in London, who was speaking at the International Insurance Society's 36th annual seminar held in Vancouver, British Columbia, earlier this month.

More conference coverage on page 6

Chiefly, regulators should try to ensure that financial services companies' internal regulatory compliance efforts reflect the business they are transacting, he said. To achieve that goal, regulators should develop a close relationship with the senior executives of the businesses they regulate, said Sir Howard.

And as the insurance and financial services industry becomes increasingly global, regulators should exchange more information and work together more closely to find common approaches to regulation, said Sir Howard, who is also chairman of the International Assn. of Insurance Supervisors.

The role of insurance regulators is not to

See **Regulate** *on page 4*

Health plans join forces

New coalition aims to address doctor, patient complaints

NEW YORK—Nearly two dozen health insurers and managed care companies have joined forces in a bid to streamline administration of health plans for both patients and doctors while also improving health care quality.

The group, known as The Coalition for Affordable Quality Healthcare, consists of 22 total health insurers, health maintenance organizations and health insurer trade groups covering more than 100 million Americans. The participating companies hope that the collaboration will promote better medical care, and will make it easier for patients to choose physicians and to compare health plans.

The long-term goal is to "improve the health care experience for our customers," H. Edward Hanway, president and CEO of CIGNA Corp. in Philadelphia and the group's vice chairman, said at a press conference.

In addition, the plans hope that they will be able to reverse the pounding that the HMO industry's public image has suffered during the past several years.

"We have lost the trust of many Americans," Leonard Schaeffer, the chairman of the group and chief executive officer of Thousand Oaks, Calif.-based WellPoint Health Networks Inc., said at the press conference.

Principally, the group will focus on three areas:

- Improving patient access to doctors, such as permitting an obstetrician/gynecologist to be a woman's primary care physician.
- Eliminating administrative burdens placed on health care providers.
- Working with physicians to improve the quality of health care.

No timetables have yet been set with regard to the coalition's goals, Mr. Schaeffer said. Instead, he said, in six months, the coalition will announce what progress has been made.

"This effort is just the beginning," Mr. Hanway said.

The group has agreed to allow members to appeal denial of treatment decisions to independent outside reviewer, and agreeing to the decision made. Also, the group will cover the costs of emergency care when the patient believes it is truly an emergency.

The group also will work to create a standardized grid outlining all the benefits of each plan using layman's language. This will make it easier for consumers to compare plans.

Also, by sharing information the group members hope to encourage the practice of evidence-based medicine leading to higher quality care for all plan members.

—By Michael Prince

Louisiana facilities fight class action over transfusions

By MICHAEL BRADFORD

NEW ORLEANS—Louisiana hospitals and blood banks are defending themselves against scores of hepatitis C claims, some of which are so old that patient records have been destroyed and insurance coverage is difficult to ascertain.

The hundreds of suits threaten to bankrupt the facilities and could cause health care prices in the state to escalate, according to defendants and others connected to the cases.

Plaintiffs allege that they contracted hepatitis C through transfusions involving tainted blood. A suit filed last year in a New Orleans state court seeks class-action status on behalf of about 200 plaintiffs, who are seeking an undetermined amount in damages from hospitals.

If the class is certified and the plaintiffs ultimately prevail, a large award could drain most of the funds from hospitals, already operating with thin margins, and cause a rise in health care costs, according to Clark Cossé, vp of legal and governmental affairs at the Louisiana Hospital Assn. in Baton Rouge. "If this suit succeeds," he said, "it could send a lot of people into bankruptcy."

Mr. Cossé said there are "tens of millions, maybe hundreds of millions, in potential liability out there. If the class is certified, all the hospitals will be in the soup." He said some individual cases against hospitals already have made their way through the courts, with "significant" judgments against some facilities and settlements of some cases in recent years.

The suit seeking class-action status is somewhat unusual in that plaintiffs allege that the 57 defendant hospitals are responsible for their health problems under strict liability laws that were changed 18 years ago.

Plaintiffs charge that all the transfusions that led to their contracting hepatitis C occurred before July 15, 1982—the date state law changed to require plaintiffs in blood transfusion cases to prove that health care providers acted negligently. The state's blood shield

See **Hepatitis** *on page 14*

Health care plan gives consumers more choices

Strategy treats employees like adults

By MICHAEL PRINCE

NEW YORK—Adopting a defined contribution health care strategy requires a philosophical leap by employers.

By switching to a defined contribution model from a defined benefits model, employers will begin to treat their employees as adults capable of making informed decisions, three speakers said at a recent seminar in New York.

Perhaps the largest issue to be overcome in making a switch is understanding that consumers and other participants in the health care system do not realize how much they are paying for health care, said Kenneth Abramowitz, health care analyst with Sanford C. Bernstein & Co. Inc. in New York.

For example, employers are picking up the tab when one of the 44 million uninsured people in the United States gets free treatment at a hospital.

Treating the uninsured forces the hospital to bill its paying patients more, which is a major cause of health care inflation, he explained.

"Corporate America does not understand they are paying for a lot of. . .services the government is responsible for," Mr. Abramowitz said at the presentation, hosted by Foundation Health Services Inc. "Someone must convey the word to us that we're spending our own money."

Instead, employers should push for a tax to fund catastrophic care for all uninsured people, Mr. Abramowitz said.

Generally, employers are concerned about liabilities that might emerge from patient-protection bills pending in Congress that could hold employers liable for selecting a health plan, said Bruce Taylor, director of health care for GTE Service Corp. in Irving, Texas.

In addition, employers want a health care strategy that helps reduce employee complaints and makes costs more predictable, Mr. Taylor said. He said he likes to think of a defined contribution health plan as "direct to consumer," as the employee, instead of the employer, becomes the consumer.

As a result, health plans will be forced to become more consumer-friendly, he said.

The downside is that with the employer's role diminished, it's unclear who will evaluate the different health plans and push them to improve their quality, Mr. Taylor said.

But switching to a defined contribution system won't be easy. "Corporate America has made a grave mistake and now it's time to correct this mistake and stop treating its employees as babies," Mr. Abramowitz said. This means giving people a choice and forcing

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Regulate

Continued from previous page

guarantee that there will be no insurance failures, Sir Howard said. "That is impossible and undesirable."

The scope of such an initiative would be prohibitively inefficient. Instead, he said, regulators should focus on what is reasonably attainable to reduce the risk of insurer failures.

In the United Kingdom, the FSA weighs the underlying risk of an insurer's business, Sir Howard said. "For example, in the London market, the underlying business risk is higher than in retail insurance," he said.

On the other hand, the customers of retail insurers usually are less sophisticated—and thus more vulnerable—than a knowledgeable commercial insurance buyer purchasing coverage in the London market, Sir Howard said.

Given the varying needs with regard to regulatory control, the FSA focuses on the internal compliance measures insurers have in place in determining the degree of scrutiny the companies warrant, he said.

"There is a tradeoff between a firm's compliance and outside regulatory measures. The more internal compliance, the less intrusive we will be," Sir Howard said.

To assess the adequacy of compliance measures, the FSA looks at the business strategy of a financial services company and then examines whether its risk management is consistent with that strategy, he said.

One illustration of a disparity between those two elements is the collapse of the British merchant bank Barings P.L.C. in the 1995, Sir Howard said.

Barings embarked on a strategy of trading in highly volatile investments, but it lacked the risk management needed to control that strategy, he said. As a result, the bank collapsed after a huge derivatives investment made by one of its traders in Singapore, Nicholas Leeson, turned sour.

To reduce the chance of such problems occurring, regulators need to develop a direct relationship with the top managers of the businesses they regulate, Sir Howard said.

"It is crucial that the boards of insurance companies understand how they are seen by regulators," he said.

The regulation of insurers is becoming more challenging as insurers merge with banks and as securitization of insurance products becomes more common, Sir Howard said. For one, capital requirements for banks and insurers differ. Insurers and reinsurers become involved in buying risks from banks through securitized bonds. Banks, by issuing wind and disaster derivatives, become involved in insurance underwriting, he explained. Further complicating matters is that the derivatives are often issued through special vehicles located in offshore jurisdictions, he said.

"In the long term, regulatory structures will need to adapt to market forces," Sir Howard said.

In particular, international insurance regulators need to collaborate to agree on a common approach to regulation and to develop an exchange of regulatory information, he said.

Regulation is also a competitive business, Sir Howard said. With the development of technology, insurers and reinsurers are often able set up shop wherever they choose, he said.

"But that doesn't mean that they will gravitate to (the) regime with the lowest regulation, because their customers want regulation," Sir Howard said. Nevertheless, if regulations in one domicile are not cost-effective, then insurers will move elsewhere, he said. Consequently, regulators need to ensure that their regulations keep pace with mobile businesses and mobile customers, Sir Howard said.

Regulation of Internet insurance business also highlights the need for common regulatory principles, Sir Howard said.

Insurers can easily establish themselves in remote parts of the world, and consumers can access the products over the Internet, he said.

As a result, consumers need to be educated to understand the risks involved in buying products from poorly regulated domiciles, Sir Howard said. "People have to understand that if they make deposits in an obscure part of the former Dutch empire, then they have got what's coming to them," he said.

Overall, regulators need to strive to create an environment that does not stifle businesses but, at the same time, provides reasonable safeguards of policyholders, Sir Howard said. "We want to be an organization that is helpful when appropriate and rigorous when necessary," he said. BI

Poll, honors all part of IIS seminar

VANCOUVER, British Columbia—The 36th annual seminar of the International Insurance Society Inc. attracted a record 704 attendees to Vancouver July 9-12.

Insurance executives from 55 countries attended the plenary sessions and discussion groups.

At the awards dinner on July 10, Hans Gerling, a former senior executive of Gerling Group, and Jose Pinera, the author of Chile's private national pension system, were inducted into the New York-based IIS' Insurance Hall of Fame.

At the conference, participants completed a survey on what are the main challenges for the future for insurance companies.

The top five selections were: technology and e-commerce, 25.1%; retaining and acquiring talent, 17.6%; rapidly changing markets, products and services, 12.9%; effective distribution, 10.1%; and creating an environment of innovation, 10.0%.

Next year's IIS seminar will take place at the Hotel Inter-Continental in Vienna, Austria, July 8-13.

For more information contact: International Insurance Society Inc., 101 Murray St., New York, N.Y. 10007. 212-815-9291. Fax: 212-815-9297.

—*By Gavin Souter*

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What can we do to help you?

M&A minutiae can be distracting, execs warn

By GAVIN SOUTER

VANCOUVER, British Columbia—Insurers engaged in mergers and acquisitions should be wary of becoming bogged down in the merger process at the expense of ongoing business, an insurer executive says.

Although new initiatives and services should not be put on hold during the integration process, great care also needs to be taken to ensure that large mergers are successful, said Antoine Jeancourt-Galignani, chairman and chief executive officer of Paris-based Assurances Generales de France.

Managers must know what changes are taking place, appointments should be based on ability rather than internal politics, older managers should work with younger ones, and common management incentives such as stock options should be introduced across the whole group, he said.

Those were some of the lessons learned by AGF when it was demutualized and bought by Allianz A.G., Mr. Jeancourt-Galignani said.

Also, merged companies should ensure that they have a decentralized management structure and give their managers a sense of ownership in the company, recommended Brian Duperreault, chairman, president and chief executive officer of ACE Ltd.

The two executives made their comments during the 36th annual seminar of the International Insurance Society held earlier this month in Vancouver, British Columbia.

AGF underwent profound changes when it was privatized in 1996, after 50 years as a state-owned insurer, said Mr. Jeancourt-Galignani.

The insurer suddenly had to focus on providing shareholder value and it soon became embroiled in mergers and acquisitions, he said.

A decentralized management approach is helpful. 'You have to allow managers to operate' and have 'a sense of ownership,' says ACE's Brian Duperreault.

"It was a shock to management," Mr. Jeancourt-Galignani said.

In 1997, AGF bought a rival French insurer, Athena Assurances, and then AGF itself was the target of a takeover bid from Italy's Assicurazioni Generali S.p.A.

After rejecting the Generali bid as insufficient, AGF turned to Allianz as a white knight and it merged with Allianz's operation in France, he said.

"So we had quite a lot of challenges," Mr. Jeancourt-Galignani said, "but by mid-2000, we have made large steps towards achieving our objectives."

AGF learned the following five key lessons from the experience:

- Don't get bogged down in the merger process.

Insurers should keep pursuing new opportunities while they merge with other companies, and find new ways to grow rather than become absorbed with the internal workings of their companies, Mr. Galignani said.

AGF, for example, launched a new Internet-based service as well as other major initiatives during the merger process, he said.

- Senior executives should ensure that they communicate with their managers.

At AGF, in particular, managers had to grasp from executives the "new concept of profitability" and understand the culture of Allianz, Mr. Jeancourt-Galignani said.

- Managers of a newly combined company should be appointed according to their talent, not the organization they came from.

"That sounds obvious, but when you merge three companies with different cultures, it is not that easy not to try to build some political balance. If you start doing that, you will have a lot of problems," Mr. Jeancourt-Galignani said.

To aid it in this process, AGF employed an independent consultant to evaluate the managers, he said.

- Compensation should be based on the whole organization's performance.

"We felt that that was important for people to come together," he said of adopting a uniform compensation structure.

- Management teams need to be mixed to balance differing abilities.

At AGF this mixing of teams involved younger managers, who easily adapt to an international environment, working together with older managers, who are more used to the domestic environment or have difficulty mastering English, which is the official language of the group, Mr. Jeancourt-Galignani said.

That way, older managers make an easier transition and younger managers are not held back, he said.

ACE Ltd. has also gone through a transforming merger, said Mr. Duperreault.

In 1999, it bought the property and casualty and international operations of CIGNA Corp. and changed from being a largely Bermuda-based specialty insurer into a worldwide commercial insurance company, he said.

With the huge increase in the size of the operations, ACE had to adopt a decentralized approach to management, Mr. Duperreault said.

"You have to allow managers to operate. You have to give them room to maneuver and a sense of ownership," he said.

ACE regards its senior managers as CEOs of their individual units, Mr. Duperreault said.

"Through that process we look to coordinate policy so things are being done to the common good," he said. BI

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OPINIONS

More tort reforms needed

A FLORIDA JURY'S RECENT award of nearly $145 billion in punitive damages in a class-action suit against the tobacco industry ought to breathe new life into the tort reform movement.

You don't have to like tobacco or tobacco companies to feel that something's seriously awry with the civil justice system when a jury that had previously awarded less than $13 million in compensatory damages to three representatives of the class deliberates for only a few hours before returning with a whopping punitive damage award of almost $145 billion.

That the punitive damages award seems almost certain to be reduced—or even reversed—on appeal is beside the point. Such an outrageous award should never have been made in the first place. After all, it was only four years ago that the U.S. Supreme Court ruled in *BMW of North America vs. Gore* that punitive damages can indeed be so disproportionate to compensatory damages as to violate a defendant's constitutional rights. Unfortunately, the high court didn't provide a calculus for determining the point at which a punitive award is so out of whack with the underlying compensatory award that it violates the Constitution.

Nonetheless, the punitive award in the landmark *BMW vs. Gore* case was about 500 times the compensatory award. In the recent Florida smoking case—*Engle vs. R.J. Reynolds Tobacco Co. et al.*—the award was more than 10,000 times the compensatory award made so far.

Under Florida law, defendants in cases like *Engle* have to post a bond of up to $100 million to appeal the award. Outlandish as that may seem, until recently, the law required defendants to post bond in excess of the actual award. Still, $100 million is a pretty steep price for anyone to have to pay to get a day in court.

As we said earlier, you don't have to be sympathetic to the tobacco industry to feel a sense of outrage at what happened in that Florida courtroom. That outrage ought to be channeled into a renewed drive at both the state and federal levels for fair and meaningful civil justice reform.

A good starting point would be the issue of punitive damages, to make sure that state laws are in line with *BMW vs. Gore*, hazy as that guideline might be. This would require lawmakers to set limits on the size of an award relative to compensatory damages, which would serve as a reasonable guideline.

Class-action reform, which is drawing some support in Congress but is highly unlikely to become law this year, also merits some attention. Although the proposed federal legislation—which would allow the removal of certain class actions to federal court from state court, where interstate interests are involved—would have had no effect on the Florida case, it would help curb so-called forum shopping, in which plaintiffs' attorneys file interstate suits in state courts most favorable to their clients.

Tort reform advocates can look back at an impressive series of victories, primarily on the state level, over the past decade or so. But the Florida tobacco award underscores that much, much more needs to be done. The best possible effect of that unreasonable punitive award would be its transformation into the rallying point for a successful drive to restore reason to the civil justice system.

Y2K time bomb still ticking

THE HYSTERIA AND FEAR over the millennium bug may seem like a distant memory to many, but its potential to bite the insurance industry is still very much intact.

It turns out, as we now know, that the actual losses resulting from the Y2K bug were few and far between. There were no widespread meltdowns caused by malfunctioning elevators, embedded chips, medical devices or traffic signals.

Although very little in the way of actual damage occurred after the clock struck midnight on Dec. 31, 1999, that fact is irrelevant to many companies that spent billions of dollars to eliminate this risk. Indeed, several companies now contend that the costly efforts they undertook to avoid those losses should be covered by insurance. Their argument for indemnification under their insurance policies has yet to play out in the courts.

Many in the industry—across the spectrum from buyer to intermediary to seller—likely have forgotten about these lawsuits, or thought they would disappear when nothing happened on Jan. 1. They may be even more surprised to learn that new lawsuits seeking indemnification for Y2K remediation efforts continue to be filed (*BI*, July 17).

The argument in all of these cases is that the "sue and labor" clause in all-risks insurance policies should cover the cost of those remediation efforts. The clause provides coverage if a policyholder should act to "sue, labor or travel" to minimize or avoid an actual or imminent loss to covered property. It was introduced in the 17th century to assure that ship owners would take necessary steps, such as jettisoning cargo, if it meant avoiding the loss of an entire ship.

To the Y2K claimants, the analogy is apt, as there was a very real fear that their insured operations could be stalled or idled by the failure of computers to read the change to the year 2000. Y2K remediation efforts were made to avoiding business interruption that would have proved costly to insurers, they argue.

If there's a chance that there may be coverage of these remediation costs, companies may feel a duty to file a claim or else face charges of negligence and possible directors and officers liability exposures.

If a court upholds buyers' sue and labor coverage argument, Y2K will swiftly return to the forefront of the industry's mind as more companies file claims for coverage and sue when those claims are denied. If insurers win, the stakes are such that few plaintiffs will throw in the towel before several appeals have been exhausted.

Regardless of the outcome of the first cases to go to trial, this issue will take years to untangle. The Y2K bug, therefore, is likely to continue biting the industry for some time to come.

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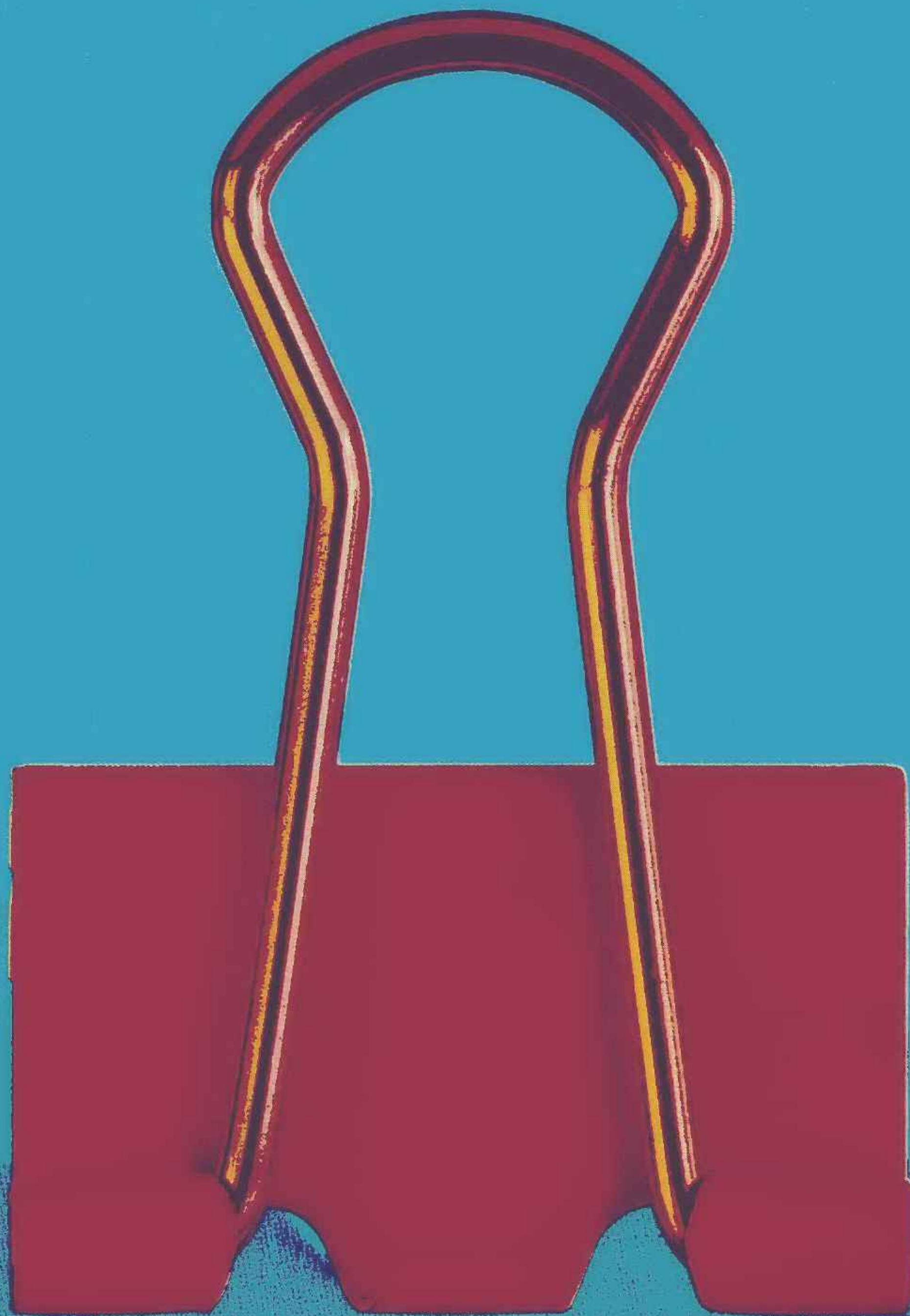

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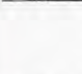

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Preliminary Agenda

Monday, October 16

9:30 AM
GOLF TOURNAMENT
Hosted by: NCCI

3:00 PM
EARLY REGISTRATION

4:00 PM
EMPLOYERS' PRIVATE ROUNDTABLE
Moderator:
Kathryn J. McIntyre
Vice President, Publisher and Editorial Director
Business Insurance

5:30 PM
PRE-CONFERENCE WELCOME RECEPTION*

Tuesday, October 17

8:00 AM
REGISTRATION AND CONTINENTAL BREAKFAST
Hosted by: GENEX Services

9:15 AM
KEYNOTE PRESENTATION:
"SECURITY ON THE ROAD TO RECOVERY" SNAP-ON INC.'S WORKERS COMPENSATION MANAGEMENT SYSTEM FOR INJURED WORKERS
Dan Kugler, CPCU, ARM, CEBS
Director of Risk Management
Snap-On Inc.

10:15 AM
TABLE-TOP EXHIBITS & REFRESHMENTS
Hosted by: Commonwealth Risk

10:45 AM
STRATEGIES FOR REDUCING HEALTH CARE COSTS
Moderator:
Robert L. Gelb
President, Bay Brook Medical Services
A Division of QTC Management Inc.

Panelists:
Fred Scardellette
Vice President, Disability Management
Product Development
Intracorp

Victor L. Paganucci
Director, Integrated Disability Systems
Champion International Corporation

William P. Molmen
General Counsel
Integrated Benefits Institute

12:00 PM
LUNCHEON
Hosted by: Hack, Piro, O'Day, Merklinger, Wallace & McKenna Hall & Evans, L.L.C., Hinshaw & Culbertson and Litigation Solutions Law Group LLP

1:15 PM
THE NEW WORKPLACE: MANAGING LIABILITIES DUE TO CHANGING EMPLOYMENT RELATIONSHIPS
Moderator:
Barry Thompson
National Practice Co-Leader of Disability Management Services
Deloitte & Touche LLP

Panelists:
David J. Thompson
Work/Life Manager Diversity
Microsoft Corporation

Jeffrey W. Pettegrew
Vice President, Risk Management & Insurance
Westaff

James R. Nau, CPCU, ARM
General Manager, Workers Compensation Residual Markets
NCCI

2:15 PM
TOP WORKERS COMPENSATION ATTORNEYS TELL YOU HOW TO AVOID PROBLEMS WITH CLAIMS

Moderator:
RISK MANAGER OF THE YEAR
Paul F. Buckley
Treasury Director, Risk Management
Lucent Technologies Inc.

Panelists:

Patricia J. Clisham
Member & Chief Marketing Officer
Hall & Evans, L.L.C.

John T. West
Partner
Hack, Piro, O'Day, Merklinger, Wallace & McKenna

Mary Skelton
President of WORKDOTCOMP.COM
Workers Compensation Solutions, Services & Consulting

Cheryl Wilke
Partner
Hinshaw & Culbertson

3:15 PM
TABLETOP EXHIBITS & REFRESHMENTS
Hosted by: Bayne Consulting Group, Ltd.

3:45 PM
ADDRESSING PRIVACY ISSUES AND LEGAL EXPOSURES FACING EMPLOYERS: WHAT EMPLOYERS NEED TO KNOW

Eric Oxfeld
President
UWC Inc.—Strategic Services on Unemployment & Workers' Compensation

Terrence Delehanty
General Counsel
NCCI

4:30 PM
FIGHTING FRAUD IN AN INCREASINGLY CHALLENGING ENVIRONMENT

Moderator:

Tim Fargo
President
Omega Insurance Services

Panelists:

L.A. Andy Casto, CPCU
Director, Workers Compensation
Kmart Corporation

Anshell Boggs
Workers Compensation Manager
Pep Boys

Tim East
Manager, Risk Management Business Process
The Walt Disney Corporation

5:30 PM
COCKTAIL RECEPTION
Hosted by: Kemper Insurance Companies

WEDNESDAY, OCTOBER 18

7:45 AM
CONTINENTAL BREAKFAST
Hosted by: Intracorp

9:00 AM
A PRACTICAL GUIDE TO DEVELOPING AN AWARD WINNING ERGONOMICS PROGRAM: CENTER FOR OFFICE TECHNOLOGY WINNER

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PRESENTED BY:
The Center for Office Technology

Panelists:

Elizabeth A. Grosh, CSP, ARM
Loss Control Specialist
The Prudential Insurance Company of America

Pamela Faccone, MS, ETT, HFI
Exercise Physiologist
The Prudential Insurance Company of America

Diane Lee, MS
Ergonomist
Safety and Health Team
Seattle City Light

Steve M. Davis, M.Ed
Consulting Ergonomist
Prezant Associates, Inc.
Former Ergonomist, Seattle City Light

10:00 AM
TABLE-TOP EXHIBITS & REFRESHMENTS
Hosted by: Omega Insurance Services

10:30 AM
IMPLEMENTING SAFETY AND LOSS PREVENTION STRATEGIES THAT WORK

Robert S. Anderson, ACII, ARM
President
The Worksafe Group

John Leonard
President
Maine Employers' Mutual Insurance Co.

11:15 AM
BEST PRACTICES: HOW TO MEASURE THE PERFORMANCE OF YOUR DISABILITY MANAGEMENT PROGRAM

Moderator:

Maria A. Bayne
President
Bayne Consulting Group, Ltd.

Panelists:

Elise Macinka
Safety and Risk Manager
Cox Communications OC

Peter Rousmaniere
President
Rousmaniere Designs

Bernadette Melchionne
Senior Corporate Insurance Administrator
Mattel Inc.

12:45 PM
LUNCHEON WORKSHOP:*
INNOVATIVE TECHNOLOGIES TO SAVE MONEY AND EMPOWER WORKERS

Greg Owen
Claims Manager
Sears Roebuck & Co.

2:00 PM
CONFERENCE ADJOURNS

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Costs

Continued from page 3

average for the respondents within each industry.

According to the findings, Texas appeared at or near the top of the medical cost averages for each industry in both years. The survey used a point system, in which a state was assigned 10 points each time it ranked—in either 1997 or 1998—as the highest in a given industry sector. Points were assigned to states on a descending scale—nine points for second-highest, eight points for third-highest, and so on—for each sector. According to the survey, the four states with the highest workers comp medical costs were: Texas, with 76 points; Delaware, 48 points; California, 47 points; and Hawaii, 30 points.

"I think (the RIMS survey) has reconfirmed the premise that we put out there—that our medical costs are out of line; they are too high," said Eric Glenn, governmental affairs manager for the Texas Assn. of Business & Chamber of Commerce based in Austin.

"It doesn't make sense when our accident and severity rates are going down but our costs are going up," said Mr. Glenn said. "That suggests that we need to take some action."

Howard Stansell, president of the Dallas/Fort Worth RIMS chapter, said he hopes that the RIMS survey will be submitted to the Texas Legislature alongside other documents to show that Texas' medical costs are higher than other states' costs for the same types of injuries.

"We do not want the quality of care to suffer for injured workers, we just want to make sure that the businesses that are paying for it are paying appropriate fees," said Mr. Stansell. He is director of risk management for Thousand Trails Inc. in Dallas, which owns and operates membership campgrounds across the country.

The Texas Legislature last year addressed the medical cost issue by passing a bill that authorized the state's Research and Oversight Council on Workers Compensation to conduct four studies on the state's workers comp system, three of which will focus on medical costs, including cost drivers. A spokesman for the Austin-based agency said that the studies are expected to be complete in November. Once the studies have been completed, the research council will examine the findings and make recommendations to the Legislature, he said.

"It's the most ambitious project that we've done in our five-year existence," the spokesman said.

While the research council's work is still under way, a study conducted by the Cambridge, Mass.-based Workers Compensation Research Institute supports the findings of the RIMS study.

> **'One of the biggest financial items in a company's total cost of risk is workers comp cost, and that is a number that is experiencing upward pressure,' says Jim Green.**

According to the soon-to-be-released study, the WCRI found that workers comp medical costs are higher in Texas than in all other states analyzed, said Richard Victor, executive director of the WCRI. The WCRI compared the performance of the workers comp systems in eight states that represent 40% of the workers comp benefits provided in the United States.

The WCRI will publish a second study at the end of this year that analyzes the drivers behind medical cost trends, Mr. Victor said.

Jim Green, risk manager for manufacturer Justin Industries Inc. in Fort Worth, Texas, and coordinator of the RIMS survey, said that the WCRI and research council studies, combined with the RIMS study, will be a "tremendous tool" in assessing the drivers behind the increasing medical costs and in effecting change in the state.

"We've scratched the surface of what is a big problem in the area of risk management," Mr. Green said. "One of the biggest financial items in a company's total cost of risk is workers comp cost, and that is a number that is experiencing upward pressure. If we are going to be good risk managers, we must work together to control and contain the upward pressure of medical costs" and, at the same time, deliver quality medical care to injured workers, Mr. Green said.

While Mr. Green said that he wasn't surprised to find Texas near the top of each list, he was a little surprised to find that medical costs seem to be on the rise in his state and three others.

According to the RIMS survey, the overall average medical cost per claim was $1,415 in 1997 and $1,458 in 1998. Eight states appear on both years' lists with higher-than-average medical costs: Delaware, Texas, California, Hawaii, Alaska, New Hampshire, Montana and Colorado. Of those eight, four show a higher average medical cost per claim on 1998 claims than on 1997 claims. Colorado, for example, reported a 44.4% increase in its average medical cost per claim, which rose to $2,055 per claim in 1998 from $1,423 in 1997. Likewise, Alaska showed a 31.3% rise in medical costs to $2,282 per claim in 1998 from $1,738 per claim in 1997.

Texas reported a 9.0% rise in medical claim costs to $2,314 per claim in 1998 from $2,122 in 1997, while California reported a 4.0% rise to $2,062 per claim from $1,983 in 1997.

Mr. Green, who described the increases as a "disturbing trend," said they are of particular significance because 1998 claims are 12 months less mature than 1997 claims, so 1998 costs will most likely be even higher when adjusted to their final cost, he said.

Out of the five industry groups analyzed, the hospital and inpatient care industry reported the highest average medical cost per claim, with $1,996 in 1998 and $2,218 in 1997. The average medical cost per claim for the grocery store industry was $1,795 in 1998 and $1,812 in 1997. The cargo and package handling industry reported an average medical cost per claim of $1,491 in 1998 and $1,377 in 1997; the restaurant industry reported an average cost of $1,110 in 1998 and $1,082 in 1997; and the retail industry reported an average cost of $1,024 in 1998 and $1,070 in 1997.

Copies of the Dallas/Fort Worth RIMS chapter's survey will soon be available on the national RIMS Web site at *www.rims.org* under "What's New." **BI**

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Avoiding job discrimination lawsuits

By Gerald L. Maatman Jr.

Human resource professionals, corporate counsel and risk managers take heed: The U.S. Supreme Court's recent decision in *Roger Reeves vs. Sanderson Plumbing Products Inc.* gave workers a significant victory in employment discrimination litigation. It makes even more important the need for careful risk management of employment practices liability exposures.

In its June 13 decision, the Supreme Court eased the evidentiary burden on plaintiffs in age discrimination cases by lowering the amount of circumstantial evidence a plaintiff needs to prevail on the merits.

In practice, the Supreme Court made it considerably easier for workers to get to a jury by avoiding summary judgment. While the decision involved an age discrimination case, the ruling affects all types of employment discrimination cases, such as sex, race, national origin, and disability discrimination litigation.

Most employment discrimination cases are resolved on the basis of circumstantial evidence. Employers rarely admit to job bias, and plaintiffs customarily litigate workplace discrimination cases by focusing on facts from which a judge or jury may reasonably infer that the employer intended to discriminate. For over 30 years, such cases have been tried under an evidentiary framework stemming from the seminal decision in *Green vs. McDonnell Douglas*, which lets workers prove their case through inferences drawn from circumstantial evidence.

In the three stages of that framework, a worker must first establish a prima facie case: generally by demonstrating that he or she was a member of a protected class, was otherwise qualified for the position, and that the employer fired or treated him or her in an adverse fashion.

The employer then must show that the personnel decision was supported by legitimate, non-discriminatory reasons.

To prevail, the employee has to prove that the reason given by the employer was just a pretext for discrimination.

The question presented in *Reeves* involved whether an employee must produce additional evidence that illegitimate reasons motivated the adverse personnel decision, or whether merely showing that the employer was not motivated by the offered reason—combined with the prima facie case—is enough. Many circuit courts had held that "pretext plus" other evidence of discrimination was necessary before an employer had to answer for damages in a jury trial.

In *Reeves*, the Supreme Court rejected the pretext-plus standard as a misconception of the evidentiary burden borne by plaintiffs in workplace bias cases. The Supreme Court indicated that when a worker demonstrates that an employer's explanation of the personnel decision is unworthy of belief, a judge or jury can infer discrimination by the mere fact that the employer falsified the reason for the personnel decision or covered up its true motivation.

In theory, the ruling holds open the possibility that a showing of pretext for discrimination might not always be adequate to sustain a finding of liability for an employee; in practical terms, *Reeves* demonstrates that such circumstances would be rare in the real world.

The Supreme Court also addressed an important subsidiary issue regarding the evidence an appellate court may consider when ruling on a motion for judgment as a matter of law under Rule 50 of the Federal Rules of Civil Procedure. This issue is critical in workplace litigation because employers have had considerable success—particularly in age discrimination cases—in overturning jury verdicts based on arguments of bias or insufficient evidence of pretext.

At issue is whether courts should consider all the evidence in the case, or only facts that favor the winning litigant. Associate Justice Sandra Day O'Connor wrote that an appellate court should review all the evidence in the record, but "the court must draw all reasonable inferences" in favor of the victorious party, "and it may not make credibility determinations or weigh the evidence." In essence, the ruling will make it harder for employers to overturn jury verdicts rendered in favor of plaintiffs in job bias cases.

Employers are already feeling the impact of *Reeves*. More cases likely will survive summary judgment, and there will be an increase in the settlement value of such claims. Not unexpectedly, members of the plaintiffs' bar also have predicted an overall increase in workplace litigation, explaining that the decision in *Reeves* will strengthen the resolve of lawyers who have been reluctant to take on worker's cases. Because settlements often are evaluated on the basis of a plaintiff's ability to survive summary judgment, settlement values and negotiation dynamics undoubtedly will be affected by the decision.

The impact of *Reeves* also will be felt by employers that have lost jury trials, as plaintiff's lawyers will now have a powerful argument with which to prevent a trial court from overturning a jury's verdict.

At the heart of *Reeves* is a lesson in risk management: Employers are playing with fire if they don't handle personnel decisions with care, candor, consistency and compassion. Proactive risk managers and human resource professionals must structure personnel decisions in a manner that safeguards employers' interests. *Reeves* confirms that any adverse employment decision should have a basis in fact and a legitimate business purpose supported by contemporaneous documentation.

The termination of a worker is a good case study in this context. Under *Reeves*, termination is easier to defend and justify if an employer can show that it passes a notice-and-fairness test. In other words, did the employer warn the employee of the company's expectations—provide notice—and did the employer afford the worker a sufficient opportunity to conform his or her behavior to company standards? In this respect, employers have more discretion and ability to terminate employees who did not follow the company's rules and expectations.

An employer that uses a thorough set of personnel practices, and administers them in a fair and impartial fashion, can more easily show that its treatment of workers is fair. Because courts and juries often view anything that has the appearance of unfairness as constituting unlawful discrimination, employers can more easily avoid discrimination problems by ensuring that employees know the basic ground rules and expectations. To that end, before firing any worker, employers should be able to answer the following questions:

- Does the employer have all the facts pertinent to the worker and his or her particular situation?
- Was the employer's investigation of the employee's situation fair and objective?
- Did the employee know what the company expected in terms of job performance or workplace rules?
- Did the employee have a forewarning or knowledge of the possible consequences of repeated rules violations or a failure to improve job performance?
- Has the employee had a fair and reasonable opportunity to improve his or her performance?
- Is the proposed discipline or termination reasonably related to the seriousness of the employee's offense?
- Is there adequate documentation of previous discussions between management and the employee to show notice and fairness?
- Has the company treated similarly situated employees in a consistent fashion in terms of discipline or termination for violation of workplace rules or poor job performance?
- Did the manager handle the termination in a manner which he or she would expect if the roles were reversed?

Adoption of such loss control and risk management techniques will promote sound decision making. Employment discrimination lawsuits under the new standard in *Reeves* can be more easily avoided or defended by proactive employers. BI

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LEGAL BRIEFS

Worker with prior injury entitled to compensation

An employee's injury occurred in the course of employment even if his fall was caused by a pre-existing, work-related injury, the Oklahoma Court of Civil Appeals ruled.

Herschel Oldham worked with heavy equipment. He suffered a work-related neck injury in 1991 but declined surgery until April 1995. During the period between the initial injury and the surgery, Mr. Oldham experienced falls due to numbness in his legs. In August 1995, Mr. Oldham was operating a heavy crane at work. A relief operator arrived and Mr. Oldham climbed down the crane cab. He rested against the crane's track and then either turned and fell or took a few steps and fell as a result of the numbness. His left shoulder was injured in the fall.

He filed for and was awarded workers compensation benefits. But a panel of the compensation court reversed the award. Mr. Oldham appealed.

The appellate court said that when an employee is injured in the course of employment and such injury is the direct and natural consequence of a prior work-related injury, then the new and distinct subsequent injury likewise arises from employment, absent some intervening cause. Thus, the new injury was deemed compensable and the lower court decision was reversed.

Oldham vs. OK Iron & Metal, Court of Civil Appeals of Oklahoma, Oct. 18, 1999, Certiorari Denied Oct. 18, 1999. (*BI*/01/Au. -$10)

Injury while off duty compensable

An employee who sustained an injury while off duty but present at her employer's workplace to obtain her paycheck, was entitled to workers compensation benefits, the Pennsylvania Supreme Court ruled.

Namie G. Hoffman, a clerk/secretary for Westmoreland Health System, was paid biweekly. Employees had three options for obtaining paychecks, one of which was personal retrieval by the employee from her workstation. On Aug. 20, 1993, Ms. Hoffman was not scheduled to work but visited the employer's premises only to obtain her paycheck, as was her longstanding practice. While there, she fell and injured her knees, left hand and lower back. She filed a workers comp claim, which was denied. The compensation board and trial court affirmed the denial. Ms. Hoffman appealed.

On appeal, the employer argued that Ms. Hoffman's presence at her workplace merely to obtain her paycheck was not in furtherance of the business or affairs of the employer and, thus, her injuries did not arise in the course of her employment. The court concluded that, regardless of other available options, an employee's presence at the workplace to obtain a paycheck pursuant to an employer-approved practice bears a sufficient relationship to a necessary affair of the employer—payment of due wages—to fall within the course of employment. Consequently, the court said that Ms. Hoffman should receive workers comp benefits.

Hoffman vs. W.C.A.B., Supreme Court of Pennsylvania, Dec. 23, 1999. (*BI*/03/Au. -$10)

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available by sending a $10 check payable to Mayo H. Stiegler, to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Provide the listed number for each opinion.

Latex

Continued from page 2

against it will preclude it from filing liens against Ms. McGinnis to recover the workers compensation benefits it paid her, he said.

Judge William Pate, who presided over the recent jury trial, denied the plaintiff's request that the jury consider awarding punitive damages, Mr. Harley said.

Ms. McGinnis, now 41, has been unable to find a job in an environment free of latex-related products that could trigger symptoms affecting her skin and respiratory system, the attorney said.

Reactions of latex allergy sufferers typically range from skin rashes to respiratory problems similar to those seen in an allergic person after a bee sting and, in rare cases, can include death.

The McGinnis case was the first of about 40 latex glove cases in California to make it through trial.

"We were pleased with the verdict. It was the first (in California), and the first cases are always difficult," Mr. Harley said. The history of such mass cases is that plaintiffs typically get better and better verdicts as time goes by, he said.

An Allegiance spokeswoman offered a different perspective. "Baxter and the industry has a pretty good track record," she said.

The McGinnis case was the first jury verdict against Baxter in any latex-related case, she said. Baxter has never settled any such cases filed against it, she added.

Overall, jury verdicts against latex manufacturers have been "mixed," and about 200 cases have been dismissed, she said.

As part of Baxter's 1996 spinoff of the company, Allegiance agreed to indemnify Baxter for any glove-related claims, the spokeswoman said.

'It basically comes down to what did the manufacturer know and when did it know it,' says Christian C. Mester.

Regardless of the outcome of the appeal, though, Allegiance has "adequate insurance to cover this claim," she added. She declined to provide additional details.

Hundreds of other cases, however, are pending in federal courts in California, and even more cases are pending in other state and federal courts nationwide.

In addition, some federal and state jurisdictions have consolidated large numbers of latex glove cases, which allows attorneys pursuing individual cases to share evidence and submit common motions.

Pending cases are being brought under several theories, including negligence, product liability, fraud, failure to warn, failure to take action to reduce the dangers, and breach of warranty, according to Christian C. Mester, a plaintiffs attorney with Freeman & Freeman P.C. in Rockville, Md. "It basically comes down to what did the manufacturer know and when did it know it."

Standard defenses emphasize that latex is a common material found in many products outside health facilities and that health care workers are sophisticated users.

In addition, many would-be plaintiffs are precluded from bringing lawsuits because of statutes of limitations. Also, the exclusive remedy doctrine generally limits workers' recoveries for job-related injuries to workers compensation benefits, although that is subject to challenge.

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McGinnis vs. Baxter Health Care, Alameda Superior Court, No. 771258-2.

Hepatitis

Continued from page 3

statutes do not apply to cases involving transfusions performed before that date.

The class-action suit was filed in June 1999, after Louisiana lawmakers last year passed a bill that required claims for injuries occurring before July 15, 1982, to be filed by July 1, 2000.

Suits involving transfusions performed after the law change date are being treated as malpractice cases.

Mr. Cossé said suits against hospitals have the potential to drive up health care costs, as price increases may be needed to fund large awards. While hospitals have coverage to pay for current losses, any uninsured losses from old hepatitis C cases would have to come out of pocket, said Mr. Cossé.

"Margins at hospitals are very, very thin right now. Hospitals just don't have the cushions they once had," Mr. Cossé said.

A further complication is that many facilities have been unable to find proof of insurance coverage for claims that stretch back into past decades, he said. And even if coverage is unearthed, limits probably were written to no more than $100,000 on policies from the 1960s, he said. Some later policies may have higher limits, Mr. Cossé noted, but prior claims could have reduced or exhausted those limits.

In addition, coverage disputes are likely to arise among those insurers identified as underwriters on some of the old claims, Mr. Cossé said. General liability insurers and malpractice insurers likely will engage in finger-pointing until a court determines who is on the hook, he said.

A plaintiffs attorney said that if the class is certified, plaintiffs will seek a large award.

"You have to know that when someone has hepatitis C, they are going to die," said Darleen Jacobs, an attorney with the New Orleans firm of Jacobs & Serrat, who represents plaintiffs in the class action. "So how do you put a value on human life? It has to be done—and it will be high."

Ms. Jacobs said that if the class is not certified, plaintiffs will bring their cases against the hospitals individually.

Dwight Sledge, executive director of United Blood Services, a Lafayette-based blood bank, said that "depending on the outcomes," suits against blood banks in Louisiana have the potential to "bankrupt our systems." He said two suits are pending against United.

Mr. Sledge said United doesn't have patient records stretching into past decades, but the blood bank does have information on its historical insurance coverage. An undetermined amount of coverage is in place that will cover claims if the lawsuits are successful, Mr. Sledge noted.

As do most blood banks, United today self-insures its liability risks and buys excess coverage above its retention, according to Mr. Sledge.

Blood banks are named in many of the individual suits in Louisiana, but they have been dropped from the lawsuit seeking class-action status. Although plaintiffs said they dropped the facilities because "they didn't deliver transfusions, the real reason is because they are not-for-profits and many have no insurance and few assets" to pay awards, charged Gary McGoffin, an attorney with Durio, McGoffin & Stagg in Lafayette, who is representing hospitals in the class action.

'Louisiana is alone in the U.S. in having a period of time in which transfusions are deemed strict-liability claims,' says Gary McGoffin.

Of the hepatitis C suits filed in the United States, most have been in Louisiana, where plaintiffs can take advantage of the state's strict liability standard that doesn't require proof of negligence, observers note.

Theresa Wiegmann, general counsel for the American Assn. of Blood Banks in Bethesda, Md., said that while hepatitis C cases are pending in other states, Louisiana is believed to have most of the cases "because of the uniqueness of Louisiana law" with regard to strict liability. She said she is unaware of any blood bank cases that resulted in judgments, but "a number have settled" across the country, and rulings in some suits have favored defendants.

Mr. Cossé said some of the claims in the class action date back to transfusions that were performed in the 1960s. "No other state allows these things to drag on for 40 years," he noted.

"Louisiana is alone in the U.S. in having a period of time in which transfusions are deemed strict-liability claims," said Mr. McGoffin.

Mr. McGoffin said plaintiffs cannot prove that a transfusion caused the illness, so they use a process of elimination to determine that a transfusion was responsible. By claiming they were not intravenous drug users, sexually active with high-risk partners or participants in other lifestyle situations that could cause the illness, claimants are attempting to discount all causes except the transfusion. "That's the plaintiffs' theory," he said.

Mr. Cossé said it is unfair to ask hospitals to pay the claims for an illness that could not be detected until well after most of the plaintiffs contracted hepatitis C.

"There was no reliable test for hepatitis C before 1991. We couldn't find it, and we couldn't test blood for it," he said. "We saved lives," yet hospitals now are being accused of exposing patients to the disease even though the transfusions were life-saving measures, he said.

Plaintiffs attorney Ms. Jacobs, however, asserts that "there was a test as early as 1956" that cost one dollar to administer and was used in hospitals outside Louisiana.

She said it is not known why the test was not used in the state. "Hopefully, our discovery will tell us." BI

New plan

Continued from page 3

them to acknowledge they are in fact paying for their own health care.

To start the conversion process, employers need to educate employees about how much of their compensation goes to pay health care benefits. For example, employers could spell out on workers' paychecks their total compensation and the amount they're paying for health care, Mr. Abramowitz said.

But to switch successfully to a defined contribution plan, employers need to manage that plan—just as they do a defined contribution pension plan—not simply give employees money and dump them into the health care marketplace, he said.

In a defined contribution health care plan, employees are responsible for selecting a health care plan and paying any difference between the employer contribution and the plan costs.

Without management by employers, many people simply will pull out of the insurance system if they pay more in premiums than they receive in benefits, leaving only the sick in the program, Mr. Abramowitz said.

Currently, three obstacles exist to adopting a defined contribution plan, said Kenneth Sperling, a consultant with Hewitt Associates in Rowayton, Conn.

- Money given to employees to buy health care is taxable as income.
- Employees can't buy insurance as individuals in many places, especially if they are in poor health. "The people who need it the most won't be able to get it at any price," Mr. Sperling said.
- The amount given will be too much for some people who are healthy, while not enough for others who are ill and have to pay a higher premium.

To overcome these barriers, a system could be implemented that would give employees credits, but not actual money, toward buying a plan. Also, the employer would still be the actual contractor, ensuring employees access to the system at a group rate, while still providing enough choices to satisfy employees, he said.

And finally, the employer subsidy can vary by employee, making it easier for sick employees to buy coverage.

One solution Mr. Sperling touted was the Sageo online system that Hewitt unveiled earlier this year. With Sageo, which becomes active this month, an employer gives its employees numerous options of plans from various insurers. The employees enroll over the Internet, where they also can tap into a huge library of health-related information (*BI*, March 20).

Mr. Abramowitz, however, disagreed with a fundamental aspect of Sageo. With Sageo, employees can choose from health plans from various insurers. But Mr. Abramowitz said a better approach would be to have one insurer offer various plan types, such as HMO and PPO, and cover all employees of one employer. The employer would provide money at a set level and the employee would pay for the costs of a health plan that exceeds that amount.

Despite its drawbacks, Mr. Taylor maintained that Sageo is a move in the right direction for employers.

"It may not be perfect, but let's not let perfect get in the way of a good step," he said. BI

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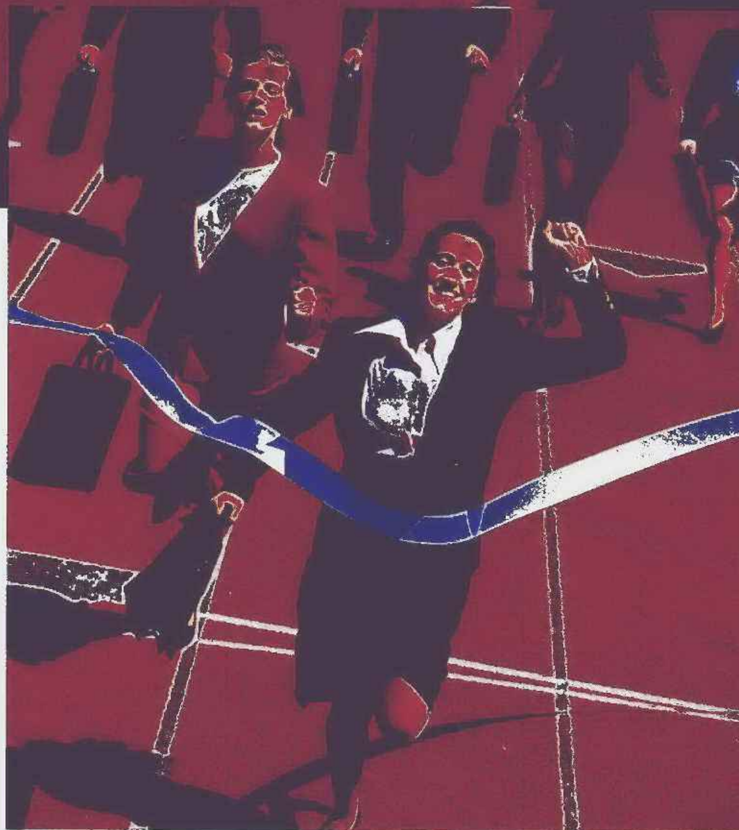

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GLOBAL BRIEFS

Cordis Consulting Ltd., the consulting division of London-based Willis Group Ltd., has been hired by the Turkish government to help create a national insurance plan for earthquake and flood risk. Cordis will provide catastrophe and financial modeling services and hazard mitigation advice. The plan is being sponsored by the World Bank, as part of the Turkish Emergency Flood and Earthquake recovery program. . . .Sales at London-based **CGNU P.L.C.** grew 24% in the first half of 2000, the company announced. CGNU said new-business sales totaled £3.7 billion ($5.54 billion) in the first half, giving the company a 10% share of the U.K. long-term savings market. . . .CGNU also announced it is forming **a bancassurance venture with Royal Bank of Scotland.** CGNU is to pay £600 million ($898.7 million) for a 50% stake in Royal Scottish Assurance and National Westminster Life Assurance, two RBS subsidiaries. . . .London-based Moody's Investors Services Inc. has **downgraded Markel Syndicate Management syndicate 329** to C- from B-. U.S.-based Markel Corp. announced earlier this year that it would withdraw its backing from syndicate 329 at the end of 2000. Markel acquired the marine syndicate after a merger with Terra Nova but said syndicate 329 no longer fit its strategy. Moody's said the downgrade reflected concerns about the "material uncertainty over the future of the syndicate." . . . **Lloyd's aviation loss adjusting division** has been sold to Charles Taylor Group P.L.C. Lloyd's Aviation was formed in 1960 to provide aviation loss adjusting and surveying services. Its current chief executive officer, John McKay, will become CEO of the newly created Charles Taylor Group LAD (Aviation) Ltd. . . .Nelson Hurst Professional Indemnity and the U.K. Law Society's Sole Practitioners Group have chosen **Hiscox P.L.C.** as the insurer of the professional indemnity plan developed for sole practitioners. The SPG appointed Nelson Hurst, a division of Johannesburg-based Alexander Forbes Group Ltd., as its recommended provider of E&O insurance to its members in February. Members of the Sole Practitioners Group comprise almost half of the United Kingdom's law firms. . . .**Munich Reinsurance Co.** has announced it expects a 6% increase in premium volume for 2000. The world's largest reinsurer had previously forecast a 3% to 4% rise in premiums. At the reinsurance company's annual meeting, CEO Hans-Juergen Schinzler said that favorable exchange rates and recent acquisitions would help boost the company's growth. Mr. Schinzler predicted that Munich Re's reinsurance income would rise by about 7% in 2000, while primary insurance income would go up by about 5%. In 1999 the company recorded $25.37 billion of premium income. . . .The **abolition of capital gains tax on shareholdings** in German companies will likely produce a surge in profits for large insurers in the country, according to ratings agency Standard and Poor's Corp. in London. S&P warned, though, that small insurers may become vulnerable to takeover or rating downgrades when the new rules go into effect in January 2002. The abolition of CGT on shareholdings will allow insurers with large cross-shareholdings to sell their holdings and gain more flexibility to expand abroad, S&P said. . . .The U.K. Trades Union Congress has gone to the Court of Appeal to contest the government's implementation of **European Union parental leave regulations.** The TUC took the government to court in May, arguing in the U.K. High Court that the government's imposition of a cutoff date for parents qualifying for parental leave was unlawful. The High Court referred the case to the European Court of Justice. The court could take up to two years to reach a decision.

Jaffray arguments end

Autumn verdict expected in case

By SARAH VEYSEY

LONDON—Arguments in the high-profile *Jaffray vs. Lloyd's* fraud trial have ended, after eliciting testimony from many key figures from Lloyd's of London and forcing the market to revisit one of the most painful periods in its 312-year history.

The 20-week trial attracted worldwide media attention, as witnesses such as former Lloyd's Chairmen Sir Peter Miller, Walter Nicholas "Murray" Lawrence and Sir David Rowland took the witness stand and were questioned about the market's years of struggle in the 1980s and early '90s and names' allegations that they were fraudulently recruited to invest in Lloyd's.

The presiding judge, Mr. Justice Cresswell, is expected to deliver a verdict in the fall. The *Jaffray* case is the last that can be brought against Lloyd's in U.K. courts over allegations of fraud with regard to asbestos-related losses from the period 1978 to 1988.

In the final week of the trial, all three parties involved—Lloyd's, the Jaffray names, and litigants in person—were invited to present their closing arguments. Litigants in person are names who are pursuing individual lawsuits against Lloyd's apart from the *Jaffray* suit, which was backed by members of the United Names Organisation. Ironically, Sir William Jaffray—whose original suit developed into the class action—himself appeared as a litigant in person, because he split with the UNO over ideological differences last year.

In a suit that named 33 senior figures at Lloyd's as defendants, the more than 200 litigating names argued that Lloyd's had concealed the true extent of asbestos-related losses that threatened to hit the market in the 1980s and fraudulently recruited investors to provide capital to bolster the market when those losses hit.

"When matters came to a head in 1981, 1982, the one thing Lloyd's could not properly do was allow external names not to know the problem was there," said Simon Goldblatt, lead attorney for the names class, in his closing remarks.

One thrust of Mr. Goldblatt's arguments was that misrepresentations were made in the brochures sent to prospective names in the 1980s.

"The brochures are the essence of the misrepresentation. You read them and you think you are entering a well-regulated market in which you could rely on theresults," said Mr. Goldblatt. "But you couldn't."

Mr. Goldblatt argued that key insiders at Lloyd's knew about the impending asbestos problem and the difficulties there would be

See **Jaffray** *on page 20*

EPL is among niches behind Besso's growth

By EDWIN UNSWORTH

LONDON—Employment practices liability is a growing problem for U.K. employers and insurers, resulting in a growing amount of business for one Lloyd's broker.

Colin Bird, chief executive officer of Besso Ltd., said, "It is a constantly evolving risk for employers, and it is one of the areas that almost every employer will have to address at one stage or another. That includes the brokers that are selling the product."

Mr. Bird explained that legislation on both sides the Atlantic is making it more and more imperative that an employer "deal sensibly" with its staff.

The obvious areas of exposure include sexual and gender discrimination, but Mr. Bird noted that there are a number of less-overt areas, such as claims of disability and of trauma to employees as a result of company mergers.

Employee stress is also increasing as an employment exposure, with myalgic encephalomyelitis, or chronic fatigue syndrome, an example of this type of exposure, Mr. Bird said. In Britain, ME is regarded as a permanent disability, because there is no known cure.

Mr. Bird said that "even simple things," such as giving employee references, can become an employer liability. This is "one of the biggest growth areas of employment practices liability," he said. In Britain, an employer is legally obliged to provide a reference when asked. Consequently, a company could, on the one hand, be sued by a former employee for writing something that prevented him or her from getting another job; on the other hand, the company could be sued by the new employer if it omitted something from a reference that resulted in a problem at the new place of employment.

Besso started out as an independent Lloyd's broker in 1967 and eventually was acquired by Jardine Lloyd Thompson P.L.C. It became an independent broker again in February 1995, following a management buyout led by Mr. Bird. The buyout was backed by a U.S. financial group, First Union Corp. Initially, First Union took a 5% shareholding, which it increased last month to 20%.

Mr. Bird said the increased commitment of First Union will enable Besso "to accelerate the development of the company and increase the number of areas in which we operate"

See **Besso** *on page 18*

Groups respond to E.C. pollution white paper

Proposed regs criticized

By CAROLYN ALDRED

BRUSSELS, BELGIUM—Both public-sector risk managers and insurers are expressing concerns that passage of the European Commission's proposed "polluter pays" environmental liability regulations could hinder the development of appropriate insurance products.

In their separate responses to the "White Paper on Environmental Liability," published in February by the European Commission, both the Assn. of Local Authority Risk Managers and the Comite Europeen des Assurances expressed dissatisfaction with the proposed legislation's calls for ecological liability for protected habitats and species and requested the addition of more defenses for polluters.

Interested parties had until July 1 to comment on the white paper, which outlines an E.C. environmental liability program that would impose strict liability for hazardous operations throughout the 15 member states of the European Union (*BI*, March 20). Implementation of the white paper's measures would require adoption by the European Commission of one or more directives detailing the environmental liability that should be adopted by all E.U. states; next, the proposed legislation would have to be passed by the Council of Ministers—comprised, in this case, of the ministers of the environment from each E.U. state—and by the 700-member European Parliament.

Passage of the strict-liability legislation would mean that companies that engage in hazardous operations—as specified in a handful of other, existing E.C. directives—could no longer use as a defense that they were not negligent or that they had complied with regulations. Furthermore, the white paper's proposals would introduce fault-based liability for non-hazardous activities that cause damage to nationally or E.C.-protected areas and species.

In a July 5 written statement about its response to the white paper, the Devon, England-based ALARM said that the European Commission's recommendation of a new liability for "damage to nature," in addition to the traditional "damage to persons and goods," has raised concerns within the public sector.

The ALARM statement also questioned the white paper's wording, which "appears to open

See **Polluters** *on next page*

PHOTO: AFP

Indian police explore the wreckage of an Alliance Air Boeing 737 that crashed last week in Patana, India.

Scores killed in Indian air crash

PATANA, India—More than 50 people were killed—including six individuals on the ground—when Alliance Air Boeing 737 crashed in Patana, India on July 17.

The hull of the 20-year-old aircraft, which is a total loss, was insured for $8 million. Coverage was led in London by ACE London Aviation Ltd. and was brokered by Marsh & McLennan Cos. Inc. Details of the airline's liability coverage were not available.

The plane was en route from Calcutta, India, to New Delhi and crashed into a residential district in the northern Indian city of Patna, where it was making a scheduled stop. There were 58 passengers and crew on board, of whom at least six survived after being thrown clear before the plane burst into flames.

An inquiry into the cause of the crash has been launched by Indian authorities.

Alliance Air is a subsidiary of Indian Airlines.

—By Edwin Unsworth

Polluters

Continued from previous page

the way for claims for retrospective liability payments for which there has been no accrued budgeting and for which there is no insurance cover."

"The key sticking point is over the trigger for liability being linked to the 'date of knowledge,' which could include historic environmental damage," the ALARM statement said.

Overall, ALARM said, the insurance market in Europe has yet to "respond adequately and cost effectively" to the liabilities that would stem from such environmental liability regulation throughout Europe.

Echoing ALARM's concerns, the CEA, the Brussels, Belgium-based association of European insurers, said in its response to the white paper that extending liability to ecological or environmental damage, including biodiversity damage, would present a difficult challenge to insurers.

"In many cases, restoration of this type of damage is not possible. To meet the prerequisites of insurability, means would have to be decided to establish the quantum of compensation to be paid by the liable party. The means would need to be reliable and consistent within the E.C and not be subject to variations due to emotive influences," the CEA noted in its response, dated June 27.

"This is a highly complex area and may be better served by the imposition of other penalties upon the polluter to act as a deterrent," stated the CEA response, which suggested that this type of damage be excluded from the regulations "until such a time that all the difficulties in quantifying ecological damage have been resolved, to which end insurers, for their part, are ready to contribute."

"To secure the ongoing contribution by the insurance industry for the benefit of society as a whole, (we need) an economically well-balanced regime in the environmental area, with clear basic rules fully in line with the polluter-pays principle," the CEA stated in its response.

"Efforts should be made by all of the parties to ensure that any environmental liability regime does not have an adverse impact on the further development of a viable insurance market," the CEA response stated, adding that the industry "wishes to enhance existing covers and introduce new types of insurance protection, as well as maintain its leading role in loss prevention."

The white paper's objective, to seek compensation by the polluter to pay for the "decontamination, restoration and reinstatement" of polluted sites, including ecologically sensitive sites not owned by the polluter, would bring "completely new aspects to liability law (and) create a number of specific issues which are extremely complex and for which no ready-made solutions are currently available," according to the CEA response.

Nonetheless, "the insurance industry is ready to work with stakeholders to seek solutions," it said.

Among the changes that the CEA called for in the proposed legislation was that regulations not apply retroactively. "This will assist businesses considerably in obtaining suitable insurance protection," the response said.

The association response also stated that absolute liability for polluters can be provided for by the insurance industry only if polluters are allowed more defenses than would be permitted by the proposed legislation. Those defenses are an act of God, an intervention by a third party, a contribution to damage, and the consent of a plaintiff. In particular, the CEA recommended the adoption of the state-of-the-art defense, which would absolve a polluter of liability if it could prove that its processes incorporated the most-modern technological and scientific information available at the time that the pollution occurred.

"Such a defense provides for a degree of legal certainty which will help insurers to decide to whom insurance may be made available and on what terms. Without such a defense, it is a distinct possibility that the businesses which deal in hazardous substances or activities will be unable to obtain insurance or, at least, in adequate quantities," said the CEA response.

"Where a business has gone through the due process of risk assessment, appraisal, management and communication in circumstances where science cannot yet evaluate the risks fully, it would be inequitable to attribute liability or blame to the business if the activity subsequently proved harmful," the CEA response explained.

"The insurance industry is anxious to make products available which provide the right level of protection to businesses. Insurers must, however, be able to assess and quantify risk and reinsurers must, similarly, be able to assess and quantify the business accepted," the CEA response noted.

The ALARM statement also said that the allowable defenses for environmental damage proposed by the white paper are too limited and should be widened to include a defense based on "state of knowledge."

In addition, ALARM called for further clarification of some of the "woolly wording in certain sectors of the legislation—for example, no definition of 'significant harm' within the biodiversity regulations."

Also of great concern to public-sector risk managers is the proposal that, if the polluter cannot be found, strict liability would apply to the authority that issued the environmental operating permit. If enacted, this proposal would make local authorities reluctant to issue such permits unless they had adequate insurance protection, according to ALARM's chief executive officer, Liz Taylor.

"It is vital for local authorities that this is resisted strongly, since it would mean that the encouragement of essential enterprise and economic growth is restricted, due to draconian standards imposed by regulatory bodies," Ms. Taylor said.

Ms. Taylor said that this proposal should be reconsidered, and enactment delayed, until appropriate insurance products are available.

At the moment, there is "no proposal to cap liabilities under the legislation, and any insurance company would want to protect its product portfolio," Ms. Taylor said.

The white paper's proposal to extend the eligibility of those who can claim compensation for ecological damage to non-governmental organizations, such as environmental groups, is also considered complex and difficult to insure, according to the CEA response.

"A viable insurance market is more likely to develop if the eligibility for claiming is limited to those persons who have a legal ownership of the property affected, plus competent authorities carrying out their statutory duties," the insurers' response said.

"It appears to be optimistic to state in the white paper that the availability of insurance cover for natural resource damage is likely to develop in the near future," the CEA response said. BI

Besso

Continued from previous page

and the revenues they generate.

Besso plans to strengthen its position by acquiring businesses and taking on new brokering teams that possess specialist-market knowledge. Besso has already attracted a property team away from a rival Lloyd's broker, said Mr. Bird, who declined to name the other broker.

When Besso left JLT in 1995, it had a staff of about 25 and just over £2.0 million ($3.0 million) in annual brokerage revenues. It now has 114 employees and estimates that it will finish the year with £12.0 million ($18.0 million) in brokerage revenues, up from £8.5 million ($13.8 million) in 1999. It is expected to produce profits of around £2.0 million this year, up from £1.1 million ($1.8 million) in 1999.

"At the moment, we're far exceeding the estimate. Not that I expect that to continue, but I am fairly confident that we'll come in the way we're supposed to come in," Mr. Bird said.

He said that much of this success stems from the fact that most of Besso's senior management team has been together for 15 years. Another element of Besso's success is its expertise in specific areas. It has traditionally concentrated on North American property/casualty business, marine, aviation and professional indemnity insurance.

"Our attention to your business is done at the highest level. . . .We offer a personalized service that the big broker can't offer. . .and, for some reason or other, insurance is still very personal," Mr. Bird said.

When asked if he regards Besso as a niche broker, Mr. Bird replied in the affirmative. "Yes, I would define us as a niche broker, but I would define it in a fashion that says that one of the things we can do well is move quickly. . . .We are small enough to be flexible enough to move to the demands of the market," he said.

In the future, Mr. Bird said, he expects Besso to continue to expand beyond brokering business that is predominantly based in North America.

"When we started Besso in '95, we were 100% North America. We're now about 60/40 in favor of North America. And it has been the company's strategy to spread some of its reliance from America to the rest of the world, and that will continue," he said.

Mr. Bird said that this development arose not so much from implementing a strategy as from taking advantage of opportunities.

"If tomorrow an opportunity came along that turned us back into 85% North American because another team showed up, I'd do that as well," he said.

The other 40% of Besso's current business is split fairly evenly among marine and aviation coverage and an international division, operating mainly in Europe, that handles all non-marine business other than that from North America. BI

PHOTO: AFP

Visitors to a museum in Rome admire "La danse," by Henri Matisse. The painting was on loan from the Hermitage Museum in Russia.

Broker was poised for a quick move

Six weeks ago, on the morning of June 13, organizers of an exhibition in Rome of French Impressionist paintings on loan from the Hermitage Museum in St. Petersburg, Russia, were given three hours notice to get some $500 million worth of paintings out of Italy. If the paintings weren't shipped out by midday, the organizers were told, they might be subject to confiscation, pending a court case.

Lloyd's of London insurance broker Besso Ltd. had brokered the coverage for the transport of the paintings between St. Petersburg and the art gallery in Rome, which was located at the Quirinale Palace, the residence of the Italian president. Besso was hastily called in again to arrange the additional coverage required for the speedy return of the paintings to Russia.

The situation arose when a Frenchman, Andre-Marc Delocque-Fourcaud, claimed ownership of one of the exhibit's paintings. Mr. Delocque-Fourcaud said that his grandfather, who was Jewish, had owned "La danse," by Henri Matisse, and that the painting had been illegally confiscated from him after the Russian Revolution of 1917.

To prevent the impounding of that painting, and possibly others, by the Italian courts, the Hermitage decided to ship some of the works back to Russia immediately. But the original insurance coverage had placed on it a sublimit of $55 million on any single shipment—a common practice, used to discourage the transport, and possible loss, of too large and valuable an individual shipment of artworks at any one time.

Colin Bird, Besso's chief executive officer, said that the broker secured an extra $50,0000 in premium by quickly arranging for the transport of $500 million worth of paintings in a single shipment from Rome to St. Petersburg.

Mr. Bird said that the possibility of descendants, particularly those of Jewish heritage, making claims of historical ownership of works of art is now a particularly large exposure for international art exhibitions.

-By Edwin Unsworth

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LEGAL NOTICES

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

IN THE MATTER OF THE LIQUIDATION)
OF RCA SYNDICATE #1 LTD.) NO: 00 CH 07217

NOTICE OF CLAIM FILING DEADLINE AND PROCEDURES

PLEASE TAKE NOTICE, that on June 5, 2000, the Circuit Court of Cook County, Illinois, entered an Order of Liquidation With a Finding of Insolvency against RCA Syndicate #1 Ltd. ("RCA Syndicate"). Nathaniel S. Shapo, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of RCA Syndicate ("Liquidator").

TAKE FURTHER NOTICE, that on June 16, 2000 the Circuit Court of Cook County, Illinois, entered an Order Fixing Rights and Liabilities and Providing for the Filing of Claims and the Setting of Claim Filing Deadlines ("Fixing Order"). Pursuant to the Fixing Order, all rights and liabilities of RCA Syndicate and its policyholders, creditors and stockholders, and all other persons interested in its property or assets, are fixed as of June 5, 2000, unless otherwise provided in prior or subsequent orders of the Court.

TAKE FURTHER NOTICE, that all persons, companies or entities who have, or may have claims, against RCA Syndicate, its property or assets, or against an RCA Syndicate insured or policyholder, shall have the right to present and file with the Liquidator proper proofs of claim on or before June 5, 2001 at 4:30 p.m. (C.D.T.).

TAKE FURTHER NOTICE, that any insured under an insurance policy issued by RCA Syndicate shall have the right to present and file with the Liquidator a proper proof of claim setting forth a contingent claim on or before June 5, 2001 at 4:30 p.m. (C.D.T.). No contingent claim shall be allowed for purposes of participating in any distribution of estate assets that may be made at the fourth priority level [215 ILCS 5/205(1)(d)] unless such claim has been liquidated and the insured claimant has presented and filed evidence of payment of such claim to the Liquidator on or before June 5, 2002 at 4:30 p.m. (C.D.T.). Any contingent claim for which a proper proof of claim is filed on or before June 5, 2001 at 4:30 p.m. (C.D.T.). but which is not liquidated on or before June 5, 2002 at 4:30 p.m. (C.D.T.), may be estimated pursuant to 215 ILCS 5/209(4)(b) for purposes of participating in any distribution of estate assets that may be made at the fifth priority level [215 ILCS 5/205(1)(e)] unless otherwise directed by the court.

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

THE LAST DATE FOR FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR IS SET FORTH ABOVE. NO PERSONS, COMPANIES OR ENTITIES HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST RCA SYNDICATE, ITS PROPERTY OR ASSETS, OR AGAINST AN RCA SYNDICATE POLICYHOLDER, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE PROPERLY FILED WITH THE LIQUIDATOR ON OR BEFORE JUNE 5, 2001 AT 4:30 P.M. (C.D.T.)

Cathleen Travis
Special Deputy Receiver

REQUEST FOR PROPOSALS

INVITATION FOR BID

CONSULTANT'S GENERAL & PROFESSIONAL LIABILITY

The New York City Housing Authority ("NYCHA") requests Proposals from qualified **INSURANCE CARRIERS** for Consultant's General & Professional Liability Insurance Coverage's.

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Proposals shall be made in the format included in the Invitation For Bid package containing instructions, specifications and detailed submission requirements. Packets may be obtained by calling NYCHA's Insurance Consultant: **Cunningham Group Inc., 101 Maiden Lane, Suite 301, New York, NY 10038 at (212) 509-0393. In order to be eligible, the complete bid proposals must be received by 4:30 P.M. on September 15, 2000.**

All inquiries for additional information regarding the Invitation for Bid are to be directed, in writing to Mrs. Michelle Mason, Cunningham Group Inc., at the aforementioned address/phone.

Rudolph W. Giuliani, Mayor, New York City
John G. Martinez, Chairman, NYCHA

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Business Insurance

Business Insurance Circulation Breakdown

Commercial Consumers

Category	Count
Administrative:	
CEO's, Presidents, and Owners	4,281
Vice Presidents, General Managers and Other Administrative Personnel	4,046
Financial:	
Chief Financial Officers and Vice Presidents of Finance	4,252
Secretaries, Treasurers, controllers and other Financial Personnel	4,927
Risk/Employee Benefits:	
Vice Presidents, Directors, Managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	14,047
Sub-total	**31,553**
Associations	242
Government, Unions and Educational Institutions	939
Commercial Consumers Sub-total	**32,734**
Insurance Agents and Brokers	7,636
Insurance Companies	6,047
Accountants, Actuaries, Attorneys & Consultants	2,213
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,232
Others Allied to the Field	1,227
Total Qualified	**51,089**
Non-qualified/Paid Subscriptions	44
Single Copy Sales	11
TOTAL CIRCULATION	**51,144**

★ Source Business/Occupational breakdown of qualified circulation, November 29, 1999 Issue, as submitted to BPA for December 1999 BPA Publisher's Statement

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Jaffray

Continued from page 17

in quantifying the resultant losses. But that information, he said, was not passed on to names.

"We place very grave evidence on the fact that the Neville Russell letter was written, spelling out the size of the problem and the impossibility of quantification. There was nothing the committee could do to make that evidence go away," said Mr. Goldblatt. "They could not say that they did not know the problem was there."

The letter in question was sent to Lloyd's in February 1982 by the accounting firm of Neville Russell. It warned that losses from asbestos-related claims could be considerably larger than Lloyd's had originally estimated, court records show.

Mr. Goldblatt noted that some senior Lloyd's figures continued to maintain that they were unaware of the problem after that letter was sent. "Sir Peter Miller, in the witness box, claimed that 'asbestosis was below the level of his horizons,' yet we know that it was communicated to him," said Mr. Goldblatt.

Mr. Goldblatt said that the market was vastly underreserved for the looming asbestosis disaster. "There was huge underreserving, which got worse, and not better, as the asbestosis claims continued to flow," he said. "Lloyd's knew that the market was underreserved for asbestosis-related losses, and it knew that it was impossible to quantify the losses."

Mr. Goldblatt said that he found nothing surprising in the fact that impending losses had not been communicated to names, however, because of the "climate of arrogant secrecy" that he charged existed in Lloyd's at the time.

Mr. Goldblatt also roundly criticized the regulation in place at Lloyd's during the early 1980s.

"An enormous gap existed in the area of reinsurance-to-close between regulation and an absence of regulation," he said. "A coach and horses could have been driven through the gaps in the audit regime."

The most vocal of the litigants in person was Sir William Jaffray himself, who spoke of "hypocrisy, deceit and double standards" at Lloyd's during the period from 1978 to 1988.

Sir William claimed that Lloyd's was "bust" by 1982 and that he and other names would not have joined the market had they been made aware of the difficulties it was facing. He described the recruitment brochure produced by Lloyd's as "a lie promoted by Lloyd's to willfully deceive both existing and prospective members."

Sir William alleged that asbestosis became a "taboo" subject at Lloyd's during the 1980s and that the problem was kept quiet to ensure that the market's recruitment drive was not hindered. The decision was made that "the crisis must be hushed up and nothing must be done to slow the recruitment drive," he claimed.

The names allege that Lloyd's operated a "recruit-to-dilute" policy to bring new capital into the market to absorb the asbestos-related losses it knew would cripple the market.

But Charles Aldous, the lead attorney for Lloyd's, refuted the claims of Mr. Goldblatt and the litigants in person. He said the "grand conspiracy" alleged by names to have taken place would have required the involvement of individuals from all sectors of the market. Such a widespread coverup, he said, was impossible for the names to establish.

Names allege Lloyd's operated a 'recruit-to-dilute' policy to bring new capital into the market to absorb asbestos losses.

Mr. Aldous claimed that the 33 senior Lloyd's figures whom the names accuse of fraud had no more information about asbestos-related losses than did other market participants. "If Lloyd's was fraudulent, then so was nearly everyone else who had the same kind of information," including managing agents and intermediaries, he said. "But the grand conspiracy is impossible, as the names now know."

Mr. Aldous also denied the names' claims that Lloyd's brochures and global report and accounts contained misrepresentations about the state of the market.

"There were no inaccuracies in either the brochures or the globals," he said.

Mr. Aldous picked out some key statements from the Lloyd's brochure to illustrate that it contained warnings about the risk of underwriting at Lloyd's. "The insurance business is a risk business—it is cyclical—there is no guarantee that a member will make a profit," he quoted. Mr. Aldous said it was inconceivable that any prospective member reading the Lloyd's brochure could have failed to appreciate that he or she would have unlimited liability.

Mr. Aldous claimed that the names' case hung on Lloyd's role as regulator of the market. "The case against Lloyd's seeks to put the responsibility on Lloyd's as regulator, irrespective of the advice expected to be given to names by their syndicates, managing agents, etc. Lloyd's as regulator does not owe a duty to names," he said.

Mr. Aldous also expressed incredulity that 33 figures at Lloyd's could all have behaved dishonestly. He highlighted the fact that, during the very same period that the names allege Mr. Lawrence and Sir Peter Miller were concealing information about asbestos-related losses, members of their own families were underwriting on syndicates exposed to such losses.

Mr. Aldous described the losses incurred by names who refused to pay their premiums to Equitas Ltd., the runoff reinsurer of Lloyd's pre-1993 long-tail liabilities, as "a personal tragedy." But, he said, Lloyd's duty was to those names who had accepted the 1996 reconstruction and renewal plan and had paid their premiums into Equitas.

Many market observers say that Lloyd's will likely win the case, as the names' accusation of widespread fraud will be difficult to prove. But few deny that having the old charges once again dragged through the press will do nothing to enhance the market's reputation.

Although he said he did not want to comment specifically on the *Jaffray* case, David Brotzen, the director of London-based reputation protection consultant Brotzen Mayne Ltd., said that communication is a key factor in reputational risk management. "The issue is mistrust and how you get over it. It all boils down to having communicated too late," Mr. Brotzen said.

"Those companies that do actually keep people informed are the ones that avoid the surprises," Mr. Brotzen said. "And when things do go wrong, they seem to be given a second chance." BI

Tobacco

Continued from page 1

In a statement, Mr. Donahue said, "Federal courts, and all but one other state court, have agreed: smokers have such different lifestyles, genetic factors, occupations and smoking histories that those differences far outweigh the one thing they have in common—the fact that they chose to smoke. The *Engle* case is the only case to come to trial where the court has not recognized that, because of the differences, smokers cannot be treated as a class."

"So far, there has been a lot of case law in their favor in that regard," said Philip D. Miller, a consultant with Tillinghast-Towers Perrin in New York. "It has proved to be difficult to sustain a class action in many jurisdictions" in tobacco cases, he noted.

Tort reform advocates also say the class never should have been certified.

Sherman Joyce, president of the Washington-based American Tort Reform Assn., said it was "totally inappropriate" to award punitive damages based on the evidence of just three people who represented a class of 500,000 to 700,000 people (see story, page 1).

But other legal experts called the class certification proper.

Richard Daynard, chairman of the Tobacco Products Liability Project and a professor at Northeastern University in Boston, said that in cases such as *Engle*, "if the court is interested in justice, it has to be sympathetic to the class-action approach."

While a class action might not be perfectly suited for such a case, "would it be very helpful in getting a plaintiff's day in court?" Mr. Daynard asked. "Absolutely."

"The Florida court said this is what a class action is for"—bringing cases that otherwise would be difficult or impossible to hear, he said.

William Ohlemeyer, vp and associate general counsel for Philip Morris, said at a press conference that 28 attempts to certify tobacco suits as class actions have been rejected, and, therefore, "this verdict is going to be subject to a lot of scrutiny on appeal and is unlikely to withstand the appellate process."

RJR's Mr. Donahue said the class of plaintiffs is so large that it makes the judgment phase nearly impossible to complete. "It took over two years to try just three individual cases," he said, and trying hundreds of thousands of cases would take decades. "It's just unworkable."

Plaintiffs' attorney Susan Rosenblatt told reporters that the next phase could be completed much faster than the industry claims. She said no mechanism has been established to hear individual cases but there is the possibility that cases could somehow be heard in groups.

Mr. Daynard said he believes an award will be upheld and agreed that individual cases could be heard much faster because many of the questions answered in the trial do not have to be rehashed and witnesses won't be recalled.

Still to come, however, is a ruling on whether the judgment will stand. Florida law prohibits a damages award that would bankrupt a company, and the $145 billion is almost 10 times the amount tobacco companies say they are worth.

Stanley Rosenblatt, also a plaintiffs' attorney, said immediately after the jurors announced the award that he "couldn't be happier" with the size of the judgment. He had asked for damages ranging up to nearly $200 billion. He wouldn't answer when asked if there was an amount he would consider to settle the case.

Tobacco company attorneys plan to argue that the award is so large that it is afoul of guidelines for such damages.

"We believe the verdict is grossly excessive. . .and the punishment is wildly out of sync with the evidence the jury heard and the law governing such damage awards," Mr. Ohlemeyer said.

Indeed, in the case of *BMW of North America vs. Gore*, the U.S. Supreme Court in 1996 ruled that a punitive damage award can be so disproportional to a compensatory award that it is unconstitutional. In that case, an Alabama doctor was awarded $4,000 in compensatory damages and a punitive award of $4 million because the automaker failed to disclose that it had retouched the paint job on his car after it was damaged in transit.

'The tobacco industry is under siege, and some of this is going to spill over' to insurers, says Best's W. Dolson Smith.

Mr. Daynard said that while tobacco companies love to cite the *Gore* case, it actually provides "a strong case" to support the award in the *Engle* case. "The court talked about circumstances in which huge damages are appropriate," he said of *Gore*.

Although such a large award was not appropriate in *Gore*, partly because the automaker did not endanger anyone's health and showed no reprehensible conduct, that is not the situation with the *Engle* case, Mr. Daynard suggested. "All those points cut exactly the opposite way in this case."

Whatever the final outcome in *Engle*, tobacco company insurers are helped by Florida law, which doesn't allow punitive damages to be insured except in cases of vicarious liability.

Florida is among many states that prohibit insurers from paying punitive damages, according to Jim Taylor, Atlanta-based southeast regional manager of the National Assn. of Independent Insurers. "That would defeat the purpose of punitive damages," he said, which are levied to punish wrongdoers.

W. Dolson Smith, senior financial analyst with A.M. Best Co. in Oldwick, N.J., said that while it is hard to say how or when insurers might be dragged into tobacco litigation, their duty to defend policyholders could be the most likely route.

"We don't see companies about to put up reserves," he said of insurers, but there could be "some expenses along the way."

Depending on policy language, Mr. Smith explained, insurers may find they have a duty to defend tobacco companies in litigation even if it is decided that no coverage is in place. "There could be some impact, but we don't see it as something of immediate, severe impact."

"The tobacco industry is under siege, and some of this is going to spill over," he said. "But it's difficult to define in what area."

But that doesn't mean insurers should not keep a close eye on tobacco litigation in case they are eventually found by courts to be responsible for coverage, said Mr. Miller of Tillinghast.

Insurers have avoided liability in tobacco cases based on exclusions for bodily injury and property damage claims. Even so, Mr. Miller noted that a handful of tobacco liability cases have named insurers.

In one closely watched case, Liggett is suing more than 30 of its insurers under the personal and advertising injury sections of its policies, where the company claims the exclusions do not apply (*BI*, Feb. 14).

A spokeswoman for Hartford Accident & Indemnity Co., which was named as a defendant in the suit along with six Hartford affiliates, said the insurer maintains that its coverage for tobacco companies has always contained exclusions for health hazards related to cigarettes. "That has been historic with the tobacco industry and insurance companies."

She said no other tobacco makers have sought coverage from Hartford.

Because these suits do arise from time to time, insurers "should be looking at where their exposure is," Mr. Miller said. If insurers are found to be liable for coverage, defense costs alone "are not a trivial issue," he warned. "It can become expensive and certainly is an area that needs to be planned for."

Insurers say they are not too concerned with being dragged into tobacco litigation.

"It's on the radar screen" but not a big concern at CNA Financial Corp., a spokesman for the Chicago-based insurer noted.

Likewise at Travelers Property Casualty Corp., a spokeswoman said the insurer's attorneys had little concern that tobacco makers would be able to tap coverage. BI

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Industry inspires ideas for reality TV

In case you haven't noticed, there's a new breed of television programming that is seizing the attention of millions of households, sweeping aside such traditional favorites as "60 Minutes," "Judge Judy" and "WWF Smackdown."

These new favorites are prime-time game shows and so-called reality-based TV. Every few weeks, the networks steal another idea from European broadcasters and repackage it to run on prime-time American TV, and the public gobbles it up faster than a pink-frosted doughnut. Eventually, though, they are going to run out of good European concepts and be in dire need of fresh programming ideas.

So far, the ABC and CBS networks are running away with the ratings, based on ABC's "Who Wants to Be A Millionaire?" and CBS' double-barreled lineup of "Survivor" and "Big Brother."

Demand for these kinds of stimulating and soul-stirring programs and ideas eventually will outstrip available supply, however, both here and in Finland and Wales, where many of these plots may have originated. Once that supply dries up, U.S. television magnates will have to seek a different muse.

That's where we come in.

I think this presents a real opportunity for creative insurance industry types to come up with gripping and exciting ideas for new TV programs based on everyday occurrences in this industry.

Paul D. Winston

Male and female television viewers in the 18-to-49 demographic that is so coveted by advertisers may be surprised to learn there's a lot of drama in insurance. But, just as they discover watching some reality-based programs, that drama may be surrounded by long stretches of mundane, boring periods in which nothing happens. That's OK, though, because that downtime builds "dramatic tension" over when the good stuff's gonna happen. That's the magical bond that keeps people glued to their television screens and coming back night after night.

I've come up with a few insurance-based TV ideas that I have sent to the big network executives in Hollywood. Let me share them with you:

- **"Who Wants Their Million-Dollar Claim Paid?"** In this show, a panel of contestants vies to have their claims paid by an insurer without any reservation of rights letters, foot dragging, outright denials or litigation.

The format will be like a high-stakes quiz show, with contestants facing a series of difficult questions on actuarial science and reinsurance contract law, for which correct answers raise the amount of money paid on the claim.

Contestants can decide to stop at any time and claim their winnings before reaching the $1 million jackpot, but if they go for it and give a wrong answer, they forfeit all money, get slapped with a lawsuit for contributory bad faith and have their current coverage canceled.

- **"Consolidation Survivor!"** In this program, 50 insurance brokers are dropped on a desert island and have to forage for rodents, edible berries and fresh water while their employers engage in merger and acquisition negotiations. As brokerages disappear due to consolidation, their employees are kicked off the island. The best part is that when the contestants dwindle down to three remaining brokers from Aon, Willis and Marsh, the 47 others whose brokerages have been absorbed get revenge by picking who gets to win.
- **"Who Wants to Marry an Actuary?"** Although this is based on a popular Fox television program that ended in disgrace, annulment and a Playboy pictorial, I think it has a real shot at success with an insurance theme. That's because of the element of surprise.

You see, few people outside of insurance know what an actuary does and will be leery of marrying one, especially when they learn that most actuaries majored in mathematics in college and are the butt of so many jokes. But the joke will be on them when they discover that actuaries have one of the highest-ranked careers in terms of job satisfaction, make a lot of money and often wind up becoming CEOs of Bermuda insurance companies.

- **"I-Spy"** in which a team of insurance fraud investigators follows workers comp claimants around with hidden spy-cams in the hopes of catching them hoisting anvils, polka dancing or twirling Hula-Hoops around their allegedly broken necks.

I'm expecting a bidding war to erupt at any time for these ideas from the major networks.

Do you think they'll make it in prime time? Would you watch them?

Is that your final answer?

Editor Paul D. Winston's commentary appears fortnightly and at www.businessinsurance.com. He can be reached at pwinston@crain.com.

Tort

Continued from page 1

"It's good in the sense that it raises the public's awareness that one jury can have this kind of power over an industry," Mr. Lammi said.

One tort reform opponent, however, downplayed the likelihood that reformers will be able to use the Florida verdict to their advantage.

"It was just a matter of time. They've known an award like this was coming for years, which is why they've been on a mission for the last 15 years to get themselves immunized from suits," Joanne Doroshow, executive director of the New York-based consumer activist organization Center for Justice and Democracy, said of both the tobacco companies and pro-tort reform forces in general.

"I don't think they're going to succeed" in having the award overturned, she said, because "now we know what the documents say" about tobacco companies' knowledge of the adverse effects of cigarette smoking.

ATRA's Mr. Joyce said that the details of the case raise some troubling legal questions.

"As a threshold matter, the case should not have been certified as a class," he said, pointing out that the court heard direct evidence from only three of the 500,000 to 700,000 people who make up the class. "We believe it was completely inappropriate for a court to award punitive damages to a whole class based on the evidence of only three people," he said.

Mr. Joyce also pointed to the Supreme Court's 1996 decision in *BMW of North America vs. Gore*, in which a sharply divided court ruled that there can be some circumstances under which a punitive damage award is so disproportionate to compensatory damages that it is unconstitutional.

"I think that *BMW* stands for the proposition that there needs to be a reasonable relationship" between actual damages and punitive damages, he said. "If you haven't determined what the actual damages are for the class, it's inappropriate to determine what the punitive damages should be."

'I think that there is a huge difference between being punitive and being asinine,' says Lance J. Ewing.

In the *BMW* case, Alabama physician Ira Gore Jr. was awarded $4,000 in compensatory damages and $4 million in punitive damages because BMW had failed to disclose that it had retouched the paint job on his sedan after it was damaged in transit.

Mr. Joyce also noted that, in the tobacco class action, "the judge specifically prohibited the jury from considering that these defendants have entered into these unprecedented settlements with the states" to compensate the states for the costs of providing medical care for people allegedly harmed by tobacco.

A prominent risk manager also minced no words in criticizing the award.

"I think that there is a huge difference between being punitive and being asinine. The premise behind punitive damages is to have the company mend its ways, not be placed on the brink of financial ruin. This is why serious tort reform and not lip-service tort reform will be critical following the elections in November," said Lance J. Ewing, vp-external affairs for the Risk & Insurance Management Society Inc. in New York and senior director-insurance and loss prevention for GES Exposition Services & Exhibit Group in Las Vegas.

"One of the problems with this award is now there is a new high-water mark for other juries to shoot at. I think it will energize the business community, and it's beginning to sort of disgust the public," said Jim Wooten, president of the U.S. Chamber Institute for Legal Reform, a Washington-based group that lobbies for tort reform on behalf of the U.S. Chamber of Commerce.

Mr. Wooten also said that he has detected a change in public opinion with regard to smokers' role in their own illnesses. "It's very interesting that after the state settlements, there wasn't a lot of comment that smokers knew smoking was dangerous." In the wake of the Florida award, the observation that smokers knew that their habit was harmful yet continued to smoke is becoming more common, he said.

Mr. Wooten said he has received calls from business people outside the tobacco industry who fear the possible impact of even an overturned award.

"They're all wondering who might be next, but they're also living in the reality that the bonding of these verdicts is in itself a tremendous cost," crippling their ability to get credit and to tap capital markets even if the verdict is overturned on appeal, he said. BI

PBGC

Continued from page 1

executive director said.

In fact, Mr. Strauss said, had the new guidance been in effect last year, the agency would have made 60% fewer contacts with employers with regard to corporate transactions.

Pension plan experts welcome the new guidance, saying that employers want to know ahead of time whether a transaction could trigger a PBGC response.

"Having this document reduces the surprise element," said Richard Joss, a consultant with Watson Wyatt Worldwide in Bethesda, Md.

"This will create a lot more certainty, so employers know in advance what type of situations the PBGC is interested in, and to reduce the likelihood that corporate negotiations are not derailed," said Larry Sher, a principal with Unifi Network, a benefits consulting unit of PricewaterhouseCoopers L.L.P. in Teaneck, N.J.

The technical update in effect clarifies guidelines used by the PBGC in what it calls its "early-warning program." Under that program, the PBGC monitors about 500 employers with underfunded plans and has negotiated agreements with employers when it believed transactions, such as the sale of a company, could jeopardize the health of its pension plan and ultimately lead to pension liabilities borne by the PBGC.

By taking early action, such as reaching an agreement under which the employer will boost plan funding, the PBGC reduces the likelihood of a big loss if, for example, the employer were to fail and its pension plan were terminated.

The PBGC contacted about 200 employers last year, and those contacts led to 12 settlements.

In its new guidance, the PBGC provides numerous examples of business transactions that could weaken financial support for a pension plan and that could be of concern to the PBGC. Those transactions include:

- A breakup of a controlled group, including the spinoff of a subsidiary.
- A transfer of significantly underfunded pension liabilities in connection with the sale of a business.
- A leveraged buyout.
- A major divestiture by an employer that retains significantly underfunded pension liabilities.

While these events might be of concern to the PBGC, the agency would contact a company for further information about the transaction only when:

- The employer has a below-investment-grade bond rating and sponsors a pension plan with a current liability exceeding $25 million.
- Or, when the employer, regardless of its bond rating, sponsors a pension plan with current liabilities exceeding $25 million and unfunded current liabilities exceeding $5 million.

Even if an employer meets one of the screening criteria, the PBGC would be unlikely to inquire about a proposed business transaction unless the transaction "appears to pose a significant increase in the risk of a long-run loss to the pension insurance program, or unless we require additional information about the transaction to make this judgment," the technical update says.

If the PBGC does make an inquiry, it generally would request information about the effect of the transaction on the involved defined benefit plans, such as whether the plans would remain with the current plan sponsor, shift to the new employer or be split between the current and new sponsors.

The agency also may request recent actuarial information, the update says. All initial injuries would be made in writing, rather than over the telephone.

If a follow-up inquiry is made, the PBGC may ask for financial information about the employer and any subsidiaries. It also may ask for the latest market value of pension plan assets and the number of participants—active employees, deferred vested former employees and retirees—affected by the transaction.

If, after reviewing the additional information, the PBGC concludes that no action is necessary, the agency would send a letter to the employer advising it that the inquiry was closed.

But, if the PBGC determines that the transaction could significantly increase the risk of loss to the agency's insurance program, it generally would try to negotiate an agreement with the employer as an alternative to the PBGC terminating the plan.

Based on past settlements, examples of protections the PBGC would seek include:

- Requiring the employer to make additional cash contributions to the plan.
- Obtaining letters of credit to secure promises to make future pension contributions.
- Obtaining a pledge of specific company assets to secure unfunded pension liabilities.
- In transactions involving several companies that are part of the same controlled group, the PBGC may seek to obtain guarantees by financially stronger members of the group that are leaving to assume the pension plan or pay for the termination liability if the plan sponsor cannot support the plan following the transaction. BI

Deal

Continued from page 1

while global benefits is a relatively small unit that handles benefits for U.S. employees working abroad for multinational firms, an Aetna spokeswoman said.

The deal provides that the holding company and its remaining subsidiaries, including the financial services and international businesses, will merge with a newly formed ING subsidiary.

Aetna Financial Services, the bulk of whose business comes from Aetna Life Insurance & Annuity Co., markets retirement and investment products to non-profit organizations, government entities, small businesses and individuals. It had $227.3 million in operating earnings before Y2K-related costs last year and $72.4 billion in assets under management.

Aetna International, which chiefly sells life insurance, health and retirement products in emerging markets, had $194.2 million in operating earnings in 1999 before Y2K-related costs.

The transaction, which is subject to regulatory and shareholder approval and other conditions, is expected to close by the end of the year.

Following the deal, Aetna will remain the nation's largest health care benefits company, with 19.5 million health members, 14.8 million dental members and 11.5 million group life insurance members.

In a statement, Aetna Chairman and Chief Executive Officer William H. Donaldson said, "We have taken an important step toward our stated goal of delivering value to shareholders, while also taking into account the concerns of our customers, employees and other constituents."

Ewald Kist, chairman of ING's executive board, said the Aetna acquisition—along with ING's recent $6.1 billion acquisition of Minneapolis-based ReliaStar Financial Corp., which was announced in May—"complete our strategic goal of achieving a top-10 position in the U.S. market. Building scale is absolutely essential to maintain the lead in today's financial market."

With combined U.S. premium volume of $20.2 billion and U.S. assets under management of $716 billion, the deal would put ING in the No. 1 position in the United States in terms of combined life and annuity premiums and would make it No. 6 in terms of combined statutory assets, according to ING.

The sale of these operations to ING illustrates Aetna's commitment to the health insurance business, analysts say.

"Aetna has demonstrated that they are determined to make it or break it in the health care business," said Michael LeConey, an analyst with Dirks & Co. in New York. "It's a final chapter, if you will, in Aetna's decision five years ago to focus its entire raison d'etre" on health care, and it has not been deterred by the business' difficulty and volatility, he said.

Mr. Donaldson said in his statement that "despite significant challenges, our health business is profitable, with strong cash flows. As a separate company, it should be able to bring intensified management focus on improved service to our customers and enhanced financial performance."

'Aetna has demonstrated that they are determined to make it or break it in the health care business,' says Michael LeConey.

Referring to last week's news that Aetna's second-quarter earnings will be lower than expected, Mr. Donaldson said the results provide "an even stronger sense of urgency to make the changes necessary to get our health business on the right track."

He said Aetna is implementing several initiatives to improve the performance of its health business: They are:

- Restructuring its product portfolio to provide greater balance in its range of offerings.
- Improving relations with doctors and hospitals.
- Leveraging Aetna's information technology assets to meet constituents' demand and achieve efficiencies.
- Being more selective about the markets in which it competes.
- Realigning management and employee incentives to encourage "cross-functional" cooperation.
- Restructuring sales and broker compensation.
- Strengthening management, starting with the selection of a new CEO.

Employers that now do business with Aetna U.S. Healthcare are unlikely to encounter any problems as a result of the deal, analysts say.

While the health insurance company could use proceeds from the sale to reduce some of its debt, "the impact on the health care buyer is not going to be material, really" because the businesses were operated separately anyway, said Arun Kumar, vp with Chase Securities Inc. in New York.

"If you're an employer, you're not going to see any difference, regardless of how Aetna disposes of their financial services business," agreed William McKeever, a senior analyst with Paine Webber Inc. in New York.

The financial services business is unlikely to be missed by employers that obtain health care benefits through Aetna, because there has been relatively little cross-selling.

"If an employer has thought about going to Aetna as a single source, obviously they've lost that opportunity," but few companies fit into that category anyway, Mr. McKeever said.

"There wasn't a whole lot of synergy between the two operations to begin with," agreed Douglas L. Meyer, senior director at Fitch IBCA in Chicago.

On the other hand, employers that do business with Aetna's financial services operations may be happier with ING, said John L. Ward, chairman of the Cincinnati-based Ward Financial Group. Aetna had been preoccupied with its problems with Wall Street, and "they obviously had been intending to invest their energy and capital resources into the health business."

Now, Mr. Ward said, these financial services clients "will have a slightly better chance of getting better service and a better product than had they continued forward with Aetna."

One consultant suggested, however, that the deal might have a negative impact on employers.

"Aetna will now have to survive only on its health care operations, which is probably the least financially successful of all their operations," said Richard Sinni, group and health care practice leader for Watson Wyatt Worldwide in New York.

As a result, "I would imagine the impact on employers would be less positive than we would expect," said Mr. Sinni. Because of higher medical costs, Aetna may have to go back to employers and seek higher rates, he said.

Others say employers will indirectly benefit from Aetna's exclusive focus on health care.

Right now, "management is really torn between a multiple group of products that really don't relate to one another all that well," said health care analyst Doug Sherlock of the North Wales, Pa.-based Sherlock Co.

Initiatives such as developing Internet capabilities and managing administrative expenses demand a lot of attention, Mr. Sherlock said. By divesting the financial services business, "the management team will be able to focus all their attention on the very tough business of managing health care costs," he said.

Aetna also will focus on its search for a top executive for its health care business. Michael Cardillo resigned as president of Aetna U.S. Healthcare in May. In addition, Richard L. Huber resigned as chairman, president and CEO in February, and was replaced by Mr. Donaldson, who is a co-founder of the investment banking firm Donaldson, Lufkin & Jenrette.

"We've said we have an active search under way. We've narrowed the field and we're proceeding to get a candidate on board as quickly as possible," said the Aetna spokeswoman. BI

403(b)

Continued from page 2

irrelevant to 403(b) plan sponsors.

If a significant percentage of rank-and-file employees do not contribute to a company's 401(k) plan, that increases the likelihood that the plan will not pass annual IRS non-discrimination tests. Those tests are used to compare salary deferrals by so-called highly compensated employees—those earning at least $85,000 annually—with those made by rank-and-file employees. Generally, the average contribution by highly compensated employees cannot exceed the average by made by other employees by more than two percentage points.

If a plan fails the test, the employer must cut back on the contributions it lets highly compensated employees make to the plan or must return excess contributions already made to the plan by those employees.

By getting more employees—especially lower-paid employees—to contribute to 401(k) plans through automatic enrollment programs, an employer increases the chance that its plan will pass non-discrimination tests.

403(b) plans, however, are exempt from this non-discrimination test, known as the actual deferral percentage test. That relieves non-profit employers of an administrative burden that their private-sector counterparts with 401(k) plans face.

It also means that highly compensated employees in the non-profit sector, such as veteran professors and top hospital administrators, needn't worry that how much they can defer to the 403(b) plan will depend on deferrals made by lower-paid employees.

But Watson Wyatt's Ms. Kellogg said that 403(b) plan sponsors may add automatic enrollment programs for paternalistic reasons—that is, they want to get more employees to contribute to the plans.

At the same time, extending automatic enrollment programs to 403(b) plans is an encouraging sign that government regulators are beginning to view the plans in a more unified way, she said.

And legislators also are starting to break down barriers that separate 401(k) and 403(b) plans. Last week, for example, the House of Representatives passed a measure that would allow employees moving between the private and non-profit sectors to rollover funds from 401(k) plans to 403(b) plans and vice versa.

"Perhaps, those in government are starting to think that 401(k) and 403(b) plans are more similar than different," Ms. Kellogg said.

The IRS' announcement regarding 403(b) plans goes into effect immediately. BI

UPDATES

Frontier sells renewal rights

Continued from page 2

of misrepresentations between August 1997 and April 2000. The suit charges, for example, that Frontier announced it would increase its medical malpractice business by acquiring Western Indemnity Insurance Co., when in fact it boosted premiums through relaxed underwriting standards and "predatory pricing," the complaint alleges.

Frontier shares dropped 97% to $1 per share from $38.69 during the proposed class period, according to the complaint.

Frontier in April agreed to sell Western Indemnity back to its previous owner as part of a restructuring plan.

IRB auction again postponed

BRASILIA, Brazil—The sale of a 45% stake in Brazil's state-owned monopoly reinsurer, IRB Brasil Resseguros S.A., has been postponed again following a Brazilian Supreme Court ruling that Brazil's Congress should vote again on whether to allow the privatization.

The auction, which was due to take place July 25, will be delayed at least until after the court considers the matter in mid-August.

On July 14, Judge Marco Aurelio Mello ruled in favor of a minority political party in Brazil, the Workers' Party, which argued that the Congress passed the wrong type of law to permit the privatization.

The privatization law that was passed was an "ordinary" law that required only a simple majority of the deputies voting to pass, whereas a "complementary" law, which requires two separate votes and a majority of all deputies to pass, is required, the judge ruled.

The provisional decision by one judge will now be considered by the whole court, said Jose Almeida, general coordinator for reinsurance at SUSEP, the Brazilian insurance regulator.

The postponement marks the second time that the auction has been delayed. The original April 25 auction date was delayed after another court determined that the original minimum bid for the 45% stake was too low. The minimum bid has been changed several times and now stands at 522 million reals ($290.4 million).

A group of five Brazilian and international companies have been accepted as bidders: Swiss Reinsurance Co.; Munich Reinsurance Co.; Transatlantic Reinsurance Co.; Bradesco Seguros, a Brazilian insurer; and an investment group led by Banco Opportunity, a Brazilian bank.

Airline crash suits consolidated

SAN FRANCISCO—Approximately 16 lawsuits stemming from the January crash of Alaska Airlines Flight 261 have been consolidated and assigned to a San Francisco court.

A judicial panel in the District of Columbia chose San Francisco because of its proximity to an ongoing criminal investigation of the airline over allegedly improper maintenance work at its Oakland facility, according to Juanita Madole, an attorney at Speiser Krause P.C. in Irvine, Calif., who is representing families of three of the crash victims.

All 88 people aboard died when the plane crashed Jan. 31 off the California coast. Plaintiffs are seeking hundreds of millions in dollars in damages from the Seattle-based airline and Boeing Co., which acquired the plane's manufacturer, McDonnell Douglas Corp., after the MD-80 was delivered to Alaska Airlines in 1982.

An airline spokesman declined to comment on the litigation except to confirm that the suits had been consolidated in U.S. District Court in San Francisco under Judge Charles Legge.

Boeing did not return calls seeking comment.

U.K.'s Equitable for sale

LONDON—The world's oldest mutual life insurer, Equitable Life Assurance Society, is up for sale after a ruling last week that the company must pay up to £1.5 billion ($2.27 billion) to compensate thousands of annuity owners.

The House of Lords, the United Kingdom's highest court, upheld a Court of Appeal decision that London-based Equitable had acted unlawfully in reducing the final bonus payouts of thousands of customers with guaranteed-annuity pension policies. A spokesman for Equitable said the size of the payout left the insurer with no choice but to seek a buyer.

In September 1999, the U.K. High Court ruled that Equitable had been justified in cutting the final bonus payments to about 90,000 policyholders during the 1970s and 1980s because annuity rates fell below those guaranteed by many of the policies. But in January, the Court of Appeal ruled that Equitable had acted illegally.

Analysts say Equitable is worth about £2 billion to £4 billion ($3.02 billion to $6.05 billion), though some have said it could fetch as much as £5 billion ($7.56 billion). Moody's Investors Service on Friday downgraded Equitable's financial strength rating to Baa1 from A1.

The U.K.-based mutual is not affiliated with the New York-based Equitable Life Assurance Society of the U.S., an AXA S.A. unit.

Equitas surplus grows

LONDON—Equitas Ltd., the runoff reinsurer for Lloyd's of London's pre-1993 long-tail liabilities, announced that net claims outstanding reduced by 13.1% to £7 billion ($10.59 billion) for the year ended March 31.

Gross claims outstanding fell by 12.7% to £9 billion ($13.61 billion), the company said.

Equitas' accumulated surplus rose to £784 million ($1.19 billion), up 1.5% from the previous year. The company's solvency margin, expressed as a percentage of net claims outstanding, increased to 11.2% from 9.6% the year before.

FTR FOR THE RECORD

Excerpts from *BI*'s Daily Online Updates, July 17- July 21, 2000

SUIT AGAINST RELIASTAR DISMISSED ReliaStar Life Insurance Co. is not obligated to reinsure hundreds of millions of dollars of workers compensation business that American International Group Inc. intended to cede to it, a New York court has ruled. New York Supreme Court Judge Barry A. Cozier threw out a lawsuit in which AIG units claimed they had valid reinsurance agreements with ReliaStar, a participant in the ill-fated Unicover Managers Inc. workers comp pool. Under the agreements, ReliaStar was to front the reinsurance coverage for Unicover pool members. AIG and ReliaStar never completed the agreements, though, and AIG has no contractual right to coverage for the roughly $400 million in annual workers comp premiums it planned to cede to the pool, the court found. Judge Cozier simultaneously dismissed a third-party complaint ReliaStar brought against E.W. Blanch Co., the reinsurance broker for the proposed deal. He had earlier dismissed Unicover as a defendant. The Unicover reinsurance facilities disintegrated in early 1999 amid charges by participating reinsurers and retrocessionaires that Unicover had hugely exceeded its premium volume projections. Ultimate losses on Unicover business were projected to exceed $1.5 billion.

GENETIC BIAS FORECAST Federal legislation is needed to prevent genetic discrimination in the workplace, the director of the National Human Genome Institute told a Senate panel last week. The problem of employment-related genetic discrimination, while affecting few workers now, can be expected to grow rapidly, predicted Dr. Francis S. Collins, director of the Genome Institute, which is located at the National Institutes of Health in Bethesda, Md. Dr. Collins told the senators on the Health, Education, Labor and Pensions Committee that they have the opportunity to practice "preventive legislation" by implementing safeguards for the use of genetic information by employers. Such legislation has been introduced in both the House and the Senate, but neither body has passed it and, with the legislative calendar rapidly shrinking, the chances of enactment this year are extremely remote.

Mr. Collins

BIG 'I' MARKETS FIRST SALE The first sale of an insurance coverage product using the Independent Insurance Agents of America's Internet-based system was made earlier this month. The system, Big "I" Markets, offers independent agents access to a portfolio of specialty, niche and program insurance coverages. Several insurance companies—including St. Paul Fire & Marine Insurance Co., Chubb Corp., The Hartford Financial Services Group Inc., RLI Insurance Co., Redland Insurance Co. and Virginia Surety Co.—offer policies through Big "I" Markets. The inaugural sale was registered by independent agent Greg Blair of Nottingham Insurance & Financial Services Inc. in Hamilton Square, N.J. The first policy issued through Big "I" Markets was written with St. Paul Fire & Marine. New Jersey is the first state in which Big "I" Markets is available; it will soon be launched in other states, according to the Alexandria, Va.-based IIAA. Each IIAA state organization will determine whether the Internet-based system will be available to its members.

SYNDICATE SHUTS DOWN Marlborough Underwriting Agency Ltd. syndicate 744 will accept no new business for the 2001 year of account and will be put into runoff. The move follows an announcement last week by multiline insurer CGNU P.L.C., which backed 80% of the syndicate's capacity, that it would withdraw from the syndicate for 2001. The marine excess-of-loss syndicate is one of 19 syndicates that Lloyd's has ordered to increase their capital base by as much as 20% to underwrite in 2001 (*BI*, July 17). The capital loading was imposed on syndicates with excessive losses and those that had made poor forecasts. Penalized syndicates must boost their capital by a stipulated amount to continue trading in the market. Syndicate 744 was facing the maximum penalty—a loading of 20% of capacity. Marlborough said that no decision had been made on the future of the syndicate's underwriting or back-office personnel.

KEMPER CASUALTY STARTS EXCESS UNIT Kemper Casualty Co. has launched an excess property insurance facility providing up to $50 million in capacity to domestic and U.S.-based multinational, energy, industrial and commercial large-risk customers. The new facility, Kemper Property, will underwrite all-risk coverage, including boiler and machinery, on A-rated paper on a mono-line basis. It also will support the integrated risk programs of Kemper Casualty's Kemper Solutions unit, and will offer limited Zone 1 earthquake and Tier 1 windstorm capacity to national accounts. Kemper Property's typical minimum attachment point is $10 million, and the minimum annual premium is $50,000. Susan Doyle is president of the new unit of New York-based Kemper Casualty. Kemper Casualty is a member of the Long Grove, Ill.-based Kemper Insurance Cos.

ZURICH-WILMINGTON PARTNERSHIP Zurich U.S. will partner with Wilmington Insurance Co., a minority-owned U.S. property/casualty insurer, to provide insurance to the railroad industry. The partnership will help railroad industry companies—including rail contractors, suppliers and service companies—satisfy federal, state and local government requirements for conducting business with minority-owned firms. "This agreement is in direct response to government and industry initiatives to foster private-sector business-to-business relationships that enhance the economic vitality and competitiveness of small, disadvantaged businesses," said Wilmington Chief Executive Officer Jose del Valle. Wilmington, which is based in Wilmington, Del., is certified as a Minority Business Enterprise by the National Minority Supplier Development Council. The insurer, which was founded in 1996, is rated NR1 (insufficient data) by A.M. Best Co.

GALLAGHER SEES RECORD QUARTER Arthur J. Gallagher & Co. reported record quarterly revenues of more than $158.4 million for the three-month period that ended June 30, a 9.5% increase from the company's second-quarter 1999 revenues. Gallagher's net earnings for the second quarter were more than $14.7 million, which was a 12.9% increase over the comparable period last year. J. Patrick Gallagher Jr., president and chief executive officer of Itasca, Ill.-based Gallagher, attributed the company's second-quarter results to its new business efforts and account-retention programs, as well as a move toward higher premium rates across most lines of coverage. For the first half of the year, Gallagher recorded total revenues of nearly $312.7 million, a 10.0% increase over its results from the first half of 1999. Gallagher posted net earnings of nearly $30.1 million for the first six months of 2000, which is a 12.1% increase over the comparable period last year.

BRIEFLY NOTED The tornado that struck a campground and trailer park July 14 in Pine Lake, Alberta, caused between $10 million Canadian ($6.8 million) and $15 million Canadian ($10.1 million) in **insured property damage**, according to the Insurance Bureau of Canada. Most of the recreational vehicles, trailers and automobiles that were damaged likely are insured, the IBC said. . . . **Guy Carpenter & Co.** has appointed two senior vps to help grow its specialty initiatives group, which offers cedents access to the New York-based reinsurance broker's specialty expertise. David Cameron has joined as senior vp of the Special Property Group, and Ronald Colligan has joined as senior vp of the Life Specialty Group. Mr. Cameron was formerly a senior vp at E.W. Blanch Co. Inc., and Mr. Colligan was a vp at Jefferson Pilot Financial. BI

To get breaking news as it occurs, visit Business Insurance's free online Updates at www.businessinsurance.com. All of the material in the For The Record column, as well as other content in this week's issue, is generated from daily news postings that appeared on the Web site in the previous week.

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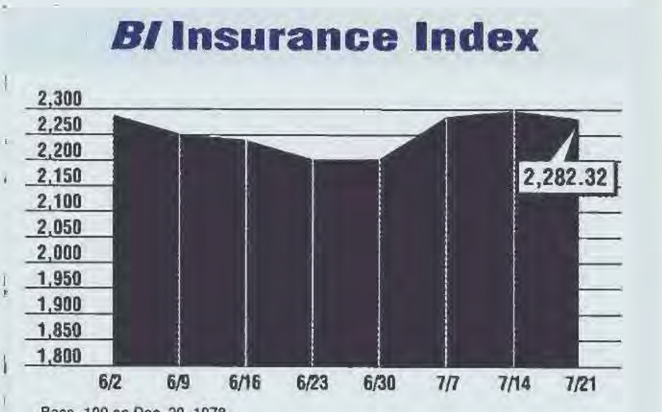
BI Industry Stock Report JULY 17, 2000, THROUGH JULY 21, 2000

		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
BROKERS							
Aon Corp.	NYS	30.50	-5.79	-23.75	43.13	20.69	3776
Brown & Brown	NYS	50.63	-0.74	32.14	52.50	30.75	40
Clark Bardes Holdings	NDQ	10.88	-36.03	-24.35	21.00	10.63	488
E.W. Blanch Holdings Inc.	NYS	21.88	4.48	-64.29	71.75	16.56	1118
Gallagher Arthur J. & Co.	NYS	44.00	8.31	35.91	44.00	23.06	779
Hilb, Rogal & Hamilton	NYS	35.56	1.79	25.88	35.56	20.75	189
Kaye Group Inc.	NDQ	6.94	-2.63	-17.16	11.88	5.00	1
Marsh & McLennan	NYS	110.50	-0.11	15.48	114.81	61.75	3943
BROKERS	AVERAGE		1.85	4.66			
INSURERS/REINSURERS							
ACE Ltd.	NYS	31.13	-1.39	86.52	32.38	14.06	3066
Accel International Corp.	NDQ	0.63	0.00	-37.50	1.88	0.50	2
Acceptance Insurance Cos.	NYS	4.31	-10.39	-25.00	15.94	2.75	264
AEGON N.V.	NYS	38.31	6.06	-19.76	49.13	31.50	876
Aetna Life & Casualty	NYS	57.25	-19.51	2.58	89.94	38.50	15363
AFLAC Inc.	NYS	49.75	-4.10	5.43	54.25	33.56	2869
Allmerica Financial Corp.	NYS	55.44	-1.66	-0.34	64.81	35.06	652
Allstate Corp.	NYS	24.75	-0.50	2.86	37.94	17.19	13295
Ambac Financial Group	NYS	61.25	6.64	17.37	63.00	38.88	2509
American Financial Group	NYS	23.88	-7.51	-9.48	35.44	18.38	562
American General	NYS	64.69	-3.54	-14.74	82.19	45.63	4610
American Intl Group	NYS	118.13	-1.46	9.25	124.06	78.56	11344
American Safety Insurance	NYS	4.50	-1.37	-30.77	8.56	3.75	13
Argonaut Group	NDQ	15.94	-9.57	-19.81	26.63	15.94	137
AXA-UAP Group	NYS	74.56	1.27	5.02	81.50	53.75	374
Baldwin & Lyons Inc.	NDQ	15.94	-6.25	-27.97	23.94	15.88	262
Berkley W.R. Corp.	NDQ	19.88	-0.63	-4.79	27.94	14.00	538
Berkshire Hathaway Inc.	NYS	53300.00	-2.91	-4.99	69500.00	40800.00	2
Capitol Transamerica Corp.	NAS	11.25	2.27	11.80	15.25	9.38	3
Chubb Corp.	NYS	65.75	-2.32	16.76	72.94	43.25	2669
CIGNA Corp.	NYS	97.06	-2.69	20.48	103.06	60.75	3395
Cincinnati Financial Corp.	NYS	34.31	-5.02	7.65	43.31	26.19	1078
Citigroup	NYS	71.00	4.41	27.50	71.00	41.19	40845
CNA Financial Corp.	NYS	36.31	-3.49	-6.74	42.13	24.56	204
CNA Surety	NYS	11.75	-3.59	-9.62	15.50	9.75	97
EMC Insurance Group Inc.	NDQ	9.00	-2.70	-1.37	13.38	6.81	154
ESG Re Limited	NDQ	3.84	-0.81	-44.59	16.75	3.19	14
Enhance Financial Services	NYS	15.00	-4.38	-7.69	22.63	8.63	464
Everest Reinsurance	NYS	35.81	-3.86	60.50	38.50	20.50	502
Fremont General Corp.	NYS	4.06	-13.33	-44.92	19.56	3.88	1854
Frontier Insurance Group	NYS	0.69	-26.67	-80.00	15.81	0.63	1066
Gainsco Inc.	NYS	4.44	-7.79	-17.44	6.94	4.44	67
Harleysville Group	NDQ	18.25	0.00	28.07	20.75	11.63	200
HSB Group Inc.	NYS	29.94	-6.26	-11.46	42.25	21.50	213
HCC Insurance Holdings	NYS	19.31	-4.92	46.45	25.13	8.00	226
ING Groep N.V.	NYS	65.31	-2.79	7.07	69.00	46.81	539
IPC Holdings Ltd.	NDQ	12.94	-7.17	-13.03	22.50	9.75	103
Hartford Financial Services	NYS	57.88	-3.54	22.16	64.00	29.38	4938
John Hancock Financial Service	NYS	23.06	-3.66	35.66	24.63	13.44	2864
LaSalle Re Holdings Ltd.	NYS	14.50	-3.73	-12.12	18.63	10.88	232
Lincoln National	NYS	43.31	0.00	8.28	57.50	22.63	4635
MAIC Holdings Inc.	NYS	12.38	10.00	-41.59	29.05	10.00	114
Markel Corp.	NYS	148.00	-1.74	-4.52	192.00	111.50	38
MBIA Insurance Group	NYS	53.00	-1.05	0.36	66.94	36.31	1944
Meadowbrook Insur. Group	NYS	4.94	0.00	-24.76	14.06	4.50	44
MetLife	NYS	20.75	-0.60	45.61	22.06	14.25	7300
Mutual Risk Mgmt. Ltd.	NYS	15.50	2.06	-7.81	35.50	9.81	892
Navigators Group	NDQ	9.63	-2.53	-1.28	16.00	8.63	24
NYMagic Inc.	NYS	15.56	5.51	18.01	16.13	12.25	56
Ohio Casualty Corp.	NDQ	9.00	-12.20	-43.97	18.63	9.00	2337
Old Republic Int'l	NYS	18.13	-0.34	33.03	18.81	10.63	1066
Partner Re Ltd.	NYS	37.63	0.00	15.99	39.75	28.38	302
Penn-America Group Inc.	NYS	7.25	0.00	-6.45	10.38	6.63	71
PMA Capital Corporation	NDQ	18.38	-2.65	-7.55	21.00	15.50	69
Philadelphia Cons. Holding	NDQ	16.00	0.79	10.34	24.44	10.81	235
PXRE Corp.	NYS	12.94	-1.43	-0.48	19.56	9.94	39
Reliance Group Holdings	NYS	0.22	-55.25	-96.70	7.75	0.19	11887
ReliaStar Financial Corp.	NYS	52.81	0.00	34.77	53.00	23.75	3198
RenaissanceRe Holdings Ltd.	NYS	44.13	3.07	7.95	44.13	33.19	228
RLI Corp.	NYS	34.63	-3.82	1.84	38.63	26.25	19
St. Paul Cos.	NYS	37.44	0.00	11.13	39.38	21.31	3443
SCOR	NYS	43.19	1.17	-2.40	53.63	38.38	19
SAFECO Corp.	NDQ	21.31	-2.29	-14.32	44.50	18.00	2608
SCPIE Holdings Inc.	NYS	21.38	-0.29	-33.46	36.94	19.00	NA
Seibels Bruce Group	NDQ	1.44	31.43	-17.86	5.69	0.75	58
Selective Ins. Group	NDQ	18.38	-0.68	6.91	22.50	14.63	253
Tokio Marine & Fire	NDQ	51.38	-7.43	-13.11	67.00	45.00	89
Torchmark Corp.	NYS	24.75	-7.04	-14.84	36.94	18.75	2539
Transatlantic Holdings	NYS	82.13	-2.74	5.20	91.56	68.75	38
Trenwick Group Inc.	NYS	15.00	-1.64	-11.44	25.06	12.00	104
Unico American Corp.	NDQ	6.50	4.00	-7.14	10.50	4.50	60
United Fire & Casualty	NDQ	20.06	1.90	-11.33	26.50	15.50	17
Unitrin	NDQ	28.50	-5.59	-24.25	42.38	28.50	207
UNUM Corp.	NYS	19.63	-6.55	-38.79	56.88	11.94	5062
Vesta Insurance Co.	NYS	6.19	-3.88	59.68	7.88	3.44	104
XL Capital Ltd.	NYS	56.31	-3.53	8.55	63.50	39.00	762
Zenith National Ins.	NYS	22.94	0.00	11.21	26.00	18.75	39
INSURERS/REINSURERS	AVERAGE		-2.86	-2.49			
HEALTH MAINTENANCE ORGANIZATIONS							
Foundation Health Systems Inc.	NYS	14.31	0.00	44.03	16.94	6.25	2802
Humana Inc.	NYS	7.56	7.08	-7.63	13.19	4.75	5881
Oxford Health Plans	NDQ	23.69	-6.42	86.70	27.19	9.75	9146
Pacificare Health Sys.	NDQ	60.81	-2.89	14.74	72.31	31.13	1608
Sierra Health Services	NYS	3.63	-1.69	-45.79	14.56	2.75	232
United HealthGroup	NYS	85.00	0.59	60.00	91.94	39.38	5024
Wellpoint Health Networks	NYS	84.25	11.68	27.77	86.69	48.25	3976
HMOs	AVERAGE		1.19	25.69			
ALL COMPANIES	AVERAGE		0.06	9.28			



Top advancing issues: Seibels Bruce Group, Wellpoint Health Networks, MAIC Holdings Inc. Leading decliners: Reliance Group Holdings, Clark Bardes Holdings, Aetna Life & Casualty. Most active issue: Citigroup. The *BI* Index decreased 0.7%; the Dow Jones 30 Industrials dropped 0.7%; the S&P 500 went down 2.0%, and the NYSE Composite decreased 1.3%. Average P/E: Brokers, 20.2; Insurers/reinsurers, 16.6; HMOs, 14.3.

Source: *CNET Investor* (investor.cnet.com) Boulder, Colo.

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Linda Candor LIBERTY MUTUAL NURSE CASE MANAGER

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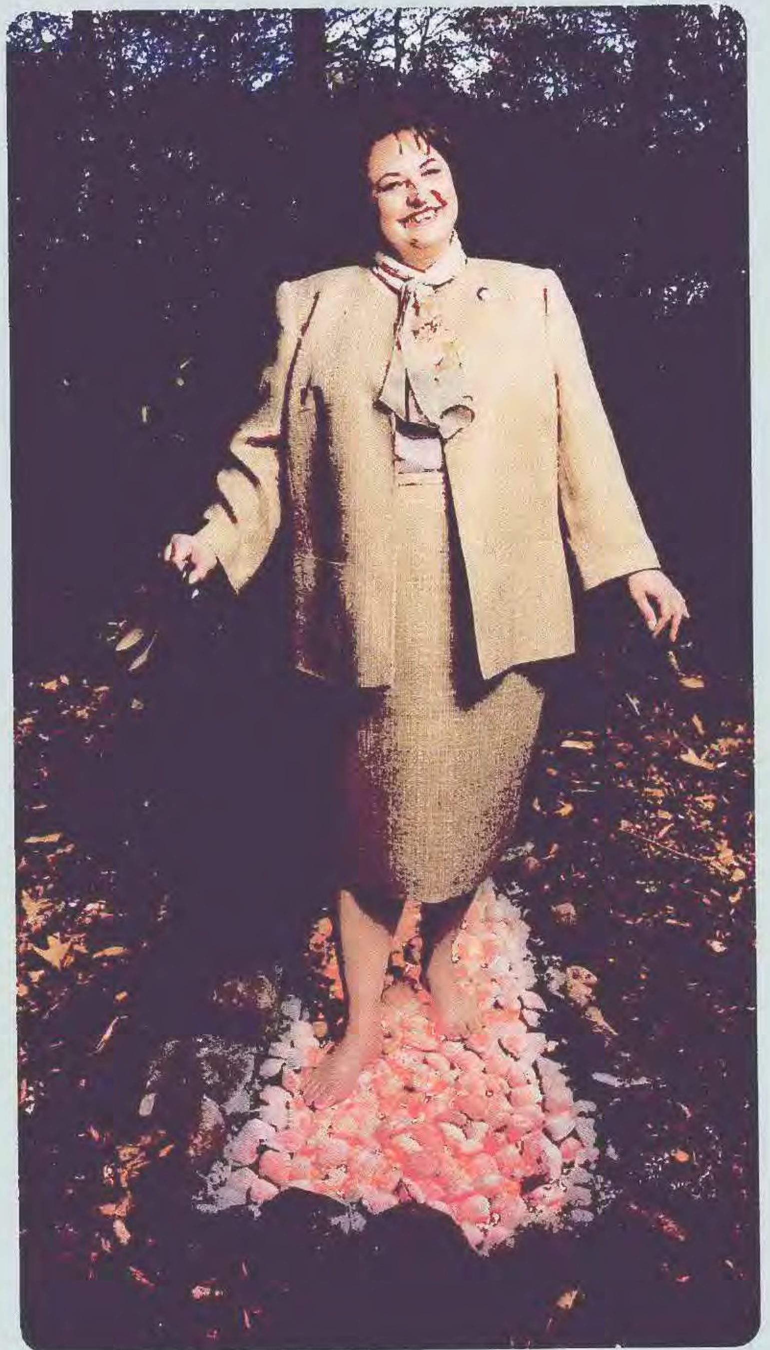

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