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Updates

Kaiser announces plans to withdraw from Northeast

LATHAM, N.Y.—Kaiser Health Plan Inc. announced Friday that it plans to withdraw from its Northeast markets by the end of the year and is now in discussion with interested purchasers.

Kaiser said its Northeast unit has 575,000 members in four states: Connecticut, Massachusetts, New York and Vermont. It operates in suburban and rural areas, excluding cities such as New York; Boston; and Providence, R.I.; a Kaiser spokesman said.

"After concerted effort, we have not been

See **Updates** *on next page*

More states enacting punitive damages caps

What seemed like the impossible dream for tort reform advocates only a few weeks ago became reality in Alabama as lawmakers approved massive changes in the state's civil justice system.

"What's probably the most remarkable is the punitive damages bill. I think if you'd asked those pushing this, they would have been very surprised" that the measure won approval so quickly, said Sherman Joyce, president of the American Tort Reform Assn. in Washington. The sudden legislative action, followed quickly by the governor's signature, was spurred, in part, by concern about a jury award of $580 million in punitive damages to two families who claimed to have been overcharged by about $1,200 for satellite dishes (*BI*, May 17). That award heightened the perception of Alabama as a prime example of a tort system run amok.

As dramatic as the Alabama reforms are, however, they did not generate the same passion as those that won approval in Florida, where Gov. Jeb Bush signed a package of tort reforms only a year after his predecessor, the late Gov. Lawton Chiles, vetoed a similar bundle. Among other things, Florida's law caps

See **Tort reform** *on page 17*

Parity measures top list of state benefit mandates

For health care legislation at the state level, 1999 may well be remembered as the year of the mandate.

While a precise count is not available, states added several dozen new benefit mandates—on top of the hundreds already on the books—that insurers and HMOs will have to comply with in the plans they offer employers.

For example, seven states enacted mental health care parity measures, which, in varying degrees, require plans offered by insurers and HMOs to offer the same benefits for mental disorders as for physical ailments.

Typical of the new mental health care benefit mandates are measures enacted in New Jersey and Oklahoma that mandate coverage equity for severe, biologically based mental disorders, such as schizophrenia.

Mental health care, though, is just one of the many types of mandates that have been enacted. For example, at least five states have passed measures requiring health plans to provide the same coverage for prescriptive contraceptives as for other prescriptions, while at least eight states have mandated coverage for

See **Health** *on page 19*

STATES MOVE TO DEREGULATE COMMERCIAL LINES . . . PAGE 12

ROUNDUP OF WORKERS COMP LEGISLATION . . . PAGE 15

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FEMA to firm eligibility rules

By ROBERTO CENICEROS

New disaster assistance eligibility rules to be proposed by the Federal Emergency Management Agency could push public entities to purchase specific amounts of property insurance.

FEMA's efforts could increase demand for insurance and affect pricing, observers have said (*BI*, June 7).

PRIMA conference coverage begins on page 3

Under congressional urging, FEMA is seeking to return to its original mandate—to provide backup support only for public entities that purchase "adequate levels" of insurance, a FEMA official said. The agency also wants to streamline its assistance qualification procedures and encourage loss-mitigation efforts.

Some public entities have come to see the agency as their insurer of last resort, said Tom Vance, risk manager for Anaheim, Calif. He helped FEMA develop the rules it is expected to propose.

Buildings owned or leased by city and state governments, schools and other public entities, such as hospitals and universities, all would have to be insured to be eligible for FEMA assistance after earthquakes, floods, named storms or damage covered under all-risk policies, according to an early draft of the proposal.

A governmental entity wishing to self-insure its buildings would have to submit a funding plan or dedicate specific funds for post-disaster use to be eligible to receive

See **FEMA** *on page 29*

Proposed FEMA rules would require government entities such as Los Angeles County, above, to have property insurance in order to obtain federal assistance following a natural disaster.

Disability ruling offers guidelines

By JUDY GREENWALD

DENVER—A federal appellate court decision issued last week gives employers a valuable road map to follow in offering reassignment to disabled employees, even though the ruling favored the plaintiff, some attorneys say.

The 9-3 decision by the full 10th U.S. Circuit Court of Appeals in *Geneva M. Smith vs. Midland Brake Inc.* overturned earlier decisions in Midland's favor by both a district court and a panel of the appellate court. The latest ruling returned the case to the district court for further proceedings.

Although Midland was on the losing side, the decision provides clear guidelines for employers faced with offering disabled employees other jobs within their companies, and it could be influential in courts nationwide, attorneys say.

The case was brought by the widow of Robert W. Smith. Mr. Smith developed muscular injuries and chronic dermatitis on his hands after working for almost seven years in the light assembly department of Midland Brake, a unit of Echlin Inc. He could not continue in his job because of his condition, and in 1993 Midland fired him after it was unable to find him another assignment in his previous department.

Mr. Smith, who died during the appeal process, filed a complaint whose charges included violation of the Americans with Disabilities Act. The decision focuses on the ADA.

The appellate court ruled that reassignment of an employee to a vacant position in a company "is one of the range of reasonable accommodations which must be considered" if the employee cannot return to his or her existing job under the ADA.

According to the decision, reasonable accommodations within the existing job are preferred, and an employer is required to take only "reasonable steps to accomplish a reassignment."

The decision then lists limits on an employer's duty to reassign. These are:

• There must be an "interactive process" between the employer and the disabled employee that includes having the worker identify the precise limitations imposed by the disability and "potential reasonable

See **Disability** *on page 31*

NEWSPAPER

Updates

Kaiser leaving Northeast

Continued from page 2
able to achieve the level of long-term success in those markets that we had hoped," the spokesman said. "Given our financial status, we are unable to continue to invest in our health care delivery system there."

Kaiser posted a $288 million net loss last year (*BI*, March 22).

Filing targets former stockbroker

BRIDGEPORT, Conn.—Federal law enforcement officials have identified a debarred stockbroker as a central figure in an alleged scheme to drain several hundred million dollars from a group of life insurers.

Martin R. Frankel, a former stockbroker banned from the business in 1992 by the Securities and Exchange Commission, used several offshore companies and aliases to gain control of Franklin American Corp. life insurance units and systematically drain their assets and premiums, the FBI charges in court filings.

According to an affidavit filed in Bridgeport, Conn., federal court by FBI agent Joseph P. Dooley, Mr. Frankel ran a sophisticated—and unlicensed—securities trading operation, Liberty National Securities Inc., from a multimillion-dollar estate in Greenwich, Conn.

Mr. Frankel also controlled the St. Francis of Assisi Foundation, a British Virgin Islands entity created in August 1998, the filing says. When Mississippi insurance regulators learned in March that the St. Francis foundation was the ultimate owner of Franklin American and an affiliated holding company, they placed several of the insurance units under supervision. The life insurers' president, John Hackney, later reported that he could not locate the insurers' assets and could not reach anyone at Liberty National Securities. The insurers' assets totalled $950 million, the majority of which was supposedly invested through Liberty National. Seven insurers affiliated with Franklin American have since been placed in receivership (*BI*, May 24).

Mr. Frankel has not been seen since early May and is believed to be in hiding, possibly overseas.

The Franklin American companies' assets may only be part of the money that flowed through the St. Francis foundation: An audited financial statement for the foundation reported that it held $1.9 billion as of March 31, and this did not include the insurers' money, according to a lawyer familiar with the case.

This money also is gone, and the origin of the funds and their ultimate disposition are unknown, the lawyer said.

COBRA expansion introduced

WASHINGTON—Legislation introduced last week by the House Democratic leadership would require employers to extend health care coverage under the Consolidated Omnibus Budget Reconciliation Act for up to 13 years, or more than four times longer than the current three-year maximum.

Under the legislation, beneficiaries age 55 and older could extend their COBRA coverage until they were eligible for Medicare at 65.

For example, a widowed spouse who took regular COBRA coverage at age 52 could, when her eligibility for COBRA ended three years later, purchase coverage for an additional 10 years.

Beneficiaries obtaining this special extension of COBRA coverage could be charged a premium equal to 125% of the group rate. They now can be charged 102% of the group rate for regular COBRA coverage.

The higher 125% premium is needed because individuals in this age range are more expensive to insure, said Rep. Pete Stark, D-Calif., the bill's chief sponsor, who introduced the original COBRA legislation in 1985.

Rep. Stark says his bill is needed because older employees who lose their jobs can find the cost of insurance in the individual market prohibitively expensive.

Connecticut HMO restructuring

FARMINGTON, Conn.—A non-profit Connecticut health maintenance organization is restructuring itself as a for-profit enterprise, citing the need to raise capital to compete in a tough marketplace.

ConnectiCare Inc., the state's third-largest HMO, with an enrollment of more than 220,000, will reorganize itself into a charitable foundation, Connecticut Health Foundation Inc., and a new, for-profit holding company, ConnectiCare Holding Co. Inc.

Initially, the foundation will own all the stock of ConnectiCare Holding, which, in turn, will own ConnectiCare Inc., the HMO; Health Management Corp. Inc., a third-party administrator; and ProValue Inc., a business services provider.

In the near future, the foundation will privately sell common and preferred stock in the holding company to buyers who will hold the stock as a long-term investment, ConnectiCare announced. The foundation does not plan a public offering of the holding company's shares.

ConnectiCare President and Chief Executive Officer Marcel L. Gamache cited the highly competitive health care market as the reason for the restructuring. "To succeed as an independent, Connecticut-focused HMO. . .we must have access to capital markets unavailable to us as a not-for-profit organization," he said in a statement.

Connecticut Health Foundation will continue to operate as a charitable organization, making health-related grants to local communities funded, in part, from dividends on, sales of, or other earnings resulting from its holdings of ConnectiCare stock.

*See **Updates** on page 30*

Errors & omissions

Maine Gov. Angus King last week vetoed a bill that would have extended workers compensation benefits for amputees. A story on page 15 incorrectly reports that Gov. King signed the bill.

Move spurs more talk of a market turn

Reliance to boost reserves

By GAVIN SOUTER

NEW YORK—Reliance Group Holdings Inc.'s announcement that it will increase its net reserves by up to $250 million is another signal that commercial insurers are struggling and that rate increases may follow, analysts say.

Reliance is one of several insurers that over the past several months have shown signs that the low rates they are charging for coverage are causing financial problems, they say.

Historically, reserve strengthening has preceded a hardening of the market, said A. Michael Frinquelli, general partner and insurance analyst at Renaissance Fund Advisors in New York. "This has typically happened in the past just before premium rates have gone up," he said.

Last week, Reliance announced that it is conducting an analysis of some commercial lines that have had poor results. The analysis, according to the insurer, will be completed by mid-July and will likely result in an increase in its net reserves of $150 million to $250 million.

Reliance continually reviews its reserves, and recent reviews indicated that reserves for some lines soon would fall "below the acceptable range" the company sets for itself, said Albert A. Benchimol, senior vp and treasurer of Reliance in New York.

The problem lines include commercial property, commercial auto, transportation and some environmental coverages, he said.

In addition to bolstering reserves, the insurer will likely increase certain rates and will cancel or not renew some of its unprofitable accounts, Mr. Benchimol said.

This year, Reliance already has canceled or not renewed $85 million in property and transportation business, he said.

The last time Reliance added a special increase to its reserves was in 1996, when it added $134 million to cover pre-1987 environmental and asbestos losses.

*See **Reliance** on page 28*

Patient protection takes early steps

But partisan wrangling threatens to slow progress

By JERRY GEISEL

WASHINGTON—Patient protection legislation is inching forward in Congress, but a bipartisan agreement that would ensure passage appears far off.

On straight party-line votes last week, the House Employer and Employee Relations subcommittee approved a series of patient protection bills introduced by Republicans.

The measures now will go to the full Education and the Workforce Committee, which could consider the bills as early as next week.

The bills approved by the subcommittee would:

- Allow patients to appeal coverage disputes to independent external review panels made up of physicians.
- Allow a woman to choose an obstetrician/gynecologist as her primary care physician.
- Allow parents to designate a pediatrician as the primary care physician for their children.
- Require health care plans to cover emergency room services if a "prudent layperson" believed the situation constituted a medical emergency.
- Ban so-called gag clauses so that physicians in managed care networks could freely discuss treatment options with patients regardless of the cost of those options.
- Create a federal Health Care Access, Affordability and Quality Commission to examine, among other things, whether more benefit mandates are needed.

In addition to the patient protection bills, the panel also approved a measure that would let

*See **Patients** on page 30*

Aetna to amend Pru bid amid reports of pressure

Status of HMO merger unclear

By JOANNE WOJCIK

DALLAS—Bad blood between doctors in Dallas and Aetna U.S. Healthcare is stirring up trouble in the insurer's attempt to take over Prudential HealthCare, doctor groups say.

The Dallas Morning News and The Wall Street Journal both reported last week that the U.S. Justice Department has told Aetna to sell off its NYLCare units in Dallas and Houston before it will grant regulatory approval of the merger. Aetna acquired NYLCare Health Plans in July 1998.

While no officials at Aetna or the federal government would confirm the published rumor, the Texas Insurance Department confirmed last week that Aetna has informed department officials that it will amend its merger application.

And the Texas Medical Assn. issued a press release stating, "We are cautiously optimistic that the monstrous Aetna U.S. Healthcare-Prudential merger, as originally proposed, has been dismantled."

The TMA, along with two Texas medical societies and the Chicago-based American Medical Assn., wrote separately to the Justice Department, protesting the proposed merger shortly after plans for it were announced last December.

Many of the medical groups' arguments stemmed from a dispute that occurred last fall between the Dallas-based Genesis Physicians Practice Assn. and Aetna.

*See **Aetna** on page 29*

Inside

- *BI*'s annual review of risk management- and employee benefits-related state legislative activity reveals more pluses than minuses, this week's editorial says. **PAGE 8**
- A turnaround at Lloyd's may not be as unlikely as underwriters had hoped, according to research published by an insurance rating analyst last week. **PAGE 25**
- Hot on the heels of Belgium's dioxin food contamination crisis this month, the Coca-Cola Co. is facing questions about contaminated products in Belgium. **PAGE 25**

Departments

Advertiser Index 28
Classifieds 26
Commentary 29
For the Record 27
Global Briefs 25
Insurance Services Guide 24
International 25
Letters 8
Opinions 8
Ticker 31

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Y2K measure advances; veto likely

By MARK A. HOFMANN

WASHINGTON—The Senate's approval of a bill providing some liability relief for businesses facing suits stemming from the Year 2000 computer problem moves the debate on to another stage.

A House-Senate conference committee will be named to iron out differences between the Senate bill and a more-expansive bill the House approved earlier this year. But any compromise appears likely to face a veto, given President Clinton's repeated objections to both bills as providing insufficient protections for consumers.

Despite the veto threat, the bill's progress drew favorable reviews from risk managers, insurers and business as a whole.

"We don't like any uncertainty," said Lance Ewing, chair of the Risk & Insurance Management Society Inc.'s External Affairs Team. If legislation can diminish uncertainty over Y2K, "that's certainly in our favor."

"From our standpoint, we need to know what exactly insurance is going to pick up in the event that there is a loss due to a Y2K problem. For the most part, risk managers are always concerned with the 'what if,' and Y2K certainly fits into that box," said Mr. Ewing, who is also director-insurance and loss prevention for GES Exposition Services Inc. of Las Vegas.

"Risk managers have to be aware how our government views the actual interpretation of what the proximate cause was for a loss in regard to Y2K. Depending on the definition that comes out of this legislation, risk managers may be forced to get new coverage, step up loss control, or not continue in that operation or production. In addition, we're also concerned about support companies that provide our companies with materials, labor, etc., who may have Y2K problems that affect our end product. Overall, I'm usually nervous when legislators tend to make decisions for risk managers," said Mr. Ewing.

Christopher Mandel, director-global risk management at Tricon Global Restaurants Inc. in Louisville, Ky., and vp-External Affairs on RIMS' Executive Council, said: "In general, the position the society takes on why we wanted this is that the whole issue of litigation ex-

See **Y2K** on page 30

Vendor marks still low on Quality Scorecard

RIMS/QIC may lengthen interval

By MICHAEL BRADFORD

Risk managers continue to show dissatisfaction with their insurers, brokers and third-party administrators in what may be the final annual scoring of those service vendors.

The results of the 1999 Quality Scorecard, released last week, show scant improvement from a year ago, when risk managers gave their business partners low grades in satisfaction and performance.

That has prompted the project's sponsors to discuss whether to conduct the survey at intervals longer than a year to let vendors implement quality improvements between the scorings.

And the broker that was ranked highest by risk managers has questioned the worth of the scorecard's grades and suggested that its use is misguided.

The scorecard is a project of the Quality Insurance Congress and the Risk & Insurance Management Society Inc. The research is conducted by the Katie Insurance School at Illinois State University in Normal. Last year's survey was the first conducted by RIMS and the QIC.

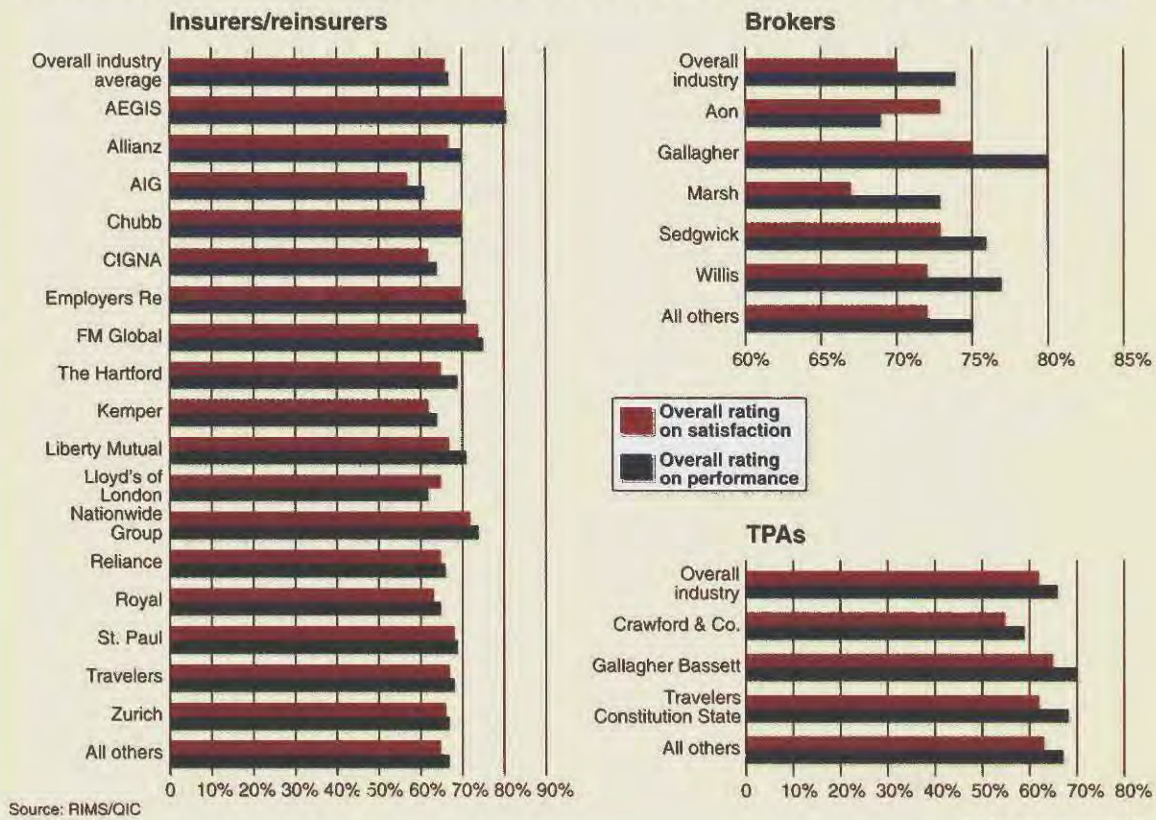
This year's full results are not a surprise; preliminary scores were released at the Risk & Insurance Management Society Inc.'s conference in Dallas earlier this year. Those results showed that insurance buyers remain largely dissatisfied with the service they are getting (*BI*, April 26).

The full results show that risk managers have seen little change in the past year in vendors' practices. On a scale of 1 to 100, they gave the overall industry a 67 in satisfaction, a 70 in performance, and a 72 in loyalty. Last year's scores were virtually the same: 67 in satisfaction, 70 in performance, and 73 in loyalty.

Risk managers gave insurers and reinsurers an

See **Scorecard** on page 28

Satisfaction, performance ratings for industry segments



GRAPHIC BY MIKE GARVEY

Public entities facing higher benefit costs

By RODD ZOLKOS

SAN DIEGO—Cutting benefits costs without sacrificing quality is an achievable goal, according to one panel at this year's conference of the Public Risk Management Assn. earlier this month in San Diego.

And that's a good way for a risk manager also involved in the benefits side of the business to become a hero in his or her organization, suggested Daniel J. Pliszka, manager of the risk management division for Charlotte, Mecklenburg County and the Charlotte-Mecklenburg Board of Education in Charlotte, N.C.

It's a safer route than achieving "hero" status on the basis of insurance cost savings, said Mr. Pliszka, who moderated the session, "because if the market gets hard and your costs go up, does that make you a jerk?"

Jelka S. Petrovic, sales and marketing director for Detroit Medical Center in Southfield, Mich., agreed. "When your insurance costs go down, you're a hero. Unfortunately, in the insurance industry, it's an underwriting cycle," Ms. Petrovic said.

And, she noted, at least in the health care area, the market is "entering a period of increases."

Ms. Petrovic estimated that, on average, for 2000 and 2001, employers will see increases of 12% in each of those years in their employee health care costs.

The reasons for the increases are several, including technological and medical advances that are resulting in new but expensive treatments and drugs; increased charges by providers stemming from government cuts

See **Benefits** on next page

Creating The Perfect Climate

Local governments have a role to play in achieving tort reform

Page 10

Risk of violence pervades workplace

By RODD ZOLKOS

SAN DIEGO—Americans have grown increasingly fearful of violence in their streets, in their schools and in their workplaces—a concern that is well founded, said an attorney who has focused on workplace violence.

Speaking as part of a panel on violence in society at the annual conference of the Public Risk Management Assn. earlier this month in San Diego, San Francisco employment lawyer Rebecca A. Speer said, "That feeling, that caution, that fear, is justified."

"Workplace violence is pervasive," she said. "Workplace violence takes a variety of forms that are tremendously disruptive to an organization."

Whether through actual violence, implied threats or aberrant behavior that alarms people, employers face large liability issues, Ms. Speer noted.

Through discussing the issue with employer clients, she concluded that "many employers are just throwing up their hands to the issue."

Problems often "just fell through the cracks," Ms. Speer said. "A lot of problems that I felt could have been dealt with at early stages were allowed to fester and become full-blown crises."

But, she said: "We all can learn how to manage the problem well. Not to do so would be a significant omission, from a risk management perspective."

Non-fatal incidents of workplace violence are significantly underreported, Ms. Speer said, and one private study suggests that one in four workers will

See **Violence** on page 6

Benefits

Continued from previous page

in Medicare and Medicaid payments; higher prescription drug costs; and an increase in mandated benefits.

A traditional response would be for an employer to cut benefits, alter premium contributions or increase copayments and deductibles, Ms. Petrovic noted.

But that traditional approach is "really not a cost-effective way to handle increased health care costs," she said. "Because, instead of controlling your costs, you're shifting them onto your employees."

There are other options that can benefit both employers and providers and hospitals, Ms. Petrovic suggested, such as physician-hospital organizations. Organizations like her facility have crafted such physician-hospital partnerships to develop and market "private label" health care products.

Such organizations work with fronting insurers or reinsurers and say, "This is our product that we are marketing to employer groups," Ms. Petrovic said.

In such private-label programs, plan participants get the greatest benefit when they use the organization's facility, get the next greatest benefit when they use a facility in a designated network, and get the lowest benefit if they go outside the network for care.

"What we have found is we have been able to bring our rates down on our private-label product about 15% below the commercial rates," she said.

A key to reducing costs with private label products is better care management that focuses on the quality of care, disease management through health risk appraisals and coordination with the participant's primary care physician, wellness programs built into the plan, and case management, Ms. Petrovic said.

"The whole goal is to keep that member healthier," she said. "We're seeing the primary care doc not as a gatekeeper but as the member's partner."

Another key is a somewhat unusual approach to carving out benefits—for example, in the area of high-cost, low-frequency procedures.

Using that approach, through direct contracts with providers, plans can achieve packaged pricing savings of 30% to 45% on such procedures as bone marrow transplants, other organ transplants or other specialty services, Ms. Petrovic said.

"There are centers of excellence," she said. Plans look nationally for such centers, she said, because even after paying the plan member's transportation costs to the best heart transplant facility in the country, for example, the plan still can realize a savings through negotiated package pricing.

"You're sending them to the best in the country, and you're cutting costs," Ms. Petrovic said. "It's a win-win situation."

Another panelist, Stanley Fayne, risk manager in the Oakland County Risk Management and Safety Department in Pontiac, Mich., noted that, through the strategic use of case management, organizations also can achieve savings while improving employees' care.

For example, "we've identified a $25,000 figure as a trigger for using a case manager," Mr. Fayne said. Those sorts of cases involve only 1% to 3% of an organization's health care population but generate 45% of its cost, he said.

Using a case manager to ensure that the plan member is being treated appropriately and that treatment guidelines are being followed can reduce the chances of further problems with their associated higher costs.

And, by using a case manager in cases of chronic ailments such as asthma, congestive heart failure or diabetes, the organization can "improve the quality of life for your employee and control cost by effectively controlling your case management," Mr. Fayne said. BI

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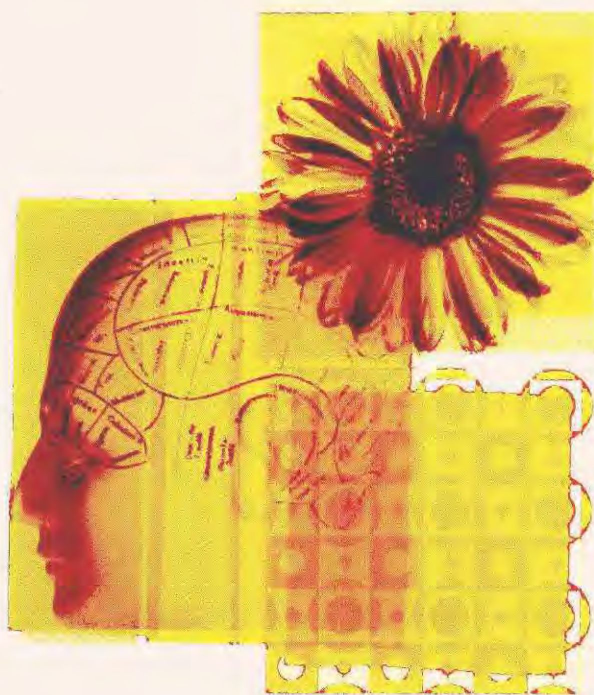

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Panel: M&A no need for worry

By RODD ZOLKOS

SAN DIEGO—Public sector risk managers shouldn't worry that consolidation in the reinsurance industry bodes ill for their operations, according to a panel of reinsurance industry executives.

Speaking to the Public Risk Management Assn.'s annual conference earlier this month in San Diego, Patrick Jasper, senior vp at Swiss Re New Markets in Chicago, described the consolidation as "just part of a general cycle."

"I really don't think the convergence that's going on is going to be the end of a competitive reinsurance market," Mr. Jasper said.

Another member of the panel on the public entity reinsurance market, Mark Peterson, vp at Towers Perrin Reinsurance in Seattle, suggested that risk managers could benefit from consolidation. The mergers and acquisitions rampant in the industry are, he said, "motivated by bringing you better service on a lower-cost basis."

That, if true, is good news for risk managers, because consolidation will continue, according to Blaine Bontempo, vp at Genesis Underwriting Management Co. in Chicago.

"The consolidation routine seems to be accelerating, and we would think the next wave may be in the smaller reinsurers," Mr. Bontempo said.

In addition to consolidation among reinsurers, the integration of banking and insurance also should bring some changes to the reinsurance landscape. Once again, though, the changes should offer opportunities for better service to public sector buyers, the panelists said.

That integration will result in "very interesting combinations" of reinsurers, insurers and brokers, said Edd Erickson, president-alternative markets at Signet Star Reinsurance Co. in Florham Park, N.J.

The anticipated lifting of existing federal prohibitions against bank, insurance and security dealer affiliations may well take such shapes as "a dream team of Berkshire Hathaway and Goldman Sachs,"

See **Market** *on page 6*

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Market

Continued from page 4

Mr. Erickson said.

But whatever shape such combinations might take, traditional reinsurers will still have a place, as long as the new laws are written fairly, said Mr. Bontempo. "We don't care who our competitors are and how they're built; we just want a level playing field," he said.

On other issues in the public entity reinsurance market, Mr. Erickson said he sees "a gigantic difference" in the degree to which various public entity insurance pools have addressed the Year 2000 computer issue, and he advised the risk managers attending the session that reinsurers do take note of such matters.

"I would impress upon you that your reinsurers are looking at your risk management efforts all the time," Mr. Erickson said.

"One issue I haven't heard anyone mention is mitigation," he added. "A policyholder has a duty to mitigate damages."

And for public entities that might seek coverage should they face Y2K-related losses or claims, Mr. Erickson said, "If you've got a lot of bad chips" but don't do anything about them, "I don't see where you'd have any coverage."

Mr. Erickson also acknowledged that a soft market for municipal liability coverage might prompt some public entities to consider leaving their pools for the traditional market. He offered two causes for caution, however.

The first is the prospect of "giving up all the hard work" that went into creating and developing the pool.

The second reason for caution is the potential attitude of regulators and legislators toward such moves, particularly if the market should later harden and a group of municipalities seeks to re-form a dissolved pool.

"If a pool goes out of business, then you're going to have to go back to your legislators and say, 'Please, can we do this again?' " Mr. Erickson said.

Violence

Continued from page 3

face violence or threats of violence on the job.

Despite a general drop in crime, there doesn't seem to be an accompanying decline in incidents of workplace violence, she said.

"Workplace violence costs American organizations billions of dollars every year," Ms. Speer said. That cost can result from lost productivity, employee turnover and medical and security costs.

"Part of the cost also comes from legal liability," she said. She noted courts are ruling that while employers don't have to guarantee workers' safety, they must take steps to prevent violence that is foreseeable and to control situations that come to light.

"Public entities, just like the private sector, are dealing with workplace violence in its many forms every day," she said.

Ms. Speer advised all employers to implement formal workplace violence prevention and identification programs.

Programs should include such elements as a written policy "prohibiting violence or threats of violence at any time" and an interdisciplinary team within the organization that is trained to receive and address reported threats of violence, she said.

The programs also should include: a reporting and response mechanism under which employees are required to report violations of the workplace violence policy and the interdisciplinary team is required to respond; employment practices, such as prehiring screenings; and effective management when situations do arise to identify and resolve potential threats. There also must be adequate training for managers and employees in dealing with workplace violence issues.

"I think criminal background checks on all employees typically aren't doable for most organizations," Ms. Speer said. But she suggested employers should undertake some kind of pre-employment checks consistent with what state laws allow.

"I think the trick is, once you have the information, what do you do with it,"

'Public entities, just like the private sector, are dealing with workplace violence in its many forms every day,' says Rebecca A. Speer.

she said, adding that it's not appropriate for most organizations to say, "We'll never hire anyone who has a criminal record."

In reporting and investigating incidents, Ms. Speer conceded that some comments made in the heat of the moment might sound like verbal threats but aren't serious. "People say things they don't mean," she said.

But a workplace violence policy should require that no matter what's intended, the team designated to deal with such issues should investigate and determine whether a threat exists.

"You take something that might be minor but treat it seriously, no matter what," she said.

On the schools front, despite recent "horrific" events, Richard Verdugo, coordinator of the Safe Schools Program of the National Education Assn. in Washington, told public risk managers that "by and large, schools are safe places."

"However, the NEA believes that even one incident is one too many," he said.

The group has taken a number of steps to deal with school safety. While the NEA believes the problem has its basis in society, Mr. Verdugo said, the organization realizes that "schools can be facilitators of the problem if they don't stop inappropriate behavior early and if they don't enforce rules fairly and consistently."

While 60% to 70% of schools now have some sort of crisis prevention plan, "the problem there is they'll say, 'Well, we don't practice it, and I kind of forget how it works,' " Mr. Verdugo said.

The NEA is working to address the issue of violence in schools through three areas: school management, curriculum and physical plant, Mr. Verdugo said.

Schools can incorporate programs on social skills and appropriate behavior into the curriculum, as well as such programs as peer mediation, conflict resolution and race relations, the NEA suggests.

In the area of the schools' physical plants, "there it has to do with the appearance of the school, getting rid of areas that block the sight of adults looking on," Mr. Verdugo said. "But the biggest idea here is that maybe big isn't better, smaller is better." In large schools, students can feel like "a cog in a machine."

The panelists noted that in the effort to reduce incidents of violence, it's important not to label workers, students or members of society as potential threats.

In the workplace, for example, "don't label the employee who acts out; just deal with the behavior," Ms. Speer said. BI

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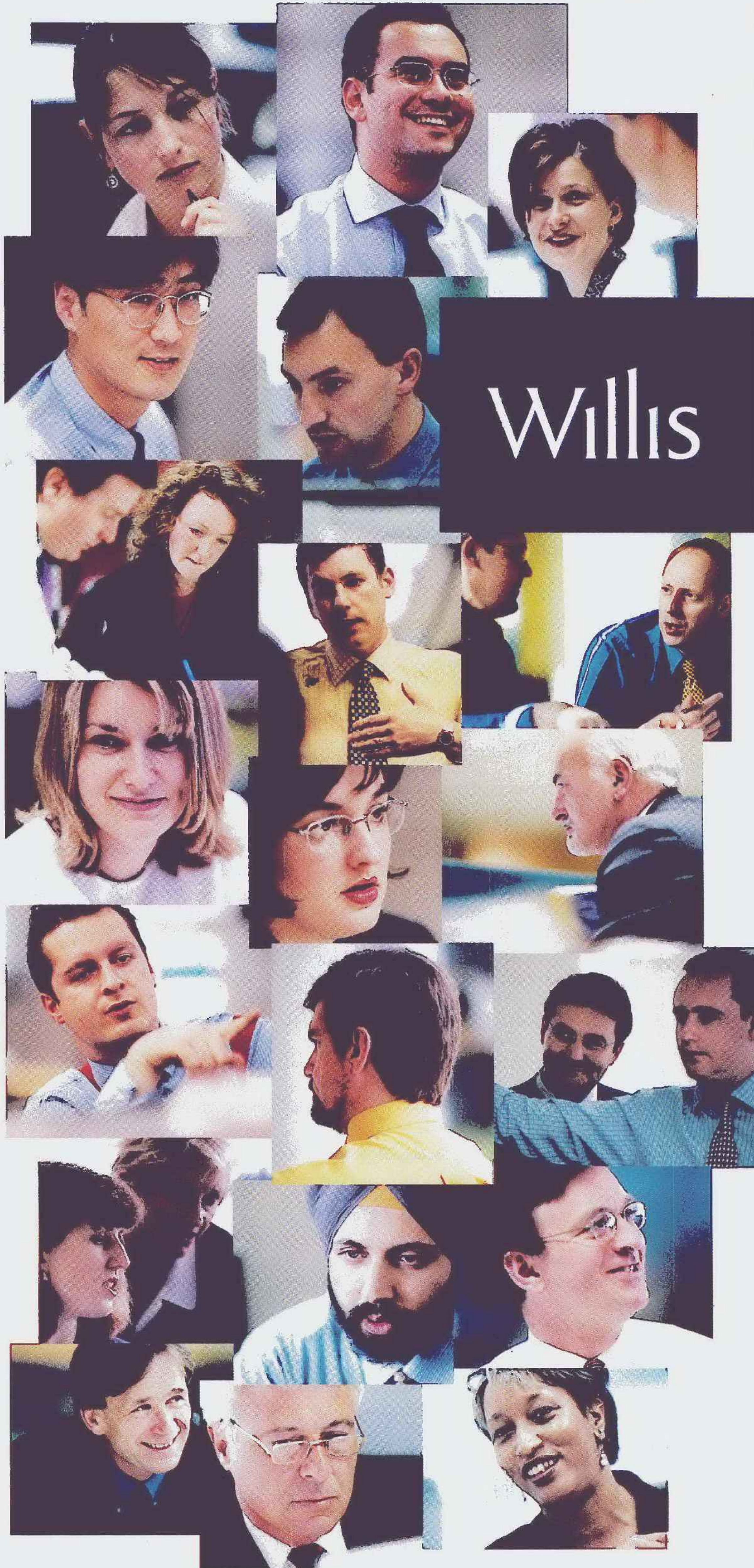

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Opinions

State actions largely sound

AS WE REVIEW this year's risk management- and employee benefits-related state legislative activity, we think the pluses, for the most part, outweigh the minuses.

On the plus side is tort reform. While state reform efforts have slowed compared to previous years, the measures enacted so far this year are striking given the states where those measures passed as well as the scope of the measures.

One state that enacted surprising and welcome tort reform is Alabama. The outlandish punitive damage awards Alabama juries have handed down in recent years—including a $580 million award earlier this year in a case involving a $1,200 overcharge—have tarnished the state's image in business circles.

But Alabama legislators—perhaps in response—enacted legislation that will cap punitive damage awards in non-injury cases against large businesses to three times the compensatory damages awarded or $500,000, whichever is greater.

In Florida, legislators passed a product liability measure that eliminates joint-and-several liability for defendants only slightly at fault and sets a reasonable time limit of 12 years after a product was manufactured for filing a suit.

But on a matter of special urgency—limiting liability for losses that arise from the Y2K computer problem—the record is mixed.

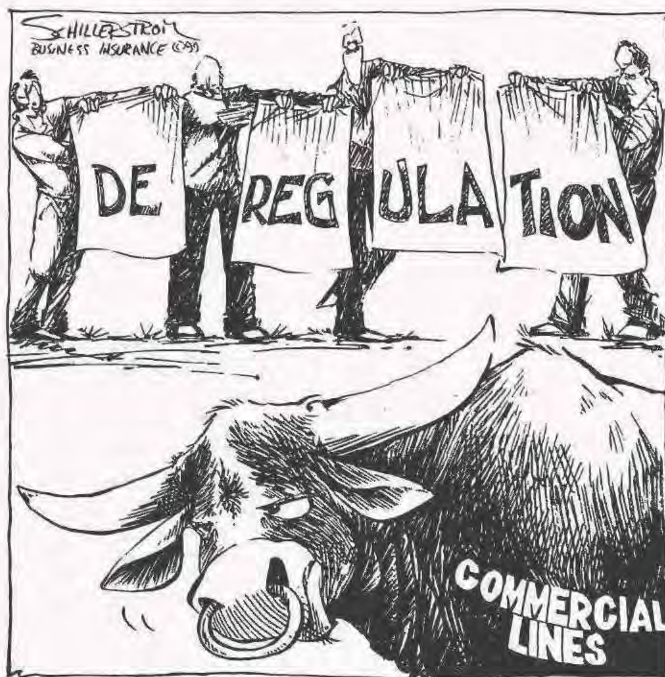
While some states, such as Texas, enacted relatively broad Y2K liability protections, others focused such relief, directing their efforts on narrow segments of the spectrum of likely defendants, notably public entities.

But in other states, such as Iowa and Maryland, even modest reforms were vetoed.

The state record on another risk management related-issue, commercial lines deregulation, also is encouraging.

Ten states this year passed legislation to give buyers more freedom to tailor forms individually and to negotiate rates with their insurers. In our view, commercial lines deregulation—done right—cuts overhead and leads to more competition. Large corporate buyers may, in fact, be more sophisticated than those regulating the specialized rates and forms those buyers need.

Our only concern is that the threshold some states have adopted for deregulating commercial lines may be too low. That could lead to unsophisticated buyers making mistakes and triggering a regulatory backlash.



On the employee benefits side, we are glad to see that legislators, for the most part, are rejecting extreme approaches to curb managed care plan abuses.

A hot issue just a couple years ago, state legislators by and large have rejected proposals to expand the liability of health care plans for coverage decisions.

Instead, states are passing bills allowing patients to bring coverage disputes to independent external review boards for their rulings. That strikes us a balanced approach that gives patients more rights against ever-more-powerful managed care plans without imposing new liabilities—and much higher costs—on the plans.

On the other hand, states are showing no letup in heaping new benefit mandates on commercial health insurers and HMOs. We've often said that these mandates have more to do with the clout of provider groups—which view mandates as a way to perform more services and increase their revenue stream—than good public health policy.

But many of this year's crop of mandates appear more modest, such as parity in coverage of severe biologically based mental illnesses, than in the past and with minimal price tags for buyers.

Letters

Embracing technology key to survival

To the editor: In response to May 31 letter to the editor, "Benefits of Captive Brokers Overstated," by Eric S. Tachau, I can only cite actual case statistics.

The CIA Direct program developed by Insurance Data Systems is averaging a 23.1% cost reduction. I respect Mr. Tachau's comments and his 50-plus years in the business. But Mr. Tachau must think young if he is going to survive in the 21st century. The power of automation, electronic commerce and the Internet is changing the world dramatically.

Ten years ago, no one would ever have thought that computer geeks such as Bill Gates and Michael Dell would become business icons. I couldn't carry their bags on my best day, but I can and will learn from every move they make.

My money is on the progressive insurance firms using electronic commerce and the Internet. Those who ignore it will soon be left far, far behind.

Richard Kerr
Chairman and Chief Executive Officer
Insurance Data Systems
Dallas

Remarks about Alabama defy logic

To the editor: This letter is in response to Lance Ewing's letter in the June 7 issue.

Mr. Ewing, in his letter, tries to link the high jury awards in Alabama to the state's educational system in a way that defies any definition of logic. Mr. Ewing assumes that high jury awards are indicative of uneducated citizens/jurors.

I seriously doubt that Mr. Ewing knows anything about any of the jurors that have been a part of any court proceeding in Alabama. If Mr. Ewing knew anything about civil law, he would know that these amounts are greatly reduced in subsequent legal proceedings. Companies such as Mercedes, 3M and now Honda know this, and they have located large manufacturing facilities in the state. That is a logical choice, given the business atmosphere in the state at this time.

It seems as if Mr. Ewing just engaged his mouth—or pen—before engaging his brain in his bashing of Alabama. Our state's reputation is not entirely undeserved, but that does not preclude the rest of the population from using logical thought when evaluating any kind of situation. It would be logical for Mr. Ewing, in the future, to use more rational thought before committing his thoughts to paper, or he could just close his mouth when he doesn't know what he is talking about.

Philip Petersen
Birmingham, Ala.

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Governments can help in tort reform

By RODD ZOLKOS

SAN DIEGO—Local governments can be key players in state tort reform coalitions, and they stand to gain by participating in those efforts, according to an Illinois tort reform advocate.

Speaking to the Public Risk Management Assn.'s annual conference earlier this month in San Diego, Edward D. Murnane, president of the Illinois Civil Justice League in Chicago, said that while major corporations often are at the heart of tort reform coalitions, local governments and non-profit entities also are key to the success of those coalitions.

"To us, the partnership, as important as it was to get the big corporations, the big organizations, it was just as important to get the local governments and the not-for-profits," Mr. Murnane said, detailing his coalition's ongoing effort to push for tort reform in Illinois.

"I will admit to you, we had financial support from some of the major corporations in Illinois," Mr. Murnane said. But while such companies as Deere & Co., Caterpillar Inc. and Ameritech Corp. were at the heart of the coalition, the local governments and non-profits provided the effort's "human face."

The participation of governments and non-profits also made it more difficult for tort reform opponents to argue that tort reform would benefit only big business, he said.

"If you can translate into tax dollars, that's going to cause legislators to pay more attention. That's going to cause the public to pay more attention," Mr. Murnane said.

While he says he's not advocating that local governments "sell out your interests" to the big manufacturers in their states, Mr. Murnane said he does think governments should look for ways to form coalitions with business to address common concerns.

"You have to protect your interests when you get involved in these coalitions," Mr. Murnane cautioned the public sector risk managers.

Such coalitions can be mutually beneficial, he said. Local governments can provide credible information that is difficult for tort reform opponents to challenge, and the large corporations can finance the effort.

The trial lawyers' lobby, he said, will continue lobbying against tort reform.

"There is an opponent out there who will do everything they possibly can to continue to go after local governments, to continue to go after manufacturers and the insurance companies," Mr. Murnane said.

"One thing that continues to make local governments so vulnerable is, yes, they have deep pockets, but they have the ability to make those pockets deeper by raising taxes," he said.

Mr. Murnane suggested that local representatives of the American Tort Reform Assn. could be key contacts for local government officials.

Examining his coalition's experience, Mr. Murnane said that, in 1995, Illinois enacted what was considered the most comprehensive tort reform legislation ever produced in the United States. Since then, seven states have passed laws patterned on Illinois' legislation, he said.

But, Mr. Murnane noted, 30 minutes after then-Gov. Jim Edgar signed the tort reform measure into law in 1995, the Illinois Trial Lawyers Assn. challenged it in court. In 1997, the Illinois Supreme Court ruled the measure unconstitutional.

"The problem that we have is we're still engaged in a battle, and there's really no end in sight," he said.

Tort reform advocates need to work with partners and form alliances, he said.

In Illinois, the four key objectives of the tort reform coalition that formed in 1993 were to build a strong, diverse coalition; to educate the public; to determine the shape of appropriate legislative solutions; and to create a friendly political climate to get that legislation passed and enacted.

"Don't be afraid to get mixed up in the political process," Mr. Murnane said.

"In Illinois, the tort reform battle has been sharply divided on partisan lines," Mr. Murnane said. That's not true in every state, he noted, "and it need not be true. In many states, it's been a bipartisan campaign or a nonpartisan campaign."

The Illinois coalition targeted a group of legislators opposed to tort reform and succeeded in defeating enough of them to create the favorable legislative climate the coalition sought.

Now, as the Illinois coalition works once again at achieving tort reform, it is taking a long look at creating a judicial climate more favorable to its cause.

Mr. Murnane noted that, next year, the positions of four of seven members of the Illinois Supreme Court are up for election to or retention in 10-year terms, and the Illinois coalition will be involved in the campaign. BI

Meeting draws 2,000

SAN DIEGO—The 20th Annual Conference of the Public Risk Management Assn. drew approximately 2,000 attendees to San Diego June 6-9.

The theme of this year's conference was "Creating the Perfect Climate." During the gathering, Daniel J. Pliszka, manager of the risk management division for Charlotte-Mecklenburg County and the Charlotte-Mecklenburg County (N.C.) School Board in Charlotte, N.C., was awarded PRIMA's 1999 Public Risk Manager of the Year Award.

Mr. Pliszka is the sixth recipient of the award, co-sponsored by Coregis Insurance Co.

Next year's PRIMA conference, titled "Community-wise Risk Management-Mapping the Road Ahead," is scheduled for June 4-7 in Charlotte.

For more information, contact PRIMA at 703-528-7701, or visit the organization's World Wide Web site at www.primacentral.org.

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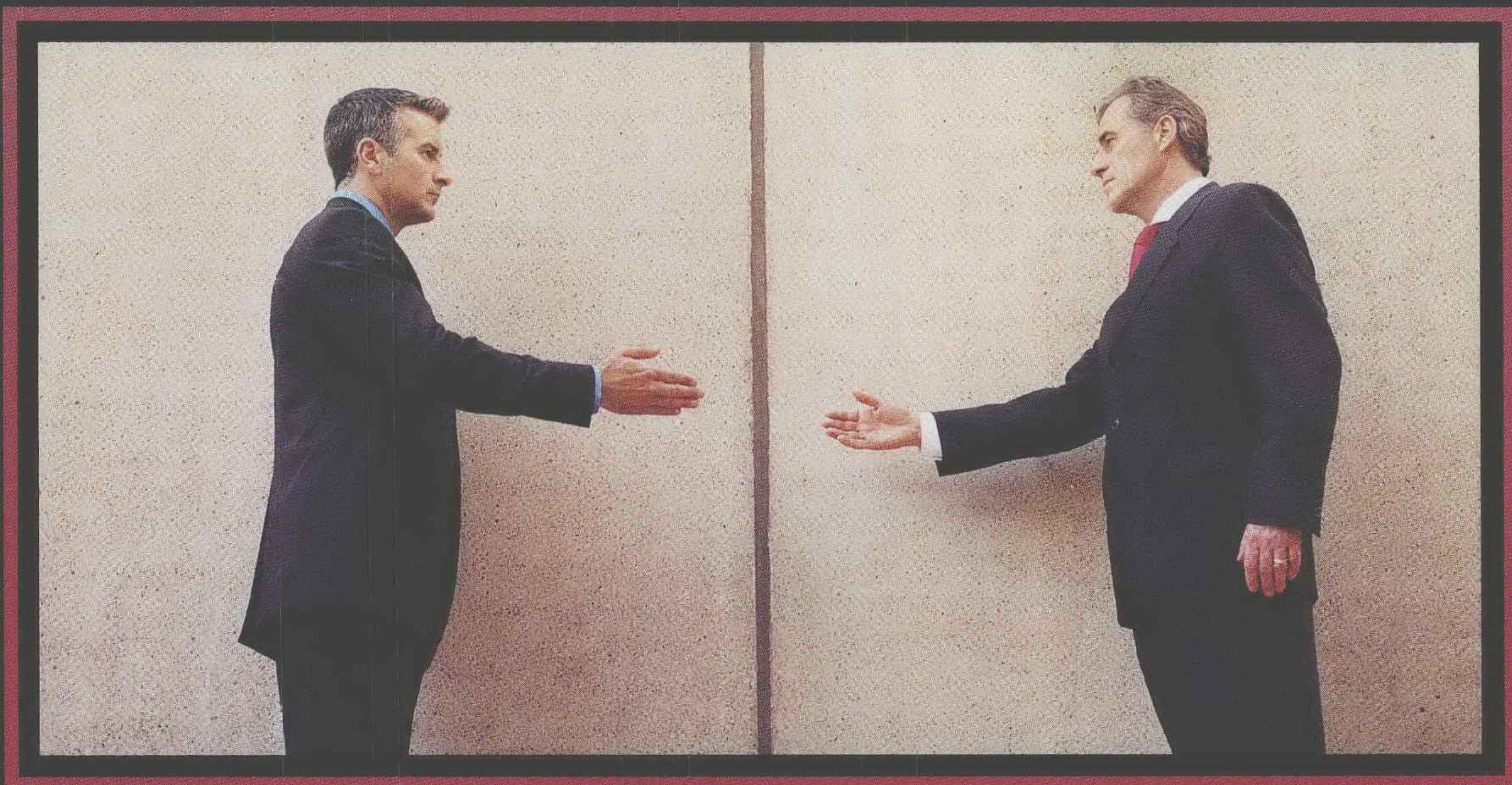

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1999 STATE LEGISLATIVE WRAP-UP

States taking steps on deregulation

By MEG FLETCHER

Large commercial insurance buyers are expected to see more competition and to have more options for protecting many of their property/casualty risks in the 10 states whose legislatures recently have approved laws that reduce regulation of rates and forms.

But legislators' eagerness to adopt low thresholds for exempting commercial buyers from market restrictions is raising concerns among risk managers that some states may have gone too far.

Legislatures that have approved general commercial deregulation laws during current legislative sessions are Arkansas, Colorado, Indiana, Kansas, Louisiana, Maine, Missouri, Oklahoma and Rhode Island. In addition, Virginia's deregulation law applies only to large-deductible workers compensation plans for large risks, though most deregulation laws often exclude that state-mandated coverage to ensure that workers are protected. Governors in most of those states have signed the deregulation laws, which are detailed below.

Large buyers and insurers are generally optimistic about the freedom these laws bring to tailor forms and negotiate rates without delays imposed by what many have long considered to be unnecessary oversight.

"The Risk & Insurance Management Society (Inc.) for a long time had pursued opening up of the market for large policyholders and buyers," said Lucille "Lucky" Gallagher, a risk management consultant with Lockton Group Inc. in Denver and a past president of RIMS. The foreign and alternative markets that commercial buyers go to are much less regulated than the U.S. market, said Ms. Gallagher, former vp-risk management at Greeley, Colo.-based Monfort Inc. and ConAgra Red Meat Cos.

"It is almost like that old adage: Be careful what you wish for—you might get it," said Lance Ewing, chair of RIMS' External Affairs Committee. Now, "we have to be overly cautious about small companies without good risk management expertise having the same broad freedoms as larger companies" in some states, added Mr. Ewing, director of insurance and loss prevention for GES Exposition Services in Las Vegas.

No matter how large commercial risks are defined, though, "commercial lines deregulation will mean more options and choices for buyers," said Joseph DiGiovanni Jr., senior vp-state affairs for the American Insurance Assn. in Washington. The AIA pushed commercial lines deregulation as its major state legislative issue this year and tracked it extensively.

Paul Blume Jr., vp-Midwest Region for the AIA in Skokie, Ill., said, "We are just trying to change the process and make insurance products—like defense costs within limits—more available and bring them to market more efficiently."

U.S.-based insurers and regulators hope such changes will encourage buyers to use regulated domestic insurers rather than offshore companies or alternative markets.

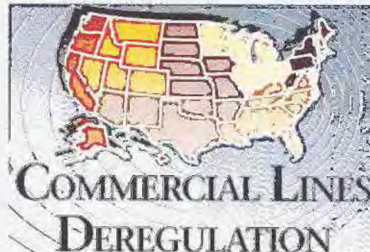
In the process, many state legislators have adopted widely varying criteria defining which kinds of companies can enjoy the new easing of rate and form regulation.

Most states use six threshold criteria a risk must meet, at least in part, to be considered an exempt commercial policyholder. In Pennsylvania, for example, one criterion in a 1998 law exempts companies that generate as little as $25,000 in annual property/casualty premiums, excluding workers comp.

"That is way too liberal," Ms. Gallagher said.

Risk managers generally prefer defining an "exempt commercial policyholder" as the National Assn. of Insurance Commissioners did in a white paper it adopted last September, Ms. Gallagher and Mr. Ewing said.

The white paper defines an exempt policyholder as meeting two of these criteria: net worth of more than $5[illegible] million; net revenues/sales of more than $100 million; more than 500 employees per individual company or 1,000 per holding company; procures insurance through the use of a risk manager who is either employed or retained; aggregate premiums of more than $500,000; is a non-profit or public entity with an annual budget or assets of at least $45 million; or is a municipality with a population of more



than 50,000.

The white paper recommendations, though, are contained only as a drafting note in the latest version of a uniform rate and form law that is being crafted by the NAIC's Commercial Lines Re-Engineering Working Group. The note is addressed to legislators who want to provide more-explicit criteria, rather than delegating that to the insurance commissioner.

"The working group is taking a very conservative approach," said Larry Kibbee, vp and director of public affairs for the Alliance of American Insurers in Downers Grove, Ill. For example, the group's default on both commercial and personal lines forms is prior approval, while its default on both types of rates is file and use.

Many states already have relaxed their regulations even further for commercial lines, according to AIA statistics that the NAIC compiled at the beginning of this year. Rate-approval laws varied, with 23 jurisdictions having file and use; 13 with prior approval; six, use and file; five, flex rating; and four, no filing requirements. Form-approval laws also varied, with 38 jurisdictions having prior approval; six, file and use; four, no filing; and three, use and file.

In addition, Rhode Island and New Hampshire are two of a few states whose deregulation measures were

Continued on next page

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1999 STATE LEGISLATIVE WRAP-UP

Continued from previous page
similar to the NAIC's proposals.

Ms. Gallagher and some state regulators historically have been concerned that low eligibility thresholds for exemptions will give too much freedom to unsophisticated buyers. The fear is some buyers will err in assessing their coverage needs or in dealing with advisers who may be motivated more by self-interest than getting the best deal for the buyer.

Such negative scenarios eventually may cause companies—and third-party claimants suing them—financial hardships. It also could hurt all participants in the market generally and prompt a regulatory backlash in the future, Ms. Gallagher warned.

At the very least, such problems may result in increased litigation, said Mr. Ewing. He was not sure about backlash.

Buyers need to be concerned about the qualifications and affiliations of advisers, too, the risk manager representatives said.

There is "a severe disparity" if a law exempting a commercial insurance buyer equates the quality of advice from a risk manager with 15 years of experience to that of a recent college graduate with a new insurance agent's license, Mr. Ewing said.

A commercial insurance buyer also should require full disclosure of all advisers' commission arrangements, Ms. Gallagher said.

Meanwhile, RIMS is monitoring deregulation activity, Mr. Ewing said.

Following is a roundup of activity on commercial lines deregulation, compiled by *Business Insurance* staff:

Maine enacted legislation that lifts rate and form regulation for large commercial policyholders that meet an annual premium threshold, employ a full-time risk manager and meet one of five other criteria: net worth of at least $10 million; net sales or revenue of $5 million; more than 25 employees, or more than 50 for a holding company group; annual budget or assets of $25 million for a non-profit or public entity; or population of at least 20,000 for a municipality.

Annual premium thresholds will be phased in over four years. In the first year after enactment, premiums excluding workers comp and medical malpractice must total $90,000, with the figure dropping to $75,000 in the second year, $60,000 in the third year and $50,000 in the fourth year. The law takes effect Jan. 1, 2000.

Rhode Island Gov. Lincoln Almond is expected to sign a bill that would exempt large commercial policyholders from rate and form filing requirements if they meet two of five criteria: net worth of $50 million; net revenue/sales of $100 million; 500 employees at each company or 1,000 employees under a holding company; use a risk manager; and have annual aggregate premiums of $150,000 excluding workers comp, group life, group health and professional liability.

New Hampshire and **Pennsylvania** enacted deregulation laws in 1998.

A bill awaiting **Louisiana** Gov. Mike Foster's signature last week would exempt large commercial risks from form filing requirements. The bill calls for the insurance commissioner to set the premium threshold for exemption from filing regulations.

Virginia enacted a law deregulating large-deductible workers comp plans.

Indiana Gov. Frank O'Bannon signed a law exempting commercial policyholders from rate and form regulation. To be exempt, policyholders must use an agent or broker and meet three of these criteria: at least 25 employees; annual premiums of at least $75,000, excluding professional liability insurance and workers comp; revenues of $50 million for the prior fiscal year or $25 million at the time insurance is written; or employ a risk manager. In addition, public entities and non-profits must have a budget of at least $25 million and have coverage from an insurer rated A or higher.

Kansas Gov. Bill Graves signed a measure that streamlines rate filing for commercial and personal lines. The law includes an exemption from rate filing requirements, excluding medical malpractice and workers comp insurance, for large commercial risks. Policyholders would have to meet at least one of these criteria: total insured property values of at least $5 million; total annual gross revenues of $10 million; total paid property premium of $50,000 or more; total paid general liability premium of $50,000 or more; or total paid multiple lines premium of at least $100,000.

Missouri Gov. Mel Carnahan is expected to sign a bill that gives a large commercial risk two ways to qualify for the deregulated market.

First, a buyer can self-certify it is a large commercial risk and uses an "independent insurance adviser," who must be qualified through education, training or experience and may not be an employee of participating insurers.

Second, a buyer without such an adviser must self-certify and meet two of these six criteria to qualify: 100 or more employees; net worth of more than $25 million; net revenue/sales of more than $50 million; aggregate annual premium of more than $50,000, excluding workers comp and employers liability insurance; for a public entity or non-profit, assets of at least $25 million; for a municipality, at least 50,000 residents.

An **Arkansas** law that took effect June 12 exempts from rate and form filing large commercial property/casualty risks, or those with a total premium of $250,000 or more, at least 25 employees and a full-time risk manager with insurance certification.

Oklahoma Gov. Frank Keating signed a measure that will exempt insurers from rate-filing requirements for commercial risks with a cumulative premium of $10,000 or more. The law does not apply to workers comp risks. For commercial risks with a cumulative premium of less than $10,000, insurers now are subject to a file-and-use rating system. Insurers had been subject to a prior-approval system for all commercial risks.

Arizona enacted a rate and form deregulation measure for large commercial risks in 1998.

Colorado enacted legislation that deregulates rate and form filing for commercial policyholders that have a risk manager and meet premium and employee thresholds set by the insurance commissioner.

No commercial lines deregulation measures have been passed so far in **Alabama**, **Alaska**, **California**, **Connecticut**, **Delaware**, the **District of Columbia**, **Florida**, **Georgia**, **Hawaii**, **Idaho**, **Illinois**, **Iowa**, **Maryland**, **Massachusetts**, **Michigan**, **Minnesota**, **Mississippi**, **Montana**, **Nebraska**, **Nevada**, **New Jersey**, **New Mexico**, **New York**, **North Carolina**, **North Dakota**, **Ohio**, **Oregon**, **South Carolina**, **South Dakota**, **Tennessee**, **Texas**, **Vermont**, **Washington**, **West Virginia**, **Wisconsin** or **Wyoming**.

Kentucky lawmakers were not in session. BI

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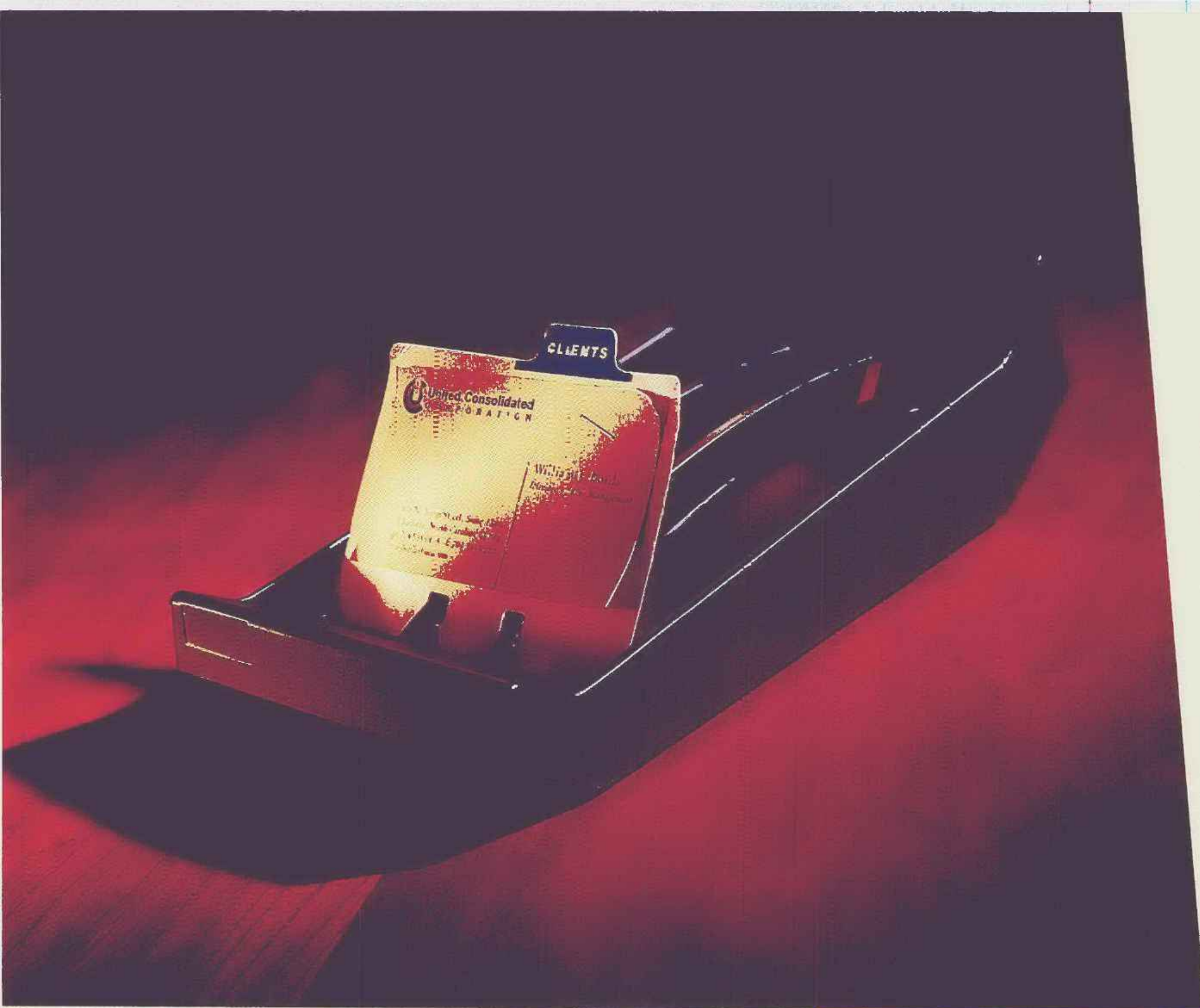

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PROMISES KEPT

1999 STATE LEGISLATIVE WRAP-UP

Work comp action targeted, not broad

Unlike the broader reform efforts of the past, legislative changes in state workers compensation laws enacted or discussed this year center on some small themes in specific states.

For example, benefit increases are one issue over which labor and business are wrangling in California. A pending bill in that state would raise benefits by more than $1 billion.

"It is open season on employers as organized labor and the trial bar step up activity to increase benefits," said Eric J. Oxfeld, president of UWC Inc., a Washington-based business advisory and research organization.

The AFL-CIO, however, sees the California benefits increase as necessary and fair, especially because a study documented inadequacies in some benefits, said Jim Ellenberger, assistant director for the labor federation's Department of Occupational Safety and Health in Washington.

Both sides view the bill as a major test for California's new Democratic governor, Gray Davis. He ran as a moderate who pledged not to upset the business community, Mr. Oxfeld said.

Gov. Davis also received strong support from labor, however, and the AFL-CIO hopes he will remember workers' interests, Mr. Ellenberger said.

Labor representatives also are concerned about a new Colorado law that caps benefits for workers with mental conditions that cause physical ailments at 12 weeks unless the injury caused brain damage, he said.

Business-backed groups, meanwhile, continue to make progress in their efforts to eliminate second-injury funds, as the South Dakota Legislature voted this year to abolish its fund.

The funds, created to encourage the hiring of disabled workers, were intended to help compensate employees who suffer a subsequent injury that increases an existing disability.

Employers and insurers, however, contend the federal Americans with Disabilities Act eliminates much of the need for the funds. In addition, they allege that some funds are poorly administered and face significant unfunded liabilities, which insurers and self-insured employers must pay through assessments.

Labor opposes such changes and efforts to eliminate coverage for injuries and illnesses that stem from pre-existing conditions. Such changes shift the risk "back onto the backs of injured workers," Mr. Ellenberger said.

Several state legislatures also considered bills that would undo previous pro-employer and insurer changes that reduced benefit durations or eligibility, though none has been enacted yet.

"There has been a fair amount of churning, but not to adverse result," said Bruce Wood, assistant general counsel with the American Insurance Assn. in Washington.

"I'm surprised, given labor's unhappiness," as well as support from academicians who have pointed out benefit inequities, said Nancy Schroeder, director of workers compensation for the National Assn. of Independent Insurers in Des Plaines, Ill.

"It seems to be pretty quiet compared with the recent past, because most states have already done" what Mr. Ellenberger calls "deform legislation." In his view, such changes "are in danger of damaging public support for this system," he said.

Arizona, Oklahoma, Oregon and Utah are among the states studying how best to incorporate multiple rating and statistical organizations into their workers comp systems, said Ms. Schroeder. The National Assn. of Insurance Commissioners also is studying that issue.

The impact of having multiple entities is unclear, because it "has the potential of decreasing costs and the potential of increasing costs," UWC's Mr. Oxfeld said.

Recent legislative proposals to protect patient privacy in states such as Connecticut, Kansas and Massachusetts have swept in workers comp claimants along with recipients of general health care, said the AIA's Mr. Wood. However, a new Illinois law expressly eliminates workers comp claimants.

The main focus of privacy legislation is federal, however, Mr. Wood said.

Business and labor interests strongly disagree about extending privacy protections to workers injured on the job.

Business interests emphasize that it would be cumbersome and costly because of the collaborative nature of workers comp medical care and claims handling. Labor supports broad privacy protections for workers injured on the job because they now are often required to sign broad releases that allow access to non-relevant medical history.

Workers comp insurers' deteriorating results may spawn requests for higher premiums and more legislative relief.

The workers comp system generally is facing rising medical costs as well as a drop in the number of claims, Ms. Schroeder said.

Here is a roundup of workers comp legislative activity around the states, based on reports by *Business Insurance* staff and coordinated by Senior Editor Meg Fletcher:

Connecticut has enacted no major workers comp changes, but the state treasurer has projected a potential $17 million shortfall in the state's second-injury fund by 2005 and is expected to raise assessment rates next year. Assessments for the fund will remain at 10% of work comp premiums for insured employers and 14.5% for self-insured employers until the end of the June 30, 2000, fiscal year, but they will likely rise after that, Treasurer Denise L. Nappier has announced.

The **Maine** Legislature has passed three measures that erode previous workers comp reforms, including bills that provide cost-of-living adjustments for benefits; increase the maximum benefit to 100% from 90% of the state's average weekly wage; and provide amputees lump-sum payments in addition to normal workers comp indemnity payments. Maine Gov. Angus King last week vetoed the first two measures but did sign the bill extending benefits for amputees. The Legislature had until last Friday to try to override the vetoes.

In **Massachusetts**, a workers comp competitive rating bill is heading into committee. The measure would replace the current system, in which the state insurance division determines the rate for all insurers. The bill provides for prices to be based on the loss-cost filings of all insurers in the state. The loss-cost filings would be used to determine advisory rates, and the rates of individual companies would be adjusted based on their own loss experience and expenses.

No major workers compensation legislation passed in **New Hampshire**, **Rhode Island** or **Vermont**.

Legislation pending in **Delaware** would require workers comp insurers to presume medical bills for claims are valid. The measure would require insurers to have a medical specialist refute disputed claims.

The **District of Columbia**'s City Council approved a reform bill—which Congress approved in April—that, among other things, eliminated the District's second-injury fund and capped the duration of certain benefits. In addition, it requires insurers to cut premiums by 5% for policyholders deemed by the District's department of employment services to have a safe workplace program.

Maryland enacted legislation extending the 6.5% second-injury fund assessment against workers comp insurers and self-funded employers to June 30, 2003, from June 30, 1999.

West Virginia Gov. Cecil Underwood signed legislation reducing to 40% from 50% the disability threshold injured employees must meet to qualify for permanent total disability benefits.

No major workers comp bills were passed in **New Jersey**, **New York** or **Pennsylvania**.

Georgia Gov. Roy Barnes signed a measure that, among other things, allows cross-appeals to the appellate division of the State Board of Workers Compensation within 30 days of the notice of an award by an administrative law judge. The measure also authorizes the board to review the status of a self-insured employer after that employer has been involved in a merger or acquisition.

In **Louisiana**, at least one bill had passed as of June 14 in a series of bills that would privatize the Louisiana Workers Compensation Corp., which was created in 1992 as a competitive state workers comp insurer.

If all the bills are passed and signed, the LWCC would participate in the state's guaranty fund as a private insurer. Two of the proposed bills are constitutional amendments that would require approval by voters in the fall.

In early June, **North Carolina** Gov. James B. Hunt Jr. signed a measure that removes provisions in a 1997 law that required the state Industrial Commission to adopt new rules governing communication between employers paying workers comp benefits and physicians treating injured workers. Risk managers and insurers charged that the rules, which were never implemented, would have been unjustifiably burdensome and could have invited workers comp fraud.

A bill that **Tennessee** Gov. Don Sundquist signed requires that workers comp disputes be filed in the county where the injured worker lives or in the county where the "alleged accident occurred." In cases in which the worker lives out of state, the proceedings can be held in any county where the employer maintains an office.

The **Virginia** General Assembly approved and Gov. James Gilmore signed a bill that deregulates large-deductible workers comp plans. The measure defines "large risks" as those that generate annual premiums of at least $250,000.

Several smaller bills also were signed into law. One allows employers or insurers to include chiropractors on workers comp physician panels, provided that the employee injuries fall under the scope of chiropractic care. Another measure allows the Virginia Workers Compensation Commission to waive the penalty for failure to pay benefits within two weeks under some circumstances. Yet another measure requires all "health care providers" treating injured workers to provide employers and insurers with those claimants' medical records. The use of the term "health care providers" clarifies that not only physicians are covered by the requirement.

No significant workers comp legislation passed in **Alabama**, **Florida**, **Mississippi** or **South Carolina**. **Kentucky** lawmakers were not in session.

Illinois lawmakers passed a measure clarifying that the corporate officers of any domestic or foreign corporation may choose not to be covered by the state Workers Compensation Act. The law also clarifies when members of a limited-liability corporation may elect not to participate in the workers comp system.

Legislation enacted in **Indiana** will increase the permitted assessment for a state-established second-injury fund by half a percentage point to a maximum of 1.5% per assessment for self-insurers and insured employers. Assessments will be made only when the fund falls below $1 million, up from $500,000 previously. Due to changes in financial accounting standards, employer assessments—previously based on paid losses—now will be made from a premium surcharge that has not yet been determined.

A new **Minnesota** law requires courts to approve qualified assignment agreements in structured settlement arrangements before long-term settlements can be sold to factoring companies. The law takes effect Aug. 1.

No major workers comp legislation has been enacted so far in **Ohio**, **Wisconsin** or **Michigan**, whose Legislature meets year-round.

Nebraska Gov. Mike Johanns approved a measure giving the state's Workers Compensation Court authority to rule on allegations of unfair claims practices involving insurers and self-insurers. The Insurance Department would enforce any penalties involving insurers.

In **North Dakota**, a new law allows the state's Workers Compensation Bureau to cover employees of North Dakota companies when they are working outside the state. The measure, which took effect upon Gov. Edward T. Schafer's signature March 17, also directs the bureau to create work safety and loss prevention programs and allows the state's exclusive fund to create a retrospective rating program.

In **South Dakota**, Gov. William Janklow signed a measure that contains two key recommendations called for late last year by the governor's task force on workers comp.

One provision prohibits compensation for "mental/mental" injuries. For example, a claim for depression brought on by stress in the workplace would not be compensable. To be compensable, the claim for depression would have to result from a physical injury.

The provision codifies recent case law that eliminated the potential for mental/mental claims.

Another provision is designed to encourage injured workers to return to work. Previously, an injured worker could return to work only for his or her employer. Now, an employee can accept from a new employer either a job similar to the one he or she held before being injured, or a different job that is better suited for his or her limited capabilities. The worker's pay would have to at least equal what the worker would receive in workers comp benefits.

The law also will:

• Require employers to file with the state Department of Labor first reports of injuries within seven days instead of 10.

• Set a seven-year limit on applying for workers comp benefits. If a worker does not require medical treatment for seven years after an injury, compensation is barred forever.

The National Council on Compensation Insurance estimates the new law in its first year will save 1% of total workers comp costs. The law takes effect July 1.

Another new law eliminates the state's subsequent injury fund for claims filed after July 1, the date the law takes effect. The fund was designed to encourage employers to hire workers with disabilities. It spreads among the entire workers comp market the cost of any subsequent injuries that those workers suffer, rather than requiring the worker's employer and workers comp insurer to bear the full cost. State lawmakers reasoned that the Americans with Disabilities Act makes the fund unnecessary.

No significant workers comp legislation was passed in **Iowa**, **Kansas** or **Missouri**.

See **Work comp** *on next page*

1999 STATE LEGISLATIVE WRAP-UP

WORKERS COMP

Work comp

Continued from previous page

Arizona Gov. Jane Hull has signed a measure that will increase several workers comp benefits.

It will boost the state's maximum monthly wage replacement benefit to $2,400 from $2,100.

The burial expense benefit will increase to $5,000 from $3,000.

The death benefit for a surviving spouse without children will jump to 66.67% from 35% of the deceased worker's average monthly wage. If there are surviving children, then the spouse would receive 35% and the children would equally split 31.67% until they reach either age 18 or, if they are in college, age 21. After the children's eligibility ends, a spouse who has not remarried would receive the children's benefit. Upon remarriage, the spouse would receive a final lump-sum benefit equal to two years' worth of benefits.

Also under the law, employers with established drug- and alcohol-testing programs now may require blood tests of injured or deceased workers within 24 hours of being notified of a workplace accident. Losses would not be compensable if a worker or the worker's family refuses the tests.

Defenses for positive test results include that the worker's use of the substance did not contribute to the accident, that the substances were present in nominal levels, and that the employer knew of and condoned the worker's use of the substances.

The law takes effect Aug. 5.

Arkansas Gov. Mike Huckabee signed three workers comp bills during the state's most recent legislative session.

One law revises procedures for the selection and changing of physicians under the workers comp laws. The law allows employees covered by a managed care plan to select a new physician under workers comp provisions. This physician must be associated with a managed care plan certified by the Workers Compensation Commission or have maintained a regular relationship with the employee and regularly maintains the employee's medical records.

Another law requires permanent total disability benefits to be paid during the period of such disability until the employee reaches age 65. Injuries occurring after the employee reaches age 60 will be paid for a period of 260 weeks.

A third law provides for the termination of workers and denial of workers comp benefits for violations of drug-free-workplace policies. The law requires employers to notify employees of such policies and the penalties for violations.

In **New Mexico**, Gov. Gary Johnson signed a measure amending the state's workers compensation insurance law. The measure, which was unanimously approved by the Legislature, set the minimum benefit for total disability at 100% of the average weekly wage, effective Dec. 31.

Among the measure's other provisions, which take effect July 6, is an increase in funeral expenses for workers killed on the job to $7,500 from $3,000. The amendments were agreed to by business and labor, said J.D. Bollington, vp at the Assn. of Commerce & Industry of New Mexico in Albuquerque, N.M.

Shortly before adjourning on May 28, the **Oklahoma** Legislature passed a workers comp reform bill that the NCCI said does not address the state workers comp system's main cost drivers. The governor signed the measure.

Under the law, the estimated $30 million deficit in the state's second-injury fund, the Special Indemnity Fund, would be financed through a mandated dividend of half of the surplus of the competitive state fund. State public entities' share of that dividend would be used to finance the deficit in the Special Indemnity Fund, which would be renamed the Multiple Injury Trust Fund.

The deficit-financing provision becomes effective in February 2000, but it could face legal challenges because of decades-old case law on dividend distributions, said Peter Strauss, Western region state relations director for the NCCI.

The new law also will alter how the MITF would handle permanent partial disability claims. The law will terminate benefits for material increases in disability caused by a second injury. Take, for example, a claimant who had returned to work after suffering a 5% disability to his arm and then suffered a second arm injury. If that second injury by itself resulted in another 5% disability but together the two injuries created a 50% disability, the claimant's benefits would be based on only a 10% disability.

But while altering PPD claims handling in that manner was the Legislature's intent, the American Insurance Assn. is concerned about whether the language of the measure accomplishes that goal.

The law also will eliminate the current provision that requires public entities to purchase their workers comp coverage from the competitive state fund.

Those portions of the law become effective Nov. 1.

The assessment on paid losses that insurers and claimants pay to fund the MITF was cut, effective immediately, to 4% from 5%.

Mr. Strauss said the law does not address the system's main cost drivers. For example, the system allows too many permanent partial disability claims, he said. The number of PPD claims in Oklahoma is more than 230% higher than the average for the states in Oklahoma's region, he said. In addition, the system allows some claimants—particularly those with soft-tissue injuries—to continue to collect disability benefits even if they have returned to work at full pay and have not suffered significant lifestyle changes, Mr. Strauss said.

If Gov. George Bush signs a bill ordering the payments, **Texas** employers will receive a portion of the Texas Workers' Compensation Insurance Fund's $400 million surplus via refunds of a maintenance tax surcharge.

Insurers and self-insurers that paid the surcharge for the years 1991 through 1996 will receive the refunds. Under the law, insurers would be required to use a formula to determine how much of the tax they charged to their individual policyholders and to refund those amounts.

Insurers would be required to make the refunds by Sept. 1, 2000.

Surplus funds also would be used to pay for studies conducted jointly by the fund and the Research and Oversight Council on Workers' Compensation. The studies would consider ways to improve worker safety and facilitate return-to-work programs, examine the quality and cost-effectiveness of the health care delivery system in workers comp, and look at health care providers' treatment patterns and insurers' utilization review practices in workers comp cases.

The bill also requires the fund to become a member of the Texas Property & Casualty Insurance Guaranty Assn. As such, it would be subject to

WORKERS COMP

Colorado lawmakers passed several workers comp bills during its most recent session. All have been signed by Gov. Bill Owens.

One law sets out the procedural requirements for the selection of an independent medical examiner in cases of disputes under the Workers Compensation Act of Colorado. The law takes effect Sept. 1.

Another amends state statutes to say that when injury or occupational disease causes disability, a disability indemnity shall be payable as wages except in cases where it is determined that a temporarily disabled employee is responsible for termination of employment. In that case, the resulting wage loss shall not be attributable to the on-the-job injury. The law takes effect July 1.

Another law re-establishes an exclusive schedule for permanent partial disability under the workers compensation law and increases permanent partial disability benefits to $176 per week from $150. The law also says mental stress benefits must arise out of the course of normal employment. This law takes effect July 1.

Colorado also will enact a law that reduces workers compensation benefits by 50% in cases where a claimant makes a materially deceptive statement that willfully misleads an employer as part of the job application process concerning the physical ability of the claimant to perform the requirements of the job. The law takes effect Sept. 1.

Another law reduces non-medical benefits otherwise payable to an injured worker by 50% where injury results from the presence in the worker's system, during working hours, of controlled substances that were not medically prescribed. This law takes effect July 1.

In **Idaho**, the legislature approved a measure that changes the current system, under which an employer must pay in advance a portion of the worker's attorneys fees in litigation involving a third party. The sum has been based on an estimate of future recovery, but under this legislation, employers will pay when the recovery actually is received.

Another measure allows an employer, in essence, to buy back up to the first $1,000 of an employee's medical claim by repaying the money to the workers comp insurer, in order to avoid the claim having a negative impact on the employer's experience rating.

A third measure offers an insurer the option of giving a discount to an employer if the policyholder operates and maintains a drug- and alcohol-testing program that is in compliance with state law. All three bills take effect July 1.

In **Montana**, employers will have to provide employees written notice that workers injured on the job can choose their own initial treating physician even if a preferred provider organization is in place. The law takes effect Oct. 1.

Also in Montana:

- Disability benefits paid to individuals with silicosis, a chronic lung disease, will be increased $25 per month. The law takes effect July 1.
- Licensed occupational therapists now can provide functional capacity evaluations in workers compensation claims filed in Montana. The law took effect March 30.
- The assessment on workers compensation insurers for the workers compensation fund has been increased to 3.5%. Different provisions of the bill have three effective dates: April 20, 1999; July 1, 1999; and July 1, 2000.
- A resolution passed requiring a study of the level of workers compensation benefits paid for permanent total, permanent partial and temporary total disabilities as well as the frequency of those types of claims.

In **Nevada**, which until now has had a monopolistic state fund, legislators followed through on a legislative package passed in 1995 that permits private insurers to write workers comp coverage in the state beginning in July.

Legislation approved at this year's session provides for the privatization of the state fund under certain conditions, including provision for sufficient reinsurance and the establishment of a domestic mutual insurance company.

The legislation also restores to injured workers some benefits reduced several years ago when the state fund was in financial crisis, said Vance A. Hughey, senior research analyst with the state of Nevada Legislative Counsel Bureau's research division.

"Now that the system appears to be on its way back, the legislature felt it was appropriate to restore some of those benefits," said Mr. Hughey.

The third major part of the legislation creates a cabinet-level office of Consumer Health Assistance within the Governor's office. The new office will provide ombudsman services for workers comp as well as other insurance issues. Many of the bill's sections are effective July 1, though some, including revised provisions governing compensation for permanent total disability, are effective Jan. 1, 2000.

Other legislation authorizes workers comp insurers to provide coverage for consolidated insurance programs on construction projects. Most of the measure's provisions take effect Oct. 1.

Among its provisions, the law requires a wrap-up coverage program as well as a safety program for employees. The program can be established and administered by the principal contractor or by the construction project's owner.

Another measure creates a seven-member appeals panel for workers comp insurance that will hear grievances from employers regarding their experience modification factor, risk classification and application of supplementary rate information.

Mr. Hughey explained that with privatization, as many companies move from the state fund classification system to the National Council of Compensation Insurance classification system, many employers are likely to be put into different classifications; that could affect their rates. This panel will handle their complaints.

Effective Oct. 1, another measure increases the penalties for employers who fail to obtain or maintain workers compensation insurance.

Also signed by Gov. Kenny Guinn were several workplace bills in reaction to an accident at an explosives manufacturing plant last year that resulted in the deaths of four employees.

In **Utah**, the legislature approved legislation that says an employee will not receive workers comp coverage if he or she at the time of the injury tests positive for intoxication, use of illegal drugs or use of more than the prescribed amount of prescription drugs, though the employee's medical bills still will be paid. This bill shifts to the employee the burden of proof as to whether alcohol or drugs caused the accident, said Utah Director of Industrial Accidents Joyce Sewell.

Also approved by the legislature was a measure that set a time line for applying for disability benefits of 12 years after the injury, provided the application for hearing is filed within six years.

Both bills have gone into effect.

Also approved in Utah was a measure providing for workers comp coverage for volunteers at the Winter Olympic Games of 2002 in Salt Lake City.

The **Wyoming** Legislature has eliminated the transfer of workers compensation and unemployment insurance account liabilities to the new owners of a business after it has been sold. The state also lowered premiums and rates for industrial classifications with 12 or fewer employees in which a single employer pays more than 50% of the total premium in that classification.

Volunteer firefighters and volunteers who assist law enforcement agencies will be covered under workers compensation in Wyoming beginning July 1.

Also, nurse practitioners are now permitted to serve as providers in the Wyoming workers comp system.

WORKERS COMP

California state senators and assemblymen amended the rules to permit a workers compensation benefits increase bill to stay alive past the June 4 deadline for passing bills out of their respective houses. The bill would increase workers compensation benefits paid by $3.1 billion over two years. Total work comp costs in California paid by both insured and self-insured employers are currently estimated at $9 billion annually.

The exclusive remedy may be eroded somewhat if both legislative houses approve a bill that would enable a worker to sue his or her employer for willful negligence if the worker's injuries were caused by the employer's failure to remove a "known hazard." Two employer groups, Californians for Compensation Reform and the California Self Insurers Assn., oppose the bill because, they say, it too broadly defines the type of injury that could result in such suits. It also does not fully define "known hazard," they say. An employer in California already is subject to criminal liability if an employee dies as a result of the employer's criminal misconduct.

Another California bill would increase the fines and penalties for employers that don't buy workers comp insurance.

Oregon legislators introduced several workers comp bills, including one that increases permanent partial disability benefits by 9.6%, resulting in a projected total increase of nearly $10 million annually. Gov. John

Continued on next page

Insurer Topics

A special editorial section sent exclusively to insurers and reinsurers

Inside:

'E-business' environment becomes a necessity as customers gain confidence in using the Web
page 16B

Cedents and reinsurers can avoid potential disputes through closer communications
page 16F

Regulatory initiative will force managed care organizations to examine their risks carefully
page 16H

Informed business decisions rely on effective use of information technology
page 16H

Insurer Topics

Sophisticated buyers demand 'e-business'

Web technology can satisfy customers, expand distribution options

By SALLY ROBERTS

As consumers become more comfortable conducting business on the Internet, those in the insurance industry will have to develop an "e-business" environment, two insurance technology experts say.

According to a recent IVANS survey of 2,000 Internet-connected consumers, 26% said they were interested in buying auto and home insurance via the Internet, said Clare DeNicola, vp-marketing and communications at Insurance Value Added Network Services in Greenwich, Conn.

While 61% said they were interested in buying goods and 43% said they were interested in conducting banking activities via the Internet, "this is not bad news," Ms. DeNicola said of online insurance sales.

"You need to pay attention to this," she told a group of insurance agents attending a seminar on transforming agencies into e-businesses at the annual conference of Insurance Marketing & Management Services, held last month in Boston.

"Consumers are getting used to this medium," and, as more consumers go online, they are developing more expectations about what they can do with the Internet, she said.

Lucianne Sarlo, marketing manager in the Tampa, Fla., office of IVANS told those at the session that "it's time for change."

The convenience and accessibility of the Internet has shifted the balance of power to the consumer, Ms. Sarlo said. For example, consumers today know that they can either browse in bookstores, or, if they know what

books they want, buy them online. "Consumers have choice in deciding how to do business," she said.

Today's consumers also "expect pre- and post-sales support via the Web," Ms. Sarlo said. For example, on Delta Air Lines' World Wide Web site, customers can look up various airline routes and ticket prices and check flight arrival and departure times—in addition to purchasing tickets.

Current technology allows e-businesses to customize Web content for individual customers, she said. For example, online bookseller Amazon.com can offer individual consumers suggestions on books that may be of interest to them based on their previous purchases, Ms. Sarlo explained.

Those selling insurance face many challenges today, including increased customer sophistication; competition from new distribution channels; the need to increase profits and reduce expenses; the need to increase the focus on customer service and value; the need to consider new technologies; the need for real-time service delivery; and the removal of geographic constraints.

What this all comes down to, Ms. Sarlo said, is that those in the industry must resolve business issues and meet these challenges with leading-edge technology.

She noted that one of the key concepts that often gets lost in the current hype surrounding e-business is that of "relationships." Conducting insurance business electronically is not just about the medium; it's about providing a service that is of greater value to the customer, Ms. Sarlo said. It's also about opening new distribution channels and becoming more efficient and profitable, she said.

Ms. Sarlo described the four stages involved in the transformation into an e-business.

The first step is to create a Web site with marketing information. In this stage, communication is one way, pushed out to the customer via the Web, Ms. Sarlo said.

"There is nothing wrong with taking a (company) brochure and getting it out to customers," Ms. Sarlo said. She pointed out, however, that a company still needs a comprehensive marketing program to draw traffic to its site. She suggested that agencies put their Web site addresses on business cards and on advertisements to get the word out.

At this stage, a company will

Continued on next page

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Continued from previous page

see little or no return on its investment, Ms. Sarlo said, except that there might be incrementally more business from new customers.

In the second stage of the e-business evolution, two-way communication with customers and trading partners takes place on the Web site, Ms. Sarlo said.

At this stage, the Web site is interactive and customers can send e-mail, post messages, use financial calculators and download forms, she said.

Agency forces are also better able to provide pre- and post-sales support to customers at this stage, Ms. Sarlo said. For instance, customers who need to provide address changes could go to a Web site and do so electronically.

At this point, the return on investment remains limited, she said. There still are no broad revenue gains from direct sales, but some expenses are reduced due to faster, less expensive communications and better retention through improved customer support, she said.

At the third stage of the process, the Web site is equipped to provide customers access to products, processes, policy information and people in the agency or company, Ms. Sarlo observed. The site can accommodate customer requests for services such as rate quotes and policy sales, and it can handle the submission of claims and endorsements.

At this stage, the Web and other online approaches are helping to reduce costs for existing processes, she said. A company can examine its costs for mail and toll-free telephone service to determine whether such expenses could be reduced through an e-business approach.

As technology evolves, retention will increase because of improved customer support, says Lucianne Sarlo.

It is at this stage that the company will begin to see some return on investment, Ms. Sarlo said. If the company quotes and binds policies online, it will see some revenue from direct sales. Expenses will be reduced because communications are faster and less expensive and because customers are obtaining support through alternative methods. In addition, retention will increase because of improved customer support, she said

At the final stage comes the creation of new and better ways to sell and serve business, she said.

At this stage, new electronic service and distribution models can be used to re-engineer how business is conducted. These approaches will allow customers and trading partners to conduct business with the company on their terms, using the media that are most appropriate for them, Ms. Sarlo explained.

The largest return on investment occurs at this stage, Ms. Sarlo said. Revenues are gained from direct sales. Expenses are reduced through more-efficient communications, and savings are realized from improved processes and from customers obtaining support online. At the same time, loyalty and retention are increased because of better customer support. BI

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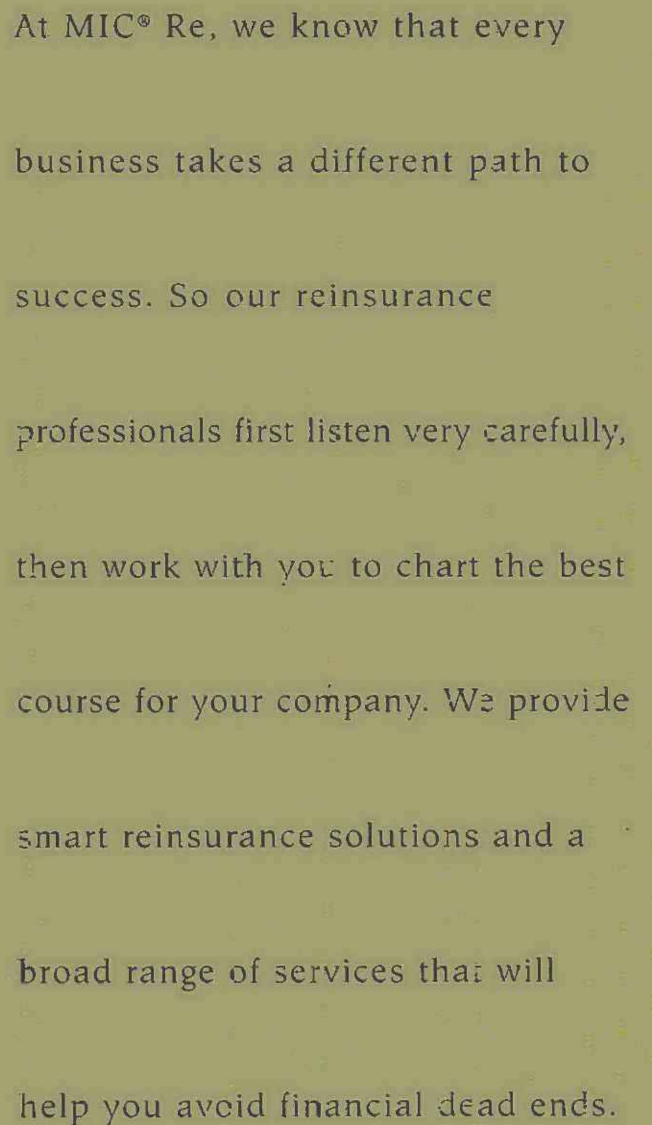

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Insurer Topics

'Utmost good faith' only a start for cedents, reinsurers

To avoid disputes, both parties need closer communications: Execs

By ROBERTO CENICEROS

Amicable resolutions continue to give way to adversarial disputes in the relationships between ceding companies and reinsurers, experts say.

The trend, which began two decades ago in the property/casualty industry, has spilled into the life and health industry.

But insurers and reinsurers can manage their relations to obviate many potential disputes, according to the experts who spoke at the Insurance Accounting & Systems Assn.'s 71st Annual Educational Conference and Business Show in San Diego.

Because transactions still are based on a handshake and on the principle of "utmost good faith," business often is ceded before a treaty is completed, the speakers said. As a result, a lot of gray areas can result if parties misunderstand each other's intentions.

"The best way to avoid disputes is to ask the correct questions before entering a treaty," said Ronald L. Klein, executive vp and chief pricing officer for Swiss Re Life & Health in Stamford, Conn.

"You would be surprised how simple a question you can ask and how complicated an answer you can get," Mr. Klein said. "For example, 'What is the purpose of reinsurance?' would be my easiest question. You want to know what the other party is thinking in the reinsurance negotiations."

Audits are another way to uncover misunderstandings early on, the reinsurers said, as most disputes concern underwriting practices.

The reinsurer should supervise the ceding company by exercising its right to conduct routine audits, said Vincent J. Vitkowsky, a partner at Edwards & Angell L.L.P. in New York.

And these audits should be systematic, he urged. "I don't mean the kind of audit where you breeze in for an hour, go to lunch with the top people and then go home."

During an audit, a reinsurer should advise the cedent of any objections to its operational practices, such as those related to underwriting standards, facultative submissions, claims processing or settlements. The reinsurer needs to act with the understanding that its own money is at risk, Mr. Vitkowsky advised.

Moreover, the reinsurer should establish a pattern of close communications and should document all its efforts to advise the ceding company, he said.

"All this seems pretty simple, but you would be surprised how often it is not done," he said.

Direct companies usually cooperate with reinsurers' audits because the audits demonstrate that the reinsurers have an interest in the ceding companies' business and in maintaining a common understanding of their operations, Mr. Klein said.

But a reinsurer conducting audits must also be prepared to take action.

"If you audit and you find a problem, do something about the problem, because not doing something about the problem is a very strong case for the other company to win an arbitration dispute," Mr. Klein said. "They will say, 'You came in; you looked at it. You saw it, and you didn't do anything about it. So you said it was OK.'"

Just knowing that a reinsurer will conduct audits can prevent a direct writer from making poor decisions based on the belief that it can easily pass the losses off onto the reinsurer, Mr. Klein said.

Audits are most crucial for new reinsurance agreements, the experts agreed. But Mr. Klein advised reinsurers to "audit early and often" in all cases, to stay on top of any changes in insurers' underwriting practices.

Cedents should welcome reinsurers' examiners or auditors, advised William C. Hassard, chairman of the board for Republic Financial Services Inc. Companies should be up front with reinsurers, as the reinsurers will recognize any attempt to stall and immediately make your life difficult, Mr. Hassard said.

Reinsurers "can smell a stall a mile off," he said.

Mistakes can be made by both parties, but a ceding company can use the audit outcome to reduce its mistakes and improve its operations.

In addition, insurers need to know the financial background of their reinsurers, Mr. Hassard said.

Understand, however, that there are some disputes that cannot be avoided, he said. And a cedent should cut its losses and make the best settlement possible if a reinsurer falls into financial distress, he said.

"Because, if you get into a situation where you are looking at an insolvent reinsurer, you will pay," Mr. Hassard said.

Do more than just correspond with reinsurers, he advised. Visit their offices and invite them to your office—both before and after the contract is negotiated. If a broker is involved, have the broker arrange the visits.

Once a dispute does occur, legal precedents are of limited use in managing life and health reinsurance, Mr. Vitkowsky said. Because reinsurance agreements carry arbitration clauses, arbitrators are not required to apply the strict rules of law, and decisions are private.

Therefore, a heightened awareness of the principles of reinsurance, such as the "duty of utmost good faith," remains important. That duty, among other things, calls for the ceding company to disclose material information at the time of placement and for it to comply with provisions requiring notice of loss. BI

Web site aims to help market group health insurance

By JOANNE WOJCIK

Health insurers will soon be able to connect with agents and brokers shopping for their clients' health insurance 24 hours a day over the Internet.

Colorado Springs, Colo.-based ChannelPoint Inc. on June 30 will launch ChannelPoint Commerce Broker, a Web site that agents and brokers can use to find insurers to underwrite group health risks.

The site will automate functions such as rating, quoting and requests for proposal and can be accessed through a user's standard Web browser, according to Peter Rodes, product marketing manager.

While ChannelPoint initially is using the site to market group health insurance in the New York tri-state area, the company plans to branch out nationwide and eventually to include all types of personal lines property/casualty coverages.

The cost is assumed by participating insurers; agents and brokers pay nothing to use the exchange.

So far, eight health insurers have signed up to participate in ChannelPoint Commerce Broker: Health Net of Woodland Hills, Calif.; United HealthCare Corp. of Minneapolis; Physicians Health Services of New York; United States Life Insurance Co. of Neptune, N.J.; Guardian Life Insurance Co. of New York; HIP Health Plan of New York; QualMed of New York; and CAREington International, a dental health maintenance organization based in Dallas.

Once agents and brokers register to use ChannelPoint Commerce Broker, they can access from the site all of the coverage and premium information they must submit. They can then import that information into various off-the-shelf software programs.

For example, users can retrieve price, plan, provider and policy information from insurers via the Web site, paste it into a Microsoft Excel spreadsheet file and then prepare comparison quotes for their clients. Adobe Acrobat Reader software can be used to print all application and enrollment forms on the Web site.

As an additional marketing tool, the ChannelPoint Commerce Broker can search insurer databases to determine, for example, whether a particular client's preferred provider is included in the networks being considered.

Small-business owners often seek such information, Mr. Rodes explained.

Because the participating insurers have included their rating information on the site, agents and brokers can complete requests for quotes online and get responses immediately.

In addition, the Web site can be used to request information from insurers not participating in the system. In such cases, ChannelPoint will collect the information submitted to the site and fax it to the insurer, according to Mr. Rodes.

This process is much slower, but "by adding these non-participating insurers, ChannelPoint is including as many product choices for the broker as possible," he said.

Eventually ChannelPoint plans to provide online enrollment in addition to the online quoting function, he added.

ChannelPoint's address on the World Wide Web is www.channelpoint.com.

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MCOs' risks to come under microscope

NAIC issues stricter solvency requirements

By ROBERTO CENICEROS

New filing requirements and a model law initiated by the National Assn. of Insurance Commissioners will force managed care organizations to look more carefully at the risks they bear, a health care consultant says.

The NAIC's filing rules and model law are intended to give regulators an early-warning system for potential solvency problems. Because it is public information, other parties also will be able to access a managed care organization's risk-based capital.

The initiative also ensures that organizations taking similar risks have similar capital requirements, said John Stenson, a Minneapolis-based principal in Deloitte & Touche L.L.P.'s Integrated Health Group. Mr. Stenson spoke recently at the Insurance Accounting & Systems Assn.'s 71st Annual Educational Conference and Business Show, which was held in San Diego.

But the initiative won't affect organizations' statutory requirements only, he said. Evaluations of risk-based capital by regulators and employers choosing health plans will force MCOs to examine their management and financial decisions, Mr. Stenson said.

To calculate a managed care organization's risk-based capital ratio, regulators use a formula incorporating the MCO's statutory capital and surplus, asset risks, underwriting risks, credit risks, business risks, the risk of affiliated companies and other factors, said Mr. Stenson.

Premiums, claims, reinsurance purchases, product development and even the capital held in a specific subsidiary all will affect the RBC ratio.

Some states eventually will adopt the NAIC model law for risk-based capital. That will require many managed care organizations to increase their minimum capital, depending on the risks they face, Mr. Stenson said.

The model law also calls for specific regulatory responses, depending on the RBC calculation. A company with an unfavorable outcome may have to submit a plan for improvements or, in more serious cases, may be placed under regulatory control.

Health maintenance organizations, provider-sponsored organizations, preferred provider organizations that assume risk, Blue Cross & Blue Shield plans, and any insurers offering health-related coverages all will be affected eventually, Mr. Stenson said.

Even if a state does not adopt the

model law, the NAIC's initiative still has a de facto impact on MCOs, Mr. Stenson said. Beginning with year-end 1998 statutory filings, most states required the incorporation of the RBC information, making it available for regulator scrutiny.

Employer clients will want to use the information to evaluate the financial viability of their health plans, Mr. Stenson said. Rating agencies already are using the formula, and that action will have ramifications for MCOs' creditworthiness and value.

Therefore, the RBC calculation will impact not only the statutory requirements of MCOs but also management decisions and pricing strategies, Mr. Stenson said. Action to assure appropriate future financial results will be necessary.

"Even if it is just from a publicity perspective or from the way your employer clients will look at you, or if you operate in a state that will pass a model law," Mr. Stenson said.

The RBC will become a part of every financial decision, Mr. Stenson said. Capital sources may diminish or become more costly as capital markets see the MCO as riskier relative to other investment alternatives.

MCOs may have to contribute more up-front investment into specific ventures and entities. Reinsurance considerations also will change as MCOs look for ways to improve their RBC.

"Reinsurance could help, because you could lower the amount of risk you have in any one life by having a catastrophic stop-loss," Mr. Stenson said.

The filing requirements are sure to influence managed care organizations' product offerings, because MCOs operate in a dynamic market where products continually are under development.

"If you are going to implement some fairly significant product strategy or changes, you should look at the effect that that could have on your RBC calculation," Mr. Stenson said. "Incorporate it into your forecasting and other monitoring that you do."

In fact, enhanced financial forecasting, experience monitoring and pricing methodologies will be needed to maintain the RBC at acceptable levels over time, because the RBC is not a static measurement. It can change with each decision.

Provider contracts also will effect the RBC outcome. Therefore, MCOs may have to "tighten up" their provider contracts with measures such as stop-loss provisions, Mr. Stenson said.

An MCO's concentration of business among fully insured, partially insured or fully self-insured groups also will be a factor. The less concentration in the higher-risk type of business, the better your RBC will be, Mr. Stenson said.

It will be interesting to see how RBC calculations impact future merger and acquisition activity because the RBC is not a "additive" number, Mr. Stenson said. "The RBC of company A and company B will not necessarily be equal to A plus B," he explained. BI

Intelligent decision-making requires effective use of data

By Sidney C. Lejfer

IT Perspective

Data—factual information (as measurements or statistics) used as a basis for reasoning, discussion or calculation. (Merriam Webster)

Data—all those little bits of information you have gone to great lengths to collect.

Which definition of data applies to your sales force automation database? It should be both. More often it is only the second definition. Why?

Data analysis

There is no question that to compete in today's market, your business must embrace information technology. On a daily basis, your company is processing and collecting a tremendous amount of data in your accounting, order processing, sales, marketing and human resources systems.

These systems streamline the work and store myriad relevant details about customers, business and daily transactions. You probably have a pretty good feel for what the data looks like as a whole.

Now here's a question: When you are competing to win, are you satisfied with "pretty good" tools? Probably not. So how do you get an excellent look at that data? How do you make sure your business decisions are based on the best information available to you in today's information age?

You report on the data you have so carefully stored. Your databases contain a veritable treasure chest of information. That information is the raw material you need to make business decisions. Reports will take that raw material and refine it to your specifications.

Whether your systems have collected 5,000 lines of information or 5 million lines of information, it is too much for a person to analyze efficiently. That is, after all, why we have computers.

There are a wide variety of powerful business intelligence tools that will allow you to look at all your data or some subset that you define. They will let you easily add or count all the records that meet certain criteria and compare those counts to records that meet other criteria.

You can quickly find out what your top five selling products were last year, and what they are this year to date.

Wouldn't it be nice to know, when you walk into the sales meeting, who your top three sales people were for the last month?

How about knowing which 10 products accounted for the most returns? You probably can name seven of them correctly without running a report. What about the other three?

Which customers are using your customer-service resources the most heavily? No doubt you can name at least one problem customer. Can you name four more in order of the number of calls for service? Would that be useful in deciding how to manage those customers?

What are the top 10 sources you have for prospects? Is that list similar to your top 10 sources of customers? Wouldn't you like to know for sure?

Human factor

There are two major issues with trusting human evaluations for these questions. First of all, as mentioned above, there is just too much data for one person to sift through. Second, human nature will color the evaluation.

See **Data** *on next page*

Is your Internet strategy taking you nowhere?

The power of Internet technology is without doubt going to change the way you do business. You probably have a Web site - but what does it do? Who does it touch? Is it generating revenue? Cutting costs? If you seem to be swimming in circles then we have a few answers!*

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*HomeCom was selected as one of "The Twenty Best Internet Consulting Firms" in the May, 1998 issue of Internet Computing Magazine.

Data

Continued from previous page

You might ask your customer service manager, Joe, what customer has called in the most frequently. He responds that Mary of Acme Fireworks is by far the most difficult to please, with the most calls.

In fact, Jason of WidgetWorks has called in more times than Mary and generally spent longer time on the phone. But where Jason is calm and reasonable, Mary has been very difficult to deal with. It seems like Mary has tied up customer-service resources the most. Actually it was Jason.

Our brains make judgments. That is the advantage we have over computers. Computers assemble and manipulate enormous amounts of data so that we can analyze the results and make decisions. The computer will collect the data we ask for and manipulate it as we want, all without making judgment calls about what goes into the final report.

Decisions

It would be great to have reports analyzing our data so that we can make the best decisions possible. But then again, is the advantage of business intelligence worth the costs?

Maybe you remember the day when creating a report required two weeks of programming time, if you were lucky. Certain reports still require a substantial investment, but many can be written in an hour or two.

Accessing reports

Another decision you will have to make with regard to business intelligence is how your people will access the information. The days of the reams of green-bar paper are over. (Did anyone ever read those reports anyway?)

Today, you have many choices as to how you will distribute the data: printouts, e-mail, the World Wide Web. There are advantages to each of these approaches.

The key to any business intelligence tool you use is to make sure that it will leverage your existing technologies, as well as stay current with the latest technologies.

Distribution of reports opens a can of worms with which many organizations are only now beginning to struggle. The mantra of ad hoc reporting says that anyone can run any report at any time. Most end-users are not cognizant, however, of the implications of their actions.

When all of your sales representatives come in at the beginning of the quarter and want to see their commissions for the prior quarter, how are we going to make the information available to them in a timely manner, without overwhelming the information technology group, not to mention the database?

The answer may be a managed business intelligence environment, where reports can be scheduled and run during off-hours and be made available to the users in a number of different formats.

Ad hoc reporting can also present security issues. Do we really want to give our users access to sensitive financial data or salary information? In some cases the answer is yes, in other cases, no.

Managed business intelligence can give IT the ability to define one report that will incorporate departmental or user security as opposed to many reports, each specifically tailored to different departments' or users' security rights.

Fact gap

One area of concern with regard to business intelligence is the discrepancy between the sheer volume of data that business can generate and the number of available analytical personnel to make sense of this data, something that Howard Dresner of The Gartner Group refers to as the "Fact Gap."

The number of critical decisions that an organization is making is increasing every day, which is nothing new. What is new is the speed with which these decisions are being made.

A year ago, the Internet was nothing more than an amalgamation of slick marketing brochures. Today, the Internet is the preferred location for the collection and presentation of meaningful business data for more and more businesses.

A business intelligence strategy needs to take into account today's business environment. Information must be relevant, timely, consistent and complete to be of any use. It must be presented to the right person at the right time.

A business intelligence solution needs to cut through the information overload and focus on the areas that are causing problems or that lead to solutions.

Emerging trends

Some of the emerging trends in business intelligence involve things like data mining, guided analysis and 3-D visualization.

These trends involve complex, system-driven algorithms that are capable of searching through terabytes of data and finding trends and patterns. This is so-called agent-driven exploration, which involves programs that are capable of learning. Whether these technologies are ever adopted by the masses remains to be seen.

Summary

Currently, business needs to use business intelligence to access information, monitor and analyze the facts, share and collaborate with other users and ultimately to alter processes or reinforce decisions. This needs to be accomplished within the current constraints and realities of the business environment. BI

Sidney C. Lefer is president of Success Automation, a Waltham, Mass., firm specializing in sales force automation and business intelligence consulting and training services.

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NAMIC names Schmelzer vp of regulatory affairs

INDIANAPOLIS—The National Assn. of Mutual Insurance Cos. has named Roger H. Schmelzer vp of regulatory affairs.

Prior to joining the Indianapolis-based NAMIC, Mr. Schmelzer served as the chief legal counsel to the speaker/minority leader of the Indiana House of Representatives. He was the principal adviser to the House Republican leadership on policy, legislative and legal matters.

From 1985 to 1989, Mr. Schmelzer was executive assistant to U.S. Sen. Richard G. Lugar (R-Ind.). He also was affiliated with the Kightlinger & Gray law firm, where he specialized in business associations and public policy management.

Mr. Schmelzer earned both his undergraduate and masters of public administration degrees from Indiana State University, and he graduated from the Indiana University School of Law-Indianapolis in 1986.

In other NAMIC news, the organization has improved its Web site, www.namic.org. The site has a new look, and visitors now can search the World Wide Web using seven search engines and get weather and other information.

Site visitors also can get information about and register for NAMIC's 1999 convention, which will be held later this year in San Antonio.

IT Briefs

S&P expands training

NEW YORK—Standard & Poor's Corp. has expanded its series of credit training programs to include courses focusing on credit risk analysis of the insurance industry.

S&P's Credit Training Services program provides comprehensive credit risk analysis and risk assessment training to intermediate-level financial professionals. The insurance courses are designed to increase participants' financial knowledge and analytical skills, and to provide exposure to key industry issues.

Participants in the program can increase their familiarity with S&P's insurance rating methodologies and criteria, strengthening business development structuring skills for their organizations. The small classes are taught by S&P senior analysts.

For additional information, contact a Standard & Poor's office, send an e-mail to cts@standardandpoors.com or visit S&P's Web site at www.standardandpoors.com/ratings and follow the links to Credit Training Services.

Company name change

HANOVER, N.H.—Shareholders of Fund American Enterprise Holdings Inc. have voted to change the company's name to White Mountains Insurance Group Inc., reflecting the company's transformation from a holding company of passive assets to a financial services operating company specializing in property/casualty insurance and reinsurance.

The company also changed its New York Stock Exchange ticker symbol to WTM from FFC June 1.

New moniker adopted

DENVER—Security Life Reinsurance has changed its name to ING Reinsurance, reflecting the Denver-based reinsurer's focus on providing integrated institutional financial services through the global resources of its corporate parent, The ING Group.

The move acknowledges a growing trend among insurance companies of integrating management of exposures across the entire spectrum of their business, and the reinsurer's effort to combine traditional reinsurance with integrated financial and traditional risk management services, said Thomas F. Conroy, president of ING Reinsurance.

"It is more than just a name change," Mr. Conroy said. "We are bringing together the total group resources in a way to see how they can be leveraged for a life insurance company to manage all its risks."

As part of its new effort, the reinsurer has formed a Corporate Structures Group to craft reinsurance solutions that draw upon other insurance, banking and asset management operations of its Dutch-based parent. BI

Insurer Topics

ADVERTISER INDEX

Issue of June 21

ADVERTISER	PAGE #
American Insurance Assoc.	16F
HomeCom Communications	16G
ING Reinsurance	16C
MIC Re	16D-16E
Strohl Systems	16B

1999 STATE LEGISLATIVE WRAP-UP

Continued from previous page

Kitzhaber has signed the legislation into law; it goes into effect 90 days after the current legislative session ends. The law also will extend for four years the sunset provision embedded in Oregon's workers compensation exclusive remedy provision.

Another bill would require that the Department of Consumer and Business Services hold a public hearing before increasing the premium fees and assessment that the department collects from self-insured employers. This assessment is used to fund the monitoring of workers comp programs. The bill received final approval by legislators May 20 and is awaiting action by Gov. Kitzhaber. The Oregon Self Insurers Assn. supported the legislation.

Other legislation seeks to expand an Oregon law that allows employers to band together to self-insure for workers comp injuries. Oregon law currently allows only employers in similar industries to join together. But a bill that received final legislative approval June 3 would allow employers from diverse industries to band together to self-insure. As of June 15, the bill was awaiting action by Gov. Kitzhaber.

Another bill that passed both chambers and awaits action by the governor would release the Department of Consumer and Business Services from establishing utilization and treatment standards for work-related injuries. The bill would leave the task to private companies, such as health maintenance organizations.

Yet another measure would require insurers and self-insured employers to pay a workers comp claimant's medical bills for the first 30 days of treatment or until the claimant receives notice of denial, regardless of whether the claim ultimately is accepted. As of June 15, the bill had not passed out of the Senate.

Washington Gov. Gary Locke signed a measure to expand a state law allowing business associations to offer members retrospectively rated workers comp insurance programs. Previously, associations could offer retrospective programs only to memberships made up of employers in similar industries. Now, however, they can offer those programs to memberships of employers from differing industries.

No significant workers comp legislation was passed in **Alaska** or **Hawaii**. BI

Tort reform

Continued from page 1

punitive damages and frees employers from certain liabilities.

Consumer advocate Ralph Nader wrote in a statement: "This anti-consumer, anti-worker legislation will harm the most vulnerable of Florida's citizens and significantly lessen the responsibilities of drug companies, reckless manufacturers, toxic polluters or other perpetrators to compensate their victims."

Employers, however, applauded the reforms.

"Obviously, we're pleased at what happened down in Florida," said Lance Ewing, chairman of the external affairs team of the Risk & Insurance Management Society Inc. and director-insurance and loss prevention of GES Exposition Services Inc. in Las Vegas.

Sweeping reform, however, was generally not the order of the day. Proposals throughout the country "basically cover the waterfront," said ATRA's Mr. Joyce. There really isn't a single definable arena outside of Y2K liability relief legislation, he said.

"Every state has a different twist" to how lawmakers approach the Y2K issue, noted Mr. Ewing. Some laws provide broad protections, while others apply only to municipalities or governmental entities, he noted. Still others deal with the problems that a single industry, such as banking, is likely to face.

If the breadth of Y2K legislation varied, so did reactions to it. For example, Republican Gov. George W. Bush of Texas and his brother, Jeb, both welcomed relatively broad Y2K liability control legislation passed by their respective legislatures.

"At the state level, I think the bill enacted in Texas, signed by Gov. Bush and pushed by the Texas Civil Justice League, really is the comprehensive bill that all others will be measured against," said Mr. Joyce.

But the welcome accorded to Y2K legislation was far chillier in both Iowa and Maryland, where liability bills fell to governors' vetoes. In some other states, bills languished in committee and died by recess.

Lawmakers in other states dealt with more-local tort and risk management-related matters. Hawaii and Rhode Island—the former an established captive domicile and the latter a newcomer to the domiciliary ranks—both enacted legislation allowing the formation of "rent-a-captives." Rhode Island also slashed its captive premium tax to allow that state to compete more effectively with other domiciles, particularly Vermont.

Louisiana lawmakers, irked at the city of New Orleans' decision to sue gun manufacturers for damages, approved legislation banning state municipalities from doing so.

Following is a roundup of tort reform, property/casualty insurance and risk management legislative activity around the country, based on reports by *Business Insurance* staff and coordinated by Washington Editor Mark A. Hofmann:

PROPERTY/ CASUALTY

Maine Gov. Angus King signed legislation requiring prior court approval of any agreement to sell or transfer structured settlements. The law is intended to protect recipients of structured settlements in tort cases from aggressive marketing by companies that buy out the settlements at discounted cash value.

A **Massachusetts** bill would exclude any company with a net worth of $25 million or more from making claims on the state guaranty fund.

Rhode Island enacted a protected cell law that will allow the formation of rent-a-captives. The act allows insurers and captives to isolate individual accounts by segregating assets and liabilities into cells. Under the law, cells also can be used in insurance securitization deals.

Other legislation is pending in Rhode Island, including bills that would allow third-party bad-faith lawsuits against insurers and permit insurers to keep confidential the results of self-audits for regulatory compliance.

Rhode Island established a new tax structure for captives in the state. The minimum tax is $2,500. Direct premiums are then taxed at between 0.2% and 0.0375%, depending on the size of the premiums. Reinsurance premiums tax rates range from 1.25% to 0.0125%.

No significant tort reform measures were enacted in **Connecticut**, **New Hampshire** or **Vermont**.

PROPERTY/ CASUALTY

Maryland Gov. Parris Glendening vetoed a measure that would have shielded businesses from legal liability arising out of the Y2K problem. The governor said the bill did not adequately protect consumers in the event of injury or death stemming from Y2K-related computer failures.

The governor did sign legislation that provides immunity from liability to cooperative library associations. The law takes effect July 1.

Gov. Glendening also signed a measure that authorizes some courts to refer medical malpractice claims—where both parties agree—to a state Health Claims Arbitration Office for neutral case evaluation. The law takes effect on October 1.

West Virginia Gov. Cecil Underwood signed legislation that gives liability immunity—except in cases of gross negligence—to physicians who provide medical services to the indigent at clinics that provide free health care. The new law, though, does not extend immunity to the clinics themselves and requires the clinics to maintain liability coverage of at least $1 million per occurrence.

No significant tort reform legislation was enacted in **Delaware**, the **District of Columbia**, **New Jersey**, **New York** or **Pennsylvania**.

PROPERTY/ CASUALTY

Alabama enacted several tort reform measures, including a cap on punitive damages. Alabama juries have a history of making large awards. Earlier this year, a jury awarded $580 million in punitive damages in a case centered on a $1,200 overcharge.

The new act, which is now in effect, limits punitive damages in non-injury cases against large businesses to the greater of three times the compensatory damages or $500,000. Punitive damages against small businesses are capped at $50,000 to $200,000, depending on company size. In injury cases, punitive damages are capped at the greater of three times compensatory damages or $1.5 million.

Other legislation enacted in Alabama and now in effect requires notice of a hearing seeking class-action certification and gives both parties the right to immediately appeal a class certification order.

Florida Gov. Jeb Bush signed a package of tort reforms that caps punitive damages and frees employers from some types of liabilities.

Although employers supported the legislation, consumer advocates quickly criticized the law. Ralph Nader wrote that "this anti-consumer, anti-worker legislation will harm the most vulnerable of Florida's citizens and significantly lessen the responsibilities of drug companies, reckless manufacturers, toxic polluters, or other perpetrators to compensate their victims."

The law also eliminates joint-and-several liability for defendants who are found to be less than 10% at fault. If fault is found to be at least 10% but less than 25%, damages are capped at $200,000. The cap rises to $500,000 from 25% to 50%, and a defendant whose fault is greater than 50% is subject to damages of up to $1 million.

Caps on punitive damages are the greater of $500,000 or three times compensatory damages. A cap of $2 million or four times compensatory damages applies if the plaintiff proves the defendant's conduct was motivated solely for unreasonable financial gain and the defendant knew its conduct was dangerous. If a plaintiff proves a defendant intended harm, there are no limits on punitive damages.

The new law also says an employer cannot be liable for punitive damages for employee conduct unless the employer is found guilty of gross negligence or to have knowingly condoned the wrongful conduct.

The law established a 12-year statute of repose, limiting the period during which lawsuits can be brought against most product manufacturers. The law establishes a 20-year statute of repose for cases involving commercial aircraft. Gov. Bush, however, has said he will seek a repeal of the 20-year statute next year.

The law protects employers from liability for negligence in hiring if the employers conduct reasonable background checks.

Florida also enacted a law, now in effect, that limits businesses' Y2K liability. The law sets a minimum loss of $50,000 for each member of a Y2K class action, permits courts to assign claims to undergo mediation and prohibits class actions against government agencies. The law also provides immunity to businesses' directors and officers if they took action to make their companies' products Y2K compliant.

Louisiana Gov. Mike Foster signed a bill that protects gun manufacturers from lawsuits filed by municipalities and voids a suit filed by the city of New Orleans. The law gives the state government sole authority in filing suit against gun makers.

New Orleans filed a product liability suit against the gun industry last fall, seeking to recover the public cost of handgun violence in the city. The suit charged, in part, that handguns were unreasonably dangerous because they have no safety systems to prevent children and other unauthorized persons from using them.

The law does not prevent municipalities from filing suits against firearms manufacturers for breach of contract with regard to the purchase of firearms or ammunition.

Other legislation pending in Louisiana would:

- Curb frivolous lawsuits by creating a "loser pays" system in civil cases. The bill, passed by the House but pending in the Senate, would allow a defendant to sue a losing plaintiff to recover defense costs. Recovery would be permitted if the defendant proved that the suit was filed to encourage settlement, if plaintiffs' attorneys knew or should have known the original suit was groundless, or if the original suit was filed to cause the defendant to incur defense costs rather than to recover damages.
- Establish a standard of gross negligence for lawsuits against directors and officers. The legislation, passed by the Senate and now in the House, aims to supersede a Louisiana appellate court decision that applied a simple negligence standard in a D&O liability case.

A **Georgia** law that becomes effective July 1 regulates the transfer of structured settlement payment rights. The measure requires disclosure to the payee of all financial and tax implications of any settlement transfer, as well as a 10-day waiting period before a transfer takes effect.

Two bills awaiting **Tennessee** Gov. Don Sundquist's signature provide some liability protections in Y2K cases.

The first bill would give the state immunity from tort claims arising from computer malfunctions in processing dates or times before Jan. 1, 2005. The measure would apply if the failure was unforeseeable or if a plan for preventing it was in place according to generally accepted computer design standards.

The second bill would prohibit any "foreclosure proceeding, default or other adverse action against a person" due to the incorrect transmission of information resulting from a computer's failure to properly process the year 2000. The bill also would bar suits against any "person or entity" that cannot make financial transactions on time because of Y2K problems.

Part of the effect of legislation pending in **North Carolina** would be to eliminate punitive damages for Y2K liability and limit the liability of corporate directors and officers.

North Carolina lawmakers in both houses have approved a measure that reinstates the insurance commissioner's authority to create a standby joint underwriting association for coastal property.

A **Virginia** law that took effect April 7 limits Y2K liability by prohibiting punitive damages under most circumstances.

Virginia legislators also amended the state's medical malpractice cap statute. Effective Aug. 1, the cap will rise to $1.5 million from $1 million and increase each year until it reaches $2 million in 2008.

No major tort reform or property/casualty legislation was enacted in **Mississippi** or **South Carolina**. Lawmakers were not in session in **Kentucky**.

PROPERTY/ CASUALTY

The **Illinois** Legislature approved a bill that would expand tort liability by extending benefits in wrongful death cases to a beneficiary, as long as he or she was less than 50% responsible for the decedent's death. Gov. George Ryan is expected to sign the bill, which would apply to pending cases.

Legislators also approved a bill that would provide some relief from Y2K claims for banks and their customers. For example, the measure would protect financial institutions' officers, directors and employees from personal liability, except for cases in which they were involved in fraud. Relief for

Continued on next page

1999 STATE LEGISLATIVE WRAP-UP

1999 STATE LEGISLATIVE WRAP-UP

Continued from previous page
the general business community still is being discussed and is expected to be considered this fall, said Donald S. Cleasby, assistant general counsel with the National Assn. of Independent Insurers.

Indiana Gov. Frank O'Bannon signed several environmental bills from this year's legislative session, including measures that:

• Place a permanent cap of $300,000 on aggregate damages for the loss of a non-dependent's love and companionship in wrongful death cases. The law, which will take effect next year, also prohibits recovery of punitive damages and damages for an individual's grief in such cases.

• Encourage environmental audits by making the audit reports privileged, confidential information.

• Provide immunity from civil liability to property owners who are not responsible for leaks found in underground storage tanks. Current owners, however, must clean up sites within a year.

• Clarify the definition of "operator" as it pertains to liability for fuel delivery.

• Impose a $1,000 fee on every cask of high-level radioactive material passing through Indiana by truck or rail. The fees, which are paid by waste generators, such as utilities, will be allocated for emergency response training of local police, fire and emergency crews in the municipalities that may have to react in the event of a disaster.

Minnesota Gov. Jesse Ventura signed a bill that changed the statute of limitations for medical malpractice claims to four years from the date of occurrence from the previous two years. Minnesota does not have the discovery rule.

The governor also signed a bill that addresses the Year 2000 problem. The bill will provide individuals and small businesses an affirmative defense to breach of contract and tort actions if the defense can show that Y2K failure was not in the defendant's control and that the defendant could have wholly satisfied the contractual obligation had the Y2K problem not occurred.

A modification to the Landfill Cleanup Act added seven closed landfill sites to the 100 sites whose cleanups currently are being funded by bonds, fees charged to businesses, and insurance recovery settlements. The seven new sites will not be subject to the insurance recovery settlements, however.

Another new law in Minnesota limits the liability of municipalities when public land is used for recreational use.

Similarly, another bill clarifies municipal liability regarding snow and ice removal. For municipalities that own land or buildings in another municipality, the owner municipalities are not immune from claims or lawsuits arising from snow or ice conditions.

Minnesota, which has in place a seat belt gag law that prohibits mentioning whether a person involved in an accident was wearing a seat belt or had a child secured with a restraint, has restructured the law to make this information admissible in product liability cases. Lawmakers overrode the veto of Gov. Ventura, and the law became effective immediately.

Ohio Gov. Bob Taft is expected to sign a bill that would clarify interest calculations in cases involving declaratory judgments. It basically resolves problems created by a previous Ohio Supreme Court decision, which the business community considered too "liberal," said Patricia Holden, assistant vp of state affairs for the American Insurance Assn. in Skokie, Ill.

However, insurance industry representatives and consumers are awaiting word on the Ohio Supreme Court's ruling on the legislatively approved tort reform measure in 1997. "The general feeling is that tort reform will be overturned," she said.

The **Wisconsin** Assembly has passed a measure that would enhance Y2K immunity for units of government in the state.

Although state and local governments already enjoy sovereign immunity protections from liability, the measure would offer additional protection to government officials from claims related to errors or omissions stemming from good-faith efforts to resolve Y2K computer problems. The Senate has yet to act on the measure.

In addition to addressing the state budget, Wisconsin's budget bills also contain liability and insurance items.

Among their provisions are additional governmental immunity for problems arising from Y2K computer disruptions and a provision that the state's insurance commissioner may exempt by rule classes of insurance policy forms from prior filing and approval requirements.

The bills were introduced by the Joint Commission on Finance at the request of Gov. Tommy R. Thompson. If enacted, the Wisconsin budget bills would take effect July 1 or one day after publication, whichever is later.

No significant property/casualty or tort reform legislation has been enacted in **Michigan**.

North Dakota Gov. Edward T. Schafer signed into law a bill that establishes a statutory acknowledgement of the National Assn. of Insurance Commissioners' Codification Project. The measure, sponsored by the Senate's Industry, Business and Labor Committee and introduced at the request of the state's insurance commissioner, directs the commissioner to adopt by rule a version of the accounting practices and procedures published in the NAIC's manual.

North Dakota has two new laws related to indemnity for claims arising from Year 2000 computer problems. One indemnifies financial institutions against claims arising from failures of computers or other electronic systems as a result of Y2K disruptions. The other indemnifies the state and its local units of government against claims arising from Y2K computer disruptions.

In **Iowa**, a bill that would have shielded insurance companies and financial institutions from liability stemming from the Y2K computer problem passed both legislative chambers but was vetoed by Gov. Thomas Vilsack.

A bill that legalizes alcohol testing of private-sector employees and potential hires was enacted into law.

Public entities in **Missouri** will be liable for higher damages under a bill the governor is expected to sign. The bill raises existing caps to $300,000 from $100,000 for a single plaintiff and to $2 million from $1 million for any one event, regardless of the number of plaintiffs. The measure also requires that the Consumer Price Index be used to adjust caps in future years. If enacted, the measure will apply to events that occur after its Aug. 28 effective date.

South Dakota Gov. William Janklow has signed into law two bills that provide a liability defense for businesses and local governments that had made good-faiths efforts to make their computer systems Y2K compliant.

In addition, a new law authorizes the state's Division of Insurance to create a fraud investigation unit.

All the new laws will take effect July 1.

Next year, the American Insurance Assn. plans to push for a law requiring court oversight of any deal in which the recipient of a structured settlement intends to sell his or her settlement for an up-front sum. The AIA is concerned that many settlement beneficiaries are making unwise deals that leave them in poor financial shape and give a black eye to the structured settlement concept, which insurers strongly support.

No significant tort reform or property/casualty legislation was passed in **Kansas** or **Nebraska**.

Arizona Gov. Jane Hull signed a Y2K liability bill designed to promote computer system remedies without litigation and to provide defendants limited liability immunity. The state constitution prohibits the Legislature from barring lawsuits outright.

Under the law, a plaintiff must provide a defendant 90 days' notice before filing suit, so the defendant has time to insist on a systems inspection and try to correct the Y2K problem.

The law creates several defenses against liability, including proof that a defendant:

• Warned the plaintiff of the problem and offered a no-cost solution.

• Relying on an upstream vendor's assurances, did not know its own Y2K compliance guarantees were false or misleading.

• Believed its product was Y2K-compliant.

• Fixed a known problem with a system, after which tests showed that the system was Y2K-compliant.

A court presiding in Y2K litigation may reduce a final award by the amount the defendant spent to fix the problem or would have spent if the plaintiff had not rejected the offer.

The state also has several other new liability reform laws.

A litigant who rejects a settlement offer will have to pay the other party's attorney's fees if the subsequent court award in the case equals or is less than the rejected offer. Gov. Hull signed the measure on May 4.

A new law will allow colleges and universities to recover damages, such as lost revenue, that are attributable to misconduct by sports agents. Gov. Hull signed the measure on April 22.

A new law grants operators of closed-course motor sport facilities immunity from liability for the death or injury of spectators who sign liability releases, except in cases of intentional misconduct or gross negligence by the operator. Gov. Hull signed the measure on April 26.

All the laws become effective 90 days from the Legislature's May 7 adjournment.

The **Arkansas** Legislature passed several tort reform and property/casualty-related measures, including legislation that:

• Relieves policyholders of liability for defense attorneys' fees in suits against insurers where an insurer is not found liable for loss.

• Requires the state Department of Education to purchase excess liability insurance to provide $250,000 in coverage per incident per student passenger on school buses in accidents where the driver is at fault.

• Provides limited immunity to current or former employers that disclose job-related information on employees to prospective employers.

• Grants limited immunity to state and political subdivisions, officers and employees for the failure of government computer systems or errors resulting from the Y2K problem.

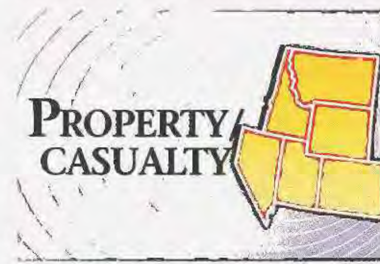
A major tort reform initiative died in committee. The bill included limitations on attorneys' fees, the repeal of joint and several liability, caps on punitive damages, and product liability reform.

Oklahoma Gov. Frank Keating signed legislation that grants businesses limited protection from liability for Y2K computer bug problems. The law, which took effect June 4, prohibits class-action suits against businesses that had conducted reasonable Y2K testing, remediation and contingency planning. The law also bars punitive damage awards in Y2K-related judgments against businesses.

The governor also signed an insurance anti-fraud law. The law, which took effect immediately after the governor signed it on June 8, creates an anti-fraud unit in the state's Insurance Department. It also shields insurers from liability if they mistakenly suspected parties of fraud and reported those suspicions to state authorities.

Texas Gov. George W. Bush signed a measure that provides Y2K liability protection to businesses and municipalities. The law, which took effect immediately after being signed, provides protection to organizations that make good-faith efforts to identify potential Y2K problems and to make their computers compliant. Computer product manufacturers and sellers that make good-faith efforts to notify customers of potential problems and offer low-cost solutions to correct any Y2K snafus are protected under the law.

New Mexico did not pass any significant tort reform legislation.



Colorado lawmakers were active in tort reform and other property/casualty initiatives during the 1999 legislative session. Measures have been signed into law that:

• Grant licensed physicians immunity from civil liability while performing volunteer work.

• Grant limited immunity from civil liability to an employer that provides information about an employee to a prospective employer of that employee.

• Limit a business' liability for damages in any civil action based upon a Y2K failure to the amount of actual damages. In addition, civil actions must be brought within three years of the alleged cause of action.

The act, which takes effect July 1, also grants immunity to a business and its directors and officers if what the bill terms "reasonable and timely efforts" have been made to identify potential Y2K failures in order to attempt to prevent them.

Another new law amends Colorado employment discrimination laws by making harassment during the course of employment an unfair employment practice. The law, effective July 1, defines "harass" as "to create a hostile work environment based on an individual's race, national origin, sex, disability, age or religion."

Idaho Gov. Dirk Kempthorne signed into law a measure that immunizes employers from being held liable for information an employee might disclose to an employee assistance program counselor. The measure also guarantees employees the right to confidentiality in these sessions.

That measure—and another that failed—were drawn up in response to a 1998 Idaho Supreme Court decision that created a new liability for employers, said Dawn Justice, vp-human resources at the Idaho Assn. of Commerce & Industry in Boise.

Insurers in **Montana** no longer can non-renew or cancel insurance policies based on a single loss unless the terms of the cancellation previously were discussed with the policyholder.

Under another law, the Montana Insurance Department now has just two years from the date of discovery to investigate and prosecute suspected insurance law violations. In addition, the triggering violations must have occurred within five years' of the date of their discovery.

Also in Montana, clinics that provide free health care now are exempt from tort liability.

Nevada becomes a captive domicile effective Oct. 1 under legislation signed by Gov. Kenny Guinn earlier this month that provides for the licensing and regulation of captive insurers.

Although the bill permits single-parent captives, it was intended to be most attractive to group, association and agency-owned captives,

Continued on next page

1999 STATE LEGISLATIVE WRAP-UP

Continued from previous page
said Allon J. Greene, principal with Tustin, Calif.-based consulting firm New Directions Group. He said he drafted the legislation along with former Nevada Insurance Commissioner James Wadhams.

The measure calls for the Insurance Commissioner immediately to establish regulations to carry out the act's provisions. Mr. Greene said the legislation "uses the best parts of both Bermuda and Vermont's captive laws."

Also in Nevada, legislators approved a bill that says if a party to an arbitration requests a jury trial, the arbitrator's findings must be submitted into evidence. Another law authorizes parties in civil actions to use a settlement conference, short trial and other alternative methods of resolving disputes if the state Supreme Court adopts rules authorizing these methods. Both laws take effect Oct. 1.

A new law in **Utah** that took effect June 2 restores proportional liability provisions that had been removed by a court case last year. It allows the allocation of fault in negligence actions to be attributed to all parties who contributed to the injury. Another bill focused on arbitration agreements by physicians and other health care providers and patients. The law, which took effect May 2, details provisions that must be included in binding arbitration agreements, as well as the requirements such agreements must meet.

Several insurance-related bills have been signed into law in **Wyoming**:

- Insurers no longer are required to issue non-renewal and cancellation notices to policyholders when: a property/casualty insurance policy is transferred from an insurer to an affiliated insurer under common management and control; the insurer changes as a result of a merger, acquisition or company restructuring; or the transfer results in the same or broader coverage.
- Wyoming is permitting tax-exempt religious and charitable organizations to self-insure their auto liability coverage obligations if they can demonstrate to the state auditor that they have met certain minimum financial responsibility requirements. Instead of proof of insurance, these groups may now file cash, securities or a surety bond in the amount of $50,000.
- Wyoming has adopted the National Assn. of Insurance Commissioners' model act that treats service contracts and other types of warranties as insurance products for regulatory purposes. Now companies and organizations that sell such contracts in the state must either purchase reinsurance to back them up or establish reserves to ensure they will meet their obligations. Fees paid for the service contracts will not be subject to state premium taxes, however.
- The Wyoming Legislature has granted civil immunity to government entities and their employees for any computational, operational or interpretive errors, malfunctions or failures caused by the Y2K date change. The immunity pertains to all types of computer and information system hardware and software, including, but not limited to, devices containing date-dependent embedded chips.

PROPERTY/ CASUALTY

The **California** Senate approved a measure that would permit bad-faith claims-handling lawsuits against insurers by third parties. Dubbed the "Royal Globe Bill" because it would make statutory case law that had existed as a result of a third-party bad-faith decision in a case involving Royal Globe Insurance Co., the bill has been opposed by insurer and tort reform organizations. But it is backed by trial lawyers and the Democrat-controlled legislature.

The Sacramento-based Civil Justice Assn. of California estimates the bill would raise insurance costs by more than $1.5 billion a year as a result of frivolous lawsuits, coerced settlements, reduced protection against fraudulent claims and increased court caseloads.

Trial lawyers are attempting to limit the statutory $250,000 cap on non-economic damages that has been in place in California since the 1970s. A bill that passed the Assembly would erode the cap by providing for increases tied to the cost of living.

Another bill that passed the Assembly could increase employment litigation in the state by virtually eliminating arbitration clauses in employment agreements.

Any information in a lawsuit that indicates allegations of a product or environmental hazard or financial fraud must be made public under another trial lawyer-supported bill. However, the bill contains no guidelines to permit a judge to sort out a genuine threat from junk science, vindictive exaggerations or vague rumors, the Civil Justice Assn. points out.

All the bills have passed the chamber in which they were introduced and next go to the other chamber, either the Senate or the Assembly.

Hawaii Gov. Benjamin Cayetano is expected to sign a bill that would allow the formation of rent-a-captives.

In **Oregon**, the legislative session began Jan. 11, and legislators were still weighing bills as of June 16. Legislators are considering a few tort-related bills. Policyholders are backing The Oregon Environmental Cleanup Assistance Act, which would require commercial general liability insurers to provide defense costs and coverage for any fees and expenses incurred for voluntary cleanups, regardless of whether a cleanup results from a lawsuit or is requested by the Department of Environmental Quality or other third party. The bill passed the state Senate June 11.

Also in Oregon, employers are sponsoring a bill to address the state's Employer Liability Act, established in 1910. The act predates the state workers compensation system and exclusive remedy provision. Plaintiffs have been using the ELA to circumvent the exclusive remedy system, because the ELA allows employees of a subcontractor to sue the general contractor or the property owner where an injury occurred. The act currently does not have a cap on non-economic damages. This bill would limit non-economic damages to $500,000 in death actions. It also would make it impossible to recover if the plaintiff is more than 50% at fault.

Another Oregon bill would provide a liability shield for uncompensated care provided by doctors. If a physician provides services and is not compensated, a plaintiff would face a higher burden of proof for gross negligence and intentional recklessness. The bill has passed the House and moved to the Senate.

Washington Gov. Gary Locke signed into law a bill that extends Year 2000 liability protections to government agencies and certain public utilities. The law took effect upon the governor's signing. Under the law, any liability will be several and not joint. Liability will be determined as a percentage of fault. The law also establishes, among other things, that agencies will have no liability for the first $100 of damages. Additionally, it provides for an affirmative defense in some cases. For example, an affirmative defense is permitted where a defendant can show that, were it not for the Y2K failure, the defendant could have satisfied the contractual obligation that was the basis for the claim.

No significant tort reform legislation was enacted in **Alaska**. BI

Structured settlement reform makes progress

By MEG FLETCHER

WASHINGTON—Six state legislatures have adopted structured settlement reforms during the current term, and more states are expected to do so in the future.

Similar measures have been introduced in about 20 states recently and have been signed into law by the governors of Maine, Minnesota, Virginia and West Virginia. Another bill is awaiting the governor's signature in Missouri.

Meanwhile, Georgia enacted another version of the law recently, but it lacks some key protections favored by the Washington-based Structured Settlement Trade Assn., according to Randy Dyer, executive vp of the SSTA.

The American Insurance Assn. joined with that trade association to launch a campaign early this year to better protect shortsighted injury victims from selling their structured settlement rights to companies that buy them for sharply discounted lump sums (*BI*, Jan. 18).

Structured settlements are voluntary agreements that provide long-term financial protection for injury victims. They are intended to protect the victims and their families against the loss or dissipation of lump-sum recoveries.

The targeted transactions involve specialty finance companies—known as factoring companies—that make significantly discounted cash payments to settlement recipients in exchange for all or part of the periodic payments, which often are paid through an annuity sold by a life/health insurer.

Factoring companies maintain that such settlement resales provide claimants with needed flexibility and immediate, lump-sum cash in times of special need.

Certain insurers are seeking greater oversight of settlement resales, hoping to slow the use of the practice. Such insurers say the widespread resale of structured settlements could jeopardize the current tax-free status of all such settlements. Current law lets the injured person receive the settlement benefits tax-free, but the recipient cannot change the terms, such as the amount or the frequency of payments.

Insurers also are concerned about a Florida judge who required an insurer to twice pay state-ordered workers compensation benefits to a recipient who sold his rights to the first set of payments to a factoring company.

Joining in the lobbying effort for greater oversight of resales are many property/casualty trade associations, state attorneys general, trial lawyers and the Consumer Federation of America, as well as organizations representing veterans and those with spinal cord injuries.

Certain insurers are seeking greater oversight of settlement resales, hoping to slow the use of the practice.

At the state level, insurer trade groups encouraged the adoption of several key provisions in the legislative proposals:

- The recipient of the structured settlement payments must demonstrate hardship to transfer a structured settlement to another party and must receive independent professional advice concerning the financial impact of the proposed transfer.
- There must be clear, written notification of the key economic terms of the proposed transfer, including the net amount payable by the settlement purchaser as well as any additional costs and fees.
- A court must approve the transfer.
- All parties involved—the purchaser, seller and insurers—must be fully informed of all provisions of the settlement transfer.

These provisions have been included in the majority of bills adopted this year. Also, laws with a similar intent previously have been enacted in Connecticut, Kentucky and Illinois.

The new Georgia bill, which was based on a state law to encourage fair business practices, does not require a seller to demonstrate financial hardship and does not require court approval of the resale, Mr. Dyer said. In addition, the highest penalty for an infraction is only $1,000, which may not be much of a deterrent to a factoring company, he said.

Generally, "legislators are shocked to see that residents of their state are subject to these kinds of abusive practices from unregulated companies" such as factoring companies, Mr. Dyer said.

According to statistics from the Insurance Services Office Inc., structured settlements are used to settle about 12% of all injury cases, though the percentage rises to more than 20% in cases involving $1 million or more in damages.

"Structured settlements help resolve these cases," Mr. Dyer said. When such settlements are used, cases settle sooner and cost less, he said.

In addition, legislation is pending in both the U.S. House and Senate to impose a 50% excise tax on settlement purchasers; the Clinton administration previously proposed a 40% tax. "To be enacted, either measure will likely be attached to a larger tax bill that is expected to develop later in the congressional session," according to the AIA statement. BI

Health

Continued from page 1
general anesthesia for dental work.

While perhaps the most popular mandate among state legislators requires insurers and HMOs to offer coverage for certain benefit expenses, that is only one type of mandate.

In response to public criticism of HMO decision-making, about 10 states so far have passed measures mandating managed care participants' right to appeal coverage decisions to external review panels.

But if benefit mandates are the order of the day, other once-popular initiatives have largely fallen by the wayside.

For example, while measures were introduced in 37 states opening up health care plans that improperly deny coverage to causes of action under state law, only Georgia passed such a measure this year.

And even the Georgia law is limited. Under the new statute, managed health care plan administrators who fail to exercise due diligence in considering claims can be held liable for compensatory—but not punitive—damages.

While measures are pending in more than a dozen states that would hold insurers and HMOs liable for coverage decisions, those measures are unlikely to pass in any of those states, predicts Susan Laudicina, director of research in Washington for the Blue Cross & Blue Shield Assn.

"Radical reforms are not happening. Liability (for health plans) is being defeated. The revolutionary blood-letting has passed," Ms. Laudicina said.

At the same time, compromise is the order of the day on many mandates.

The mental health care mandates are examples of political compromise. Typically, the mental health care mandates only apply to severe, biologically based disorders, while several states have exempted small-group plans and others exempt plans whose compliance would cause group health care costs to exceed a certain percentage of premiums.

Compromise is a political necessity, says Susan Dore, senior legislative adviser in Cape Elizabeth, Maine, for the National Alliance of the Mentally Ill. "Republicans do not like voting for open-ended mandates," she said.

Here is a roundup of state health care legislative activity, based on reports by *Business Insurance* staff and coordinated by Editor-at-Large Jerry Geisel:

Continued on next page

1999 STATE LEGISLATIVE WRAP-UP

Continued from previous page

The **Connecticut** Legislature has passed an omnibus managed care bill that requires parity for mental health benefits; extends required coverage for experimental treatments; protects the confidentiality of patient records; limits the use of drug formularies by health plans; and creates new health plan mandates, including coverage for prostate cancer screening and Lyme disease treatment. Early versions of the bill also would have funded a study into expanding health plan legal liability, but that provision was dropped from the final bill. The measure is expected to be signed into law by Gov. John Rowland, who earlier this month signed a bill mandating health plan coverage for prescription contraceptives. The mandate takes effect Oct. 1.

Maine has enacted a trio of managed care mandates, including laws requiring reimbursement of registered nurse first assistants and nurse practitioners and requiring drug plans to cover prescription contraceptives.

In **Massachusetts**, a bill pending in a House committee would require managed care plans to offer an external appeals programs. The measure also would require health plans to cover emergency room care.

Another bill still in committee in Massachusetts would mandate parity for mental health care benefits. The measure, among other things, would eliminate the current $500 cap that health plans can impose on payments to mental health specialists.

Action on several bills in **New Hampshire** has been delayed while the Legislature deals with education funding reform measures. Nevertheless, the Legislature is expected by the end of this month to enact "The HMO Accountability Act." The act, as proposed by New Hampshire Gov. Jeanne Shaheen, would provide for external review of HMO decisions involving the denial of care; make HMO medical directors accountable to the state board of medicine for treatment decisions; require HMOs to disclose financial arrangements or incentives with medical providers that may affect treatment decisions; and allow patients to sue HMOs for negligence after exhausting internal and external grievance processes. Another pending bill would require health plans to give physicians 60 days' notice before making any changes to the physicians' contracts.

In **Rhode Island**, a managed care liability bill giving patients the right to sue HMOs is pending before the House and Senate.

In **Vermont**, legislation was enacted that requires health plans offered by insurers and HMOs to cover clinically necessary services provided by chiropractic physicians on the same basis as they do other services.

Another new law requires insured health care plans that offer prescription drug benefits to cover prescription contraceptive devices approved by the federal Food and Drug Administration on the same basis as they cover other prescriptions.

In addition, the Senate approved a bill that would make health insurers and HMOs liable under state law for their medical decisions. The Vermont House is expected to consider the measure next year when the session resumes.

In **Delaware**, three bills that would affect health insurance plans remain in committee. The first would mandate insurance coverage for contraceptive drugs. The second bill would require that managed care organizations in Delaware be headed by a Delaware doctor. The third, a managed care liability bill, would give patients the right to sue health plans and providers.

The **District of Columbia** City Council passed a "bill of rights" for health benefit plan participants in 1998 . Among other things, the measure requires the establishment of internal and external review mechanisms to resolve grievances and requires that female plan beneficiaries have direct access to obstetrician/gynecologists. The new law took effect in April.

A new **Maryland** law requires HMOs and insurers to cover hearing exams for newborns on the same basis as they cover other medical procedures.

Maryland legislators also passed a measure—later signed by Gov. Parris Glendening—that requires HMOs to allow enrollees with life-threatening, degenerative, chronic or disabling medical conditions to see a specialist in the network for continuing care without first going to the plan's gatekeeper or primary care physician.

Under this law, HMOs and other managed care plans must establish a procedure in which members with a standing referral from an HMO gatekeeper could directly go to a specialist.

The law also imposes a new coverage mandate affecting patients who undergo a mastectomy or have a testicle removed. Patients undergoing such procedures who are discharged after fewer than 48 hours of hospitalization shall have coverage from their insurer or HMO for one home visit within 24 hours of discharge. Such patients also are entitled to coverage for one additional home visit if prescribed by the patient's attending physician.

In addition, the measure requires HMOs and insurers with prescription drug formularies to provide coverage for a drug not in the formulary if any one of several conditions is met. Those conditions are:

- There is no equivalent prescription drug in the formulary.
- The equivalent prescription drug in the formulary has been ineffective in treating the disease or condition of the enrollee.
- The equivalent prescription drug in the formulary is likely to cause an adverse reaction or other harm to the member.

Gov. Glendening also signed a measure that bars health insurers from offering employers stop-loss policies with attachment points of less than $10,000 for specific claims or aggregate attachment points of less than 115% of expected claims.

New Jersey Gov. Christine Whitman signed a limited mental health parity measure that requires insured health plans to provide equal coverage—including equalization of deductibles, copayments and lifetime limits—for physical illness and severe biologically based mental illness.

Awaiting Gov. Whitman's signature is a bill that sets the standards for electronic filing of health claims. The bill also requires health insurers to pay uncontested electronically filed claims within 30 days of receipt.

The legislative session doesn't close until the end of the year, and many bills remained pending. One such measure—with versions pending in both chambers—would impose a surcharge on HMO premiums to create a $150 million fund to pay providers who were left with unpaid bills when two New Jersey-domiciled HMOs failed earlier this year.

Another bill would make health plans liable under medical malpractice laws for their coverage decisions.

No health care measures have become law this year in **New York**, but a few bills have passed the Assembly and are pending in the Senate. These include a measure that would hold health plans liable for harm caused by the wrongful denial or delay of care or payment for covered services. Also pending in the Senate is a bill that would let a patient continue care with a provider for up to one year after the provider has left a network. A mental health parity bill also is pending in the Senate.

In **Pennsylvania**, several health care bills are pending, including:

- A House bill that would mandate the creation of statewide HMO report cards and require HMOs to provide information necessary to create them.
- A measure pending in the Senate would require health plans to allow members direct access to chiropractors.

Meanwhile, three health care-related laws were enacted in Pennsylvania in late 1998.

One new law requires health plans to cover the costs of equipment and supplies for diabetics. Also made law was a mandate requiring health plans for employers with 50 or more employees to cover 30 inpatient days of mental health treatment and up to 60 visits for outpatient treatment annually. Another law requires health plans to cover emergency screening and stabilization for plan members.

No significant health care legislation was passed in **West Virginia**.

A **Florida** bill signed by Gov. Jeb Bush will require HMOs to give employers at least 45 days' notice before renewing a group plan that includes increases in copayments. That notice also must be given if the renewal deletes or limits benefits previously offered in the plan. The same bill, which takes effect July 1, will require HMOs that cover massages to cover the cost of all massage services prescribed as medically necessary by a licensed physician.

Another law that will take effect July 1 will require health care plans to cover, without prior authorization, one annual visit to an obstetrician/gynecologist and follow-up care if needed.

Under a measure that will take effect Jan. 1, insurers and managed care plans would be required to cover the costs incurred by a bone marrow donor to the same extent coverage is provided to the insured recipient. Some restrictions are allowed with regard to costs related to locating a donor.

In **Louisiana**, a bill that narrows employers' liability for the cost of medical monitoring passed the Louisiana House and was sent to the Senate.

The bill addresses the Louisiana Supreme Court's ruling in an asbestos case, *Bourgeois vs. A.P. Green*, which some have interpreted to mean businesses can be liable for medical monitoring of individuals who have been exposed to a harmful substance but show no signs of illness. The bill specifies that compensable damages do not include costs for monitoring, future medical treatment, services or procedures unless they are "directly related to a manifest physical or mental injury or disease."

Louisiana lawmakers also passed a bill under which insurers would be required to offer employers coverage for mental illnesses. The bill says insurers' group plans must include coverage for mental illness under the same terms as coverage for other illnesses. The insurance would have to cover 45 inpatient days and 52 outpatient visits. Gov. Mike Foster had not received the bill as of June 14.

The **North Carolina** House approved a managed care bill that contains a number of mandates, including an any-willing-provider provision, a broad point-of-service provision and a provision requiring direct access to eye care providers. The measure now is before the Senate.

The measure is one of more than 40 health care-related bills introduced in the current General Assembly; only two have passed both houses. One of those that awaits the governor's signature would require health plans to cover non-formulary drugs and devices when they are deemed medically necessary. The other requires health insurers to have procedures to guarantee that plan members can get an extended or standing referral to an in-plan specialist for chronic or life-threatening diseases.

In **Tennessee**, a bill awaiting Gov. Don Sundquist's signature would require health insurers and HMOs to offer women under age 29 coverage for tests to detect chlamydia if such a test is determined to be medically necessary. The coverage would be available in policies written or renewed after July 1, 1999.

The **Virginia** General Assembly approved, and Gov. James Gilmore signed, a few managed care measures in its 1999 session. One requires external review of coverage disputes, creates a managed care ombudsman's office, requires standing referrals for people with "special conditions" and mandates coverage for clinical trials for cancer.

A mental health parity measure that takes effect Jan. 1, 2000, requires that insured plans offer the same level of coverage for biologically based mental illness as they do for physical conditions. The law does not apply to employers with fewer than 25 employees.

Georgia Gov. Roy Barnes signed two measures that formed his major health care initiative this session. The first allows enrollees to seek compensatory damages against anyone administering a managed care plan who does not "exercise ordinary diligence." Before going to court, plan enrollees must exhaust the plan's external review process.

The other law requires managed care plans to provide additional access to and reimbursement for services of out-of-network providers and hospitals. It also requires full disclosure to potential enrollees of such information as covered services or benefits, rules such as copayments or prior authorization requirements, and financial obligations of the enrollee. Both measures take effect July 1.

Other new laws taking effect July 1 in Georgia:

- Insured health plans must provide coverage for prescription contraceptives.
- Attending physicians get complete discretion in determining a patient's length of stay in a hospital after a mastectomy.
- Health insurers and HMOs are required to cover general anesthesia and related care when required for the treatment of a child, developmentally disabled adult or in other cases when the patient's well-being might be jeopardized by performing the procedure under local anesthetic.
- Health insurers and HMOs will be required to provide unlimited coverage for prescription inhalants for asthma or other bronchial ailments.

A bill signed into law by **Mississippi** Gov. Kirk Fordice requires health insurers to cover anesthesia for dental treatment when the mental or physical condition of a child or mentally handicapped adult requires dental treatment to be provided under physician-supervised anesthesia. The measure takes effect July 1.

No major health care legislation passed in **Alabama** or **South Carolina**. **Kentucky**'s lawmakers were not in session.

The **Illinois** Legislature recently approved a major patient protection bill that applies primarily to HMOs, although it excludes union HMOs and those dealing with workers compensation cases. The utilization review part of the bill applies to a broader range of plans, including PPOs and insured plans. That provision essentially requires that health plans comply with the standards of the American Accreditation Health Care Commission/URAC, though plans need not be accredited.

If enacted, the general measure would ensure patients enrolled in most HMOs freedom to choose a participating physician responsible for coordinating their care, and it

Continued on next page

1999 STATE LEGISLATIVE WRAP-UP

1999 STATE LEGISLATIVE WRAP-UP

Continued from previous page

would ban so-called gag clauses so that physicians can freely discuss treatment options with patients. The measure also would allow patients with conditions that require ongoing care from a specialist to apply for a standing referral so that a patient does not have to go to a gatekeeper each time. It also would ensure privacy and confidentiality of medical records as well as the right to use a broader range of pharmacies, including local ones.

The measure also would require that emergency services be rendered without prior authorization in cases where a prudent person believes the condition requires emergency care.

HMOs also would have to provide enrollees and prospective enrollees with information about operating policies and appeals and give 60 days' notice of termination of a health care provider.

The measure also would create a committee to identify consumer concerns and make recommendations to health care plans.

In addition, the Legislature approved a bill that requires health plans to pay patient care costs associated with investigatory cancer treatments, such as special trial programs.

Both bills are awaiting the signature of Gov. George Ryan.

Still pending in the Senate is a House-passed measure that requires health plans to pay for all FDA-approved drugs for treatment or prevention of breast cancer.

Indiana Gov. Frank O'Bannon has signed legislation that establishes a process for health plan enrollees to appeal coverage denials to an independent external review organization.

Another bill signed by Gov. O'Bannon removes the upcoming expiration date of an existing health insurance-related law. The law mandates that if a health insurance plan offers mental health benefits, the coverage must have limitations and financial requirements similar to that of other medical benefits. Under the measure, health plans for employers with fewer than 50 employees are exempt from this mandate. A business also is exempt if complying with this mandate would raise rates or HMO contracts by more than 4% percent annually.

Both measures take effect on Jan. 1, 2000.

No significant health care legislation has passed so far during **Michigan**'s year-long legislative session. Health care bills under consideration include:

- A continuity-of-care bill that would provide extended coverage to terminally ill and pregnant women if their physician leaves the practice.
- A bill that would require health plans to provide an exception to drug formularies in cases where a suitable substitute is not available.
- A proposal that would require health plans to allow direct access to pediatricians for dependents without prior approval. This measure would affect health plans that require enrollees to designate a primary care provider.
- Bills that would prohibit an insurer from requiring a patient to take a genetic test or provide genetic information.
- Both the House and Senate are considering bills that would make health insurers accountable for treatment decisions.

Minnesota Gov. Jesse Ventura signed legislation that allows health plan enrollees to appeal coverage denials to an independent reviewer.

In **Wisconsin**, a bill has been introduced that, among other things, would create a small-employer health care purchasing pool. The provision would allow the commissioner of insurance to make a grant of not more than $200,000 to a private organization to establish a health insurance purchasing pool for small employers. If passed and signed, the budget measure will take effect on the later of July 1 or the day after publication.

Another measure would require the state's Department of Employee Trust Funds to design, establish and administer a health care coverage plan for private-sector employers. It also would create a health care coverage board responsible for approving the health care plan before it is implemented. The plan would be open to any private sector employer with two or more employees. Participating employers would be required to offer coverage to all permanent employees working more than 30 hours per week and would be required to pay at least 50% of the lowest premium available for the coverage. Any insurer offering the plan must provide coverage to any employer that applies, as long as the employer pays the premium and agrees to comply with plan requirements. If enacted, the plan would take effect on the date after publication and includes a provision to sunset on Jan. 7, 2007. The measure is in the Assembly's Small Business and Economic Development Committee.

Another proposal would require insurers to cover acupuncture treatment and would not require a physician's referral for such treatment. The measure has been referred to the Assembly's Committee on Health.

Other legislation includes a measure that would require health plans to cover smoking cessation treatment and a bill that would require coverage for contraceptive articles and services if the insurance policy covers outpatient health care services. The contraceptive coverage would be limited to drugs or devices used to prevent pregnancy and would not apply to drugs or devices prescribed for terminating pregnancy. Both measures have been referred to the Assembly's Committee on Insurance.

No significant health care legislation has been passed so far during the legislative session in **Ohio**.

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1999 STATE LEGISLATIVE WRAP-UP

Continued from previous page

Kansas Gov. Bill Graves signed two health care measures.

One requires group health insurers and managed care organizations to provide coverage for general anesthesia and medical care facility charges for dental care to children under five years old, persons who are severely disabled, and those whose medical or behavioral condition requires hospitalization or general anesthesia for dental care. The law also requires group health insurers and managed care plans that cover mastectomies to provide coverage for the costs for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and physical complications in all stages of mastectomy.

The other law affects small employers—those with no more than 50 employees—and will provide tax credits to employers paying group health insurance premiums. The tax credits will be offered over a five-year period.

Missouri Gov. Mel Carnahan is expected to sign legislation that would require parity in the number of covered inpatient days and outpatient visits for treatment of severe biologically based mental disorders and physical ailments. In the case of substance abuse, though, plans could impose a 30-day annual inpatient limit and a 20-visit outpatient limit. Employers that experience a 2% increase in premiums as a result of complying with the requirements can request an exemption from the Missouri Department of Insurance.

That bill also includes other health care-related provisions, including one that would require health plans to cover tests for the screening of several forms of cancer, including cervical, prostate and colorectal.

Also, the governor is considering a measure that would require health plans to pay for hearing deficiency screening for newborns.

Another bill on the governor's desk establishes an advisory commission on health insurance mandates that will review future proposals.

Nebraska Gov. Mike Johanns signed into law a bill requiring that group health care plans provided through insurers and health maintenance organizations offer the same number of covered inpatient days and outpatient visits for treatment of severe biologically based mental disorders as they do for physical ailments.

The governor also signed a bill that requires health plans to cover equipment, supplies and self-management training for those needing dialysis.

South Dakota Gov. William Janklow signed a bill that requires health plans to cover emergency services if a "prudent layperson" would agree that a plan enrollee needed the services.

The governor also signed a bill that requires managed care health plans to provide plan enrollees "adequate" networks of doctors and hospitals.

Another new law requires utilization review service providers to obtain state certification.

A law that mandates coverage for the cost of equipment, supplies and training for diabetics also was passed. All of the laws will take effect July 1.

North Dakota Gov. Edward T. Schafer signed a measure that amends state law governing health insurance and public retirement system coverage of mammograms. Among other things, the law requires that health insurers cover annual mammograms for women over age 40. Previously, the law had provided for coverage of mammograms every two years for women over 40 and annually for women over 50. The act takes effect Aug. 1.

Another measure signed into law changes state laws pertaining to health care service utilization review and preferred provider organizations. The law, among other things, requires health care providers that contract with other parties for utilization review to ensure that those UR providers meet all state requirements. The measure also stipulates that preferred provider plans may not offer inducements to preferred providers to provide less-than-medically-necessary services to covered persons, and it provides that health care insurers may not penalize providers who, in good faith, report to state or federal authorities any acts they believe are jeopardizing patient health or welfare. The act takes effect Aug. 1.

A major health care bill that addresses continuity of care, emergency services coverage, discussion of treatment options, external review and utilization review was signed by **Iowa** Gov. Thomas Vilsack.

The bill provides for continuity of care for pregnant women in the second or third trimesters through the postpartum period and for terminally ill patients for up to 90 days. Under the measure, such an individual may remain with a provider for the specified period after an involuntary change in his or her health plan even if that provider is not a participant in the patient's new plan. Payment for covered benefits and the level of benefits follow the patient's new plan, the bill says. In addition, the new law requires an insurer to cover emergency care services regardless of whether the provider is in the plan.

Additionally, the bill requires insurers that limit coverage for experimental treatments, devices and drugs to submit to the state's Division of Insurance their procedure for evaluating such treatments.

These components of the measure take effect July 1.

Health plan enrollees also are granted the right to appeal coverage decisions to an external review organization. This component takes effect Jan. 1, 2000.

Another Iowa bill signed by the governor requires insurance coverage for supplies, equipment and self-management training for diabetics.

Arizona lawmakers agreed to ask the state's Department of Administration to study the feasibility of adding long-term care coverage to state employees' benefits package. Gov. Jane Hull signed the measure April 27, and the study is due by Nov. 15.

Health care legislation, including a mental health parity bill, largely died in the Arizona Legislature this spring.

Oklahoma Gov. Frank Keating has signed into law several patient protection acts and benefit mandates.

On May 28, the governor signed a bill that protects and expands the rights of managed care plan enrollees; the measure goes into effect Nov. 1.

The measure's provisions, among other things:

- Direct the State Board of Health to promulgate regulations ensuring that managed care and utilization review firms are treating patients fairly.
- Require that plans without network specialists needed to care for patients with life- or limb-threatening conditions refer the patients to nonnetwork providers. The patients' care must be covered as though they had received in-network care.
- Require plans to establish procedures that allow specified patients, such as pregnant women, to continue to see their physicians for up to 90 days after the physician voluntarily leaves the plan or is terminated for reasons other than cause.
- Direct plans that require enrollees to obtain prior authorization for certain drugs to decide whether to approve a request within 24 hours of receiving it. Otherwise, the enrollee is entitled to a three-day supply of the drug. Approval of the drug is auto-

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1999 STATE LEGISLATIVE WRAP-UP

Continued from previous page

matic if the plan does not rule on the enrollee's request by the end of the three-day period.

The governor also signed legislation that creates an external review process to help resolve health plan enrollees' grievances. After a complaint goes through two internal reviews at the health plan, the enrollee can request an outside medical reviewer to issue a non-binding recommendation. The health plan chooses the reviewer from a list of reviewers certified by the State Department of Health. The law takes effect Nov. 1.

Blue Cross & Blue Shield of Oklahoma supported the law because the outside recommendation is non-binding and because lawmakers killed a more-onerous measure that would have extended medical liability to health plans and medical directors if plan enrollees were unhappy with the care they received.

Gov. Keating signed a mental health parity law that applies only to individuals with severe biologically based mental disorders. The law exempts employers with 50 or fewer employees. And, if an employer's premium costs rise more than 2% in the first year, that employer would subsequently be exempted from the law. In addition, the law would be repealed in 2003 if an Oklahoma Insurance Department study shows that the mandate has increased employers' health care costs by 6% over three years from its Nov. 1 effective date.

The governor also has signed several benefit mandates into law. One requires health plans to cover audiology services and hearing aids for children 13 and younger; another requires plans to cover prostate cancer screenings. The mandates also take effect Nov. 1.

In addition, the governor on April 19 signed into law a measure that clarifies the dental anaesthesia mandate the Legislature passed last year. That law took effect immediately.

Arkansas lawmakers passed and Gov. Mike Huckabee signed health care measures that:

- Impose NAIC risk-based capital requirements on HMOs.
- Prohibit group disability insurers from denying or reducing benefits because of the existence of other like insurance, except in cases where the total benefits received from multiple policies would exceed actual medical expenses.

"Other like insurance" may include group or blanket disability insurance or group coverage provided by HMOs; hospitals and medical service corporations; government insurance plans, except Medicaid; union welfare plans; employer or employee benefit organizations; or workers comp or no-fault automobile coverage.

- Require health plans to provide the minimum benefits for medical foods and low-protein modified food products for the treatment of a covered individual with phenylketonuria, or PKU, as long as the foods are prescribed as medically necessary and the cost of the food products exceeds the $2,400 per-year per-person income tax credit individuals and families get for the purchase of such products.
- Require every health insurer to offer coverage for hospice facilities and programs.
- Require group health insurers to disclose non-confidential information to group policyholders with more than 99 employees under a comprehensive health insurance policy. Information would be from the most recent 12-month period, including claims incurred, premiums paid and claims exceeding $10,000 on individuals with a diagnosis during the same period.
- Require all health insurers that provide or arrange for one or more managed care plans to establish a program of grievance and quality assessments and improvement procedures.
- Require health plans with dental plans to include a dental point-of-service option.
- Allow HMOs to offer health benefit plans that reimburse for covered health services through limited network plans under certain conditions. The law does not prohibit HMOs from pricing any health benefit plan according to sound actuarial principles or require HMOs to cover any specific health care services.

Texas lawmakers passed the nation's first bill that allows doctors to band together to negotiate rates and contract issues with health care plans.

Gov. George Bush is expected to sign the bill, which insurers and employers fought, arguing that it would raise costs.

"Those that support it would like us to believe it's about everything but increasing fees," said Ralph Kimmich, president of the Texas

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Business Group on Health. "I guarantee you, (physicians) won't negotiate on reducing fees."

The Texas Medical Assn. and other proponents of the measure said physicians have been offered take-it-or-leave-it deals from health plans and threatened with antitrust actions if the doctors attempted to negotiate higher fees or different contract terms. The law takes effect Sept. 1.

A bill awaiting Gov. Bush's signature contains the single coverage mandate passed during the session. It calls for insurers to cover the cost of hearing tests for newborns and applies to health plans written or renewed after Jan. 1, 2000.

Another bill awaiting Gov. Bush's signature calls for a study, to be completed by Jan. 1, 2001, that would analyze the effects of mandates on the cost and availability of health care.

Gov. Bush has signed a bill that requires HMOs authorized to provide basic health services to maintain a minimum net worth of $1.5 million. Those that provide limited health care services must maintain $1 million in net worth, and for HMOs that offer a single health care service plan, the net worth requirement is $500,000. The bill takes effect Sept. 1.

No significant health care legislation passed in the most recent legislative session in **New Mexico.**

Colorado passed several health care bills.

One law clarifies that insurance benefits available to newborns shall include coverage of all medically necessary care and treatment of medically diagnosed congenital defects and birth abnormalities for the first 31 days of the newborn's life. The law, which will take effect Jan. 1, 2000, also requires health plans to provide medically necessary physical, occupational and speech therapy for the care and treatment of congenital defects and birth abnormalities in children up to age 5.

A new law requires HMOs to pay for continuing care services by an out-of-network provider if:

- The beneficiary is returning to the same location where he or she lived prior to hospitalization.
- The beneficiary has a continuing care contract or rental agreement with the facility at that location.
- The service is one for which the HMO would be liable if provided by an in-network provider.
- The beneficiary needs the level of care provided by the continuing care provider.
- The provider is willing to accept payment under the same terms as an in-network provider.

This law also will take effect Jan. 1, 2000.

Another law requires health plans that provide coverage for second opinions to disclose the availability of the second opinion coverage along with the health benefit description form.

The law, which takes effect July 1, also permits the use of standing referrals to specialists for certain treatments and sets forth the procedures for denying benefits.

Legislation enacted in **Montana** includes:

- Insurers in Montana that limit health benefit payments to charges that are "reasonable and customary" must provide the insured with a schedule that shows how the reasonable and customary fee is calculated. This law will take effect Oct. 1, 1999.
- As of Jan. 1, 2000, insurers must pay the costs associated with a policyholder's self-referral to a naturopathic physician.
- Health plans will be required to provide the same coverage for severe mental illness and chemical dependency treatment as for any physical illness. The new law takes effect Jan. 1, 2000.
- The benefit mandate for coverage of the treatment of phenylketonuria, a protein deficiency in newborns, was expanded. Insured health plans now must also pay for prescription medical foods and dietary supplements in addition to any medical treatment for the condition.
- Independent review must be made available for health insurers' and managed care plans' coverage denials. In addition, insurers and managed care plans no longer can include indemnification or hold-harmless clauses in their provider contracts. And insurers and managed care plans cannot terminate their contracts with pro-viders without just cause, such as the failure to satisfactorily perform contract obligations. This new managed care liability law, which takes effect Oct. 1, 1999, does not apply to Medicaid, the new Children's Health Insurance Program or to other state-funded health care programs.
- Insurance companies in Montana no longer can disseminate the medical information they collect for underwriting purposes to third parties without first obtaining the written permission of the policyholders and/or health plan members affected.

A Senate bill signed into law by **Nevada** Gov. Kenny Guinn mandates that health insurers and HMOs must offer coverage for at least 40 days of hospitalization and 40 outpatient visits for mental disorders, but limits coverage to these six conditions: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders and obsessive-compulsive disorder.

Another new law requires insurers to notify employees of any denied health care claims within 10 working days and clarifies that managed care organizations must provide coverage for medically necessary emergency services provided to an insured at any hospital. These provisions take effect Oct. 1.

Other health care legislation approved and signed into law in Nevada includes measures that:

- Requires insurers to provide coverage for prescription contraceptive drugs and devices and for hormone replacement therapy. Under the measure, no higher deductible, copayment or coinsurance can be charged, nor a longer waiting period required, for use of these services.
- Provides insured women access to certain obstetric and gynecological services without prior authorization or referral from a primary care physician.
- Requires health insurance policies to pay for federal Food and Drug Administration-approved drugs that have been medically recognized as effective in the treatment of cancer, even if the drug was originally developed for other purposes. The bill does not specify level of coverage.
- Among other things, prohibits insurers from making partial payments on fully payable claims.

Wyoming enacted a measure establishing a health insurance program for uninsured children whose families are not eligible for Medicaid and whose household income is less than 133% of the federal poverty level. The program also provides vouchers for families earning between 133% and 150% of the federal poverty level. The vouchers can be used to purchase coverage for children from a state-run insurance program. That program, which was scheduled to begin July 1, is behind schedule because the governor has not yet appointed the 10-member Health Benefit Committee that will design and implement the plan, the Insurance Department's attorney said.

Wyoming also passed a law requiring group and individual long-term care insurers to return to policyholders any unearned premiums if the policyholder dies before he or she can file a claim. The law takes effect July 1.

Beginning July 1, group and individual life insurers in Wyoming will be required to pay interest on death benefits from the date of death until the date final payment is made. Under this law, life insurance claims also must be paid within 45 days of the date of a policyholder's death.

No significant health care legislation passed in **Idaho** or **Utah**.

HEALTH CARE

At least 65 pieces of legislation that run the gamut from mandating new health benefits to imposing greater liability on managed care plans have been passed by at least one legislative house in **California** this year.

There appears to be no end to the managed care backlash in California now that Democrats control both the legislative and executive branches of government, observers say.

"Both the Assembly and Senate leadership have said they're going to pass everything and let the governor sort them out," said a spokesman for the California Assn. of Health Plans, an HMO trade group based in Sacramento. "They're just passing things through with no debate or concern about the cost or impact."

Newly elected Gov. Gray Davis has not yet indicated how he will act on the bills when they reach his desk. Instead, his focus has been on revamping the state's educational system.

"It's going to be messy if he ends up with three different (managed care) liability bills and some of the bills conflict," the CAHP spokesman said.

Some of the major bills in California, whose legislative session runs through September, are:

- A bill that would allow HMO members to sue their health plans for improper denial of coverage or for perceived poor treatment.
- A bill that does the same as the former but also adds an external review process that would not be admissible in court should a lawsuit be filed.
- Two mental health parity bills that require insured plans to cover mental illness and substance abuse with the same copayments and limits as for other medical conditions on or after July 1, 2000.
- Two bills requiring insured health plans to cover prescription contraception.
- Two bills requiring the commissioner of corporations, who regulates HMOs in the state, to allocate funding for an independent health care ombudsman program on or before July 1, 2000.
- A bill requiring all insured health plans to provide coverage for prosthetic devices for the partially sighted, and a bill prohibiting health plans from refusing to cover or charging higher premiums to hearing or visually impaired individuals.
- A type of any-willing-provider bill that requires health plans to let enrollees choose their own primary care physicians, even if that provider is not a member of the network.
- Two bills requiring that all utilization review decisions be made by licensed medical providers, and a third bill that would virtually prohibit UR by permitting only health care providers, not plan administrators, to make treatment decisions.

All the California bills are pending.

In **Hawaii**, several health-related bills passed and were sent to Gov. Benjamin Cayetano on May 7. He has until June 25 to veto the bills or until July 25 to sign them.

One bill aims to protect the confidentiality of medical records and requires that employers and insurers safeguard information. The bill describes, within narrow parameters, the type of information that can be shared without plan member consent and information that requires consent. Information that can be legally shared requires health plans to notify members that there is a potential for the release of their health information. The bill would make it a crime and creates a civil cause of action for selling or improperly releasing information that requires consent.

Another measure establishes a $1 million revolving fund for the Insurance Division to regulate health plans. Health insurers will be assessed for the money, but that cost is likely to be passed on to employers, a Blue Cross of Hawaii spokeswoman said. Another bill calls for mental health parity for the treatment of serious mental disorders, which are defined to include illnesses such as schizophrenia and bipolar mood disorder. Another proposal yet to be acted on by the governor mandates hospice care.

Hawaii's governor already has signed one bill mandating that health insurers cover mammograms.

In **Oregon**, the legislative session began Jan. 11 and legislators were still weighing bills last week. A few health care-related bills were still under consideration at that time. A mental health parity bill had not yet been voted on by the full Senate, but made it out of a Senate committee. A bill requiring that the first 90 days of prescription drug orders be covered by a local pharmacy did pass the House on May 10, but had not passed through the Senate committee.

No significant health care legislation was passed in **Alaska** or **Washington**. BI

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INTERNATIONAL

Global Briefs

Ockham Holdings P.L.C. is to invest up to £2.5 million ($4.0 million) over the next two years in the development of **Premier Plus**, a new Windows-based quotation and administration software system for insurance brokers. Premier Plus is being developed by Stevenage, Hertfordshire-based New Millennium Technologies P.L.C., a subsidiary of Encompass International Holdings P.L.C. . . **The Strike Club**, a mutual that insures ship operating members against losses caused by strikes, has reported that the policy year to Feb. 1, 1999, was its worst for nearly a decade, with gross claims paid estimated at about $9 million. It said most of the claims came from a port dispute in Australia, industrial action in the Far East, and strikes in South America and Europe. . . French reinsurer **SCOR Group** has launched a 203 million euro ($209.2 million) convertible bond issue to help fund an expansion drive into new geographical markets and business sectors. One of its first investments has been to acquire full control of Commercial Risk Partners Ltd., a Bermuda-based non-traditional and alternative risk transfer reinsurer in which it previously held a 65% stake. . . A.M. Best Co. has assigned a B++ claims-paying ability rating to **Labuan Reinsurance (L) Ltd.** of Labuan, Malaysia. Best said the rating reflects its view that Labuan Re has good capital strength, strong support and long-term capital commitment from shareholders, and strong potential for internal capital generation and access to additional capital in the future, giving it a "good ability" to meet ongoing obligations to its cedents. . . The **Lloyd's Policy Signing Office** has introduced a new quality information system designed to reduce its costs to the market. The system aims to improve the quality of documents, such as premium accounting submissions and policies from brokers and underwriters, to improve the speed and accuracy of handling. The results of the assessments will allow the LPSO to offer support, such as training courses, guidance notes and consulting services. . . XL Capital Ltd. was planning to complete its $1.05 billion **merger with NAC Re Corp.** last Friday. Having already gained approval from shareholders and most regulators, the merger cleared its last hurdle after New York's Superintendent of Insurance gave approval last week. . . **Peter Christie** has left Aon Group Inc., where he was London-based vice chairman, to set up his own consulting business, Peter Christie Associates. . . **David Allvey** is to resign by September from Zurich Financial Services, where he is chief of corporate operations and a member of the board. A company statement said Mr. Allvey, who was instrumental in helping plan the merger of the financial service businesses of B.A.T Industries P.L.C. and Zurich Insurance Group that formed Zurich Financial last year, is leaving "to pursue other opportunities" because the merger has progressed more rapidly than expected. . . XL Capital Ltd. has named **Fiona Luck** to the newly created post of executive vp of group operations beginning July 1. She has been with ACE Bermuda since 1997, where she was promoted to executive vp last year. . . London-based **Prudential Corp. P.L.C.** plans to cut 4,000 jobs during the next three years, mainly in its pension and life insurance operations. The cuts are intended to enable Prudential to compete more effectively in the fast-changing U.K. financial services market.

Lloyd's losses forecast

By SARAH GODDARD

LONDON—A turnaround at Lloyd's may not be as likely as underwriters had hoped, according to research published by an insurance rating analyst last week.

Speaking at the launch of the 1999 Lloyd's Syndicate Rating Guide, Mark Hewlett, managing director of European property/casualty insurance and reinsurance at Moody's Investors Service Ltd., warned that Moody's research does not bear out speculation at Lloyd's that the insurance cycle is about to turn.

The London-based rating agency is anticipating a 2.2% loss on capacity, or £220 million ($351 million), on 1999 underwriting under current market conditions. That prediction is based on Moody's assumption that 1999 will be an average loss year.

"If the rest of the year is clear (of losses), 1999 could be better than 1998," said Mr. Hewlett, but the figures need to be considered against a background of rising loss frequency and severity.

The rating guide reinforces this point, using the words of Christine Dandridge, underwriter for syndicate 609. "There is much talk about the market turning. I am far from convinced about this, and I think we should prepare for a very lean year in 1999," the guide quotes her as saying.

The 1999 loss will follow an an-

See **Moody's** on page 27

Lloyd's top-rated syndicates

Syndicate	Agency	Syndicate rating	Volatility rating
557	RJ Kiln & Co. Ltd.	A (Very good)	Extremely High
779	Cassidy Davis Syndicate Management Ltd.	A (Very good)	Low
33	Hiscox Syndicates Ltd.	A- (Good)	Above Average
609	Atrium Cockell Underwriting Ltd.	A- (Good)	High
2020	Wellington Underwriting Agencies Ltd.	A- (Good)	Above Average

Source: Moody's Investors Service Ltd.

Swiss Re creating Lloyd's syndicate

LONDON—The seemingly gloomy prospects at Lloyd's of London don't appear to be discouraging new entrants to the market.

The London operation of Swiss Re Group, Swiss Reinsurance Co. UK Ltd., is venturing for the first time into Lloyd's by setting up a marine syndicate for the 2000 year of account. The new hull syndicate is a joint venture among Swiss Re, mutual insurance company manager Thomas Miller & Co. Ltd. and Lloyd's agency Chartwell Managing Agents Ltd.

The new syndicate will be backed by Swiss Re and Chartwell Re, and it will be managed by Chartwell Managing Agents. Thomas Miller will be the main shareholder in a company set up to market and service the syndicate. All three participants have signed a 10-year agreement supporting the new operation. Some of Chartwell's existing marine hull business, currently written into syndicate 741/2741, may be transferred to the new syndicate when it begins underwriting next January, according to a joint statement issued by the three companies participating in the venture.

At the same time, Lloyd's corporate capital provider, Benfield & Rea Investment Trust P.L.C., said it is in discussions with Benfield Greig Group P.L.C. regarding the acquisition of the remaining 70.01% of BRIT Insurance Ltd. that Benfield & Rea currently does not own. BRIT also is in talks with Wren P.L.C. about taking over the balance of the Wren shares BRIT does not own. Currently, BRIT holds 28.7% of Wren shares; the two deals together would mean Benfield & Rea, to be renamed BRIT Insurance Holdings P.L.C., would become a £300 million ($478 million) insurance group.

Coca-Cola products have been removed from shelves in Europe following a massive product recall.

AP/ WIDE WORLD PHOTOS

No long-term health consequences expected

Illnesses spur Coke recall

By SARAH GODDARD

Hot on the heels of Belgium's dioxin food contamination crisis this month, one of the world's most famous brands is facing questions about substances that may have contaminated its products in Belgium.

The Coca-Cola Co. recalled millions of cans and bottles of its soft drinks in Europe recently after dozens of people in Belgium and France became ill. Coke attributed the illnesses to defective carbonation and a fungicide used to treat storage pallets in a bottling facility.

Officials at Atlanta-based Coke could not be reached last week.

Insurance market sources said Coca-Cola likely has coverage for the recall, but coverage information was not available last week. Sources did confirm, however, that Coke had shopped for coverage in the London market.

The contamination came to light after more than 100 Belgian schoolchildren suffered nausea, dizziness and vomiting after drinking Coke products. The Belgian Health Ministry said there are no long-term consequences, however.

In a statement, Chief Executive Officer Douglas Ivester said Coca-Cola deeply regrets the problems. A Coke statement said the company had identified two possible sources of contamination, but "after thorough investigation, no health or safety issues were found."

See **Coke** on page 27

Big commercial losses unlikely from quake

PUEBLA, Mexico—The powerful earthquake that killed at least 15 people and damaged several historic churches and other buildings in the Mexican state of Puebla last week is unlikely to result in many large commercial losses, insurance experts in the region say.

While the city of Puebla itself contains several industrial plants, most of the damage was limited to old buildings in the downtown area that housed government offices and small businesses, said Ricardo Lopez, vp at Seguros Comercial America S.A. de C.V. in Puebla, which is about 70 miles southeast of Mexico City.

Seguros Comercial is expecting about 100 claims as a result of the earthquake, Mr. Lopez said.

The earthquake struck last Tuesday, registering a magnitude of 6.7. The epicenter of the quake was about 135 miles southeast of Mexico City.

The Volkswagen A.G. plant on the outskirts of Puebla was shut down for a few hours after the quake to check for damage, said a company spokesman. But only a few pipes and lamps were damaged, and only one shift was canceled, he said.

Brockman y Schuh, a Mexico City-based unit of Marsh Inc., has about 185 European clients in Mexico, and only two had notified the brokerage last week of claims from the quake, said Max Becker, director of the European division at Brockman y Schuh.

And while the quake was felt strongly in Mexico City, there was little damage there, said Ernesto Ramirez, a director at loss adjuster Quantum International Group in Mexico City.

The scope of the damage in Puebla, however, remains unclear, as rescue efforts were ongoing last week and the area still was largely sealed off, Mr. Ramirez said.

—By Gavin Souter

AP/ WIDE WORLD PHOTOS

Workers remove debris from a building in downtown Puebla, Mexico, that was damaged in an earthquake last week.

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LEGAL NOTICES

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss:

SUPREME JUDICIAL COURT FOR SUFFOLK COUNTY NO. 89-23

In Re the Liquidation of:

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY, and AMERICAN MUTUAL INSURANCE COMPANY OF BOSTON

NOTICE OF FILING OF MOTION FOR APPROVAL OF PLAN OF LIQUIDATION AND DEADLINE FOR OPPOSITION

TO: ALL PERSONS HAVING CLAIMS AGAINST AMERICAN MUTUAL LIABILITY INSURANCE COMPANY OR AMERICAN MUTUAL INSURANCE COMPANY OF BOSTON; ALL INSURANCE GUARANTY ASSOCIATIONS; ALL CHIEF INSURANCE REGULATORS; AND ALL REINSURERS OF AMLICO AND AMI

On May 14, 1999, Linda L. Ruthardt, Commissioner of Insurance of the Commonwealth of Massachusetts, as Permanent Receiver ("Receiver") of American Mutual Liability Insurance Company ("AMLICO") and American Mutual Insurance Company of Boston ("AMI"), filed a Motion for Approval (the "Motion") of a Plan of Liquidation (the "Plan") for AMLICO and AMI with the Supreme Judicial Court for Suffolk County (the "Court").

Summary of the Plan of Liquidation

The proposed Plan would govern future proceedings in these liquidations by providing claim determination procedures for the disposition of proofs of claim against AMLICO and AMI, providing a claim amendment deadline for perfecting contingent or unliquidated claims, and specifying the applicable priorities of distribution. The Plan provides for all proofs of claim filed on or before March 9, 1990 to be treated as Timely Filed Proofs of Claim and assigned to one of the following Priority Classes:

- Class 1: Receiver's Expenses of Administration
- Class 2: Compensation of Employees (pre-3/9/89)
- Class 3: Claims for taxes and other government debts secured by liens perfected prior to 1/17/89
- Class 4a: Claims for losses under worker's compensation insurance policies
- Class 4b: Claims for losses under other insurance policies
- Class 4c: Claims for unearned premiums under insurance policies
- Class 5a: Other claims of the United States of America
- Class 5b: All other claims

The Receiver will make a determination whether each Timely Filed Proof of Claim will be allowed in its entirety, allowed in part, or denied (although a determination may be deferred if a proof is assigned to a Priority Class below Class 4a). If a claimant has executed an acknowledgement of satisfaction, the proof will be deemed denied without further notice. The Receiver will otherwise notify claimants of such determinations, which will be binding unless the claimant objects within sixty days. In the case of an objection, the Receiver will make a second claim determination. Claimants may object to the Receiver's second claim determination and obtain a hearing before a Special Master to be appointed by the Court. They may seek review of the Special Master's decision from the Court.

Proofs of claim or other documents attempting to assert a claim filed after March 9, 1990 will be denied as Late Filed Proofs of Claim, unless the Receiver obtains approval of the Court to treat a proof as timely filed. Claimants will be notified of the Receiver's determinations denying proofs as untimely, which will be binding unless the claimant objects within sixty days. The Court will hold a hearing in the event of an objection.

The Receiver will also classify certain proofs of claim as "contingent" or "unliquidated" and notify claimants of that determination. Proofs so classified would need to be perfected by an additional filing confirming and quantifying the claim before a Claim Amendment Deadline proposed to be the date twelve months after final approval of the Plan. Proofs of guaranty funds with open claims will be classified as unliquidated and require a filing.

After all claims have been finally determined, the Receiver will begin making distributions to claimants with allowed claims in accordance with their assigned priority, proceeding to each successive Priority Class only after all allowed claims in the prior classes have been paid in full. If assets are insufficient to pay all claims in a Priority Class in full, each allowed claim within that class will receive an equal percentage distribution.

Reinsurers of AMLICO or AMI will be notified of the Receiver's consideration of proofs of claim that may give rise to a reinsurance claim against them. Potentially affected reinsurers may review documents concerning the proof and underlying claim and notify the Receiver of defenses that apply to that claim within ninety days. Timely responding reinsurers will receive notice of the Receiver's claim determination and may object as in the case of claimants. In the absence of objection, the claim determination will be binding on all potentially affected reinsurers as a determination of AMLICO's or AMI's liability under the policy or policies reinsured.

Your Rights under the Plan

Since the proposed Plan could affect your rights as a creditor or reinsurer of AMLICO or AMI, you have the right to file an opposition to the Motion seeking approval of the Plan, as outlined below. In the event that you would like to obtain a copy of the proposed Plan or the Receiver's submissions in support of the Motion, you may do so by mailing a written request to the following address:

American Mutual Insurance Companies in Liquidation
P.O. Box 1620
Burlington, Massachusetts 01803-0920
Attention: Proof of Claim Unit

The Plan may be modified during proceedings before the Court on the Motion. If you would like to be notified of the date and time of the hearing on the Motion, you may do so by mailing a written request to the above address.

Any questions concerning the Plan should be directed to counsel for the Receiver identified below. Do not call the Court.

Notice of Deadline for Opposition

By Order of Court, notice is hereby given that any person who wishes to oppose approval of part or all of the Plan must file a written opposition to the Motion, setting forth the basis for such opposition, with the Court on or before **September 15, 1999**, at the following address:

Clerk's Office
Supreme Judicial Court for Suffolk County
New Court House, Room 1404
Boston, Massachusetts 02108

A copy of such opposition must also be provided to counsel for the Receiver on or before **September 15, 1999**, at the following address:

J. David Leslie, Esq.
Rackemann, Sawyer & Brewster, P.C.
One Financial Center
Boston, Massachusetts 02111
(617) 951-1133

A date and time for a hearing on the Motion seeking approval of the Plan will be set after the deadline for the filing of oppositions. Notice of the date and time of the hearing will be given by counsel for the Receiver to all persons who file oppositions, to all persons who request notice, and to all persons who have previously filed appearances in this matter.

By the Court (Fried, J.)
/s/ Maura S. Doyle
Clerk

Entered: May 18, 1999

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LEGAL NOTICES

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IN THE MATTER OF
TRENT INSURANCE COMPANY LIMITED
(Incorporating the merged companies of Trent Insurance Company Limited and Hemisphere Marine & General Assurance Ltd.)

and

IN THE MATTER OF THE COMPANIES ACT 1981

IN THE HIGH COURT OF JUSTICE (ENGLAND)
CHANCERY DIVISION

IN THE MATTER OF
TRENT INSURANCE COMPANY LIMITED
(Incorporating the merged companies of Trent Insurance Company Limited and Hemisphere Marine & General Assurance Ltd.)

and

IN THE MATTER OF THE COMPANIES ACT 1985

NOTICE IS HEREBY GIVEN that, by an Order dated 10th May, 1999 in the Supreme Court of Bermuda and by an Order dated 21st May, 1999 made in the High Court of Justice of England and Wales in the above matter (the "Orders"), a meeting was ordered to be convened of the Scheme Creditors (as defined in the Scheme of Arrangement hereinafter mentioned) of the above named company (hereinafter called the "Company") for the purpose of considering and, if thought fit, approving (with or without modification) a Scheme of Arrangement proposed to be made between the Company and its Scheme Creditors (as therein defined) and that such meeting will be held at The Chamber of Commerce, Front Street, Hamilton, Bermuda on 15th November 1999 commencing at 10:00 am at which place and time all such Scheme Creditors are requested to attend.

The Company incorporates the merged companies of Trent Insurance Company Limited ("Trent") and Hemisphere Marine & General Assurance Ltd. ("HMG"). The Scheme will apply to all claims against Trent and HMG except for claims which are fully secured. In addition to any claims against Trent and HMG, the proposed scheme will apply to those former creditors of Capital Marine Insurance Company Limited (dissolved) (CapMar) who become Scheme Creditors of the Company by having executed and returned a Release.

The Scheme Creditor may vote in person at the said meeting or they may appoint another person, whether such person is or is not a Scheme Creditor, as their proxy to attend and vote in their place and are requested to complete the Form of Proxy and return it to the Company at Craig Appin House, Wesley Street, Hamilton HM11, Bermuda (facsimile number (441) 295-3480) Attn. Jennifer C. Woods. The Form of Proxy must be received on or before the date of the said meeting.

Each Scheme Creditor or his proxy will be required to register his attendance at the meeting prior to its commencement. Registration will commence at 9:30 a.m.

By the Orders, the Courts have appointed Paul Anthony Brereton Evans or failing him, D. Geoffrey Hunter to act as Chairman at the said meeting and have directed the Chairman to report the result of the meeting of the Courts.

Copies of the Scheme of Arrangement and the Explanatory Statement required to be furnished pursuant to Section 100 of the Companies Act 1981 of Bermuda and Section 426 of the Companies Act 1985 of Great Britain, Forms of Proxy for use at the meeting, the Claims Form and the Release are available from the Company's offices at the above address.

The Scheme of Arrangement will be subject to the subsequent sanction of the Courts.

Dated this 25th May, 1999.

Convers Dill & Pearman
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Moody's

Continued from page 25

ticipated 2.4% loss on capacity—about £240 million ($398 million)—for the 1998 year of account, according to Moody's calculations, said Mr. Hewlett.

Moody's is assessing a higher loss for 1998 than most other sources have estimated—Lloyd's itself has estimated a £60 million ($99 million) overall market loss for the year, but with the caveat that the final figure could be worse. Last week, members' agent Sedgwick Oakwood Lloyd's Underwriting Agents Ltd. said it was expecting the market to report a loss of just under 2% in 1998 and that no individual sector was looking to break even.

Sedgwick Oakwood cited falling interest rates, intense competition and an increase in both the size and frequency of insured losses as factors in the worsening conditions. If insured losses maintain their current level, Lloyd's could be £500 million ($829 million) or more in the red for 1998, the members' agency said.

Not one syndicate made the highest rating (A+) in the Moody's guide, though Mr. Hewlett said that is not surprising, given prevailing industry-wide conditions.

"There are no A+ syndicates because the ratings are investment- and performance-driven," he explained, and they are an indicator of future profitability. "With the state of the worldwide insurance market, there has been a pressure from the top down. . . I would expect a strengthening of the ratings as improvements (in market conditions) come through." The guide also takes into account the volatility of a syndicate's portfolio.

Two syndicates, 557 and 779, were rated A (very good), and 11 attained A- (good) status. The top 13 rated syndicates all write either non-marine or composite business.

Marine business, Lloyd's traditional strong suit, managed to score only two B+ (above average) ratings. Aviation showed a similar pattern.

At the other end of the spectrum, no syndicates fell into the bottom category of C- (below average), though syndicate 1206, a specialist accident and health syndicate managed by Owen & Wilby Underwriting Agency Ltd., is rated C. In the past, only one syndicate rated C has survived over the long term, said Mr. Hewlett.

This has not, however, deterred German insurer Gerling Group from purchasing Owen & Wilby. In a deal announced the day after Moody's guide was released, the Cologne, Germany-based insurer is purchasing the agency for £2 million ($3.2 million) with the aim of become an integrated Lloyd's vehicle with access to the Lloyd's license network, according to a Gerling spokesman. In addition, other investors are looking to extend their Lloyd's involvement (see related story, page 25).

Seven syndicates were rated C+, including syndicate 957, a personal accident syndicate managed by Duncanson & Holt Syndicate Management Ltd. This rating is a direct result of the managing agency being publicly up for sale by UNUM Corp., said Mr. Hewlett, who added that the agency sale rating undermines Lloyd's claims that corporate syndicate backing is more permanent than traditional unlimited liability capital.

"Capital tends to move (very) quickly to areas where it is best deployed," he said. "Unless there is a substantial return, (capital) will move."

Quoted in the rating guide, Tony Taylor, underwriting director at Wellington Underwriting Agencies Ltd., said: "There are now enough claims in the system. . .eventually to cause significant bottom-line losses to the market in general. When the implications of the unprofessional underwriting approach of many of the players in the world market come home to roost, we will see a number of very upset capital suppliers who will damn the prospects of the whole of our industry."

Mr. Hewlett also cited Capital Re Corp., which is selling RGB Underwriting Agencies Ltd. to ACE Ltd., as illustrating the potentially nomadic nature of corporate capacity. Both RGB syndicates, 490 and 1171, are rated B-(below average) in the guide.

•

Moody's Lloyd's Syndicate Rating Guide 1999 costs £500 ($797) from Moody's Investors Service Ltd., 2 Minster Court, Mincing Lane, London EC3R 7XB; 44-171-772-5454. The full Lloyd's rating service, including quarterly updates, costs £2,500 ($3,983).

Coke

Continued from page 25

The beverages affected include Coca-Cola, Coca-Cola Light, Fanta, Sprite, Nestea, Aquarius, Bon Aqua, Kinley tonic and Lift. All were banned by the Belgian Health Ministry, and neighboring Luxembourg followed suit. France also has banned all Coke-canned drinks, though the European Union has decided the contamination is contained and does not warrant a Europe-wide ban. Nevertheless, British consumers have been warned that Belgian-manufactured products may have been imported, though British-manufactured cans and bottles of soft drinks have not been found to be contaminated. At the end of last week, however, the U.K. Joint Food Safety and Standards Group issued a warning to local authority health officials "for action as deemed necessary."

Defective carbon dioxide supplied to Coca-Cola's Antwerp, Belgium, bottling plant produced an "off" taste, and the company had replaced the supply and removed all defective products from the market.

Coca-Cola also found that a substance on wooden storage pallets had contaminated the outside of cans, though "independent analysis determined the product is safe," Coca-Cola said.

Although the company might be covered by insurance for the product recall, it is more the potential damage to the brand that could be the problem. "The question is how damaging will (the recall) be in the long term," said Jan Lindemann, director of brand valuation at London-based branding consultant Interbrand Newell & Sorrell Ltd. "The management has to ensure to consumers that this is not an issue going forward," particularly because the value of the company is intrinsically linked into the brand reputation of its most famous product.

The recall had caused a fall in Coca-Cola's stock price, said Mr. Lindemann. But, he said, if Coca-Cola handles consumer relations well, the company can assure its customers that this is only a short-term problem. "Public relations handling is very crucial, especially in the early days" of a product recall, he said. Early intervention, he said, is particularly important now that technology means that consumers worldwide are aware of problems elsewhere very quickly.

Nevertheless, Mr. Lindemann said, "I think it will not be so dramatic, because people have so much trust in Coca-Cola." BI

Insurance product for e-commerce

OKEMOS, Mich.—J.S. Wurzler Underwriting Managers L.L.C. has created an insurance product for companies doing business via the Internet.

Website & Internet Security Program, or WiSP, provides coverage that addresses risks specific to the growth of technology and the Internet. WiSP protects companies from potential damage from electronic commerce, including theft of credit data; loss of Web site and advertising revenue and electronic funds; stolen, copied or destroyed intellectual property; destruction of data; unauthorized access; employee abuse; and copyright and trademark infringement.

WiSP coverage consists of two policies, Breach of Security Coverage and Crime and Intranet Insurance. Policy limits are flexible, with a maximum annual aggregate of $3 million.

The classes of business covered by WiSP include companies that use the Internet for commerce, such as retailers, manufacturers, publishers, and business-to-business users. The policy is not designed for Internet service providers. A policyholder must comply with minimum safeguards set by underwriters and undergo an external Web site security assessment.

WiSP is underwritten by syndicates at Lloyd's of London.

For information, contact J.S. Wurzler Underwriting Managers, 877-347-2040, or visit www.jswum.com.

Comings & Goings: Industry

Denver-based ING Reinsurance has appointed **Chris M. Rutten** vp-international. In his new position, Mr. Rutten, who has been with ING Re since 1989, will oversee the company's presence in new markets throughout the world. ING Re also has named **Stephen F. Kraysler** vp-structured reinsurance. Mr. Kraysler previously was executive vp and chief actuary for ITT Hartford International Life Reassurance . . . .New York-based American International Group Inc.'s American International Cos. Mass Marketing Division has named **David Jarvis** president of its bancassurance unit. . . .QBE Insurance Corp., a member of the Sydney, Australia-based QBE Insurance Group, has made four senior management appointments: **Ian Davey** has been named senior vp, underwriting and marketing; **Chris Carnicelli** has been named vp, general counsel; **Phil Figueiredo** has been named vp and controller; and **John LaCava** has been named vp, director-information systems. . . .Chubb Corp. of Warren, N.J., has named **Joanne L. Bober** senior vp and general counsel. She previously was general counsel, secretary and senior vp of General Signal Corp. in Stamford, Conn. Chubb also has named **Mark Greenberg** senior vp and chief communications officer. Also at Chubb, **Brant W. Free** has been named senior vp and director-international external affairs.

Mr. Rutten

Mr. Kraysler

Information in brief

Three managed care organizations will be using one application to **credential physicians and other medical providers** to be considered for admission into their networks. Humana Inc., Oxford Health Plans Inc. and UnitedHealthcare all use one screening company to evaluate medical providers—Aperture in Louisville, Ky. The uniform application, which other health plans are invited to use, is expected to reduce operating costs for the health plans and providers. . . .A Chicago judge **denied all of the defense's relief requests** last week in the case of Rachel Barton, a violinist who was awarded almost $30 million for injuries sustained when she was dragged by a Metra train in 1995. The strap on Ms. Barton's violin case became caught on the train's handrail (*BI*, March 8). A notice of appeal will be filed to the appellate court within 30 days, said C. Barry Montgomery, a partner with Williams & Montgomery in Chicago and counsel for Metra and Chicago & North Western Railroad, which owned and operated the railroad. . . .Virginia Insurance Commissioner Alfred W. Gross issued an administrative letter to health insurers and others last week issuing **guidelines on policy provisions** that limit liability for damages. The letter focuses specifically on legal fees, punitive damages and indirect or consequential damages. For instance, the letter states that while the Bureau of Insurance will not approve a provision under which an insurer is exempt from all liability for punitive damages, "it will approve a provision under which it is clearly stated such losses are not recoverable under the policy." BI

Teleconference: Wednesday, June 23, 1999, 11:00 AM Eastern Time
Insurance Mid-Year Outlook

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Standard & Poor's will hold a telephone conference call on Wednesday, June 23, 1999, 11:00 AM Eastern Time, on the following topic: Insurance Mid-Year Outlook, with Insurance analysts: P/C-Robert Partridge, RI-Don Watson, Health-Arun Kumar, Life-Tom Upton.

U.S./Canada Numbers: +1-888-982-4612
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Please call about ten minutes before the scheduled start of the call. If the number you dial is busy, please call one of the other numbers. The password is "Standard & Poor's." It is not necessary to call ahead of time to pre-register, and there is no charge to participate other than long-distance telephone charges, if applicable. Participants will be asked to provide their name, company affiliation, and phone and fax numbers. The entire call will last approximately one hour, and after brief presentations by the analysts, participants will be able to ask questions directly about this topic. You may also fax or email questions in advance.

Replays: Recorded replays of the call are made available about an hour after the call concludes. This recording is available at no charge to U.S. and Canadian callers (other callers will pay long distance toll charges) until Wednesday, June 30, 1999. Callers will be asked for their name, company, phone and fax number.

Scorecard

Continued from page 3

overall score of 66 in satisfaction, 67 in performance and 73 in loyalty. That compares with scores of 66 in satisfaction, 68 in performance and 74 in loyalty in 1998.

Brokers scored 70 in satisfaction, 74 in performance and 74 in loyalty this year, after getting a 69 in satisfaction, 73 in performance and 76 in loyalty in 1998.

TPAs were given a 62 in satisfaction, a 66 in performance and a 64 in loyalty in the current survey, a slight improvement from a 60 in satisfaction, 65 in performance and 59 in loyalty last year.

QIC President Stephen M. Wilder said the results are not surprising. "I'm not sure that a year is enough time to show a difference."

"I think we really need to step back and say, 'Should we really be doing it every year?' " said Mr. Wilder, who is vp-risk management at The Walt Disney Co. in Burbank, Calif. "Or should we be doing it every 18 months or two years?"

RIMS President Susan R. Meltzer said, "I didn't think there would be any significant change in the way people viewed their vendors in a year."

'I think we really need to step back' and ask if we really should do this every year, says Stephen M. Wilder.

Still, she acknowledged she is "a little disappointed" that scores weren't higher. "Service really hasn't gotten visibly better."

Ms. Meltzer, who is assistant vp-insurance and risk management at Sun Life Assurance Company of Canada in Toronto, said she thinks RIMS and the QIC need to wait at least 18 months before compiling another scorecard.

The purpose of the scorecard "is not really to publish scores but to help people get prepared for what they need to do" to improve quality, she said.

"At this point, we would probably be better served by giving people a chance to implement these kinds of things," Ms. Meltzer said.

Mr. Wilder stressed that no decision has been made to change the survey's frequency, and the advantage to conducting it yearly is that it keeps the issue of quality out front. "It keeps our eyes on the ball."

More risk managers were eager to score their vendors this year; the 1999 survey included nearly three times as many responses as the year before. There were 5,006 evaluations in the current survey, compared with 1,702 last year.

"I think if there is one message, it's the tremendous increase in responses reinforces that people do care about quality and want to get involved in the process," Mr. Wilder said.

But at least one broker is expressing concern that some of the scorecard information is confusing and questioning whether the survey is being used properly to bring about improvements in quality.

"The last thing I would do is declare some sort of victory," said J. Patrick Gallagher Jr., president and chief executive officer of Arthur J. Gallagher & Co. in Itasca, Ill. "I object to the way this thing is being used."

Arthur J. Gallagher finished on top of the broker ratings after not making the list in the 1998 survey. This year, Gallagher received a 75 in satisfaction and an 80 in performance.

Brokers, Mr. Gallagher said, "don't need more things to be competitive about; we've got them."

Mr. Gallagher said he opposes the way the scorecard is released to the press and the competitiveness that it engenders. "I don't mind if the press sees it, but I consider it to be a kind of marketing thing. Some see it as a way to pressure the industry to compete and get better." Instead, the scorecard should be used as a tool to pull all parties together to work on improving quality, he suggested.

Mr. Gallagher said that two sentences in the scorecard's summary should be the real focus of the effort. Those sentences read: "The real issue is how are we going to make things better? What are you going to do to collaborate and improve the industry?"

"That's where RIMS and the QIC need to focus," he said, and not on individual grades for the industry.

Mr. Gallagher described the grading in the satisfaction drivers, which rank vendors according to several categories, as confusing. For example, under the "trust and reliability" driver, Gallagher received an 85 for ethical standards, an 86 for providing trustworthy advice and counsel, an 80 for consistently fulfilling commitments and promises and a 65 for providing full disclosure.

The score of 65 doesn't make sense, Mr. Gallagher said. "How can you tell me you trust me if you don't think I'm being straight with you?"

Willis Corroon Corp., the top broker in last year's ranking, slipped somewhat this year. The broker received a 72 in satisfaction and a 77 in performance. Last year's scores were 76 in satisfaction and 80 in performance.

Willis is in the second year of a three-year program to improve the quality of its services, and that could have contributed to its falling score, said Luke LaBorde, senior vp in the broker's Nashville, Tenn., headquarters.

"It's ironic that here we are committed to improving quality," Mr. LaBorde said, and those efforts may have impacted the score.

An overhaul such as the one Willis has undertaken involves changing people and systems in a number of areas, and "that takes away from customer service," he explained.

"For whatever reason," Mr. LaBorde remarked, "our scores are down."

He said Willis is "happy about our relative performance but not pleased with our absolute performance. We are committed to making substantive changes to improve."

Some encouragement in this year's survey is found in the improving scores of satisfaction drivers on which risk managers graded brokers. Five of those six drivers showed improved overall scores for brokers.

The improvements were in the categories of building internal and external partnerships; identifying needs and creating solutions; two-way interactive communication; operational efficiency and competitiveness; and developing and providing expertise. Brokers' score for trust and reliability was unchanged.

"It is very encouraging in the context of people genuinely are trying and the industry is making some progress," Mr. LaBorde remarked. "Is it huge? No. But it is measurable."

'The last thing I would do is declare some sort of victory. I object to the way this thing is being used,' says J. Patrick Gallagher.

Insurance buyers put Associated Electric & Gas Insurance Services Ltd. at the top of the overall insurer/reinsurer rankings for the second time. The Bermuda-based insurer scored 80 in satisfaction and 81 in performance. Last year, AEGIS received a 78 in satisfaction and 80 in performance.

"We're thrilled to receive the top ranking for the second year in a row," said AEGIS President Alan Maguire. "We're also happy that we raised our scores a little bit from last year."

Mr. Maguire said AEGIS is using detailed information supplied by the QIC on risk managers' scoring of the insurer to "focus on further improvement."

The scorecard is an important benchmarking tool for insurers, he said, "and as such can be a useful tool for risk managers."

Mr. Maguire also addressed the issue of the study's frequency. While "you can effect a lot of change in a year, I suppose it may be more appropriate to run the survey on an every-other-year basis. You might see more change than on an annual basis," he said.

'I suppose it may be more appropriate to run the survey on an every-other-year basis,' says Alan Maguire of AEGIS.

This year's scorecard for the first time ranked individual TPAs according to their clients' grading. Gallagher Bassett Services Inc., a unit of Arthur J. Gallagher & Co., was the top scorer, with a 65 in satisfaction and a 70 in performance.

Gallagher Bassett's own client satisfaction surveys show it is doing a good job of meeting clients' expectations despite low numerical scores in the scorecard, said Peter J. Durkalski, president of the TPA. "I'm not saying one is better and one is worse," he noted, pointing out that the two approaches measure satisfaction in different ways. Gallagher Bassett's surveys do not assign a numerical score but assign rankings of excellent, good, fair or poor.

The surveys have averaged 95% "good or excellent" since 1993, Mr. Durkalski said. When fair or poor ratings are received, upper management interviews clients to find out "what the issues are," he said.

Mr. Durkalski said Gallagher Bassett has an extensive program to continually improve the quality of its service. Employee training, measurements and benchmarking of processes, and a commitment to "doing it right the first time" all are hallmarks of the program, he explained.

He noted the scorecard breaks out client satisfaction for distinct items, which helps guide TPAs "to do not just what (clients) expect, but to do what thrills them." BI

ADVERTISER INDEX

Issue of June 21

ADVERTISER	PAGE #
ACE Group	9
Acordia	10
ACSTAR Insurance	12
AGF Insurance	6
American Institute for CPCU	12
AON Corporation	11
ASA, Inc.	4
Blue Cross Blue Shield-SC/CIMR	22
Burnham Systems	24
Concentra Managed Care, Inc.	23
Crawford & Company	14
Reliance National	32
Standard & Poor's	27
Sunrock Risk Services Corp.	28
Tenconet	23
Tenfold	13
The Willis Group	7
USI Insurance Services	21
Zurich-American	5

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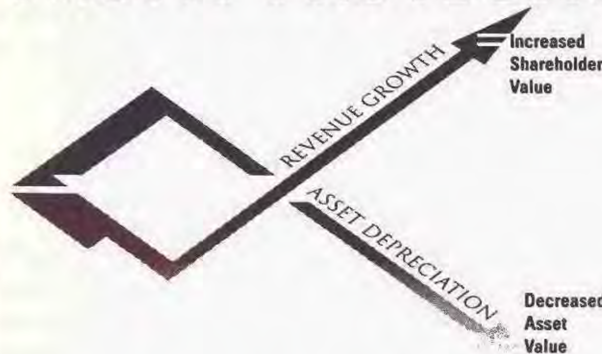

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Reliance

Continued from page 2

Currently, Reliance has $3.2 billion in net reserves, Mr. Benchimol said.

At the end of the first quarter of 1999, Reliance had a statutory surplus of $1.375 billion, compared with a surplus of $1.75 billion at year-end 1998.

Reliance is one of several commercial insurers that are showing signs that low rates and increased catastrophe losses are hurting them in 1998 and 1999, said Mr. Frinquelli of Renaissance Fund Managers.

In February 1999, CNA Financial Corp. announced a $270 million change in reserve estimates for 1998.

In addition, The St. Paul Cos. Inc. increased reserves by $250 million after its 1997 purchase of USF&G Corp., a St. Paul spokesman confirmed.

"There's no question that stresses are growing on the income statements of this industry," said Ron W. Frank, an analyst at Salomon Smith Barney in New York.

Reliance has been seeking to grow at a quicker pace than many other insurers and, consequently, may have undercut other insurers, Mr. Frank said. Nevertheless, he said, other insurers generally are showing more signs of problems due to low rates and higher-than-expected losses.

Reliance also has been less conservative in its reserving practices than other insurers, said Matthew Coyle, a director at Standard & Poor's Corp. in New York.

"Reliance is very focused on trying to manage its capital as efficiently as possible. But when you are talking about estimating loss reserves, it is more of an art than a science," so the margin of error is greater, he said.

After the announcement, S&P put its A rating of Reliance on CreditWatch with negative implications.

While specific issues are affecting Reliance, other commercial insurers are also suffering in the soft market, and more insurers are likely to announce similar actions, Mr. Coyle said.

"It would not surprise me if we saw more reserve strengthening by the commercial insurance industry in 1999 and 2000," he said. BI

Commentary

Study snuffs out popular myth

Another "harmless" vice is about to get a black eye.

Cigar smoking, which until now has typically drawn opposition only from people with noses and an abhorrence for lighting money on fire, is bad for you.

This conclusion from medical researchers may come as a complete shock to people who thought cigars somehow had more in common with, say, vegetables than with other tobacco products, almost all of which have been shown to increase the risk of cancer when used as intended.

If you're a cigar smoker—and I've attended plenty of insurance industry gatherings where cigars were widely enjoyed—chances are you have deluded yourself, as I have, into believing that, in spite of itself, cigar smoking is relatively harmless to your health.

For starters, I tell myself, cigar smoking isn't something one does very frequently. Not only do few occasions lend themselves to lighting up a stogie, but also decent cigars usually cost too much money for the average person to buy and chain-smoke them as though they were generic menthol cigarettes. The alternative—a cheap cigar—usually tastes bad and smells even worse (though the concept that some cigars smell *better* than others may be open to debate from my wife). A fine cigar, therefore, is a luxury that often is savored as part of a special event or rare occasion, such as a Chicago Bulls championship, a business golf outing or a Tuesday in June.

Paul D. Winston

In addition to cigars being a relatively infrequent indulgence, I feel OK about them because, when smoking a cigar, one does not inhale—or at least not very much—thereby virtually eliminating the risk of exposing the lungs to carcinogens. This argument assumes, of course, that one does not breathe between puffs, or else has a restaurant-grade exhaust fan nearby.

This argument against inhaling, I admit, does not always hold up well in a defense of the virtues of cigars, just as Bill Clinton's claim that he tried marijuana in college in the late '60s but did not inhale drew a fair amount of skepticism. An assertion that cigar smoking is harmless because one is not inhaling the smoke also seems to invite the question, "Well, then, what's the point?"

Another attraction for cigar smoking is that it's become ever more fashionable. Although cigar smoking's poster boy used to be George Burns, today it is popularized by a wide variety of actors and entertainers, presidents and politicians, athletes and coaches, tycoons and magnates, men and women, and so on and so forth.

The fact that so many top athletes smoke cigars, in fact, serves up a double helping of rationalization: Not only must it be cool, but it also must not be hurting their health or athletic performance. It's the Be Like Mike syndrome.

And finally, cigar smoking is OK because, unlike cigarettes or pipe tobacco or chewing tobacco, it doesn't carry any warning labels of health risks. That's because, until now, there hasn't been any research to demonstrate a link between cigar smoking and health problems, and thus the federal government lacked the ammo needed to impose such labeling.

Now, however, a team of researchers from Kaiser Permanente has reported just such a link based on a 25-year study. The researchers, who reported their findings in the June 10 issue of the New England Journal of Medicine, found that cigar smokers are at higher risk than non-smokers of a "major cardiovascular disease," and cancers of the "upper aerodigestive tract," or mouth, throat and lungs.

Lest you think the research was limited only to creatures who smoke a dozen Panatellas a day, or lab rats who were chained to a series of Churchills, I should note that it involved nearly 18,000 men, of whom the majority—76%—smoked fewer than five cigars a day.

If that doesn't take the smoky wind out of your sails, the researchers also found that the risk of certain cancers appeared to be enhanced when cigar smoking was paired with alcohol consumption, which is not an unheard-of combination.

I guess this means another "harmless" vice isn't so harmless. Cigar smoking now joins the ranks of other unsafe activities that once were *de rigueur*—such as riding in a car without a seat belt, eating Belgian hamburger, flying cut-rate airlines, driving a golf cart without a speed regulator and riding a bicycle without a helmet.

Time to find another risky behavior that, at least for now, has avoided public scrutiny and hasn't yet made the transition from cool to foolish.

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

FEMA

Continued from page 1

FEMA assistance.

The amount of money a self-insured would have to set aside or include in its funding plan would equal the coverage amounts that others would have to purchase to receive assistance, said Bob Adamcik, deputy associate director of FEMA's Response and Recovery Office in Washington.

The proposed criteria for FEMA's Public Assistance Program are expected to be published in the Federal Register by month's end, a FEMA spokesman said. A 90-day public comment period is to follow the publication of the Notice of Proposed Rulemaking.

Public entities currently must have flood insurance in order to be eligible for FEMA's Public Assistance Program. No other coverages are mandatory at this point, Mr. Adamcik said.

Under FEMA's current system, after the president of the United States declares a major disaster, FEMA will advance to local governments the money to pay for 75% of damage.

FEMA's attempt to push public entities to purchase insurance for their buildings has stirred controversy and prompted contrasting risk manager comments on the agency's efforts.

"What FEMA wants to do is not unreasonable in concept," said Mr. Vance. Under the direction of Congress, FEMA wants public entities to function more like businesses and "make reasonable decisions on risk financing for catastrophic loss," he said.

Mr. Vance played a major role in writing the rules that he expects FEMA will propose.

"A lot of public entities have simply ignored buying coverage for catastrophic losses," he said. "I'm not sure that a taxpayer in North Dakota, through FEMA, should pay for an earthquake loss in California if I have chosen not to buy any earthquake insurance and save the premium."

So what FEMA is proposing is rational "in concept," Mr. Vance said. He acknowledged, however, that it is difficult to create "one-size-fits-all" rules for public entities across the nation. Mr. Vance also said he is not convinced that the current insurance market is the best answer to a widespread catastrophe. But Mr. Vance realized that FEMA planned to change its rules, so he worked to create a proposal that reflects insurance market realities and is "something public entities can live with," he said.

Another public entity risk manager said FEMA's proposal would not present an undue burden for him. Even with the new rules, FEMA is not likely to abandon uninsured public entities following a massive catastrophe, said Dan Pliszka, risk manager for the City of Charlotte, N.C.; Mecklenburg County, N.C.; and the Charlotte Mecklenburg Board of Education.

"I don't see it as terribly unreasonable," he said. The entities under Mr. Pliszka's purview carry insurance. Mr. Pliszka also is on the board of directors of the Public Risk Management Assn. FEMA has "listened to us and partnered with the Public Risk Management Assn. to get input from the public risk manager."

FEMA's attempt to push public entities to buy insurance for their buildings has stirred controversy.

But the proposed rules could weigh disproportionately on large entities such as Los Angeles, which does not purchase property insurance for most of the approximately 1,500 buildings the city owns, said Richard J. Welch, city risk manager for Los Angeles.

FEMA's proposed rules would push Los Angeles to spend money on all-risk and catastrophe insurance that it will never use, he said.

Under the new eligibility requirements FEMA is expected to propose for its Public Assistance Program, public entities will have to purchase all-risk property insurance, either on a building-by-building basis or under a blanket policy. On a building-by-building basis, each building would have to be insured annually to 80% (or possibly 100%) of its insurable value, written on a replacement-cost basis.

The rules likely to be proposed say earthquake, flood or named-storm coverage also must be purchased in order to be eligible for FEMA money to pay for repairs after those specific catastrophes. For example, a city that wanted money for help in rebuilding after a named storm would have to have had insurance for named storms.

The percentage of required catastrophe insurance coverage depends on the catastrophe type, the insurable value of buildings and whether the coverage is purchased on a building-by-building basis or under a blanket policy.

Under an earthquake policy purchased on a blanket basis, for example, an entity with an insurable buildings value of $1 million or less would have to purchase coverage for 10% of its total insurable value. An entity with a total insurable value of $1,000,001 to $10 million would have to purchase coverage equaling 7.5% of that value. And an entity with an insurable buildings value of more than $10 million would have to purchase insurance equal to 5% of their total value, subject to maximum total coverage limits of $125 million.

Under that system, Los Angeles might determine, for example, that 750 of its 1,500 buildings were large enough to require rebuilding assistance in case of a fire loss, Mr. Welch explained. The city would have to carry all-risk insurance for those buildings.

"We might go 20 to 50 years and never have a fire in any one of those buildings. That is a lot of money to pay for insurance," he said. "The money we pay for premiums over the course of five or 10 years is going to be greater than the amount we are going to have to spend repairing damage."

Additionally, the proposed rules say that once an entity receives FEMA assistance for repairing damage with a specific cause, such as an earthquake, the entity must then purchase coverage for that peril for the life of the asset.

Mr. Welch also is concerned about administrative difficulties and costs the new rules would impose, he said.

Currently, entities can obtain waivers for a requirement that

See **FEMA** *on next page*

Aetna

Continued from page 2

Approximately 400 Dallas-area doctors who belonged to the independent practice association canceled their contracts with Aetna, complaining that the insurer wasn't providing enough information for them to adequately manage their risk.

Aetna would not comment.

The doctors also objected to the "all products" provision in Aetna U.S. Healthcare's physician contracts. That provision requires doctors who participate in the insurer's preferred provider organization and point-of-service plans also to participate in its health maintenance organization.

The doctors' move displaced some 30,000 patients enrolled in Aetna U.S. Healthcare plans in the Dallas area (*BI*, Oct. 26, 1998).

"Because of the timing of the merger announcement, it was only natural to use the Genesis Physician Group as an example of the kind of problems that could be created," said Michael Darrouzet, executive officer of the Dallas County Medical Society, one of the groups that wrote to the Justice Department to protest the merger.

"We felt we were the epicenter of the imbalance in the marketplace between insurers and physicians," he said.

The TMA alluded to the Genesis dispute in its press release acknowledging the NYLCare divestiture.

'The Aetna/Prudential merger raises issues of anti-competitive market concentration in certain markets,' the AMA says.

"A completed Aetna-Prudential merger would have significantly increased the plans' leverage over physicians and their patients," it said.

The AMA also asserted its opposition to the merger proposal earlier this year when it issued a 15-page "discussion paper" that said the acquisition would be bad for consumers and would give Aetna too much power over physicians.

"The Aetna/Prudential merger raises issues of anti-competitive market concentration in certain markets as well as a myriad of patient concerns that federal and state regulators should address as they review the implications of this merger on the marketplace," state's the AMA's paper, which is on the Internet at www.ama-assn.org.

In particular, the AMA cited Dallas-Fort Worth, Houston and San Antonio as communities in which the combined Aetna-U.S. Healthcare/Prudential would control a significant portion of the market.

According to Texas regulators, the combined Aetna/NYLCare/Prudential would control about 50% of the HMO market in the Houston area and about 38% of the HMO market in the Dallas-Fort Worth area.

By contrast, under the divested plan, the combined Aetna/Prudential would have about 24% of the Houston market and 22% of the Dallas-Fort Worth market.

If approved with the NYLCare units still part of the company, the $1 billion acquisition of Prudential Healthcare would make Aetna U.S. Healthcare/Prudential the nation's largest health plan, with 22.4 million members nationwide, or about one in every 10 Americans. BI

FEMA

Continued from previous page

insurance be purchased to cover anything repaired with FEMA assistance. Those waivers can be obtained before or after an event.

Under the proposed rules, a waiver would be obtainable only before a loss, and it would have to be requested annually. That requirement would place an enormous workload on Los Angeles and state officials who must certify waiver qualifications, Mr. Welch said.

Furthermore, the new rules do not ease the current administrative burdens and years of documentation now associated with obtaining FEMA assistance, Mr. Welch said.

Yet he agrees with FEMA officials who say that FEMA's present practice rewards entities that do nothing to fund for losses while penalizing those that insure or set aside post-disaster funding by requiring them to spend their money before providing them with aid.

Los Angeles' top political leaders, along with Los Angeles County and California officials, have requested that California's congressional representatives ask FEMA Director James Lee Witt to delay publication of the proposed rules.

Even though there will be a public comment period after the Notice of Proposed Rulemaking is published, it is usually easier to change a proposal before it is published, Mr. Welch and others said.

Fifty-one members of California's congressional delegation have signed a letter asking Mr. Witt to delay publication. That letter cites concerns that FEMA has not adequately examined the financial impact the new rules would have on public entities. California Gov. Gray Davis also has sent a letter urging the delay of publication, in part because of insurance availability concerns.

But FEMA officials said they expect the rules to be published soon despite those requests. BI

Y2K

Continued from page 3

posure under Y2K is an open-ended and unquantifiable risk for most companies. From my perspective as a risk manager, I'm not concerned about internal compliance; I'm concerned about all of the different partners we have in our business whom we rely upon and expect that they would comply, but we really have limited control over that."

RIMS issued a "talking points" document on the issue in March. The paper cites five reasons for reform:

- Employers should be encouraged to remediate Y2K problems in good faith without threat of lawsuits.
- Employers need clarification as to the extent of their responsibilities, before claims are filed.
- The right to enter into private contracts should be respected.
- Courts should be freed up to hear legitimate complaints.
- Bad actors who willfully disregard Y2K problems should be punished.

Insurers supported the measure, largely because of the impact Y2K could have on their policyholders.

"The major reason we're involved in this is because it is good for our customers. We believe the legislation will be helpful in avoiding disruption and litigation," said Melissa Shelk, assistant vp of the American Insurance Assn. in Washington. She added that the aim should be to get businesses up and running as soon as possible should failures occur.

The U.S. Chamber of Commerce echoed that concern.

"The Y2K bill will allow businesses to put their money into fixing the problem rather than spend it paying lawyers to deal with frivolous litigation," wrote Chamber President Thomas Donohue in a statement issued after last week's vote.

The 62-37 vote on S. 96—The Y2K Act—came after weeks of delay and negotiation, as Democrats sought to add unrelated measures, such as a minimum-wage provision. Later, the bill stalled because of debate over a gun control measure. But when the Senate finally voted on the measure—a compromise sponsored by Commerce Committee Chairman John McCain, R-Ariz. and Sen. Ron Wyden, D-Ore.—12 Democrats ended up voting for it and only four Republicans voted against it.

The White House, however, remains opposed to the bill. The vote fell five short of overriding a presidential veto, which appears likely if the bill remains in its current form.

Personal injury and wrongful-death claims are not covered by the measure that the Senate approved.

The legislation focuses much of its liability relief on small businesses. For example, the compromise bill would limit punitive damages arising from Y2K-related problems to the lesser of three times compensatory damages or $250,000, but only for businesses with 50 or fewer employees. There would be no limits in cases where a defendant was found by "clear and convincing evidence" to have intentionally harmed a plaintiff.

Municipalities and governmental entities, however, are exempt from all punitive damages.

In addition, most defendants in Y2K-related actions would be held liable only for the portion of damages a court attributes to them rather than jointly and severally. Once again, an exception would be where a defendant acted deliberately to harm or defraud a plaintiff.

An amendment to the bill, offered by Sen. Wayne Allard, R-Colo., and approved by the Senate, makes clear that the bill's damage limits do not pre-empt state laws that provide more extensive limits.

The measure also seeks to encourage the use of alternative dispute resolution mechanisms to solve Y2K-related disputes before they go to court and calls for a waiting period during which defendants can fix a problem before the case goes to court.

Under this provision, would-be plaintiffs must give potential defendants 30 days' notice of intent to sue, and if the potential defendant responds with a proposal to fix the problem, the potential defendant gets another 60 days to do so. If the defendant doesn't respond with a plan within the 30 days, a suit can be filed on the 31st day.

Other provisions include preserving contract rights clarifying that parties that have already agreed on Y2K terms and conditions aren't covered by the measure, setting a sunset date specifying that the measure applies to Y2K failures occurring before Jan. 1, 2003, and confirms existing law that plaintiffs have a duty to mitigate loss where possible and therefore cannot collect damages that could have been avoided.

The AIA's Ms. Shelk is optimistic about the next step of the process. "We're looking forward to the conference. We think the White House will be engaged." BI

Patients

Continued from page 2

employers band together through trade associations to self-insure their health care benefits. These new trade association plans would be exempt from state regulatory requirements, such as capitalization and state-mandated benefit laws.

Passage of these measures came after considerable partisan bickering and jockeying.

Rep. Robert Andrews, D-N.J., the panel's ranking minority member, described the Republican bills as "meaningless" because they would not give patients the right to sue health plans for coverage decisions for damages allowed under state law.

But the panel chairman, Rep. John Boehner, R-Ohio, warned of the risks of expanding health care plan liability.

"When we open the legislation up to litigation in 50 states, we are taking a dramatic step in the wrong direction," Rep. Boehner said.

The subcommittee action occurred as panel Republicans blocked as out of order amendments by Democrats that would, among other things, allow patients to sue health plans for damages under state law and give patients in health maintenance organizations direct access to specialists.

Republican panel members appealed to Democrats to break the political logjam so that a consensus patient protection bill could be enacted.

"If you want to continue to have this political logjam, we can continue to do so, or we can break the logjam and actually move the legislation," Rep. Boehner said.

But at a news conference last week, Senate Minority Leader Tom Daschle, D-S.D., said Democrats have been working toward a middle ground. He said Democrats had made a significant concession by reducing to about 20—down from 60—the number of amendments to patient protection legislation they would like to see debated.

As House Democrats and Republicans were wrangling, sniping on patient protection legislation continued unabated in the Senate.

Sen. Daschle warned that Democrats this week will begin offering their patient protection legislation, which includes expanded health plan liability, as amendments to unrelated bills on the Senate floor unless Republicans agree to debate the issue before then.

Senate Majority Leader Trent Lott, R-Miss., while saying he wants the Senate to take up patient protection legislation, also says Democrats and Republicans first must agree on rules for debating the legislation. The failure to reach such an agreement last year killed a patient protection measure that the House of Representatives had earlier approved.

At the moment, a compromise on patient protection legislation appears elusive.

While Republicans have an interest in getting legislation passed in order to get it off the table, they will not approve a bill that expands liability for health care plans, says Frank McArdle, a consultant in the Washington office of Hewitt Associates L.L.C.

On the other hand, Democrats have no reason to compromise, as they may perceive a greater political advantage to not having a bill pass compared to enactment that doesn't have the provisions they are seeking, he said.

Democrats may feel "there may be an advantage to having patient protection legislation used as a campaign issue" against Republicans instead of working toward passage, Mr. McArdle said. BI

Updates

PBGC, Allis-Chalmers settle

WASHINGTON—The Pension Benefit Guaranty Corp. will receive 35% of Allis-Chalmers Corp. common stock as part of a final agreement releasing the company for liability relating to the PBGC's 1997 termination of Allis-Chalmers's massively underfunded pension plan.

That plan, which had about 9,800 participants, was underfunded by $63 million, with $272 million in liabilities and $209 million in assets.

Allis-Chalmers shares are thinly traded on the OTC Bulletin Board. Last week, shares were trading in the $2.25 range. Just over 1 million shares are outstanding.

Milwaukee-based Allis-Chalmers, which in the 1960s was one of Wisconsin's largest private employers, now consists of a small machinery repair and service subsidiary in Houston. It emerged from bankruptcy in 1988.

Last year, the company reported net income of $618,000 on sales of $5 million. For the first quarter this year, Allis-Chalmers reported a net loss of $57,000 on sales of just over $1 million.

In 1985, the PBGC took over another Allis-Chalmers plan, which had $170 million in unfunded liabilities and at the time was the biggest loss the PBGC had incurred.

Lloyd's loses collection ruling

LONDON—Lloyd's of London cannot use U.K. bankruptcy law to collect losses from a name before the fraud trial against Lloyd's begins in October, a High Court judge has ruled.

The judgment, if Lloyds' planned appeal fails, will mean that Lloyd's will be forced to drop 47 similar demands totaling some £13.6 million ($21.7 million), confirmed Philip Holden, head of Lloyds' Financial Recovery Department.

Judge Jacob ruled in the Chancery Division that Lloyd's must put aside its demand under bankruptcy law for about £200,000 ($318,640) of liabilities owed by the name, known only as G, for a reinsurance payment into Equitas under Lloyd's reconstruction and renewal plan.

The demand was made under U.K. Insolvency Rules, and Judge Jacobs ruled that, despite the pay-now-sue-later clause in the R&R contract, the "draconian effect of bankruptcy should not be imposed" when the name "might have a perfectly good cross-claim." G is one of 200 claimants suing Lloyd's for fraud in a case due to be heard in the High Court in the fall.

Michael Freeman, a partner in the London law firm of Grower Freeman & Goldberg and a lawyer for name G, described the judgment as a test case that will "delight" many of his clients.

Mr. Holden told *Business Insurance* that Lloyd's will appeal the case.

He also said that, while the decision will hamper debt collection using bankruptcy law, Lloyd's currently is recovering debts at the rate of £1.6 million to £1.8 million ($2.5 million to $2.9 million) per month and will continue its work.

Some 1,100 names still owe Lloyd's up to £400 million ($637.3 million), he said.

Meanwhile, Lloyd's is vigorously pursuing names in the United States following a recent judgment in the U.S. District Court for the Northern District of Illinois.

In *Society of Lloyd's vs. James Frederick Ashenden & Mary Jane Ashenden*, U.S. District Judge Harry D. Leinenweber ruled that judgments obtained in England against Lloyd's members were enforceable in Illinois.

It is the first time a U.S. court has considered the enforceability of U.K. judgments obtained in March 1998 against 246 U.S. residents owing $98.4 million, according to Mr. Holden.

As a result of the judgment, Lloyd's is now pursuing 22 other names in Illinois for $12 million in debts, he said.

Second-injury fund bill advances

ALBANY, N.Y.—Workers compensation insurers and self-insurers in New York expect to benefit from a bill that would change the method of funding the state's second-injury fund.

A legislative measure that passed both the state Senate and Assembly last week represents "an important change" to the law that would help publicly held companies to comply with a new Financial Accounting Standards Board accounting standard, according to a statement by Mary Griffin, an American Insurance Assn. assistant vp for the Northeast region.

Under current law, the state's second-injury fund is financed through assessments from workers comp insurers and self-insurers based on their total paid losses in the preceding calendar year. The bill would change the fund's financing base to an assessment based on premiums written.

The new FASB standard requires that publicly held companies immediately accrue losses on their financial statements if the assessments are based on paid losses. It does not, however, require immediate accrual if they are financed through the new approach—a policyholder surcharge based on premiums.

Gov. George Pataki is expected to sign the measure. Without the change, companies would have had to reduce surplus, which could have affected their ability to provide coverage.

The AIA is encouraging such legislation nationwide, according to Bruce Wood, assistant general counsel with the property/casualty insurer trade group. He said similar bills have been approved in the District of Columbia, to fund runoff of its abolished fund; Indiana; and Montana.

Briefly noted

A federal court jury in Nashville has ordered Time Inc. to pay **$2.2 million in punitive damages** on top of $8.5 million it had earlier awarded to former heavyweight boxer Randall "Tex" Cobb, who had filed a libel suit over a 1993 Sports Illustrated article claiming he fixed a fight and later used cocaine with the loser. Time Inc., Sports Illustrated's parent company, is a unit of Time Warner Inc.

Disability

Continued from page 1

accommodations" that could overcome those limitations.

- Reassignment obligation is limited to jobs existing within the company. "It is not reasonable to require an employer to create a new job" for the disabled employee, the court said.
- The existing job must be vacant. The employer is not required to "bump" another employee to accommodate a disabled worker.
- An employer "need not violate other important fundamental policies underlying legitimate business interests." For instance, the employer is not required to disregard a well-entrenched seniority system to accommodate the disabled employee.
- Reassignment does not require promotion. The ADA "is not a statute giving rise to a right to advancement," the 10th Circuit ruled.
- Employers may choose the reassignment to offer. If a disabled employee rejects a reassignment, the employer "is under no obligation to continue offering other reassignments."
- Employers need offer only a reassignment for which an employee is qualified.
- A reassignment does not have to be offered if it would create an undue hardship on the employer.

If the decision had been in Midland's favor, "almost all employers in this area of the country would not be required to try to find accommodation for disabled employees if they can't do their own job, and that happens a lot," said plaintiffs' attorney David C. Feola of King, Minning, Clexton & Feola in Denver. He submitted an amicus brief in the case.

Mr. Feola said he is representing three injured police officers in a comparable case. The federal Equal Employment Opportunity Commission also filed a brief supporting Mr. Smith's argument.

Darold Killmer, a plaintiffs' attorney with Miller, Lane, Killmer & Greisen in Denver, said, "The decision is an emphatic statement by the court that an employer has a strong obligation to keep disabled employees employed.

"So many employers, once they discover an employee is disabled, conclude the employee is less valuable and look for ways to terminate them." This decision will put a stop to this in the 10th Circuit, he said.

'What may be significant about this decision is the detailed guidance it gives employers,' says attorney Andy Volin of Sherman & Howard.

Attorney Ann Elizabeth Reesman of McGuiness & Williams in Washington is general counsel to an employers group, the Equal Employment Advisory Council. She said the decision "makes it difficult for employers who are trying to make personnel decisions based on merit." Ms. Reesman had filed an amicus brief supporting Midland.

Midland's attorney could not be reached for comment as to whether he plans to appeal.

Gerald L. Maatman Jr., partner and chairman of the global employment law practice group at Baker & McKenzie in Chicago, said he anticipates the issues raised in this case, if not the case itself, will eventually be heard by the U.S. Supreme Court.

"What I take away from it is if I'm a risk manager or human resource manger, it requires me to work a lot harder," Mr. Maatman said. Management will have to designate someone in charge of ADA compliance to keep track of what jobs are open, what jobs are vacant, and to make sure the company is complying with the Smith ruling, he said. The company needs to "stay on top of that process," he said.

Furthermore, under this ruling, companies would need a policy to enable disabled workers to express their preferences as to the jobs they would like to fill, he said.

Although the ruling does say a employer is obligated to offer the employee only one job, "in our practical world," employees' attorneys will still point to specific jobs and ask why they were not offered. Establishing a policy puts the burden on employees to state their preferences, Mr. Maatman said.

Andy Volin, an attorney with Sherman & Howard in Denver who represents employers, said companies arguably "are already subject to the decision," as the recent decision echoes other federal courts and a recent Colorado Supreme Court ruling.

"What may be significant about this decision (in *Smith vs. Midland*) is the detailed guidance it gives employers about the limitations of this duty to offer reassignment, and how to work with employees so these claims can be resolved before trial," said Mr. Volin. He said he thinks the court's analysis will be adopted by other courts as well.

Mr. Killmer agreed, saying, "I think it'll be a highly influential case." One reason is that it was decided by the full appellate court instead of by a three-judge panel, which is the more-common procedure.

Furthermore, "it's remarkably well reasoned and comprehensive," Mr. Killmer said. Many court cases simply decide the case at hand. "This decision went out of its way to establish a framework for how employers are obligated to provide reasonable accommodation. It was written with the bigger picture in mind."

Because of the "reasonably systematic way the majority opinion is written, it does provide, perhaps in one place, something that's a little clearer than some other cases," said David Weinstein, a partner and head of the labor and employment group at Wildman, Harrold, Allen & Dixon in Chicago.

"Courts that have not addressed some of these specific points may very well look at this, because it is a reasonably comprehensive decision," he said.

Tom Klein, an employer attorney with Orrick, Herrington & Sutcliffe in San Francisco, said other courts may look to this decision for guidance, particularly in describing the limits of an employer's duty to reassign a disabled employee. "It's good to have a court that has taken the time to walk through" the issue, Mr. Klein said.

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Geneva M. Smith vs. Midland Brake Inc., 10th U.S. Circuit Court of Appeals; No. 96-3019.

BI's online discussion forum

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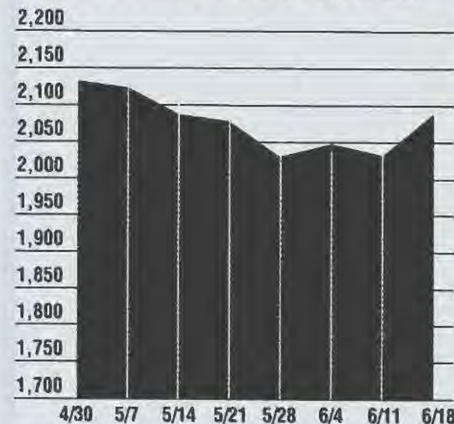
BI Insurance Index



Base=100 on Dec. 29, 1978

Source: *Nordby International Inc.* (nordby.com) Boulder, Colo.

PCS catastrophe options

As of June 18

Call spread	Price bid/ask
National Annual 1999	
40/60	15.0/19.0
60/80	9.0/16.0
80/100	5.0/—
150	5.3/9.0
200/250	3.6/6.0
Southeastern September 1999	
40/60	2.8/—
60/80	2.3/—
80/100	2.4/—
Eastern September 1999	
40/60	3.3/—

Call spread	Price bid/ask
California Annual 1999	
60/80	0.8/1.8
80/100	0.6/1.6
150C	1.2/2.5
Western Annual 1999	
80/100	0.8/1.9
Midwest June 1999	
10/20	8.5/9.5
Florida Sept./Dec. call strip 1999	
100/150	1.8/—

Total volume: 0 Total open interest: 10,676

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

British Issues

Companies	Price pence	P/E	Div. pence	Yield %	52-week high-low
Gdn Royal Exch	360	5.5	9.8	3.5	400-300
Legal & Gen	170	21.7	3.6	2.6	237-162
Royal & Sun	531	18.2	23.0	5.5	633-455
Brokers					
Lmbrt Fenchurch	87	7.0	5.7	8.3	94-58
JLT	252	10.7	12.0	6.3	252-166

Note: Prices are June 18 closings; other numbers from June 17.

Source: *Nordby International Inc.*(nordby.com) Boulder, Colo.

BI Industry Stock Report JUNE 14, 1999, THROUGH JUNE 18, 1999

		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
BROKERS							
Aon Corp.	NYS	42.56	1.34	13.88	50.38	32.19	1850
E.W. Blanch Holdings Inc.	NYS	67.50	4.15	44.58	68.00	34.88	965
Gallagher Arthur J. & Co.	NYS	49.00	1.95	12.00	50.63	34.88	130
Hilb, Rogal & Hamilton	NYS	21.63	-0.29	16.11	21.88	15.38	49
Kaye Group Inc.	NDQ	7.50	-1.64	3.45	8.38	5.00	32
Marsh & McLennan	NYS	77.50	6.26	31.08	81.13	43.38	2808
Brown & Brown	NYS	36.13	-0.17	3.40	42.50	29.31	30
BROKERS	AVERAGE		1.71	18.44			
INSURERS/REINSURERS							
ACE Ltd.	NYS	29.13	1.97	-10.90	43.00	24.38	3432
Accel International Corp.	NDQ	1.88	-16.67	-37.50	3.38	1.50	26
Acceptance Insurance Cos.	NYS	15.13	-0.82	-23.90	25.63	12.06	173
AEGON N.V.	NYS	80.50	1.02	-33.98	130.13	69.25	895
Aetna Life & Casualty	NYS	93.56	-0.40	17.23	99.88	60.19	3556
AFLAC Inc.	NYS	49.56	6.30	12.64	56.75	25.13	3981
Allmerica Financial Corp.	NYS	62.25	7.79	9.93	75.25	38.38	848
Allstate Corp.	NYS	37.63	-1.07	-2.27	52.38	34.75	12642
AMBAC Indemnity Corp.	NYS	57.50	2.56	-4.07	65.94	40.88	739
American Bankers Ins.	NDQ	54.19	0.35	13.48	61.31	30.13	1139
American Financial Group	NYS	34.13	1.87	-17.15	44.88	30.50	224
American General	NYS	73.94	5.06	-5.51	79.00	52.38	1512
American Heritage Life Ins.	NYS	24.13	4.32	0.26	26.69	18.63	120
American Indemnity/Fin'l	NDQ	14.25	2.70	34.12	15.38	10.25	25
American Intl Group	NYS	121.88	6.67	25.16	134.00	64.88	11323
American Safety Insurance	NYS	8.44	-4.26	-11.18	12.63	6.63	11
Argonaut Group	NDQ	26.75	2.15	11.46	33.25	21.25	181
AXA-UAP Group	NYS	62.13	7.23	-13.19	80.25	38.25	444
Baldwin & Lyons Inc.	NDQ	21.75	5.45	-6.95	26.00	18.50	30
Berkley W.R. Corp.	NDQ	24.88	-2.69	-26.30	49.00	23.50	432
Berkshire Hathaway Inc.	NYS	69900.00	-2.24	2.34	84000.00	57000.00	1
Capital RE Corporation	NYS	16.75	1.13	-14.38	38.19	11.94	226
Capitol Transamerica Corp.	NAS	14.88	-0.42	-15.90	22.75	13.31	39
Centris Group Inc.	NYS	9.81	2.61	4.67	14.06	7.94	101
Chartwell Re	NYS	13.88	-2.20	-40.32	30.94	13.25	195
Chubb Corp.	NYS	73.75	7.96	13.57	88.81	54.00	2409
CIGNA Corp.	NYS	95.50	2.34	22.83	98.63	57.19	3445
Cincinnati Financial Corp.	NYS	38.38	-0.97	7.53	41.88	30.50	911
Citigroup	NYS	46.31	7.55	37.39	51.75	19.00	44213
CNA Financial Corp.	NYS	41.31	1.23	5.09	47.44	33.00	468
CNA Surety	NYS	15.19	1.25	1.67	16.00	10.19	229
EMC Insurance Group Inc.	NDQ	10.88	-5.43	-14.71	15.13	9.00	21
ESG Re Limited	NDQ	14.63	-6.40	-26.18	23.88	12.75	252
Enhance Financial Services	NYS	20.19	1.25	-33.26	37.31	17.31	511
Everest Reinsurance	NYS	32.81	3.35	-10.56	43.50	28.75	687
Executive Risk Inc.	NYS	90.13	7.29	67.29	92.88	35.50	139
EXEL Ltd.	NYS	58.06	-0.11	-18.86	83.25	54.50	2033
Fremont General Corp.	NYS	18.94	-0.33	-21.50	30.06	16.50	287
Frontier Insurance Group	NYS	14.88	-6.67	19.00	24.00	10.88	482
Gainsco Inc.	NYS	4.06	-2.99	-35.64	8.06	3.94	85
Harleysville Group	NDQ	20.25	0.62	-20.59	27.25	17.00	140
HSB Group Inc.	NYS	41.06	0.00	2.18	59.56	34.75	282
HCC Insurance Holdings	NYS	21.06	-0.59	24.35	23.19	16.00	579
ING Groep N.V.	NYS	55.50	3.74	-9.02	76.75	36.06	233
IPC Holdings Ltd.	NDQ	19.88	-0.93	-12.64	30.63	17.38	146
Hartford Financial Services	NYS	60.44	2.55	8.29	66.44	37.63	1893
LaSalle Re Holdings Ltd.	NYS	15.25	0.41	-26.06	39.19	11.63	143
Lincoln National	NYS	104.56	3.53	26.17	106.13	67.00	1796
MAIC Holdings Inc.	NYS	28.25	0.67	-11.72	33.13	23.25	90
Markel Corp.	NYS	183.81	1.24	1.98	193.00	132.00	9
MBIA Insurance Group	NYS	65.81	1.35	-0.75	80.13	46.06	1514
Meadowbrook Insur. Group	NYS	13.31	2.40	-18.39	31.50	12.31	64
MMI Cos. Inc.	NYS	14.88	0.85	-10.86	23.44	13.75	87
Mutual Risk Mgmt. Ltd.	NYS	36.00	-1.20	-5.11	43.25	25.38	657
NAC Re Corp.	NYS	52.63	-1.64	12.72	60.81	43.69	748
Navigators Group	NDQ	14.25	-0.87	-6.56	19.50	13.25	33
NYMagic Inc.	NYS	14.00	0.45	-32.93	28.63	12.00	63
Ohio Casualty Corp.	NDQ	39.19	0.97	-4.71	47.88	33.75	222
Old Republic Int'l	NYS	17.75	-0.70	-17.20	31.25	17.06	1107
Orion Capital Corp.	NYS	29.63	0.64	-24.40	59.25	27.56	222
Partner Re Ltd.	NYS	37.38	1.70	-17.29	52.50	33.63	607
Penn-America Group Inc.	NYS	10.63	-2.86	14.86	16.00	8.13	46
PMA Capital Corporation	NDQ	20.56	0.61	5.11	23.75	16.63	71
Philadelphia Cons. Holding	NDQ	24.56	1.81	15.59	25.50	18.63	210
PXRE Corp.	NYS	17.81	-0.35	-29.46	31.13	16.00	151
Reliance Group Holdings	NYS	7.00	-28.21	-45.89	19.81	6.81	4960
ReliaStar Financial Corp.	NYS	42.00	2.28	-6.15	52.44	29.00	970
RenaissanceRe Holdings Ltd.	NYS	37.25	-1.32	3.11	48.31	30.00	51
Risk Capital Holdings	NDQ	15.63	-2.34	-26.04	25.50	12.00	87
RLI Corp.	NYS	36.94	1.55	10.67	45.63	27.88	80
St. Paul Companies	NYS	34.25	3.40	-2.14	44.50	28.06	2974
SCOR	NYS	50.38	-0.49	-22.50	72.75	48.00	30
SAFECO Corp.	NDQ	44.44	4.71	4.56	49.38	36.69	2072
SCPIE Holdings Inc.	NYS	29.38	1.08	-2.29	35.50	23.69	NA
Seibels Bruce Group	NDQ	5.25	10.53	50.00	7.50	2.69	204
Selective Ins. Group	NDQ	18.69	0.67	-7.72	24.63	16.69	369
Terra Nova Ins Co. Ltd.	NYS	26.88	0.70	10.26	35.00	21.25	216
Tokio Marine & Fire	NDQ	58.00	-2.52	-1.49	62.88	39.00	108
Torchmark Corp.	NYS	34.75	3.73	0.00	47.19	30.69	1434
Transatlantic Holdings	NYS	75.06	1.52	-0.74	94.50	72.50	361
Travelers Property Casualty	NYS	39.00	-1.89	27.35	45.75	24.13	873
Trenwick Group Inc.	NDQ	28.38	-4.62	-10.28	40.00	25.25	149
Unico American Corp.	NDQ	10.38	-2.35	-10.03	15.38	8.63	10
United Fire & Casualty	NDQ	26.25	-0.94	-21.13	41.50	22.25	32
Unitrin	NDQ	34.38	-0.36	-3.00	38.00	27.88	225
UNUM Corp.	NYS	58.50	0.75	-2.40	62.50	41.75	2968
Vesta Insurance Co.	NYS	4.75	4.11	-17.39	27.38	3.38	262
Zenith National Ins.	NYS	24.75	1.80	7.03	28.50	20.31	134
INSURERS/REINSURERS	AVERAGE		0.70	-3.79			
HEALTH MAINTENANCE ORGANIZATIONS							
Foundation Health Systems Inc.	NYS	17.75	-2.41	61.36	29.63	5.88	1063
Humana Inc.	NYS	13.69	-5.60	-27.72	32.13	10.06	3645
Oxford Health Plans	NDQ	18.00	-6.19	28.57	24.25	5.81	4510
Pacificare Health Sys.	NDQ	88.06	-2.08	23.16	98.13	53.75	120
Safeguard Health Enter.	NDQ	3.00	9.09	-15.79	7.50	2.34	14
Sierra Health Services	NYS	15.25	0.41	-26.95	26.00	10.44	225
United HealthGroup	NYS	66.88	-4.12	50.07	70.00	29.56	4978
Wellpoint Health Networks	NYS	96.06	9.40	11.86	96.06	50.50	2155
HMOs	AVERAGE		-0.19	13.07			
ALL COMPANIES	AVERAGE		0.74				

Top advancing issues: Seibels Bruce Group, Wellpoint Health Networks, Safeguard Health Enter. Leading decliners: Reliance Group Holdings, Accel International Corp., Frontier Insurance Group. Most active issue: Citigroup. The *BI* Index gained 2.7%; the Dow Jones 30 Industrials gained 3.5%; the S&P 500 rose 3.8% and the NYSE Composite increased 2.8%. Average P/E: Brokers, 19.4; Insurers/reinsurers, 19.4; HMOs, 24.4.

Source: *Nordby International Inc.* (nordby.com), Boulder, CO

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