

Business Insurance

Reporting Weekly on Corporate Risk, Employee Benefit and Managed Health Care News / \$4

Entire contents copyright 1998 by
Crain Communications Inc. All rights reserved.

Regulators expected to renew petition for EMLICO liquidation

BOSTON—The Massachusetts Insurance Division is expected to renew a liquidation petition against Electric Mutual Liability Insurance Co. after a federal judge last week turned aside a challenge to the action.

Massachusetts regulators originally filed to liquidate EMLICO in January, after the state's highest court found that the General Electric Co. insurer's 1995 redomestication to Bermuda was improper and that the hugely insolvent EMLICO remained a Massachusetts company. EMLICO's Bermuda

See Updates on next page

Justices widen room for suits on harassment

By MARK A. HOFMANN

WASHINGTON—Employers could face an increased exposure to lawsuits for supervisors' sexual harassment of employees because of a pair of decisions handed down by the Supreme Court on the last day of its 1997-1998 term.



The high court's 7-to-2 rulings in both *Beth Ann Faragher vs. City of Boca Raton* and *Burlington Industries Inc. vs. Kimberly B. Ellerth* last Friday centered around Title VII of the Civil

Rights Act of 1964. That provision governs employment-related discrimination based on an individual's race, color, religion, sex or national origin.

While the majority upheld the right of both plaintiffs to sue, it also outlined a defense that employers can use to avoid or minimize liability for such suits, which was

See Title VII on page 29

GOP backs proposal on patient protection

Health care reform legislation still could pass this year

By JERRY GEISEL

WASHINGTON—The backing of a health care patient protection proposal last week by the House Republican leadership significantly increases the likelihood Congress will pass health care legislation before the session ends this fall.

After months of discussion and negotiations, a House Republican task force reached agreement on and released last week a scaled-back proposal intended to respond to the public backlash against managed care.

Among other things, the package requires employers that offer only a traditional health maintenance organization to provide a point-of-service option. The proposal also would require health plans to set up new internal and external claim review mechanisms, give patients direct access to pediatricians and obstetrician/gynecologists, eliminate so-called managed care plan "gag rules" and provide better access to emergency room services.

Other provisions—not directly related to managed care—include imposing a \$250,000 cap on non-economic damage awards in medical malpractice cases, allow-

See GOP on page 4

Rx for health care

Here's what the House Republican task force recommends:

- + Point-of-service mandate
- + Expedited internal review and new external reviews
- + Direct access to Ob/Gyns and pediatricians
- + Improved access to emergency room care
- + New association plans for small employers
- + Expanded medical savings accounts
- + Cap on medical malpractice awards
- + Ban on provider gag rules

Lawmakers pass little in P/C arena

A stroke of the Florida governor's pen cost tort reform advocates their most significant victory of 1998.

In fact, Florida's was the only legislature to approve more than targeted tort reform so far this year, and Democratic Gov. Lawton Chiles' veto of the tort reform bill virtually guarantees it will be an issue in this fall's gubernatorial election.

"The most significant state in terms of broad-based reform was Florida, but that, unfortunately, was vetoed," said Sherman T. Joyce, president of the American Tort Reform Assn. He said the business community "seems very intent" on using Gov. Chiles' veto of the measure in the upcoming gubernatorial race between Democratic Lt. Gov. Buddy McKay and Republican Jeb Bush. Gov. Chiles cannot serve another term, and Mr. Bush, who lost a close race to Gov. Chiles in 1994, has a commanding lead in public opinion polls.

Anne Allen, director of government affairs for the Risk & Insurance Management Society Inc. in New York, agreed that the tort reform efforts could get a boost if Mr. Bush wins the governorship.

Lawmakers have yet to take up comprehensive re-

See P/C reform on page 10



Information privacy hot in work comp

Proposals governing the privacy of workers' medical records are dominating lawmakers' review of state workers compensation systems this year.

"If there is one clear, distinct, unambiguous trend, it is a recognition of the sensitivity of exchanges of medical and medical-related information," said Bruce C. Wood, assistant general counsel with the American Insurance Assn. in Washington.

In many cases, lawmakers discussing the issue focus first on restricting the dissemination of data by health insurers and managed care plans, but they then sweep in workers compensation insurers and self-insuring employers by refusing to explicitly exclude them.

North Carolina has taken the issue further than most states. Its

See Comp on page 14

A light touch carries day in health care

For state legislatures, tinkering with the health care system is in this year. Radical change is out.

The predominant theme of state activity is addressing pockets of public discontent over access to care rather than launching wholesale attacks on managed care.

"The managed care backlash is there, but legislators are not trying to legislate managed care out of existence," notes Susan Laudicina, director of research in the Washington office of the Blue Cross & Blue Shield Assn.

For example, while legislation was introduced in 30 states to create special causes of action for health plans that improperly denied claims, such bills were rejected in 23 states, with proposals still pending in seven states.

Legislators are responding to specific areas of concern, Ms. Laudicina notes.

One such area is improving patient access to specialists, a direct reaction to HMOs that have tried—in the interest of efficiency—to channel all patients through primary care gatekeeper physicians.

For example, measures enacted in Tennessee, Utah and West Virginia require health care plans to give women enrollees direct access to obstetricians and gynecologists. A bill passed in Colorado gives patients direct access to nurse-midwives.

At the same time, the decades-old trend of state legislators' often in response to pressure from special-interest provider groups—mandating that health care plans offer specific benefits continues, albeit generally in a modest way.

States adding new mandates include Kansas and

See Health on page 11

TO SUBSCRIBE CALL

1-800-678-9595

Updates

New EMLICO petition expected

Continued from previous page

liquidators, partners of Coopers & Lybrand L.L.P., then removed the petition to federal court and sought to have it dismissed (*BI*, Feb. 9).

At a hearing last week, though, U.S. District Judge Douglas P. Woodlock said he would remand the petition to state court. Judge Woodlock's written ruling is expected this week, after which the Insurance Division will seek a state court liquidation order, according to Eric A. Smith, a lawyer representing the division. If the petition is granted, Massachusetts regulators then will go to court in Bermuda for an order staying the Bermuda liquidation, Mr. Smith said.

EMLICO's Bermuda liquidators had tried to block the U.S. insolvency proceeding by arguing, among other things, that they stood in EMLICO's shoes and were immune from suit under a federal foreign sovereign immunity statute.

While agreeing that the Bermuda liquidators are protected by the immunity statute, Judge Woodlock also indicated that EMLICO remains subject to Massachusetts insolvency proceedings to the extent that it is a Massachusetts company.

The hearing did not resolve whether Massachusetts or Bermuda authorities should control EMLICO. In fact, in an indication of the case's jurisdictional complexity, Judge Woodlock said he would let stand an ancillary federal bankruptcy petition that EMLICO's Bermuda liquidators filed to halt state court reinsurance litigation with Lloyd's of London underwriters (*BI*, March 30).

The Bermuda liquidators said in a statement they are "pleased" with the judge's findings on the immunity and bankruptcy issues.

Judge Woodlock earlier this year urged the Massachusetts division and Bermuda liquidators to compromise on a joint liquidation of EMLICO, but those talks stalled in March (*BI*, March 16).

Swift reform unlikely: Gorton

WASHINGTON—Congress probably will not complete work on a limited product liability reform bill until September at the earliest, according to the measure's chief Republican sponsor.

The Senate should take up the measure early next month, Sen. Slade Gorton, R-Wash., told representatives of the National Assn. of Manufacturers last Thursday, as that organization publicly endorsed the measure.

Sen. Gorton, who with Sen. John D. Rockefeller IV, D-W.Va., drafted the measure after months of consultation with the White House, warned, however, that passage of even a mild reform bill in the Senate is not a done deal despite President Clinton's promise to sign the bill if it reaches his desk (*BI*, June 15).

He noted that several Democratic senators who supported reform in 1996 have retired and that Republican backing for the bill is not universal. That could make it difficult for supporters to muster the 60 votes necessary to cut off debate on the measure and bring it to a vote. If the Senate passes the measure, the process would have to be repeated in the House, which has yet to act on product liability legislation this year.

The bill concentrates much of its relief on the smallest businesses. It does, however, set a uniform statute of repose of 18 years for workplace goods in situations where a worker is covered by workers compensation or other insurance, create a national standard for the awarding of punitive damages in product liability cases, and provide a defense for manufacturers if plaintiffs misused or altered a product or were under the influence of alcohol or drugs at the time of their accidents.

Sen. Gorton defended the measure as the best possible under the circumstances. "We have left nothing on the table that was attainable," he said. Sen. Gorton acknowledged that he would like to have seen more reforms, particularly in the area of joint-and-several liability, and he said that on a scale of 10, the measure rated about a 3. He added, however, "I've got to say to you, this is all you're going to get while Bill Clinton is president of the United States."

The senator also acknowledged that he knew little about the workings of a workers compensation subrogation provision put in the bill by Sen. Rockefeller. He said opponents of the provision could try to persuade the West Virginia lawmaker to remove it.

Receivership protection sought

BOSTON—The National Assn. of Insurance Commissioners formally adopted a resolution last week urging Congress to explicitly exempt insurance company receiverships from a federal law that gives federal government claims priority in state insurer liquidations.

The resolution asks Congress "to explicitly exempt from its ambit the administration of insurance company receiverships in order to preserve to the states that which Congress intended in enacting the McCarran-Ferguson Act." That act allows states to regulate insurance.

The explicit carve-out is motivated by a desire to end litigation on the issue and save both sides time and expense, said Peter Gallanis, special deputy receiver for the Illinois Insurance Department.

The trail of litigation began after the U.S. Supreme Court's 1993 decision in *U.S. Treasury vs. Fabe* that, because state liquidation laws are part of the business of insurance, the McCarran-Ferguson Act partially exempts them from a 1797 federal law that gives federal claims "superpriority" in bankruptcies.

Since then, the federal government has tried to narrow the scope of the ruling, with mixed success. However, it lost its September 1997 fight during the Reserve Insurance Co. liquidation to knock guaranty funds farther back in line to recover assets. A federal district court in Chicago also ruled then that the Illinois liquidator could hold the federal government to specific deadlines for filing claims against an insolvent insurer's estate (*BI*, Oct. 27, 1997).

Tobacco ruling to be appealed

TALLAHASSEE, Fla.—Lawyers are vowing to fight an appeals court ruling in the so-called "Carter case" that overturns a \$750,000

See Updates on page 30

Privacy rules softened

NAIC panel advances proposed rules for insurers

By MEG FLETCHER

BOSTON—State insurance regulators made several pro-business changes to proposed standards on health information privacy, though insurers still have some concerns with the proposal.

Regulators drafting the 30-page proposed Health Information Privacy Model Act agreed to make several changes sought by a coalition of insurance-related organizations during the National Assn. of Insurance Commissioners' summer meeting in Boston.

NAIC

For example, drafters eliminated language about an aggrieved

party's right to sue, though a footnote in the model still notes that states could consider that issue individually. Drafters also agreed to dilute a provision governing insurers' responsibility to oversee contractor compliance with privacy provisions, though contractors still would have to comply with some privacy protections. Contractors could include third party

See Privacy on page 30

CIGNA appeal revived after court's error

By DAVE LENCKUS

HARRISBURG, Pa.—The fate of CIGNA Corp.'s restructured property/casualty operation again rests with the Pennsylvania Supreme Court.

With little explanation, the court last week vacated a series of its own orders that earlier this month had moved the dispute back to the state's Insurance Department for new trial-like hearings and a new departmental decision on the legality of the liability-based restructuring (*BI*, June 15).

The court stated only that its earlier orders had "been entered due to administrative error." The court did not elaborate. Representatives in the court's clerk's office and in the chief justice's office said they did not know the nature of the error.

There were some glitches in the announcement of those orders, which rejected all appeals of a March 1997 Pennsylvania Commonwealth Court decision in favor of those that objected to the restructuring. The Commonwealth Court had vacated former Commissioner Linda S. Kaiser's approval of the reorganization and directed the Insurance Department to reconsider the restructuring.

Initially, the state Supreme Court on June 5 issued orders that rejected only some of the petitions seeking to appeal the Commonwealth Court's ruling. When alerted, the high court a few days later issued orders that rejected the remaining petitions.

See CIGNA on page 31

Taylor maps Lloyd's future expansion

By SARAH GODDARD

LONDON—Lloyd's of London plans to expand in several key international locations over the next five years, according to Chairman Max Taylor.

Speaking at Lloyd's annual general meeting earlier this month, Mr. Taylor outlined his vision of the future of Lloyd's, based on "key projects" that Lloyd's has been working on over the past year.

Mr. Taylor said he foresees the London insurance market as "even more firmly established as the world's leading center for underwriting specialized risks."

This will be reflected, he predicted, in growing market share in such classes of business as liability; marine, aviation and transport; international property and construction; and reinsurance.

To gain a share of this business, Lloyd's aims to extend its broker network, and Mr. Taylor anticipates that "access to Lloyd's will be streamlined and simplified and driven by commercial

See Lloyd's on page 31



Mr. Taylor

Lawyers hit with record E&O award

By MICHAEL BRADFORD

AUSTIN, Texas—Three Louisiana lawyers charged with giving bad tax advice are facing an \$18 million judgment in one of the nation's largest legal malpractice jury awards.

A jury in U.S. District Court in Austin, Texas, earlier this month leveled the award against the attorneys and their Lake Charles, La., law firm of Hunter, Blazier, O'Dowd & Moreno. Jurors decided the defendants deceived two sisters who relied on them for tax advice related to proceeds they received from a real estate trust, according to court papers.

Insurance coverage is in place that could pay a portion of the award if it is upheld, according to plaintiffs attorney Daniel R. Castro of Watt & Associates P.C. in Austin.

Legal malpractice coverage written for the

See Texas on page 28

Juries vs. lawyers

The largest jury awards in legal malpractice cases. Jury awards may have been reduced on appeal or settled for a lower amount

Case	Trial Date	Award
Streber, Delony vs. Hunter U.S. District Court, Texas	June 1998	\$18.0 million
Moran vs. Vinson & Elkins Texas state court	June 1994	\$17.7 million
Ebrahimi, Panaphour vs. Sewell, Riggs U.S. District Court, Texas	January 1991	\$17.4 million
Garland vs. Ganezer, Meyer California state court	September 1997	\$8.1 million
Sanford vs. Johnson Texas state court	April 1991	\$8 million

Source: Jury Verdict Research

Inside

• GOP proposals for health care reform are a starting point, but we advise waiting for the next session of Congress to carefully craft legislation, one of this week's editorials says. **PAGE 8**

• Forbes Group unit Nelson Hurst Ltd. will become part of the FDG broker network in Europe. **PAGE 24**

• Outbreaks of E. coli bacteria linked to a delicatessen in suburban Chicago and a water park near Atlanta lead to illnesses. **PAGE 28**

Departments

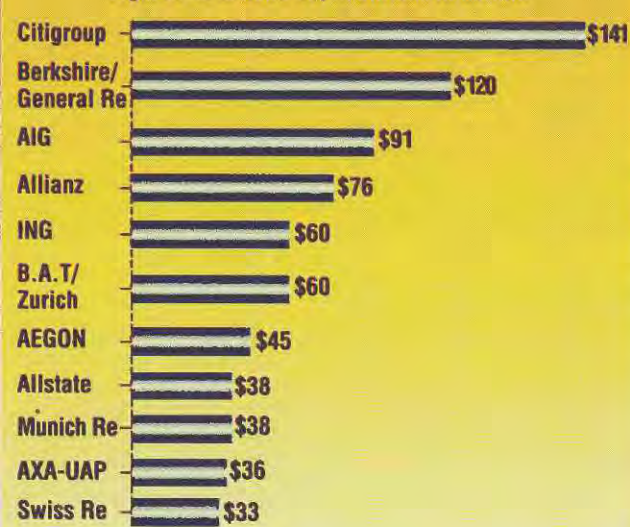
Advertiser Index.....25
Ask A Benefit Manager.....23

Classifieds.....26
Commentary.....34
For The Record.....28
Insurance Services Guide.....24
International.....23
Opinions.....8
Perspectives.....21
Ticker.....31

Business Insurance (ISSN 0007-6864) Vol. 32, No. 26, is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611-2590. Periodicals postage is paid at Chicago and at additional mailing offices. POSTMASTER: Send address changes to *Business Insurance*, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207. \$4 a copy and \$87 a year in U.S. \$105 in Canada and Mexico (includes GST). All other countries \$205 a year (includes expedited air delivery). Canadian Post International Publications Mail Product (Canadian Distribution) Sales Agreement No. 0293512, GST No. 136760444. Printed in U.S.A. Copyright 1998 by Crain Communications Inc.

Global insurers by market capitalization

Figures as of June 18; in billions of dollars



Source: Berkshire Hathaway/General Re

Capital in command

Berkshire's buyout of Gen Re to create gargantuan reinsurer

By JUDY GREENWALD

STAMFORD, Conn.—Berkshire Hathaway Inc.'s approximately \$22 billion stock acquisition of General Reinsurance Corp. is expected to create a powerful giant in the reinsurance industry but one that exercises a delicate touch.

The acquisition of the largest U.S. reinsurer, which was announced June 19, will lead to a combined company with close to \$120 billion in market capitalization (*BI*, June 22). The combined company's net worth of \$56 billion, on a generally accepted accounting principles basis, will make it the largest U.S. company.

How much of that capital will be allocated to General Re will be the decision of Berkshire Chairman Warren Buffett.

"Frankly, I hope Ron calls me up someday and says he can use another billion or two," said Mr. Buffett at the news conference announcing the deal, referring to General Re Chairman and Chief Executive Officer Ron Ferguson.

Despite the transfer in ownership, no one expects any dramatic changes in General Re's underwriting standards. Analysts, competitors and intermediaries say Mr. Buffett bought General Re, at least in part, because of its smart, savvy management, and General Re is unlikely now to change its basic strategy and embark on any reckless price cutting.

Instead, becoming part of the Berkshire Hathaway operation will free General Re of the constraints of posting quarterly earnings reports to impatient investors interested only in short-term outlooks.

With Berkshire Hathaway's backing, General Re, which will continue to operate independently, could be less concerned about earnings volatility and feel freer to write longer-term business that calls for larger capacity.

Some construe the deal, scheduled to close in the fourth quarter, as a threat to competitors, particularly small, broker market reinsurers, though others say the transaction is far from their death knell.

At the news conference announcing the acquisition, Mr. Ferguson said that, while it has not loomed as a major issue until now, without the deal General Re would have been constrained in the future by capacity limits.

This "is really something that's kind of developing here and now. I don't See Gen Re on page 27

Aon storms markets with typhoon cat bond

By RODD ZOLKOS

CHICAGO—A recent catastrophe bond deal is significant not only as the first to securitize Japanese windstorm risks, but also because it was engineered by a new player in a realm that previously has been dominated by investment banks.

Yasuda Fire & Marine Insurance Co. Ltd. used risk securitization this month to secure \$80 million in reinsurance for typhoon exposures for up to seven years.

The transaction involved the sale of \$80 million in notes by Pacific Re Ltd., a Cayman Islands-domiciled special-purpose vehicle. The notes were structured and brought to market by Aon Capital Markets Inc., a subsidiary of Aon Corp.

"Obviously it's the first transaction that was lead-managed by a non-Wall Street investment bank," said Kevin R. Callahan, president and CEO of Aon Capital Markets in Chicago.

"We have that capability on our own, and we're committed to providing that capability to our clients without ceding it, as most of the other participants in these transactions have done to the banks and the investment banks," Mr. Callahan said.

"The question has been, 'How can (Aon) ever develop a securities distribution capability?'" Mr. Callahan said, adding that the deal underscores not only Aon's commitment to developing that capacity but the fact that it now exists, he said.

See Yasuda on page 7

Human resources exposures create need for risk management

By RODD ZOLKOS

MINNEAPOLIS—The merging of the roles of risk managers and human resources professionals appears inevitable, according to a speaker at the recent Society for Human Resource Management conference.

"I think, as we see companies downsizing, right-sizing and re-engineering, everybody in this room is going to be a risk manager," Vickie R. Cortese, vp personnel/risk management for Federal Compress & Warehouse Co. in Memphis, Tenn., said at the annual conference earlier this month in Minneapolis.

"So what I think we're going to see is more and more of us having the dual responsibility," Ms. Cortese said in a presentation titled "The Inevitable Synthesis of HR and Risk Management: Are You Prepared?"

Making that synthesis an even more natural step, according to the personnel/risk manager, is the fact that the two disciplines share certain common elements. Ms. Cortese noted that the core functions and objectives of the two areas are similar. "We want to identify, assess and address the cause and effect of risks, using the findings to reduce uncertainty in our department," she said. "If your job is to reduce risk, you are a risk manager in the biggest sense of the word."

The frustrations are another similarity in the two roles. Professionals in both fields want certainty but instead face the frequent prospect of unknown expenses.

Increasing that instability, from an HR perspective, is the growing number and magnitude of employment practices claims, Ms. Cortese said.

The most notable difference between the two fields' approach to managing risk is that, typically, the human resources field doesn't transfer any of the risks it faces. "You've got the most moxie of anybody, because you're not transferring your risk to anybody," Ms. Cortese told attendees. "So, to some degree, you have been the strongest kind of risk manager. But nobody's been watching how well you do your job if you haven't had claims."

A slow departure from HR's historic disinclination to transfer its risks is leading, however, to yet more similarity between risk management and human resources professionals, as HR departments make increasing use of employment practices liability insurance coverage.

"Finally, a sleep aid that works," Ms. Cortese joked. "It may not be perfect, but it's better than nothing."

While she has some strong misgivings about EPL insurance, Ms. Cortese suggests

See SHRM on page 22



50TH ANNUAL CONFERENCE & EXPOSITION
JUNE 14-17, 1998 • MINNEAPOLIS, MINN.

Communication lacking among HMOs, doctors

Survey finds little teamwork to improve quality

By ROBERTO CENICEROS

Collaboration between doctors and health maintenance organizations on efforts to improve health plan performance generally remains poor to very poor, a new Pacific Business Group on Health survey of physician groups finds.

The employer coalition's survey of California doctor groups released last week also revealed which California HMOs the doctor groups consider to be best or worst at such functions as consumer education, quality and data reporting.

In addition to releasing the findings, the San Francisco-based PBGH also reported a nearly 4% average increase in HMO premiums for members in 1999.

Because many health plans delegate numerous responsibilities to doctor groups, the PBGH believes that strong communication between health plans and doctor groups is necessary to sustain improvements in cost, medical access and care quality, the coalition explained in the survey's results.

While managed health plans have

made improvements in their relations with doctors, "There is a need for stronger incentives and cooperation with physicians to measure quality of care and health outcomes," said Pat Powers, executive director of the PBGH and president of its "Negotiating Alliance," which is composed of several large employer members.

In 57% of contracts between the doctors and HMOs, the health plan's efforts to provide doctors with "quality benchmark data were considered poor or very poor," according to the survey.

The survey also found that in 55% of contracts, HMO efforts to collaborate with doctor groups to improve performance on HEDIS scores were characterized as poor or very poor. HEDIS is a set of health care quality measurements developed by the National Committee for Quality Assurance.

Also, in 59% of contracts, doctor groups rated the effectiveness of HMO quality improvement programs to be poor or very poor.

See PBGH on page 30

Insurers warn buyers on Year 2000 risks

AIG, others urge policyholders to fix systems

By GAVIN SOUTER

NEW YORK—Insurers are starting to put a bug in policyholders' ears about the Year 2000 problem.

In one of the largest insurer communication efforts to date, American International Group Inc. sent letters to all of its policyholders urging them to deal with potential Year 2000 problems. The AIG letter does not specifically address coverage of the risk.

Among other insurers that recently have sent letters to policyholders, agents or brokers are: Chubb Corp., Reliance National Insurance Co., Travelers Property Casualty Corp. and The St. Paul Cos. Inc. CNA Insurance Cos. plans to send out an eight-page informational booklet on the Year 2000 problem within the next two months.

The AIG letter was largely welcomed by risk managers, brokers and others as a sensible approach to a huge issue, though some attorneys and brokers see the insurer's let-

ter as perhaps the first part of a legal strategy for denying Year 2000-related claims.

The AIG letter has caused a stir, because it is highly unusual for the insurer to conduct a mass-mailing to its policyholders on such a contentious issue, according to insurance brokers. AIG would not comment on the letter.

Dated June 12 and signed by Thomas R. Tizzio, AIG's senior vice chairman, the letter informs policyholders that the Year 2000 problem could cause computers and microchips to produce erroneous calculations or cease to function.

"Inventory and accounting systems will be affected; so will credit-card validation, electronic data interchange, automated banking reports, pension benefit payments, drug distribution systems for pharmacies and hospitals, and mechanical systems operating everything from office building environmental controls and elevator banks to

See Year 2000 on page 6



Task force

Continued from page 1

ing trade associations to offer members self-insured health care plans exempt from state regulation and expanding in yet undefined ways the appeal of tax-favored medical savings accounts.

Perhaps as significant as what is in the proposal—the details of which are expected to be filled in by mid-July—is what is not.

Unlike the proposed Patient Access to Responsible Care Act, the best-known and most widely supported of the patient protection measures in Congress, the new GOP proposal would not expose employers to punitive damage awards for malpractice.

Nor does the measure require, as would PARCA, that providers receive the same reimbursement whether they perform services in or outside a managed care network, a provision

some saw as the death knell of managed care.

"I got about 75% of what I wanted," said Rep. Charles Norwood, R-Ga., the chief sponsor of the PARCA legislation. He has signed onto the Republican task force measure.

With Republicans rallying around a far more modest and less contentious proposal, the odds that Congress will pass some type of patient protection act now are much higher than just a few weeks ago, when the GOP was badly splintered on what direction to take.

"The House Republican leadership, rather than saying no (patient protection) bill, is now saying we have an alternative bill we can support. That is a very significant development," said Frank McArdle, a consultant with Hewitt Associates L.L.C. in Washington.

The short amount of time remaining in the session—perhaps as little as two months—also will not be an ob-

stacle if the Republican leadership is determined to get a bill passed.

Indeed, rumors are rife in Washington that the Republican leadership will move to bypass the normal committee consideration of legislation and have the proposal—once it is put in legislative form—be directly considered by the House and Senate, a prospect unnerving to some employer lobbyists.

"Our concern is that in a political environment with an eye toward the November elections, we could end up with a very extreme measure driven by polling results rather than what is good for health care," said Paul Dennett, vp-health policy at the Assn. of Private Pension & Welfare Plans in Washington.

"A combination of politics and short calendar may push this bill through without reflective consideration. In the past, when that has happened, there have been major problems," said Henry Saveth, an attorney

with William M. Mercer Inc. in Washington. He referred to a hastily enacted 1986 law—known as Section 89—which set non-discrimination rules for health plans so unworkable that Congress later repealed them.

Still, the road to passage of any patient protection act is strewn with obstacles. Indeed, the House proposal contains provisions—most notably the cap on medical malpractice damages and allowing trade groups to set up association health care plans free from state regulation—unlikely to be accepted by the Senate and almost certain to be opposed by President Clinton.

At the same time, some trade groups are preparing to lobby to defeat any bill that would impose new federal health care mandates.

"The public would be better served by no congressional action," said Bill Gradison, president of the Health Insurance Assn. of America in Washington.

While the Republican proposal is modest compared with patient protection measures such as PARCA, it would have an impact on employers' health care plans.

For some employers, the biggest impact would be caused by a provision mandating employers that offer only a traditional or closed panel HMO to add a point-of-service option, which allows a person to see a non-network provider at higher cost. However, this requirement would not kick in if the employer offered another plan, such as a preferred provider organization or a traditional indemnity plan, that gives employees the right to choose providers.

Only a small percentage of companies offer only a traditional HMO. For example, just 5% of employers with at least 500 employees offer only a traditional HMO, though 18% of companies smaller than that offer only an HMO, according to a Mercer survey.

"Generally, larger employers offer choice," said Mary Case, a principal with The Kwasha Lipton Group of Coopers & Lybrand L.L.P. in Fort Lee, N.J.

It isn't known, though, if legislators would impose any limitations on the differences employers could set in deductibles and copayments between traditional HMOs and POS plans.

If such a limitation were imposed, "that could be a costly proposition," said Blaine Bos, a Mercer consultant in Chicago.

And if an extremely narrow differential were set and extended to other network-type plans, such as PPOs, "it could ruin managed care," said a spokeswoman for the Assn. of Managed Healthcare Organizations, a PPO trade group in Fort Lee, N.J.

Other provisions also would have a minor impact on plan design. For example, HMOs increasingly are giving patients direct access to pediatricians and OB/GYNs, albeit with certain restrictions.

For example, HMOs often will give enrollees direct access to OB/GYNs for a specific number—one or two visits—a year. "That is pretty common," Ms. Case said.

Details still are sketchy on provisions that would set new timetables and a new appeals process for employees who challenge coverage decisions by plan administrators and health plans.

The proposal would require health care plans, including self-funded plans, to try to resolve disputes internally. At a news briefing last week, Rep. James Talent, R-Mo., said plans would have to resolve disputes within a week to 10 days for most cases and within 72 hours for emergency cases.

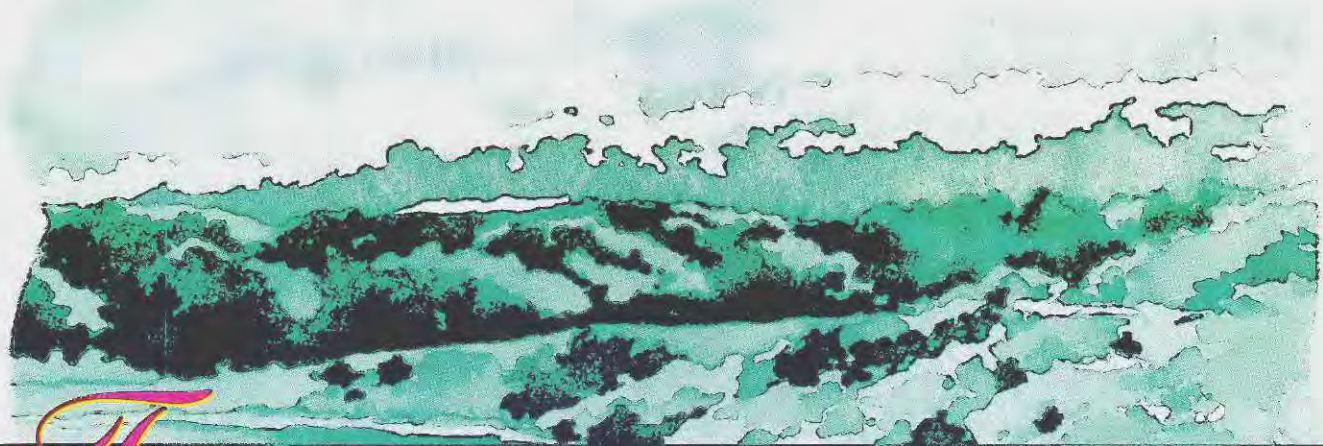
That would be a significant change from Labor Department regulations that require health plans to respond within 60 days of an appeal. However, the Labor Department already has said the existing 60-day standard is obsolete, and it is working to draft new standards.

In view of the Labor Department work in this area, "legislation is frankly unnecessary," said the APP-WP's Mr. Dennett.

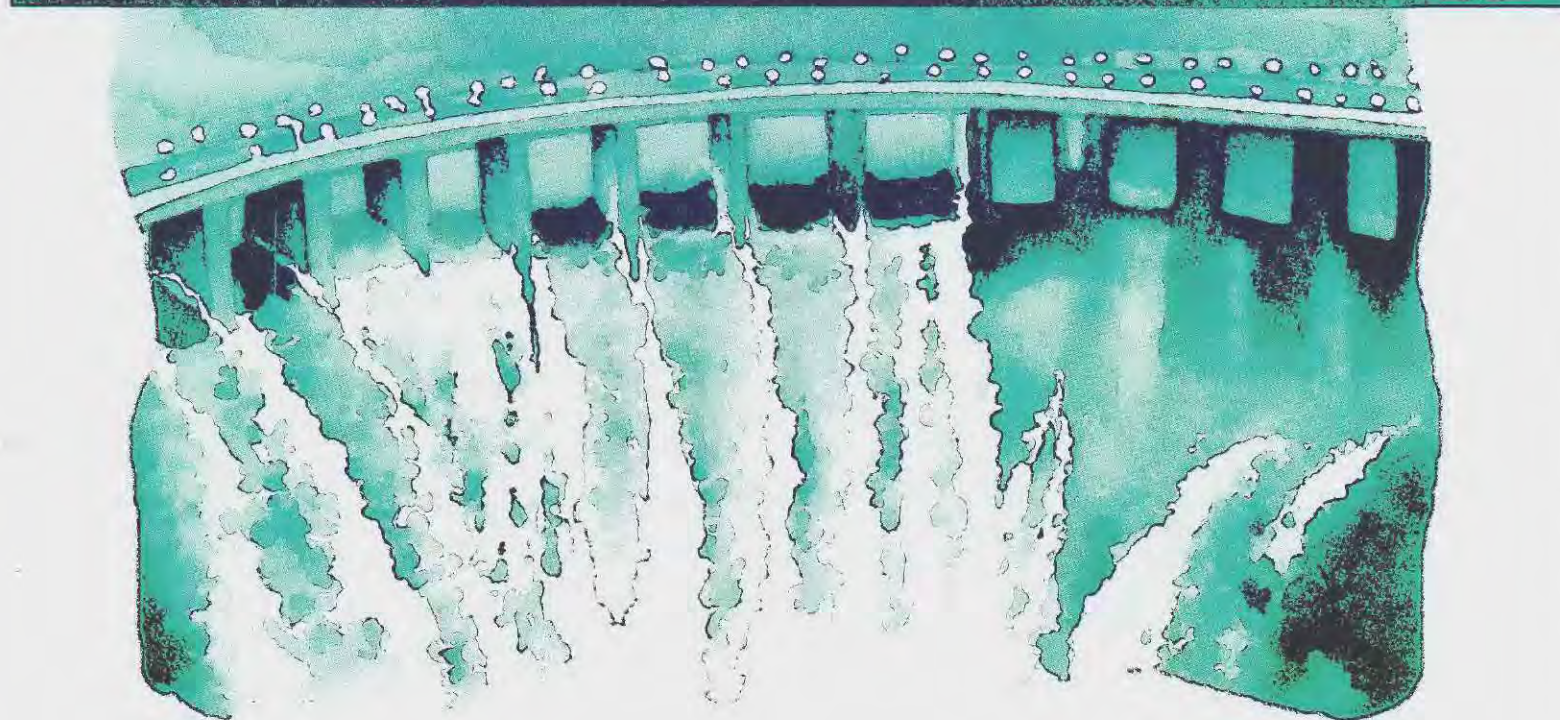
The proposal also would give patients the opportunity to appeal claims decisions to an external review board comprising experts in the field. It isn't known yet, though, who would select members of this board or who would pay for their opinions.

But some benefit managers are wary of this new board. "Would it create another new government bureaucracy?" asked Michael Pikelnny, corporate actuary and benefits consultant for Hartmarx Corp. in Chicago.

The package also envisions the creation of so-called Healthmarts, or co-operatives through which individuals could purchase health care coverage. However, the task force did not release any details on how those cooperatives would operate. **BI**



*There once was a contractor who faced a tough task.
Build and then bring to a dam guidewalls of great mass.
When McGee got the call
To underwrite it all,
They handled the coverage, and did so quite fast!*



The job was monumental. Turn tons of concrete, steel and cable into an 880-foot floating guidewall, then ship it 140 miles downstream to a hydroelectric dam.

But for Wm. H. McGee, covering the project from construction through delivery was all in a day's work. Because as marine insurance specialists for more than 100 years, we have the expertise and imagination to tackle the toughest challenges. Whether it's inland marine, ocean cargo or related property coverages, we can help you get the job done quickly and correctly.

To find out what a horse of a different color can do for you, call McGee today at 1-800-235-6029.



Wm. H. McGee
Underwriting Managers

ON THE ROAD TO RECOVERY, THERE'S
A FAST LANE.

The concept is improving the health and well-being of employees who are injured or sick. The purpose is to effectively manage these occupational and non-occupational disabilities, returning employees to work sooner.

It's called integrated disability management. Every phase of it is coordinated, from treatment to case management to rehabilitation to claim service. The process values employees by focusing on healing. Yet, it gives employers powerful tools for managing costs. Integrated disability management. It's the road to the future, and you can take it now.

THE BUSINESS
INSURANCE EXPERTS.



Year 2000

Continued from page 3
telephone switches and oil refineries," the letter says.

It also states that AIG is on course to becoming Year 2000 compliant and urges policyholders to address the issue at their own companies.

The letter also offers a few general tips on how to manage the problem. Mr. Tizzio advised policyholders to evaluate their Year 2000 exposures and to set priorities. "What is critical and what is merely important? What can be fixed and what should be junked?"

Also, policyholders should consider directly testing and evaluating their vendors' and suppliers' systems to ensure that they will not be affected by problems at third parties.

The letter concludes: "The potential for dislocation from Year 2000 problems is unprecedented. But so is the level of knowledge concerning the problem and the technical ability to solve it. I urge all of our insureds to address their Year 2000 issues promptly and aggressively."

Several risk managers who received the letter view it positively.

"I think it is a reasonable thing for them to do," said William Kelly, managing director of risk management at J.P. Morgan & Co. Inc. in New York. "AIG is one of the largest writers of D&O in the world and (Year 2000) is a very clear D&O exposure, so they need to make sure that all of their policyholders are aware of the problem," he added.

The letter did not offer much information that is not well known by most risk managers, but it is one of the few pieces of information being circulated by insurers on the issue, said John F. Riley, director of corporate risk management at The Dun & Bradstreet Corp. in New York. "The issue is becoming bigger and bigger in the industry...but I haven't seen any good informational material from insurers," Mr. Riley said.

The letter "is a good thing" and states, correctly, that the Year 2000 issue is a serious problem that should be addressed now, said Scott K. Lange, director of risk management at Microsoft Corp. in Redmond, Wash. "It is a clear message that it is management's responsibility to address this problem, and that corporations are dreaming if they think that they can sit back and let Y2K blow up and seek to sue someone and expect to recover," he said. Mr. Lange acknowledged that Microsoft could face potential claims from some software purchasers.

Many policyholders are concerned that they have not received any significant information on Year 2000 issues and coverage, and the AIG letter goes some way to redressing that, agreed Joshua Gold, a partner at Anderson, Kill & Olick P.C., a policyholder law firm in New York.

"My sense is that AIG wanted to get out there and show that they are doing something," he said.

The letter could also serve as part of a legal strategy that AIG is formulating, Mr. Gold said.

In future claims disputes, AIG may try to argue that Year 2000 is a known risk and that the letter, sent out 18 months before the crucial date, proves that policyholders knew of the risk in advance and therefore any loss is not a fortuitous event covered by insurance, he said.

"I don't want to be too cynical, but they may be setting themselves up for later defenses," Mr. Gold said.

Matthew L. Jacobs, a partner at policyholder law firm Kirkpatrick & Lockhart L.L.P. in Washington, said if policyholders do nothing about their Year 2000 problems, then the letter might make up part of a successful defense by AIG if it seeks to deny a claim. However, if policyhold-

ers try to address the issue but still suffer losses as a result of Year 2000 problems, then the letter will be of little use in denying a claim, Mr. Jacobs added.

Some brokers also were weighing the effect of the letter.

The letter offers some sound advice to policyholders but might also be used as a letter of notice to policyholders, said Charles Ruoff, chief marketing officer at Aordia Inc. in Indianapolis. "Will this constitute notice that policyholders should have protected their property?" he queried.

Philip Blais, vp at Arthur J. Gallagher & Co. in Itasca, Ill., said, "Tom Tizzio's letter is a letter of notice that needs to be taken seriously and should simultaneously be matched up to one's insurance position and the function of that insurance in the light of a claim."

The AIG letter is one of several communications that have been is-

sued by insurers on the Year 2000 issue recently.

Earlier this year, both Chubb and Reliance National sent out letters stating that they would treat Year 2000 D&O claims like any other

we felt it was necessary for us to help policyholders understand where Chubb was coming from on this issue," said Gary J. Tully, managing director-executive protection at Chubb, who signed the May 5 letter.

AIG's letter is a clear message that 'corporations are dreaming if they think they can sit back and let Y2K blow up' and expect to recover, says Scott K. Lange.

D&O claim. Both insurers stated that, like other D&O claims, there would be allocation issues to address, and both insurers offered supplementary coverage to guarantee a certain degree of allocated coverage.

"There had been such a clamoring for information in the industry that

Within the next several weeks, Chubb plans to send another letter regarding Year 2000-related coverage issues for other Chubb policies.

Over the past few weeks, Travelers and St. Paul have communicated their coverage positions to brokers and agents.

In a letter sent this month, Travelers tells agents that it will view each account separately, and in some cases it will likely issue a Year 2000 exclusion, although "there is no plan for a blanket endorsement to all policies."

Travelers will also rigorously analyze any Year 2000 claims that arise, the letter says.

"Upgrading computer code and obsolete equipment, before or after that obsolescence manifests itself, is not a cost that our policies were intended to cover. Generally, the Year 2000 problem is a business risk rather than an insurable risk," the letter says.

St. Paul has told its underwriters to judge each case individually when underwriting liability policies, said Susan Hawken, field administration officer. The insurer will likely only specifically exclude coverage when, in the insurer's assessment, a

See Year 2000 on next page

Dyscow

Dynam

GA General Accident Insurance

Personal • Small to Large Commercial • Marine •

Year 2000

Continued from previous page
policyholder is not making sufficient efforts to manage the problem, Ms. Hawken said.

St. Paul is communicating its Year 2000 position to brokers and agents through its underwriters and will respond in writing to any requests for information from policyholders, she said.

One of the most high-profile efforts in the insurance industry to communicate Year 2000 issues was made earlier this month by Guy Carpenter & Co., the reinsurance brokerage unit of J&H Marsh & McLennan Inc. In a video conference viewed in movie theaters in several major cities, Guy Carpenter executives, attorneys and a reinsurance executive gave presentations and fielded questions on the nature of the problem and coverage and claims issues.

At the video conference, Stephen Marcusa, a partner at Bigham Englar Jones & Houston in New York, said he saw three waves of litigation stemming from Year 2000 problems:

- The first wave, which has already begun, will see businesses seeking to recover the cost of making their systems compliant from computer-related vendors, he said.

- The second wave will arise from losses stemming from system breakdowns, Mr. Marcusa said.

- The third wave will involve disputes over coverage, he said.

"Among the issues that are certain to be raised by this litigation will be: whether it was a fortuitous event, whether there has been an event which caused physical damage to property, whether product literature and advertising may have created insured advertising liability, and whether or not the loss or damage was expected or intended," Mr. Marcusa said.

BI

Yasuda

Continued from page 3

"It was a bold move but apparently they sold it," said Isaac Efrat, a vp in the Structured Finance Group at Moody's Investors Service Inc. in New York, which rated the Yasuda deal Ba3.

"We're not surprised that there was enough appetite out there for this," Mr. Efrat said. "It's encouraging because a lot of these insurers have set up a financial products subsidiary."

In addition to being the first Japanese windstorm-related deal, the Yasuda deal's structure as a multiyear indemnity bond transaction "brings with it a lot of tricky issues," Mr. Callahan said.

Traditionally one of the characteristics of capital markets transactions vs. insurance market transactions is the willingness to do multiyear deals, he noted.

But in providing reinsurance coverage of insurance transactions over a multiyear period, "what you're doing basically is making a commitment based on a book of business that won't be written for several years," Mr. Callahan said.

The problem was overcome by us-

'Yasuda's concern is clearly either one huge event or two successive large events,' says Moody's Isaac Efrat.

ing modeling techniques to project future windstorm loss scenarios and by structuring the deal so that there are two possible coverage triggers, both of which will be adjusted annually in accordance with changes in Yasuda's

book of business exposed to windstorm.

The first possible trigger is a single typhoon providing losses to Yasuda that has "a little bit less than a 1% probability of occurrence," according to Mr. Callahan.

Based on Yasuda's current book, the models suggest such a typhoon would have to cause about 165 billion yen (\$1.18 billion) in losses for Yasuda to trigger the reinsurance program.

The second possible trigger, which could be exercised at Yasuda's option, would be if the insurer incurs losses from a typhoon that carries a 4% probability of occurrence.

Currently, the models suggest such a storm would produce at least 80 billion yen (\$574.2 million) in losses for the insurer.

"To the extent that that 4% probability event occurs, Yasuda has the right to move that attachment point from 165 billion yen to 60 billion yen (\$1.18 billion to \$430.7 million)," Mr. Callahan said.

In other words, for losses greater than 80 billion yen and less than 165 billion yen, it would be up to Yasuda whether to trigger its coverage or not; above the higher trigger, coverage would be automatic.

However, if Yasuda exercises the lower trigger option, the notes' yield of 370 basis points over the London Interbank Offered Rate rises to 950 basis points over LIBOR for the remainder of the contract.

Effectively the dual-trigger structure of the transaction provides Yasuda with not only high-level typhoon reinsurance at 3.7% over LIBOR but also gives the insurer the opportunity to secure a lower level of coverage at a cost of 9.5% above LIBOR, if needed.

The thinking behind that option is that if Yasuda should incur an 80 billion yen event, it may find that its costs for traditional reinsurance soar, making it more cost-effective to tap its securitized reinsurance program, Mr. Callahan said.

"There's been very little focus on that but it was a very, very important part of the deal," he said.

"It's the first time we've seen that," Moody's Mr. Efrat said. "Yasuda's concern is clearly either one huge event or two successive large events. The rating and also the spreads on the bond reflect the possibility that (Yasuda's) basically insuring itself against two different possibilities."

Munich Reinsurance Co. also was involved in the private placement in several ways, according to Mr. Callahan.

Among other things, he said, Munich Re "effectively validated the transaction from the perspective of investors" by acting as a front between Yasuda and the special-purpose vehicle, "and they ended up taking a chunk of the transaction for their own books at the same pricing that was provided to investors."

Also, Munich Re essentially will act as the claims adjuster for any claims under the contract, will close out the reinsurance contract and is providing various other reinsurance services to the special purpose vehicle.

As the pace of cat bond issuance continues to accelerate, another deal this month saw the second entry into the market by a cat bond pioneer.

San Antonio-based United Services Automobile Assn. turned to the capital markets again earlier this month to obtain a \$450 million reinsurance layer for East Coast hurricane exposures. The deal was similar to a capital markets deal the insurer did last year.

USAA obtained a reinsurance contract from Residential Reinsurance Ltd., a Cayman Islands-domiciled special purpose vehicle, which sold \$450 million in notes June 15 to fund the reinsurance contract.

The reinsurance triggers if USAA experiences more than \$1 billion in losses from a hurricane that is Category 3 or greater.

BI

Genacc

1-800-606-4233
www.genacc-us.com

Security • National Programs • International Accounts

Opinions

Starting point for health reform

PENDING RELEASE of crucial details, a health care legislative blueprint released last week by a House Republican task force does, with a few significant exceptions, address patient concerns about certain managed care practices without adding new costs for employers.

It would be hard to fault such recommendations in the proposal as giving patients direct access to pediatricians and obstetricians without having to first go through primary-care gatekeepers.

For example, what purpose is served, other than to waste time and delay care, by requiring a parent whose child has an ear infection to go first to a gatekeeper rather than straight to a pediatrician? Indeed, an increasing number of HMOs themselves now allow patients to bypass gatekeepers for such basic services.

Similarly, a recommendation to ban "gag rules"—if, in fact, any still exist—is on target. Physicians should be free to at least discuss potential treatment procedures without fear of repercussions from managed care organizations they have joined.

Other provisions, including expediting internal review of appeals of coverage decisions appear reasonable, though the devil truly will be in the details.

But other recommendations in the GOP proposal are troubling, none more so than a provision that would require employers that offer only a traditional HMO to add a point-of-service option.

Cutting through the rhetoric of giving employees more choice, what the POS mandate essentially says is that traditional HMOs are no good and should not be allowed to operate.

That, of course, is sheer nonsense. We are not aware of any evidence that employees in traditional HMOs are less satisfied with their health care than those in point-of-service programs.

We do know that POS plans are more expensive and that employees who were satisfied with their traditional HMOs will be mighty unhappy if they are forced into POS plans with higher premiums.

We also are concerned about a warmed-over proposal to allow small employers to band together through associations to self-insure their health care risks. These asso-



ciation plans would have to meet certain federal standards and be regulated by the Department of Labor.

Congress rejected this idea once before, and with good reason. Frankly put, the Labor Department lacks the resources to regulate more health care plans. In the absence of a strong regulatory hand, we think the result would be a wave of association plan failures and employees of these small companies left with unpaid claims.

Perhaps our biggest concern is the time element of the Republican package. Details are not likely to emerge until next month. We wonder if enough time remains in the congressional session to give this package the careful scrutiny it deserves. One only has to recall past congressional health care blunders to know that ill-considered proposals can have disastrous consequences.

A more sensible approach for Congress would be to use the Republican task force package as the starting point for a finely crafted and carefully considered package during the next legislative session.

Stay watchful over statehouses

BUSINESSES GENERALLY have avoided onerous legislation at the state level this year, but nothing lasts forever.

Unlike in recent years, state legislative activity has been largely limited to fine-tuning statutes that affect the risk management and benefit programs offered by employers. Businesses have been largely successful in lobbying against proposals that would expand their tort liability or increase their employee benefits and workers compensation costs.

But businesses will have little time to bask in a self-congratulatory glow, as keeping unwelcome proposals at bay requires constant effort. Indeed, legislative trouble may be brewing on several fronts.

One problem area will be state efforts to limit provider and insurer access to workers comp medical information. In North Carolina, the state Industrial Commission is due to soon present proposals that would restrict an insurer's ability to communicate with a doctor treating an injured worker (*BI*, June 8). Other states, including Maine, New Hampshire, New York and Vermont, are considering similar proposals.

As we have said previously, it is incumbent upon businesses to explain to state regulators and lawmakers that their need for this information is not to invade the privacy of workers or somehow abuse the information but to gain a realistic idea of their cost exposures and encourage workers to return to work that fits their diminished abilities. Without such access, the promise of managed care and return-to-work programs for holding down workers comp medical costs will evaporate.

In tort reform, bad news for businesses came not in what was introduced but what failed to be enacted.

Florida tort reforms were vetoed by the governor. Those reforms would have, among other things, changed the state's doctrine of joint-and-several liability, set a 12-year statute of repose for product liability and prohibited some punitive damages (*BI*, May 4).

The issue will be a factor in Florida's upcoming gubernatorial race, giving businesses an opportunity to back whichever candidate comes down in favor of tort reform.

Other storm clouds on the tort horizon include proposals that would make employers liable for the negligence of their managed care providers and efforts by lawmakers to allocate liability for Year 2000-related problems.

As for employee benefits legislation, employers generally enjoyed a respite from onerous benefit mandates and anti-managed care proposals at the state level—though such proposals are on the table in Congress.

There were some limited efforts to mandate specific benefits, such as coverage for certain diabetes treatments and medically necessary food supplements. Several states pushed for parity between levels of coverage for general health care and other types of care. Maryland mandated parity for coverage of certain clinical trials to treat cancer and other life-threatening diseases. Vetoes killed an Oklahoma mental health parity bill and an Arizona chiropractic parity bill.

We're encouraged that it was mostly a quiet year for legislation that would prove costly to businesses. But to assure that remains the case in the years to come, it will require constant effort by businesses.

Business Insurance

Reporting weekly on corporate risk, employee benefit and managed health care news

Vice President/
Publisher/Editorial Director: Kathryn J. McIntyre, ARM (Chicago)

Associate Publisher/Advertising Director: Martin J. Ross III (New York)

Editor: Paul D. Winston (Chicago)

Editor-at-Large: Jerry Geisel (Washington)

Managing Editor: Roseanne White (Washington)

Senior Editors: Meg Fletcher, ARM (Chicago)

Judy Greenwald (San Jose)

Dave Lenckus (Tucson)

Douglas McLeod (New York)

Joanne Wojcik (Los Angeles)

Regis J. Caccia (Chicago)

Assistant Managing Editor: Mark A. Hofmann (Washington)

Washington Editor: Sarah Goddard (London)

Bureau Chiefs: Gavin Sauter (New York)

Graphics Editor: Kathy L. Barnes (Chicago)

Copy Editors: Todd J. Behme (Chicago)

Mary B. Nick (Chicago)

Assistant Copy Editor: Richard Trout (Chicago)

Associate Editors: Michael Bradford (New Orleans)

Roberto Ceniceros (Los Angeles)

Robert Kazel (Chicago)

Matthew MacDermott (London)

Michael Prince (New York)

Sally Roberts (Denver)

Edwin Unsworth (London)

Rodd Zolkas (Chicago)

Directory Editor: Sandra L. Budde (Chicago)

Assistant Directory Editor: Matt Scroggins (Chicago)

Editorial Assistant: Amanda L. Milligan (Chicago)

Production Assistant: Amy R. Kepka (Chicago)

Assistant to the Publisher: Karen Brown Tucker (Chicago)

Editorial Cartoonist: Roger Schillerstrom (Chicago)

National Sales Manager: Steve Atkins (New York)

Midwest Advertising Manager: Robert L. Niesse (Chicago)

District Managers: Blake Delany (New York)

Roger Lynch (New York)

Elizabeth McGahren (New York)

Deborah D. Neale (Chicago)

Classified Advertising Manager: Cheryl Adesko (Chicago)

Sales Assistant: Lori Lieberman (Los Angeles)

Production Manager: Elmer Kerstowski (Chicago)

Director of Communications: Ronnie I. Drachman (New York)

Promotion Manager: Barbara O'Brien (New York)

EDITORIAL: Chicago: 312-649-5398

Denver: 303-698-7601

London: 171-457-1400

Los Angeles: 213-651-3710

New Orleans: 504-269-9988

New York: 212-210-0100

San Jose: 408-774-1500

Tucson: 520-579-1937

Washington: 202-662-7200

ADVERTISING: Chicago: 312-649-5276

New York: 212-210-0228

Los Angeles: 213-651-3710

COMMUNICATIONS: New York: 212-210-0132

SUBSCRIPTIONS: Detroit: 888-446-1422

Business Insurance is published by Crain Communications Inc.

Keith E. Crain

Chairman

Merrilee Crain

Secretary

Rance Crain

President

Mary Kay Crain

Treasurer

William A. Morrow

Executive Vice President/Operations

Robert C. Adams

Vice President/Production

Peter Johnson

Vice President/Circulation

G.D. Crain Jr.

Founder (1885-1973)

Mrs. G.D. Crain Jr.

Chairman (1911-1996)

S.R. Bernstein

Chairman-executive committee (1907-1993)

Published weekly at 740 Rush St., Chicago, Ill. 60611-2590, Fax 312-280-3174. E-mail: biweb@crain.com, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017-5806, Fax 212-210-0704, CRAIN COM NY; 2726 Pyramont, #6, New Orleans, La. 70130, Fax 504-269-0858; Suite 814, National Press Building, Washington, D.C. 20045-1801, Fax 202-638-3155; 6500 Wilshire Blvd., Suite 2300 Los Angeles, Calif. 90048-4947, Fax 213-655-8157; 967 Bermuda Court, Sunnyvale, Calif. 94086-6750, Fax 408-774-1155; New Garden House, 78 Halton Garden, London EC1N 8JQ England, Fax 171-457-1440; 8157 N. Torrey Way, Tucson, Ariz. 85743, Fax 520-579-3476; 777 E. Speer Blvd., Denver, Colo. 80203-4214; Fax 303-733-2244. \$4 a copy and \$87 a year in U.S. \$105 in Canada and Mexico (includes GST). All other countries \$205 a year (includes expedited air delivery). DON MIKENDORF, circulation manager. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 965 E. Jefferson Ave., Detroit, Mich. 48207-3185, or phone 888-446-1422 or 313-446-0450, Fax 313-446-6777. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: JOSEPH P. HANLEY, Crain News Service, 220 E. 42nd St., New York, N.Y. 10017-5806, 212-254-0890. For reprints or reprint permission contact: KAREN BROWN TUCKER, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, 312-649-5319, Fax 312-280-3174.



www.businessinsurance.com



TO SUBSCRIBE CALL 800-678-9595 • 313-446-0450 outside of the United States

Supercat



**Tempest Re and CAT Limited have joined forces
doubling capital, capacity and capability.**

With nearly \$1 billion of dedicated tangible capital and the ACE Group of Companies behind us, we are uniquely positioned to write the lion's share of your catastrophe reinsurance program.



TempestRe

THE CAT RESOURCE

A member of the ACE group of companies

Tempest Reinsurance Company, Limited, 14 Par-la-ville Road, Hamilton, HM08, Bermuda

Mailing address: Suite #653, 48 Par-la-ville Road, Hamilton, HM11, Bermuda Phone 441 292 2603, Fax 441 292 2395

P/C reform

Continued from page 1

forms in Massachusetts, and a broad effort died earlier this month in New York.

Given that most states already had dealt with comprehensive reforms over the past decade or so, this year's reforms tended to be very targeted.

State lawmakers wrestled with such questions as the degree of immunity to grant non-physician medical personnel who use heart defibrillators in emergency situations, liability relief for architects and engineers who volunteer their services in the wake of catastrophes, protection against liability suits for municipalities that operate skateboard facilities, and similar highly focused reforms.

In other states, lawmakers moved slightly away from reform by increasing statutory caps on awards for non-economic damages. But major liability reform initiatives were few and far between.

Lawmakers also generally avoided dealing with other risk management-related issues.

"We almost saw more risk management-related bills go through Canada than we did in the States," said Ms. Allen.

Mr. Joyce of ATRA agreed that this has not been among the more active legislative seasons. He attributed much of the quietude to the fact that this is a legislative election year in many states and, with the exception of 1996, election years have not been particularly productive in terms of significant tort reforms.

Mr. Joyce said reformers in some states have had to defend already-passed tort reforms, with mixed success.

In California, efforts to roll back medical malpractice reform were blocked. But state courts have undone some previously enacted tort reforms, he noted, pointing to rulings in Kentucky and Illinois.

Looking ahead, Ms. Allen predicted that two liability issues are likely to be the center of debate in statehouses next year.

"One of the things that is becoming worrisome is some of the health issues becoming broader business issues, particularly regarding employer liability," she said.

She noted that Illinois, for example, has a post-election session from which could emerge HMO liability legislation that could burden employers with new liability concerns.

"We may see more people galvanized if more employer health liability legislation comes up," Ms. Allen said. She called legislation that would make employers more liable for managed care errors "scary."

The other liability issue likely to cause debate is the Year 2000 computer problem, as lawmakers scramble to assess liability for the fallout from computer failures, said Ms. Allen.

State lawmakers, as well as their counterparts in Washington, probably will spend quite a bit of time and energy focusing on the Year 2000 problem, even "though it's a bit too late," she said.

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

PROPERTY/CASUALTY



Connecticut created a complex commercial litigation court within the existing court system to handle large or difficult commercial cases. Four judges have been assigned to the court, and parties must agree to have their cases referred to the court. The aim of the new system is to improve state court efficiency by funneling complex cases to judges who specialize in such litigation.

Meanwhile, Connecticut's legislature has eliminated a requirement that an insurer non-renew and reissue a policy that is being transferred to an affiliated company after an insurer merger or acquisition. Instead, insurers now may simply notify policyholders of the transfer.

Maine laws more clearly define unfair claims settlement practices by insurers and clarify the circumstances under which a policyholder may sue an insurer for unfair claims practices. Insurer actions that may trigger a lawsuit include knowingly misrepresenting coverage provisions, failing to acknowledge and review claims within a reasonable period and threatening to appeal an arbitration award to press a policyholder to accept a lower settlement.

The **Massachusetts** Legislature's joint Judiciary Committee still is considering a comprehensive tort reform bill. The bill would, among other things, eliminate joint-and-several liability, impose stricter sanctions for filing frivolous lawsuits and set up a 15-year statute of repose for all tort actions.

The **New Hampshire** Legislature passed a bill that will exempt coverages written for large commercial policyholders from state rate and form regulation. The legislation applies to any employer with annual premiums of more than \$500,000 that also meets one of six other criteria. The six criteria are that the employer have a net worth of more than \$50 million; net revenues or sales of more than \$100 million; staff of more than 500 employees for an individual company or more than 1,000 for a holding company group; a full-time risk manager; an annual budget or assets of more than \$45 million if the employer is a not-for-profit or public entity; and a population of more than 50,000 if the employer is a municipality.

In **Vermont**, a law was enacted to make clear that a claimant injured on open and undeveloped land has to prove the injury was the result of "willful and wanton misconduct" of the landowner.

Rhode Island has passed no significant property/casualty-related legislation during the current session.

PROPERTY/CASUALTY



In **Delaware** a bill has moved



through committee and is pending in the House. The bill would allow the statute of limitations for medical malpractice lawsuits to be based on the date of discovery rather than the date of injury. A similar bill is also being considered for product liability actions. The Delaware Senate has not acted on the bills, and the Delaware Legislature is due to adjourn June 30.

A **Maryland** Senate committee rejected legislation that would have replaced the state's standard of contributory negligence with a standard of comparative negligence. Under contributory negligence, if a plaintiff contributes to the cause of an accident, he or she cannot receive damages. Under comparative negligence, awards are reduced by a plaintiff's fault.

Lawmakers approved a measure that requires a claimant filing malpractice suits against lawyers, architects, engineers and certain other professionals to obtain a certificate from a qualified expert certifying that, in the expert's opinion, the professional did not meet an applicable standard of professional care. It takes effect Oct. 1.

Early this year **New Jersey** enacted a comprehensive brownfields redevelopment law. The law is aimed at providing legal and economic incentives to allow for the cleanup and development of contaminated sites.

A comprehensive tort reform package died recently in the **New York** Legislature. The bill was backed by business groups in the state.

The state also passed a measure that allows hemophiliacs to sue manufacturers of a blood-clotting product that gave them HIV, the virus that causes AIDS. The law extends the statute of limitations to allow such suits to be brought until Dec. 1, 1999. Approximately 75 New York residents opted out of a nationwide class-action settlement over the products and can now pursue suits in court.

A bill that would have permitted survivors in wrongful death suits to sue for their pain and suffering did not make it out of either chamber.

New York last year joined the ranks of states permitting the formation of captives. The law allows both single and group captives insurers whose net worth exceeds \$100 million. At least two captives were formed shortly after the bill took effect Jan. 1.

A bill that would have allowed the formation of a new type of insurer, called industrial insurance corporations, that would be able to write policies for large, sophisticated policyholders with fewer regulations died without passing either chamber of the Legislature. If passed, the legislation would have allowed policyholders to negotiate with insurers on policy terms and prices without regulatory involvement.

New York also passed a law permitting excess and surplus lines brokers licensed in New York to exercise binding authority on behalf of eligible surplus lines insurers.

The **Pennsylvania** Senate unan-

imously approved a bill that eliminates the need for insurers to file rates and forms for risks with premiums of \$25,000 or more. For policyholders to qualify, the bill requires that they have at least 25 employees, including a full-time risk manager or insurance consultant. Workers compensation policies are excluded from the bill. The House has not voted on the legislation.

In **West Virginia**, a law was enacted that bars damage awards above the limits of a physician's professional liability policy against those physicians who volunteer their services at athletic events sponsored by elementary and secondary schools.

No major tort reform legislation was enacted in the **District of Columbia**.

PROPERTY/CASUALTY



Florida lawmakers approved a bill that would have, among other things, changed the state's doctrine of joint-and-several liability, set a 12-year statute of repose for product liability suits and prohibited some punitive damages, but Democratic Gov. Lawton Chiles vetoed it.

An "insurance train" in the form of a bill that focused on changes in the way agents operate became the engine for several unrelated amendments. These included changes in the way product liability insurers furnish information on premiums, claims, reserves and other data to regulators and allowances for non-resident claims adjusters to apply for permanent Florida licensing.

Georgia passed legislation that grants civil immunity to chiropractors volunteering services.

In **Kentucky**, Gov. Paul Patton signed into law a measure that excludes reinsurers from maintaining units for the investigation of possible fraudulent cases. Reinsurers also are excluded from the requirement of printing warning statements on applications and claim forms.

A new **Mississippi** law modifies the statute of limitations for new medical malpractice actions in the state. Under the law, which takes effect July 1, new medical malpractice claims must be filed within seven years of the date the alleged act or omission occurred. Previously, Mississippi law provided that such claims be filed within two years after the date the alleged act or omission was discovered. Two exceptions to the new law provide that claims must be filed within seven years of the discovery of the alleged act or omission in cases involving foreign objects left in the body or cases of acts that are fraudulently concealed from the patient.

Several other tort reform bills introduced in this spring's session died. These included a measure that would have authorized payment of court costs and attorneys' fees to defendants prevailing in civil cases and held attorneys and

clients jointly liable for the costs of frivolous suits. Product liability reform legislation also failed.

No significant tort reform or measures related to property/casualty insurance were passed in **Alabama**, **Louisiana**, **North Carolina**, **South Carolina**, **Tennessee** or **Virginia**.

PROPERTY/CASUALTY



A new **Indiana** law creates legal immunity for some who use defibrillators on heart attack victims. The law provides that a non-physician, such as an employee of a hospital or ambulatory outpatient surgical center who has taken a defibrillator course and maintains and tests the device periodically, will face no liability unless gross misconduct is proven.

Another new **Indiana** law requires health care providers to carry malpractice liability insurance with minimum limits of at least \$250,000 per occurrence and \$750,000 annual aggregate.

Ohio enacted a law effective July 22 that allows defendants to appeal immediately the certification of a class for class-action lawsuits.

Though many of his fellow Republicans urged him to veto it, **Wisconsin** Gov. Tommy Thompson signed into law in April a law raising the caps on non-economic damage awards in wrongful death cases to \$350,000 for adults and \$500,000 for children from the existing \$150,000 cap.

The new law applies not only to wrongful death claims stemming from medical malpractice but also those from automobile, boating or other accidents.

No significant tort reform legislation was passed in **Illinois**, **Michigan** or **Minnesota**.

PROPERTY/CASUALTY



Iowa passed legislation, effective July 1, to protect municipalities from liability for public facilities designed for skateboarding and in-line skating.

A new **Kansas** law increases to \$250,000 the \$100,000 cap on non-economic damages in wrongful death cases.

Missouri lawmakers approved a bill that would extend liability protection to people responding officially to oil spills. Under current law, such persons are not liable for removal costs or damages unless they were responsible for the spill or there was willful misconduct, negligence, personal injury or wrongful death. The proposed law extends liability protection even in cases of negligence. As of June 24, the governor had not signed the bill but has until July 14 to decide on all bills.

A new law effective July 1 will give **South Dakota** juries greater say in determining whether plaintiffs in tort cases may recover damages from defendants even

Continued from previous page
when the plaintiffs are partially responsible for their losses. Under the new law, juries no longer will reveal in open court the percentage of liability they assign to plaintiffs and defendants.

Instead, the new law will not bar juries from awarding damages to plaintiffs as long as the plaintiffs are not more than "slightly" responsible for their losses. The legislative measure does not define "slightly."

The Legislature passed the measure to wipe out a 1997 state Supreme Court ruling in which the court barred a jury from awarding damages to a plaintiff who was 30% responsible for his loss.

Another law effective July 1 establishes a two-year statute of limitations for filing negligence lawsuits against regional airport authorities to recover death or personal injury damages.

Nebraska passed no significant tort reform legislation. There was no legislative session in North Dakota.

PROPERTY/ CASUALTY

Arizona did not enact any major tort reform legislation this year. The state did, however, enact legislation that allows so-called "industrial insureds," or jumbo risks defined by statute, to agree to the use of rates and forms that have not been filed with the state Insurance Department. Under another new law, insurers no longer have to file manual pages that provide their final rates for various lines of coverage. Lawmakers also passed a law that keeps open

indefinitely the Insurance Department's fraud investigation division.

Tort reform legislation, including an effort to cap punitive damages, failed in New Mexico.

The state did pass legislation that takes effect July 1 establishing a fraud bureau within the state Department of Insurance. The bill permits the bureau to contract with the private sector for investigatory services rather than using full-time state employees. Lawmakers also approved merging two state departments into a new Public Regulation Commission, in which the Department of Insurance will operate as a division.

Oklahoma lawmakers did not pass any tort reforms this year. It was the final year of their self-imposed three-year moratorium on acting on any civil justice reform measures.

The Arkansas and Texas legislatures did not convene in 1998.

PROPERTY/ CASUALTY

Colorado Gov. Roy Romer signed legislation that grants immunity, effective July 1, from lawsuits arising from personal injury, wrongful death, property damage or other loss for licensed engineers and architects who volunteer their services during declared emergencies or disasters.

In Idaho, the Legislature approved a measure, effective July 1, that provides immunity from civil liability for any health care provider who voluntarily provides health care services at a free med-

ical clinic. Both the health care provider and patient must sign a written waiver of liability.

Last year in Nevada, Gov. Bob Miller signed into law a bill effective Oct. 1, 1997, requiring that information on convictions of state-licensed professionals such as doctors or lawyers must be forwarded by the Insurance Commissioner and attorney general to the appropriate licensing agency (BI, Sept. 29, 1997).

Utah hockey facilities were provided with immunity for injuries sustained by people hit by pucks or sticks under a law that took effect May 3. The law does not apply in the case of negligence on the part of an owner, operator, player, coach or manager.

No significant tort reform legislation was considered in Wyoming. The Montana Legislature did not meet.

PROPERTY/ CASUALTY

Alaska passed legislation, effective Aug. 12, that provides immunity from damages resulting from the administration of a defibrillator by people who are trained in

use of the device, provided they notify emergency personnel immediately.

A California bill introduced as part of the nationwide backlash against managed care could allow plaintiffs to circumvent California's \$250,000 cap on non-economic damages in medical malpractice cases. The bill would make health

plans vicariously liable for malpractice if a provider's treatment decisions are influenced by the availability of coverage. The bill is modeled after a recently enacted Texas statute extending vicarious liability for provider malpractice to health plans.

Under current California law, individuals must demonstrate that a health plan failed to comply with the terms of a contract in order to prevail in court. But so far, relatively few individuals have won damages in malpractice cases against health plans. Furthermore, non-economic damages against individual providers in malpractice cases are limited to \$250,000 under the two-decade-old Medical Insurance Compensation Reform Act.

In addition, a significant tort reform battle is heating up in California over age discrimination in employment.

Two bills have been introduced to counter a 1997 appellate court decision in *Marks vs. Loral Corp.* that permits an employer to choose employees with lower salaries in hiring, promotion and discharge decisions, even though this may discriminate against older employees, who generally earn more.

But a third bill would go beyond rejecting the court decision by making any disparate treatment of workers over age 40 a discriminatory act.

According to the latest version of the legislation, which was last

amended June 4, "An employer may not refuse to hire or employ, and may not discharge, dismiss, reduce, suspend or demote, deny access to a training program leading to employment to, or discriminate in compensation or other terms and conditions of employment against, any individual over the age of 40... on the ground that a younger employee would perform the job for a lower salary."

A bill designed to encourage settlement of construction defect lawsuits by setting a limit on the duration of prelitigation talks also is wending its way through the California Legislature. The bill would limit the prelitigation process to a maximum of 180 days by permitting only one 90-day extension from the current 90-day limit.

The Assn. for California Tort Reform is seeking to amend a bill that would extend liability for childhood sexual abuse to third parties, such as schools and churches, so that only those third parties with actual knowledge can be sued.

Two trial lawyer-supported bills would permit losers in arbitration cases to file appeals to California appellate courts, just as if the decisions were made by trial courts.

In response, the Assn. for California Tort Reform has submitted its own proposal to let arbitrators reconsider their decisions.

By contrast, the trial bar-supported bills would remove any incentive to seek arbitration as a lower-cost alternative to going to trial.

In addition, a bill that would have limited liability for computer programmers and manufacturers in connection with the so-called "millennium bug" died in committee.

No significant tort reform legislation was enacted in Hawaii or Washington. The Oregon Legislature did not meet this year. **BI**

Health

Continued from page 1

Colorado, both of which passed measures requiring coverage for certain diabetes treatments and supplies.

Meanwhile, Vermont passed legislation requiring health plans to provide at least \$2,500 of coverage for medical food products prescribed for treatment of inherited metabolic diseases. Utah enacted a similar measure requiring policies to cover dietary products for the treatment of "inborn errors of amino acid or urea cycle metabolism."

But the financial impact of this latest round of mandates is modest. The Utah mandate of coverage of dietary products may be more symbolic than real, because most plans already provide coverage, noted a Regence Blue Cross & Blue Shield spokeswoman.

Still, other state mandates have been more far-reaching. In Maryland, for example, a new mandate will require health plans to provide coverage on the same basis as other medical conditions for patients in certain clinical trials for the treatment of cancer and other life-threatening diseases.

Other mandates have passed state legislatures, only to die victims of gubernatorial vetoes. Two examples:

• Oklahoma Gov. Frank Keating vetoed a bill that would have mandated health plans to cover mental health care expenses on

the same basis as physical ailments. In his veto message, Gov. Keating said he opposed the bill because it would increase costs too much for employers.

• Similarly, Arizona Gov. Jane Hull vetoed a measure requiring HMOs to cover the cost of chiropractic care when ordered by primary care physicians. She said such a mandate would have hiked HMO premiums by 2% to 4%.

Virtually absent from this year's discussion of health care measures are proposals—prominent only a few years ago—to radically overhaul the health care system, such as through single-payer systems.

While costs are again increasing, legislators may no longer perceive that the health care system is in a state of crisis.

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

HEALTH CARE

Maine Gov. Angus King Jr. signed legislation creating a consumer health care division within the state Bureau of Insurance. The

new division will collect and disseminate information about health plans and assist plan enrollees with complaints.

The Massachusetts Senate has passed legislation that health care plans provide the same coverage for mental disorders as for physical ailments. The measure now is before the House Ways and Means Committee. Another measure being considered by the Ways and Means Committee would require:

• Physicians and patients to agree on all medical decisions without inappropriate or undue pressure from third parties.

• Disclosure of plan information.

• Expedited appeals of treatment decisions.

• Internal appeals procedures.

• Mandatory point-of-service options.

• The creation of the Office of Managed Care Oversight to regulate health plans.

A new Rhode Island law requires health plans to pay for blood tests for potential bone marrow donors. A measure before a Rhode Island House committee would allow managed care patients to sue HMOs for malpractice.

In Vermont, several health care measures were enacted and signed by Gov. Howard Dean. One measure requires health care plans to provide coverage for medical foods prescribed for the treatment of inherited metabolic diseases. Health plans must provide at least \$2,500 of coverage for medical

food products within a 12-month period. Another measure requires health plans to cover musculoskeletal disorders of any bone or joint in the face, neck or head. The coverage must be the same as for other musculoskeletal disorders in the body. A third measure that was enacted creates a public ombudsman's office to represent consumers and provides health care plan enrollees an independent external review of denied claims.

No major health care legislation was passed in Connecticut or New Hampshire.

HEALTH CARE

A bill before the Delaware House Economic Development Committee would require health care insurers to pay an uncontested claim within 30 days after receipt of the claim. The Delaware Legislature is scheduled to adjourn June 30.

The Maryland Legislature passed a bill that requires health plans to have an internal procedure in place to review appeals. Another measure passed and signed by the governor requires health plans to cover—on the

same basis as other medical conditions—care for patients in certain clinical trials for the treatment of cancer and other life-threatening diseases.

Two measures have passed the New Jersey state Senate and are awaiting action in the House. The first is the Mental Health Parity Act, which would require employers to offer mental health coverage equivalent to the physical health coverage offered. But unlike the federal law, the New Jersey measure prohibits a copayment differential between mental and physical health care visits and applies to small businesses of any size, rather than the threshold of 50 or more employees under the federal law. Another bill would require providers to file claims electronically; the effective date would precede by one year the effective date to be established for the same requirement under the federal Health Insurance Portability and Accountability Act. Also, under the New Jersey bill, health plans would have to pay claims within 90 days or face a financial penalty.

A bill awaiting the signature of New York Gov. George E. Pataki would give a patient the right to an external, independent appeal when a managed care company denies coverage. However, a bill under which managed care organizations would face the same liability as physicians for medical malpractice suits died before the session ended earlier this month.

See Health on next page

Health

Continued from previous page

HEALTH CARE



A new **Pennsylvania** law will, among other provisions, require managed health care plans to have a two-tiered internal review of coverage decisions followed by an independent review by the state health or insurance departments.

The measure also will prohibit managed care companies from penalizing health providers for discussing treatment that is not covered or from discussing the decision by a plan to deny treatment. The law also has provisions guaranteeing coverage for emergency treatment and direct access to obstetrical and gynecological services.

Further, the law imposes confidentiality requirements on health insurers and utilization review companies.

Late in 1997 a law was signed preventing health insurers from requiring that mastectomies be done on an outpatient basis.

A **West Virginia** law that became effective June 12 bars individual and group health plans from requiring that a woman obtain a referral from a primary care physician in order to receive coverage of primary and preventative obstetrical and gynecological services.

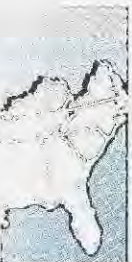
Also, for those policies providing surgical services, coverage may not be denied for breast reconstruction after a mastectomy or injury due to family violence.

Another law that became effective June 12 mandates that health maintenance organizations must provide a bill of rights to subscribers.

West Virginia also enacted a law that says patients do not need prior authorization for emergency room services if a prudent layperson, acting reasonably, believes an emergency medical condition exists.

No major health care-related legislation was passed by the **District of Columbia**.

HEALTH CARE



Health care mandates are in place in **Florida**, requiring insurers to provide coverage for some dental procedures and for some congenital conditions.

Gov. Lawton Chiles signed into law a bill that, effective Oct. 1, requires health insurers and managed care plans to provide coverage for the cost of general anesthesia and hospitalization for dental care for children under 8 and for anyone with medical conditions that would put them at risk if the services were not provided.

A bill that became law without the governor's signature requires

health insurers, effective Oct. 1, to provide coverage for treatment of cleft lip and cleft palates of policyholders' dependent children.

Another measure that became law without the governor's signature implements requirements of the Health Insurance Portability and Accountability Act.

The law also protects contributions and payments from medical savings accounts from "attachment, garnishment or legal process" by creditors of a person who made payments to an account or received payouts from one.

Additionally, group health plans that offer mental health benefits cannot have lower annual and lifetime limits for mental health expenses than for physical health care.

Small employers are exempt from this law.

Kentucky Gov. Paul Patton signed into law measures that will:

- Define autism and mandate health benefit plans to cover a maximum of \$500 per month per child for therapeutic respite and rehabilitative care.

- Require managed care plans to give enrollees a current participating provider directory, information about financial incentives for providers and notice of a designated primary care provider's withdrawal from the provider network. The bill also mandates coverage for cochlear implants in all health benefit plans.

- Mandate coverage for specific diabetes-related services and supplies as well as training and education.

- Mandate all health benefit plans to cover cancer drugs that are approved by the Food and Drug Administration and have no contraindication for that use. The Insurance Commissioner will appoint a panel of medical experts to review off-label uses and make recommendations for use.

- Mandate coverage for breast reconstruction surgery after mastectomy if the insurance policy covers mastectomies; for diagnosis and treatment for endometriosis and endometriosis if the policy covers hysterectomies; and for bone density testing for women age 35 and older when indicated by the provider.

- Bar insurance policies from being canceled or denied and claims from being denied because a person is a victim of domestic violence.

- Revise health insurance reforms enacted in the state in 1994 and 1996 and bring Kentucky law into compliance with the federal Health Insurance Portability and Accountability Act.

Legislation awaiting the governor's signature in **Louisiana** law would extend a tax credit for employers that provide alcohol and substance abuse treatment programs for their employees. The credit is equal to 5% of program costs and is available through June 30, 2000.

The **North Carolina** General Assembly convened its biennial budget session in May.

The lawmakers could take up several managed care measures that won the approval of one house during the 1997 session, but they are unlikely to deal with any new managed care measures in the short session.

One of the 1997 bills would require that health plans covering at least five or more people offer mental health coverage equal to that offered for physical illness or

injury benefits.

The **North Carolina** measure differs from the federal mental health parity law in that the bill does not allow any type of limit different from that which applies to benefits for physical illness.

In **South Carolina**, lawmakers approved two managed care bills during their short mid-June session.

The **South Carolina** Patients' Insurance and Benefits Protection Act would provide, among other things, that employers with more than 50 eligible employees and that offer "major medical, hospitalization and surgical health insurance coverage under a closed-panel health plan" must also offer a point-of-service option.

The bill also would require that the copayment differential for in-network and out-of-network covered services and supplies under a POS plan cannot exceed 20%.

In addition, neither closed-panel nor POS plans could discriminate against "a physician, a podiatrist, an optometrist, an oral surgeon, or a chiropractor by excluding the provider from participating in the plan on the basis of the profession."

The measure, however, also says health care plans covered by the Employee Retirement Income Security Act would be unaffected by this new mandate.

The second measure, the "Omnibus Health Benefits and Education Act," would require, among other things, that all health insurers and HMOs that provide mastectomy benefits provide for at least 48 hours of hospitalization after a mastectomy and that plans providing mastectomy benefits also provide coverage for reconstructive surgery and prosthetic devices.

The bill also requires coverage for mammograms, pap smears and prostate cancer examinations.

Both measures will take effect Jan. 1, 1999, if not vetoed.

Employers in **Tennessee** will see changes in the way managed care plans operate because of measures passed during the state's legislative session that ran from Jan. 13 to May 1.

Legislation signed by Gov. Don Sundquist and effective Jan. 1, 1999, calls for group health plans that offer enrollees coverage through an HMO to also offer a point-of-service option and access to a preferred provider organization. The law also will allow managed care enrollees in plans that provide coverage for obstetrics/gynecology services access to those services without a referral from a primary care provider.

Direct access also will be allowed for some services provided by optometrists and ophthalmologists.

The measure also will allow any licensed pharmacy or pharmacist to participate in any managed care plan.

Another bill signed by the governor mandates that group health plans provide coverage for mental health services equal to coverage for physical health services.

The law, effective July 1, ap-

plies to health plans with more than 25 members.

A new **Virginia** law will require all managed care plans to obtain a state certificate of quality assurance. The bill gives the state Department of Health the authority to develop quality standards that managed care plans by July 2000 have to meet.

Criteria will include such matters as the creation of reasonable systems for fair complaint resolution and availability and accessibility of providers. The measure further requires that plans meet quality standards deemed "appropriate for the type of managed care health insurance plan under consideration," thus subjecting tightly managed and loosely managed plans to different standards. A public-private task force has been charged with drafting the standards.

Another new **Virginia** law requires health insurers to cover a minimum hospitalization of 48 hours for patients with radical or modified radical mastectomy and 24 hours for total or partial mastectomy with lymph node dissection for breast cancer. In addition, lawmakers also approved a measure requiring insurers to cover up to \$5,000 of special care expenses annually for early intervention for developmentally disabled children from birth to age 3. Also enacted is a law that insurers cover hemophilia and congenital bleeding disorders on the same basis as other medical conditions.

Alabama, Georgia and Mississippi legislators passed no major health care legislation.

HEALTH CARE



The **Illinois** House added the guts of a managed care bill of rights to a technical Senate bill, then approved the bill.

However, the Senate did not concur, and the matter is pending. The bill would create a new liability for HMOs or health plans called "enterprise liability." An individual seeking medical care recommended by a doctor could sue a health plan if it failed to use "ordinary care" when making treatment decisions.

HMOs and health insurers would be required to provide coverage for colo-rectal examinations as well as education about diabetes management and supplies under a new benefit mandate on its way to the governor.

The bill also would require such health plans to notify a female patient of her right to designate a woman doctor as her personal health care provider and provide the patient with a list of female providers.

A comprehensive **Indiana** managed care law that becomes effective July 9, 1999, will:

- Mandate that an HMO file with the Insurance Department the percentage of credentialed providers within the plan, as well as the HMO's Health Plan Employer Data and Information Set scores. The insurance commissioner will review the HEDIS data annually.

- Require an HMO to provide information about its structure, health care benefits and exclusions, criteria for denying coverage, and costs for which an enrollee is responsible, to enrollees and applicants.

The law will allow the Department of Insurance to investigate complaints about HMOs on behalf of enrollees.

- Restrict the use of a financial penalty to a provider in an HMO network in retaliation for making a referral.

- Prohibit HMOs from penalizing a provider for prescribing medically necessary drugs or devices. It would also allow HMOs to apply a formulary to prescription drugs if the formulary is approved by a pharmacy and therapeutics committee. However, substitution of a generic drug for a brand-name drug would be prohibited unless approved by a provider. HMOs would be required to establish and operate a drug utilization review program and provide for members' confidentiality.

- Require HMOs to establish procedures to evaluate coverage of new medical technologies and new applications of existing technologies, and to clearly state the limits of coverages in a policy and explain any denials.

- Require managed care plans to appoint a medical director; have a sufficient number and type of providers; provide access to out-of-network providers in certain circumstances; ensure 24-hour access to plan representatives who can authorize care; establish reasonable standards for waiting periods for care; establish standards for emergency treatment, including prudent layperson standards offer a POS option starting in July 1999; and allow enrollees to get a second opinion on request.

Michigan's House Judiciary Committee passed the HMO Liability Bill, which is expected to pass the House. It would create a cause of action against HMOs if a doctor recommends a course of treatment and the HMO refuses to cover it, causing harm.

A new **Minnesota** law requires HMOs to tell enrollees they may choose to use arbitration to appeal an HMO's internal appeal decision not to certify an admission, procedure, service or extension of stay.

Minnesota also enacted a law that requires all health plans to pay for off-label drug use for cancer treatments if previously approved by the Food and Drug Administration for a different purpose.

Another **Minnesota** law creates a new office of health care consumer assistance to help people understand their contractual and legal rights vis-a-vis health plans.

Three bills are pending in an **Ohio** House committee that would increase liability for HMOs and insurers.

The bills generally would require insurers to exercise "ordinary care" in making utilization review decisions and hold them liable for damages caused by a lack of compliance or delay in care. A large coalition of employers and industry groups is opposed to these bills, and they are not expected to pass.

Wisconsin Gov. Tommy Thompson signed a bill into law in April that provides that patients' health care records must be provided to other health care providers upon request and with the patient's permission.

Under the bill, providers may be

Continued on next page

Continued from previous page
charged reasonable costs for obtaining the records.

The Legislature did not pass a health care-related bill that would have implemented various managed care provisions, including that managed care plans provide coverage for emergency treatment and provide any drug authorized by the U.S. Food and Drug Administration.

HEALTH CARE



Kansas Gov. Bill Graves signed into law a bill that requires health plans to cover prostate cancer screening examinations.

Another measure approved and signed into law requires health insurance coverage for certain diabetes treatments and supplies.

The **Missouri** Legislature discussed but did not pass some mandated benefits bills that would have required coverage for reconstructive breast surgery, cervical and prostate cancer screening and second medical opinions for any surgery case.

A new law in **Nebraska** includes two benefit mandates and consolidates many consumer protection standards and features from several model acts drafted by the National Assn. of Insurance Commissioners.

Beginning July 15, group health insurance policies and group HMO contracts must offer the option of at least \$2,500 in benefits for temporomandibular joint ailment and related disorders.

Health insurance policies issued or renewed after July 15 must cover prescription drugs for certain cancers, HIV and AIDS if the drug is recognized for treatment in the United States or medical literature and approved for sale by the FDA.

Disputes should be referred to the state's Department of Insurance, which will then refer them to the U.S. Department of Health and Human Services for medical experts' determination of appropriateness.

The law also adopts portions of NAIC model acts that:

- Specify standards for quality assessment programs, utilization review and grievance procedures, effective July 15.

- Require insurers to maintain credentialing standards for all health care professionals with whom they contract, effective July 1, 1999.

- Specifies requirements in the managed care network, including the number and type of providers insurers must maintain, effective July 1, 1999.

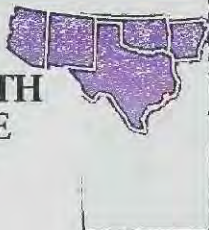
South Dakota Gov. William Janklow signed into law a bill that takes authority away from the state Insurance Department for setting the attachment points of stop-loss insurance for self-insured health care plans.

Despite the objections of business and health insurers, the governor also signed a bill that requires health plans to establish for biologically based mental health disorders lifetime benefits, deductibles, copayments and visit limitations that are identical to those for physical ailments.

Iowa passed no health care legislation pertinent to employers in the state.



HEALTH CARE



Arizona lawmakers passed three health care-related measures, though Gov. Jane Hull vetoed one of them. One new law requires health plans that cover the cost of treating diabetes to also cover the cost of prescribed and necessary equipment used in treating the illness, effective Aug. 21. Another law effective Aug. 21 allows state agencies to pool together to self-insure their health care risks. Before, they could pool only to purchase the coverage. In addition, each school district may self-insure its own health care risks. The new law also allows state agencies for the first time to pool their life risks on an insured or self-insured basis.

Gov. Hull vetoed—citing the prospect of higher premiums—legislation that would have required health maintenance organizations to cover the cost of chiropractic care when ordered by primary care physicians.

Mental health parity legislation died in the state Senate after the House approved it. The Health Insurance Assn. of America expects the issue will resurface at the federal level next year.

New Mexico's Patient Protection Act takes effect July 1. The law requires that organizations clearly disclose their benefits plans and requires that all consumers with complaints have an adequate appeals mechanism. New Mexico Gov. Gary Johnson, however, vetoed the establishment of a managed care ombudsman office, saying it created an additional level of bureaucracy whose necessity has not been demonstrated.

In addition, two New Mexico laws became effective May 20; one certifies nurse practitioners as health care providers so they can receive direct reimbursement, and another prohibits discrimination by insurers based on genetic information.

Several new laws in **Oklahoma** are designed to protect health care plan participants. One new law will require HMOs to pay so-called "clean," or completed claims within 60 days. HMOs that violate the mandate, which goes into effect Nov. 1, are subject to a penalty of 10% of the claim amount.

Oklahoma lawmakers on May 28 passed legislation that prohibits health care plans from requiring members or applicants to undergo genetic tests. The law, which takes effect July 1, also bars health plans from underwriting coverage based solely on the results of any existing tests.

In addition, a law that becomes effective July 1 requires lawmak-

ers to evaluate the economic and social impact of any health insurance benefit mandate before voting on such a measure.

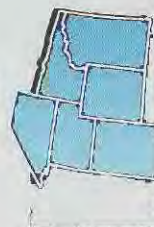
Among the significant measures that will not become law was a bill that would

have required health plans to make their mental health care benefits identical to their medical care benefits. Saying the measure would be too costly for employers, Gov. Frank Keating on April 22 vetoed the legislation. In addition, lawmakers defeated legislation that would have made health plan administrators subject to medical malpractice claims when the

plans deny coverage for necessary medical treatment.

The **Arkansas** and **Texas** legislatures did not convene in 1998.

HEALTH CARE



Colorado Gov. Roy Romer signed into law bills that will:

- Require any new proposed mandate introduced to be included in the state employee health plan, and require that the Department of Administration conduct a cost analysis for the Legislature

on any new proposed mandate.

- Require all health plans to cover the cost of medical equipment and educational programs for diabetes patients.

- Require health plans to pay for anesthesia in a hospital when a child of special needs is unable to receive local anesthesia from a dental office.

- Conform Colorado state law to the federally mandated maternity length-of-stay law.

- Require health plans to give patients direct access to nurse midwives.

Several laws become effective in **Idaho** July 1. One law will prohibit use of notice provisions, best-price clauses or "most favored nation" clauses in third-party payer contracts. Another law will allow a non-network physician to balance bill a subscriber even though

See Health on page 14

Call for Nominations

Risk Manager of the Year Risk Management Honor Roll

Nominations for the 1999 *Business Insurance* Risk Manager of the Year and Risk Management Honor Roll are now being accepted.

The Risk Manager of the Year Award was created in 1977 by *Business Insurance* to increase recognition of the risk management profession and to recognize outstanding performance in the practice of risk management.

Anyone involved in risk management for a corporation, financial institution, not-for-profit institution, self-insurance pool or government entity can be nominated.

The nominations will be judged by a panel of professionals representing all aspects of risk management and the commercial insurance industry.

The honorees will be announced in the April 12, 1999, issue of *Business Insurance*, which will be distributed at the Risk & Insurance Management Society Inc. Conference.

Business Insurance
www.businessinsurance.com

For nominating
forms and instructions,
call 312-649-5319
or e-mail:
ktucker@crain.com

Health

HEALTH CARE



Continued from previous page
he has accepted a referral from a network physician. Balance billing allows health care providers to bill patients for the portion of their charges insurers don't cover. A third law will expand nurses' scope of practice, though they would still be under physician oversight.

A law that becomes effective in January 2000 would require the boards of certain provider groups to disclose particular information about providers that would be available to the public. This would include education, credentials, certifications, hospital privileges, work history and financial ownership in companies or equipment to which the provider does referrals.

Legislation that failed to pass included a mental health parity bill more far-reaching than the comparable federal law. The bill provided for parity for biologically based mental illnesses and allowed for a broad range of providers to be reimbursed, including social workers, counselors, nurses, psychologists and psychiatrists.

A new **Utah** law that goes into effect July 1 permits women to select an obstetrician/gynecologist as a primary care physician, though it has no significant im-

pact because a 1995 statute in effect already permitted this with somewhat different language, according to Linda L. Nelson, senior director, benefit communications, at Regence Blue Cross & Blue Shield of Utah in Salt Lake City. Of 15 bills providing for benefit mandates, the only one to pass was a measure that became effective in May requiring health insurance policies to cover dietary products for treatment of "inborn errors of amino acid or urea cycle metabolism," or metabolic disease.

The **Montana** and **Nevada** legislatures were not in session. **Wyoming** passed no significant health care legislation.



HEALTH CARE

Under a new **Alaska** law effective Aug. 30, HMO patients must have access to chiropractic services.

Two bills in conference committee in the **California** Legislature would change how health maintenance organizations are regulated. One would transfer HMO regulation from the Insurance Department to the Department of Corporations, while another would transfer HMO regulation from the DOC to a new board within the Department of Consumer Affairs.

Other measures also have been

introduced that would make it harder for HMOs and other managed care plans to implement utilization review and other cost-containment procedures. For example, a bill before the Senate Appropriations Committee would make physicians liable for UR decisions. The Senate passed one bill that would limit the use of drug formularies, and another was referred to the Senate Insurance Committee.

Several other measures would require that only licensed physicians make utilization review decisions, and at least one measure would make HMOs vicariously liable for medical malpractice resulting from a UR decision.

A measure that would have required health plans with provider networks to cover visits to out-of-network providers was placed in the inactive file.

In response to the UR backlash, the **California** Assn. of Health Plans has introduced a bill that would establish an outside review process for health plan enrollees who are denied care and are dissatisfied with the result of the plan's internal grievance process. The Governor's Managed Care Improvement Task Force has recommended such an independent review process, according to Maureen O'Haren, president and chief

executive officer of the **California** Assn. of Health Plans. Specifically, the bill, which has passed the Senate Judiciary Committee, would require health plans to complete internal appeals within 14 days generally, or within 72 hours in cases where the enrollee's health is at risk. It also would authorize enrollees to seek inde-

pendent review from an outside organization selected by the Department of Corporations for all denials involving a course of treatment anticipated to cost at least \$1,000, with the enrollees paying a \$50 fee for the review. However, the enrollee fee would be waived in cases of financial hardship and would be refunded in all cases where the enrollee prevails. The bill would require the independent review entity to complete its decision within 30 days and directs the plan to promptly implement the recommendation.

The **California** Senate passed a bill that mandates mental health parity after July 1, 1999.

The bill goes beyond the federal Mental Health Parity Act by requiring health plans to provide equal coverage for physical and mental illnesses, including prescriptions, doctor visits and hospital stays.

Among the illnesses that would be covered in **California** are schizophrenia, manic-depression, panic disorder, obsessive-compulsive disorder and major depression. In addition, the bill contains a broader definition of childhood mental illness to be covered.

Although Gov. Pete Wilson says that he would support legislation to expand coverage for medica-

tions used to treat biologically based mental illness, Gov. Wilson is balking at other provisions of the bill, including one requiring unlimited hospitalization coverage. The bill authors say they will attempt to negotiate a compromise with the Wilson administration.

Employers and insurers are lobbying against legislation that would create a single-payer health care system in **California**. The bill, which recently was passed by the Senate Health and Human Services Committee, has been referred to the Senate Rules Committee. **California** voters rejected a similar proposal presented in the form of a 1994 ballot initiative.

In an attempt to ensure that people enrolled in self-insured plans have adequate coverage, **California** lawmakers have introduced legislation that would establish an interagency agreement to monitor employee complaints about ERISA health plans in the state.

The bill before the Assembly Health Committee would direct the governor to designate a lead agency or department to consult and coordinate with the U.S. Labor Department with regard to overseeing employer-sponsored ERISA health plans that serve **California** workers and their families.

In **Washington**, several pieces of anti-managed care or managed care reform legislation were introduced, but none survived. Among them was an "any willing provider" bill, which was killed in the Senate Ways and Means Committee.

No significant health care bills were introduced in **Hawaii**. The **Oregon** Legislature was not in session. **BI**

Comp

Continued from page 1

Industrial Commission is slated to propose rules soon that would restrict an insurer's authority to communicate with a treating doctor without the consent or participation of the workers comp claimant or the claimant's attorney (*BI*, June 8).

Elsewhere, the topic has been discussed—but nothing enacted—in several other states, including **Maine**, **New Hampshire**, **New York** and **Vermont**, Mr. Wood said.

Some of the lengthiest discussions involve state insurance regulators in the **National Assn. of Insurance Commissioners**. That organization is drafting a "Health Information Privacy Model Act," which will set standards designed to protect health information from unauthorized collection, use and disclosure by requiring insurers to establish procedures for the treatment of all health information.

Congress also is considering federal privacy proposals, though how they would interact with state proposals has not been determined (*BI*, April 27; March 30).

The issue is controversial.

On one side are employers, insurers and workers comp administrators. They fear the claims-handling problems and litigation that might result if privacy restrictions delay the exchange of information needed to process claims.

In addition, delay may increase the duration of wage-loss payments and make it more difficult for employers to determine impairment and sometimes eligibility for compensation through a sec-

ond-injury fund.

On the other side are consumer and labor advocates who want stronger restrictions on individual medical information for all insurers, including those that write workers comp, according to James E. Ellenberger, assistant director of the department of occupational health and safety of the **AFL-CIO**. The **Washington**-based labor federation wants to protect workers from unauthorized access to workers comp information, access that may allow businesses to discriminate against workers because of health conditions or even blacklist them for merely filing claims for on-the-job injuries.

In addition, some states—including **Illinois**—considered other health-related proposals that would make insurers and health plans refusing to approve treatments liable for adverse outcomes. Such bills may indirectly affect workers comp medical care providers and insurers, said Nancy Schroeder, director of workers comp for the **National Assn. of Independent Insurers in Des Plaines, Ill.**

While medically related topics dominated workers comp discussions, several other themes emerged from state lawmakers' actions during this year.

Overriding all in most states was a continuing lack of legislative interest in making major changes to workers comp systems.

This was true even in **Ohio**, where voters, at the urging of labor and trial bar spokesmen, refused in November 1997 to confirm significant legislatively adopted changes. The issue's sensitivity is heightened by the fact that this is an election year.

However, "states are continuing to tinker with reform," Ms. Schroeder said. Examples of that include **Missouri's** proposed omnibus bill, efforts by state funds in **Maine** and **Utah** to expand operations, and a variety of anti-fraud measures enacted in states that include **Kansas** and **Mississippi**.

Only a few states considered workers comp benefit proposals.

California lawmakers dominated this discussion by seriously considering bills in each chamber that would increase workers comp benefits by \$1.5 billion, over a three-year period.

Labor supporters say the measures are needed because workers did not get all the benefit increases they were promised when the Workers Compensation Cost Reduction Act of 1993 was passed. Meanwhile, employers are concerned that any savings from the 1993 bill will be wiped out by such an increase.

Benefit increases based on cost-of-living indexes were approved for some claimants in **Connecticut** but rejected in **Maine**, Ms. Schroeder said.

The **AFL-CIO** is particularly concerned about an "outrageous" District of Columbia proposal that would reduce benefits to injured workers in the District and bring them more into line with benefits paid in neighboring **Maryland** and **Virginia**, Mr. Ellenberger said. Workers in the District of Columbia deserve benefits that reflect their higher wages and higher living costs, he said.

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



WORKERS COMP

Connecticut enacted a law that modifies the formula for workers compensation cost-of-living adjustments.

Under the legislation, COLAs for injuries occurring before Oct. 1, 1991, will be calculated using the base weekly rate as of Oct. 1, 1990, or the date of injury, whichever is later. The new law also requires insurance companies and self-insured employers to notify survivors of a deceased recipient of workers comp benefits that dependents may be entitled to survivors' benefits. The notice must be sent to the deceased claimant's address.

Maine has enacted legislation that will allow **Maine Employers' Mutual Insurance Co.** to seek licenses and acquire or form affiliated insurance units in other states.

MEMIC is a privately held workers compensation insurer originally created to replace the state's workers comp residual market mechanism. **MEMIC** will initially apply for licenses in **New Hampshire** and **Massachusetts** to allow it to write coverage for **Maine** employers with operations in those states, said President and Chief Executive Officer John Leonard.

The workers comp insurer may eventually acquire or form a sep-

arate unit to write risks unconnected to **Maine**, according to Mr. Leonard.

In **Massachusetts**, a workers compensation reform bill has been in the joint Judiciary Committee since January.

The measure would unravel some of the workers comp reforms that the state's lawmakers instituted in 1991. The bill would extend benefit payments for temporary total disability to five years from three and extend the payment for temporary partial disability to 11 years from the current five years.

The **Massachusetts** Senate Committee on Commerce and Labor is considering other legislation that proposes increased fines for employers that do not buy workers compensation insurance. Under the bill, maximum fines would increase from the current fines of a few hundred dollars to a maximum of \$5,000 for the first offense and \$10,000 for the second offense.

In **Vermont**, a law was enacted directing the commissioner of labor and industry to review every five years the fees of attorneys handling workers compensation cases.

The measure also directs the commissioner to study the feasibility of including the cost of employer-provided benefits in calculating temporary total disability benefits. The measure stipulates that the commissioner may require workers comp insurers to perform workplace safety inspections.

No significant workers compensation legislation was passed in **New Hampshire** or **Rhode Island**.

Continued on next page

Continued from next page

WORKERS COMP



In 1997, the Delaware Legislature passed a limited workers compensation reform package. Part of the legislation established the Delaware Workers' Compensation Advisory Council, which will continue to meet periodically for the rest of this year with the aim of issuing reform recommendations to be considered in 1999.

The District of Columbia's congressionally created D.C. Control Board, which controls most functions of city government, issued a formal recommendation May 28 that the city council enact comprehensive workers comp reforms. The recommendation called upon the council to approve a bill that would, among other things: eliminate cost-of-living allowances, reduce benefits to bring them more in line with benefits paid in neighboring Maryland and Virginia, change the basis of calculating benefits from the current 66.7% of gross earnings to 80% of net earnings, and require employee selection of a treating physician from either an insurer-designated physician panel or an pre-approved provider network. The council has 90 days in which to act on the matter, but as of late June, had done nothing. If the council declines to act, the control board can seek congressional intervention to implement the reforms.

A new Maryland law denies injured workers wage-loss benefits when a claimant's abuse of drugs or alcohol is the primary cause of a work-related injury. Previously, benefits only could be denied if drugs or alcohol were the sole cause of an accident.

New York's Legislature passed a bill that would cap the amount of workers comp premiums paid by construction firms. Under the bill, which Gov. George E. Pataki is expected to sign, construction employers would not pay additional premium for workers who earn more than \$900 per week. This figure would drop to \$860 after two years. The new bill was a compromise reached after Gov. Pataki vetoed a measure passed in 1997 that would have changed the method of calculating workers compensation premiums for construction companies. If enacted, the law would have changed the method of calculation from a "total payroll" method to one based on "hours worked" (BI, Oct. 27, 1997).

No significant workers comp legislative activity took place in New Jersey, Pennsylvania or West Virginia.

WORKERS COMP



Florida legislators want to make sure employee leasing companies in the state pay proper workers comp premiums. Under legislation that became law without the governor's signature, leasing compa-

nies will be required to provide insurers with information such as employers' loss data, payroll documentation, job classifications and other information that will enable insurers to properly calculate experience modification factors of employers that terminate a relationship with a leasing company. In addition, the law will require insurers to conduct annual payroll and classification audits of leasing companies to ensure proper workers comp premiums are being paid. The law will apply to policies written on or after Oct. 1, 1998.

Florida also enacted a law that will strengthen the state's fight against workers comp fraud. The law, effective Jan. 1, 1999, will allow the Division of Workers' Compensation of the Department of Labor and Employment Security to inspect businesses at "any reasonable time" to determine compliance with workers comp requirements. The division has the authority to ask for books and records and call witnesses as part of its investigation.

Georgia enacted a law that, among other things, allows employers to maintain a list of physicians to treat injured workers as long as the physicians on that list conform to the regulations of the state's Board of Workers Compensation. Under the law, which is now in effect, injured workers may obtain the services of any physician on that panel and may later change to another physician on that panel without prior authorization providing they do so within 60 days of first treatment. That physician then becomes the primary authorized treating physician and will control the patient's care along with any consultations or referrals.

In Kentucky, a law was enacted that allows the state Funding Commission to take over unclaimed refunds of the Special Fund assessments. If the commission has held unclaimed refunds for two years after a reasonable attempt to return the funds to the insured employer, the refunds will become the property of the Benefit Reserve Fund.

A Mississippi law that takes effect July 1 creates a state Insurance Integrity Enforcement Bureau to investigate and prosecute health benefits fraud in insured and self-insured programs in the state, including workers comp plans. Under the law, the new bureau will be funded through an assessment on workers comp insurers and self-insured programs. The new law provides that the state attorney general or county district attorneys may prosecute insurance fraud. The bureau is to file an annual report to the insurance committees of the Mississippi House and Senate detailing its work over the prior year.

North Carolina is not expected to consider significant workers comp legislation this year. However, a state Industrial Commission last week began holding hearings on a proposal that would virtually prohibit spoken communications between employers and physicians and would require that injured workers be notified of written communications. Risk managers and insurers oppose the proposal, which the commission prepared after the General Assembly instructed it to do so last year.

South Carolina enacted a law that requires insurers participating in the voluntary workers comp market to take part in the resid-

al market as well. South Carolina previously was the only state that did not require voluntary market insurers to participate in the residual market.

A workers comp bill that would have weakened the exclusive remedy provision and increased benefits was introduced too late in this year's session to be considered by the full assembly.

More small employers in Tennessee, under a workers comp law that takes effect July 1, will be eligible for experience rating. The law bars voluntary market insurers from excluding any risk, regardless of premium size, from scheduled rating plans as long as the premium the employer would pay is not less than the minimum established for its classification.

Virginia lawmakers enacted a law that doubles, to 0.5%, the maximum premium tax used for the uninsured and self-insured employer fund. The maximum will revert to 0.25% on Jan. 1, 2000. The law also requires the state Workers Compensation Commission to study the fund and report to the relevant legislative committees by December. Also enacted was a law that requires the commission to distribute at the same time and in the same manner copies of any written notice, opinion, order or award regarding a workers comp case to all parties involved.

No significant workers comp legislation was passed in Alabama or Louisiana.

An Illinois measure that would

WORKERS COMP



ban balance billing passed the House and is pending in a Senate committee. Balance billing is the practice of medical providers directly billing injured workers for payments exceeding what a company's workers comp insurer or a self-insured employer consider reasonable.

Michigan legislation awaiting the governor's signature would include respiratory tract, bladder, kidney, skin, brain, blood and lymphatic cancers as illnesses presumed covered for full-time firefighters under workers comp, unless proved otherwise.

Minnesota lawmakers enacted two laws that: adopt minor technical changes to workers comp self-insurance laws, such as requiring employers terminating their self-insurance authority to obtain actuarial opinions on liabilities; and require establishment of a settlement division to which workers comp judges will be transferred.

Wisconsin enacted a law to permit disability payments to firefighters diagnosed with cancer. Under the law, cancer diagnosed

after a firefighter had 10 years of service would be considered job-related. Previous law provided that firefighters could claim disability for injuries suffered on the job or lung disease.

Other workers comp reforms failed, including measures that would have: allowed lump-sum settle-

ments in workers comp claims; required that workers comp insurers provide a 20% premium discount for maintaining a drug-free workplace; and established the Workers Compensation Insurance Pool to write workers comp risks within the state.

No significant workers comp legislation was passed in Indiana or Ohio.

WORKERS COMP



An Iowa law that became effective in April creates a special assessment for workers comp insurers and self-insurers over the next five years to bail out the state's Second Injury Fund, which is in bankruptcy. The law also will increase employer assessments for workers who die on the job to \$12,000 from \$4,000 if there are dependents and to \$45,000 from \$15,000 if there are no dependents.

Another law that becomes effective July 1 changes the workers compensation payment requirement to the first day of permanent disability rather than the first day of injury.

Kansas enacted several workers comp laws. Among other things, the provisions: end automatic workers comp coverage for self-employed subcontractors when doing work for a contractor; increase to \$5,000 from \$4,300 the maximum burial expenses an employer must pay if a worker is killed on the job; and require employers to pay \$25,000 to the estate of a worker killed on the job who has no dependents.

Other Kansas legislation grants the state's Second Injury Fund the same privilege as insurance companies and other parties in disputes over workers comp benefits; provides that fraudulent or abusive acts, for purposes of workers comp fraud, must be committed willfully, knowingly or intentionally; identifies as fraudulent or abusive acts the submission of charges for health care services not provided.

The same bill also will:

- Remove the requirement of peer review in cases where a health care provider or facility is suspected of making excessive charges or requiring unjustified treatment.

- Allow all documentation relating to the utilization review admissible during a preliminary hearing before an administrative law judge on the issues of the medical benefits to which an employee is entitled.

- Allows optional deductibles offered by insurers to the policyholder for benefits payable under the act to include allocated loss adjustment expenses.

- Allows persons with final set-

tlement authority to be present by video conference instead of being present in person, at mediation conferences.

- Amends the definition of fraudulent or abusive act, for purposes of the workers compensation act, to provide that such acts must be done willfully, knowingly or intentionally.

Missouri legislators approved an omnibus bill containing a few substantive and numerous technical changes to the state's workers comp laws.

The bill would, among other things: eliminate the employer notice and worker acknowledgment requirements for accidents involving less than \$500 in medical costs with no lost work time; allow compromise lump-sum settlements prorated over the life expectancy of the injured worker; toughen insurance fraud statutes by categorizing a second offense a class D felony; broaden the definition of "employer" to include limited liability partnerships and companies; and allow groups of qualified employers to use a uniform experience rating plan to insure their workers comp liability, though total discounts may not exceed 25%.

In addition, the measure would: increase the number of weeks of permanent partial disability benefits paid for complete deafness in both ears and for complete deafness in one ear; slightly broaden the definition of the three-day period for which compensation will not be paid unless a disability lasts longer than 14 days. The change is from the worker's first three "regularly scheduled" workdays to the first three days during which the employer is open for business.

The bill also would: establish a scholarship, funded by workers comp premium taxes, for children of workers injured or killed in work-related accidents or by occupational disease; require the Division of Workers' Compensation to issue a written award within 90 days of the last day of a maximum 30-day hearing; and authorize state appellate courts to review decisions of the Labor and Industrial Relations Commission, where the division has original jurisdiction; and increase the number of administrative law judges to 25 beginning Jan. 1, 1999, allowing one additional judge to be added each year, up to a maximum of 30.

A measure enacted earlier this year makes police officers who contract certain occupational diseases through job-related exposure to illegal substances eligible to receive benefits under Missouri workers comp law.

A Nebraska law clarified several technical provisions relating to workers comp medical issues. The key change closed a loophole that previously allowed an insurer or employer to get a contested claim dismissed, if the worker had not obtained an independent medical examination.

South Dakota enacted a law that makes dependent spouses and children of employees killed on the job eligible for a college tuition benefit as of July 1. The spouse and each child will be eligible for up to \$2,000 in aid per year for up to five years. The Department of Labor must promulgate regulations for implementing the benefit.

Efforts in South Dakota to repeal the workers comp subsequent-injury fund failed, despite support from the governor and

Continued on next page



THIS DECADE, PREMISE LIABILITY

33% OF PRODUCT LIABILITY AND

SEXUAL HARASSMENT CASES

TRUCK ACCIDENTS CAUSED

NO ONE KNOWS MORE ABOUT THE RISKS. NO ONE OFFERS MORE WAYS

Y LAWSUITS INCREASED BY 260%.

WARDS EXCEEDED \$1 MILLION.

S HAVE MORE THAN DOUBLED.

OVER 4,500,000 INJURIES.

As the largest underwriters of excess casualty coverage in
the U.S., we can offer more options and higher limits than
other insurers. Call your broker or simply visit www.aig.com

TO PROTECT AGAINST THEM. EXCESS CASUALTY COVERAGE



AMERICAN INTERNATIONAL COMPANIES, 70 PINE ST., DEPT. A, NEW YORK, NY 10270



TO ALL CREDITORS OF TRANSIT CASUALTY COMPANY

- ADDITIONAL CASH IS WAITING FOR YOU.
- WOULDN'T IT BE NICE TO RECEIVE **TWO CHECKS** IN SEPTEMBER 1998, ONE FROM THE LIQUIDATOR OF TRANSIT AND THE OTHER FROM QUANTUM CONSULTING, INC.?
- AS OF JUNE 15, 1998, THE LIQUIDATOR OF TRANSIT CASUALTY IS PROJECTING AN ULTIMATE PAY-OUT OF 48 CENTS ON THE DOLLAR TO ALL CREDITORS, INCLUDING DIVIDENDS PAID TO DATE.
- YOU HAVE ALREADY RECEIVED 25 CENTS ON THE DOLLAR. YOU DON'T NEED TO WAIT FOR THE BALANCE OF THE PROJECTED PAY-OUT. YOU HAVE OPTIONS.
- QUANTUM CONSULTING WANTS TO BUY YOUR CLAIMS TODAY. TO CASH OUT NOW ON ESTABLISHED CLAIMS, CALL:

QUANTUM CONSULTING, INC.
150 JORALEMON STREET, SUITE 6B
BROOKLYN HEIGHTS, NY 11201-4309
ATTN: JOSEPH F. SCOGNAMIGLIO, PRES.
TEL: (718) 802-9423
FAX: (718) 802-9701

Comp

Continued from page 15 business. The Senate approved the measure, but the bill died in the House after it was amended so it would apply only to self-insured employers.

The American Insurance Assn. plans to lobby next year to repeal the fund, which business views as duplicative of the Americans With Disabilities Act, said Paul Blume, a vp with the AIA in Des Plaines, Ill. The fund, which employers finance, covers the workers comp costs of disabled employees who suffer a second injury in the new jobs they find. The fund initially was established to prevent employers from discriminating against disabled job applicants for fear of being burdened by that individual's total workers comp cost if the individual suffered a second injury.

No workers comp legislation was passed in **North Dakota**.



A bill that would have increased benefits for total and temporary disability passed the **New Mexico** Senate but failed to pass the House.

Oklahoma legislators did not pass any significant workers compensation-related measures. Lawmakers failed in the last days of



the session to craft a bill to privatize the state's competitive insurance fund, which also is the market of last resort. The National Council on Compensation Insurance expects that Oklahoma lawmakers will revisit the state fund privatization issue next year.

No significant workers comp legislation was passed in **Arizona**. Neither the **Arkansas** nor **Texas** legislatures were in session.



Several workers comp laws were enacted in **Colorado**. Among other things, the measures: require insurers to notify employers in writing when a workers comp claim settlement agreement is made in the amount of \$75,000 or more; authorize the director of workers compensation to impose a fine up to \$500 per day on employers failing to maintain required coverage; subject workers comp policies and personal injury protection coverages employing an open pharmacy network to an "any willing provider" provision. Under the law, prescription benefit management companies or intermediaries that oversee open networks may contract with an exclusive pharmacy network if a 60-day notice is published in the service contract.

Another Colorado law permits discovery for a workers comp claim without approval by an administrative law judge if both parties are represented by attorneys and agree to participate. It also grants authority to the state workers compensation director and to administrative law judges to rule on discovery matters.

In **Idaho**, the Legislature repealed a section of the Workers Compensation Act relating to willful misconduct, effective July 1. The law had barred an employee or his or her dependents from recovering benefits under the act if the employee failed to observe Industrial Commission rules and regulations posted in the plant by the employer. The now-repealed section also said an employee could not collect benefits if he or she failed to use protective and safety devices provided by the employer.

Total disability income benefit changes also were introduced in a law effective March 20. The current law sets the maximum amount for payment of total disability benefits at 90% of the employee's average weekly wage for the first 52 weeks of disability. The new law provides that this can be no less than 15% of the average weekly state wage.

The **Nevada** Legislature did not meet this year. However, preparations are under way for a competitive workers comp system in the state beginning next year. In 1995, the Legislature had enacted a legislative package that permitted private insurers, beginning in July 1999, to write workers comp coverage in Nevada, which

has had a monopolistic state fund (BI, Aug. 7, 1995). That legislation also provided guidelines for associations to immediately begin self-insuring their members' workers comp exposures.

A foundation for the new "three-way" system—state fund, self-insurance and private insurers—was laid by the Nevada Legislature late in its 1997 session.

Among other provisions, an omnibus bill, effective July 1, 1997, created an account for "current claims" and for "extended claims" in the State Insurance Fund. The latter was allocated \$650 million in invested assets to be used to pay State Insurance Fund liabilities for workers comp claims incurred prior to July 1, 1995.

The purpose of this structure was to put the Fund in a better position to compete with private insurers, said Vance A. Hughey, senior research analyst with the state of Nevada Legislative Counsel Bureau's research division. Simultaneous with the \$650 million allocation, the Legislature repealed provisions authorizing a surcharge to ensure the Fund's solvency because it was no longer considered necessary, he said.

He noted a number of private insurers have already taken steps to obtain the appropriate certification to write workers compensation in Nevada.

The **Utah** Legislature enacted a law that limits the State Fund's ability to provide workers comp or occupational disease coverage outside the state to Utah employers and their subsidiaries and affiliates (BI, March 30). The Fund must also continue to serve as the market of last resort for all Utah employers. The quasi-state agency had previously proposed diversifying its operations to include writing more out-of-state coverage, as well as establishing partnerships and joint ventures to offer other lines of insurance, including 24-hour coverage.

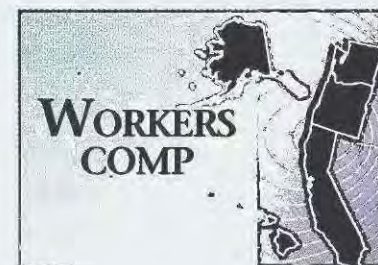
Another law that becomes effective July 1, 1999, authorizes workers compensation insurance policies to include a deductible option.

Three workers comp measures were enacted in **Wyoming**.

One new law, effective July 1, includes provisions that clarify language regarding treatment of employers that have underpaid workers comp premiums as a result of incorrect reporting of employee earnings; clarify what travel expenses connected to occupational medical care are reimbursable; and require the Workers Compensation Division to establish a policy for testing blood-borne pathogens after possible occupational exposure and for immediate prophylactic treatment if medically indicated.

Other legislation was passed that, if approved by voters as a ballot initiative later this year, would amend the state constitution to limit expenditures by the Workers Compensation Fund to financing of the Workers Compensation Act, debt service related to the Fund and state workplace safety programs.

The **Montana** Legislature did not meet this year.



Among several workers comp bills pending in the **California**
Continued on next page

Carvill

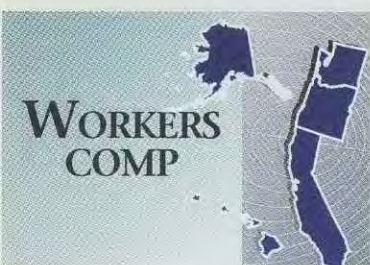
Reinsurance Intermediary

INDEPENDENCE INTEGRITY SERVICE

CONSISTENT PHILOSOPHY & PERFORMANCE

SINCE 1977

Atlanta Bermuda Chicago London Stamford



Continued from previous page
Legislature and in various Assembly and Senate committees, employers are anxiously watching legislation that would increase workers comp benefits by \$1.5 billion over a three-year period.

The bill has a good chance of passage because it was introduced by Assembly Insurance Committee Chairwoman Liz Figueroa, D-Fremont, who has considerable clout after winning big in her district in primary elections held earlier this month, explained Lori Kammerer, executive director of Californians for Compensation Reform, an employer coalition based in Sacramento.

A similar increase is proposed in a state Senate bill that was introduced by equally influential Senate Industrial Relations Committee Chairman Hilda Solis, D-El Monte.

Labor groups support both measures because they believe employees did not get all of the benefit increases that were promised when the Workers Compensation Cost Reduction Act of 1993 was passed. At the time, employers and employees were to share equally in \$1.5 billion in

savings. However, labor groups claim employees have only received \$550 million of the promised \$750 million in benefit increases.

Another bill, which would permit the Workers Compensation Appeals Board to allow liens against awards for certain expenses, also has the potential of becoming a benefit increase bill, Ms. Kammerer said. "It's a spot bill," she said, which means that it may be gutted and rewritten to serve any purpose.

Employers oppose other legislation that would let employees select an acupuncturist as their primary treating physician for a work-related injury. The bill would also permit acupuncturists to be included in the "change of physician" list from which employees can choose after the 30-day period of employer-directed treatment expires.

Under the 1993 reforms, employers that offer managed care programs can direct treatment of injured workers for up to 30 days.

CCR introduced a bill that would have extended this period to one year, but "it was pretty much DOA," Ms. Kammerer said. "Labor was lined up out the door to kill it."

By contrast, CCR backs other legislation that would enable physician assistants and nurse practitioners to initially treat injured workers as long as a treating physician signs the final report. CCR backs the bill because many large employers have physician assistants and/or nurse practitioners on staff who can respond more quickly to workplace injuries, Ms. Kammerer said.

CCR has not yet taken a position on a bill that would create a separate fund to pay for injuries to workers transitioning off welfare. While it would be funded by part of the state's general fund surplus of \$4.4 billion, there's no guarantee that funding will be available in future years, Ms. Kammerer pointed out.

A bill in the Assembly Appropriations Committee would ensure the confidentiality of workers compensation claims data and prohibit companies from obtaining personal information for solicitation purposes. While initial claim filings are confidential, the information is available to the public once the claim is adjudicated

by the Workers Compensation Appeals Board, Ms. Kammerer explained.

As a result, it is possible for lawyers and medical providers to obtain the names of claimants who are dissatisfied with the outcome of their claim and reopen their cases, she said.

Several other bills also could increase workers comp costs, through provisions that would:

- Require that employers pay more for treatment of occupational injuries than for identical non-occupational injuries. If enacted, the cost to California business could be as high as \$277 million annually, Ms. Kammerer estimated.

- Extend workers comp benefits to illegal immigrants if they were eligible as of Aug. 21, 1996. This bill would circumvent a ballot initiative approved by voters last year that cut off all medical benefits to illegal aliens in

the state.

- Allow injured workers to obtain the value of the vocational rehabilitation benefits to which they are entitled in the form of a cash settlement rather than seek retraining. Voc-rehab benefits are currently capped at \$16,000.

Several workers comp bills in **Hawaii** await the governor's signa-

ture. Among the approved bills are measures that would:

- Prohibit claims for mental stress resulting solely from disciplinary action taken in good faith by the employer. However, any standard set by a collective bargaining agreement or other employer agreement is to be applied in lieu of good faith standard. The legislation addresses the *Mitchell* case

handed down last year by Hawaii's Supreme Court (*BI*, Aug. 25, 1997).

- Allow limited use of managed care in treating workers comp injuries by allowing employers to contract with Coordinated Care Organizations for treatment of injured workers. However, an employee may go outside the contracted managed care organization after a definitive diagnosis or

three visits, whichever occurs first. The CCO must assign a nurse case manager to each injured employee.

- Require health care providers to bill for services within two years of providing workers comp services.

- Allow an injured employee to select a vocational rehabilitation provider without employer approval. But the employee must inform his or her employer of the decision to use vocational rehabilitation to treat a work-related injury.

Although **Washington** did not pass any workers comp legislation, lawmakers did approve funding for a performance audit of the State Fund. The audit will compare the Fund's performance to other state systems and make recommendations for improvement. A final report is due in November.

No workers comp legislation was enacted in **Alaska**, and **Oregon's** Legislature was not in session. **BI**

Finally, a new avenue for writing more risk.
You can guess what it's paved in.



Still looking for a way to write more risk and make money?

You just found it. With options and swaps from Aquila's GuaranteedWeather® portfolio.

Some call it the new market alternative, and others a surefire way to protect your company from unexpected losses due to the weather. That means too much rain or too little, mild or extreme temperatures, excessive snowfall — you name it. But that's not the best part. Aquila's GuaranteedWeather lets you write risk with virtually any industry you can think of. To find out more, contact one of our representatives at (816) 936-8707 or look us up on the Web at www.aquilaenergy.com because, frankly, you don't have time to chase rainbows.

AQUILA ENERGY

A UtiliCorp United Company

J&H Marsh & McLennan
Client Dialogue:

**"I want better
deals and more
efficiency in
our insurance
transactions."**



A client demand we kept hearing. And listened to.

The result: a unique strategy that creates a dynamic three-way partnership between risk managers, J&H Marsh & McLennan, and the insurance markets.

This strategy — Global Broking — joins you and your client-advisory team with the industry's only organization of placement specialists focused solely on getting you the best insurance deals. Located near all the world's major centers of risk-transfer activity, this group of 500 professionals specializes in specific carriers, industries, and insurance product lines.

This approach gives you critical advantages: Superior information on which markets are writing which lines — and on what terms and conditions. Direct access to the carriers' senior decision makers. Increased negotiating power. And greater placement efficiency.

Best of all, you're in control. With market intelligence and advice from our placement specialists, you and your

client-advisory team determine the coverages needed. You select the markets you want to meet and negotiate with. And you make the final call on carriers, pricing, and all other aspects of your program.

The client benefits of Global Broking are becoming increasingly powerful as we roll out proprietary technology that is transforming insurance placement into an even more efficient, information-driven process.

Want to see better deals and more efficiency in your insurance transactions? Look to J&H Marsh & McLennan.

**J&H MARSH &
MCLENNAN**

QUALITY LEADERSHIP IN RISK AND INSURANCE SERVICES
www.jhmarshmc.com

The key to good work comp reports: simplify

One company's two-year effort produces data useful for loss prevention analyses

By Walter E. Pliszka
and Charlotte A. Plueckhahn

IN THE FILM "SNEAKERS," while probing a computer disk, the character "Doc" uncovers a treasure trove of data, including access to such vital information as the landing patterns at all domestic airports. It is a similar store of data that has long been the quest of safety and workers' compensation professionals.

One of the most effective methods of reducing occupational injuries and illnesses is through the analysis of previous accidents. For a variety of reasons, such analysis is often stymied by poor data quality. Such was the case until two years ago at Cooper Industries Inc., a highly diversified Houston-based manufacturer that currently employs more than 28,000 workers domestically. At that time, Cooper Industries' workers comp and safety professionals reviewed and revamped the company's procedures for reporting injuries and illnesses.

To understand the changes we implemented, it's important to understand what it previously took to get the information regarding an occupational injury or illness entered into a risk management information system. The process began with the injured employee reporting the event to his or her supervisor. The supervisor then interpreted the history provided by the employee and completed an Accident Investigation Report. Next, the supervisor completing the Accident Investigation Report forwarded the form to the administrative office, where the appropriate First Report of Injury was completed. The FROI was then submitted to

Initially, accident and injury reporting was highly complex, involving nearly 100 manufacturing locations, 44 with direct RMIS input and 10 third party administrators.

the claims administrator—whether third-party or self-administered—where the data was entered into the RMIS.

From this data, loss reports were eventually produced. In recent years, various vendors had attempted to address the accuracy of the information by having claims reported to a toll-free telephone number following a pre-established script. Although this technique had its advantages, it did not eliminate other variables affecting data integrity in the accident reporting equation.

This elaborate system easily lent itself to miscommunication and improper interpretation of the facts pertaining to an accident. This project was further complicated by its scope—which involved nearly 100 manufacturing locations, 44 with direct RMIS input—and 10 third party administrators. Corporate safety personnel were, with good reason, highly suspicious of the historical accident information contained in the RMIS.

An initial problem we identified in revamping the process was the lack of standardization of the Accident Investigation Report form itself. Additional problems, we found, arose from the many varieties of special analysis codes used in injury and illness reporting; there probably are as many codes as there are employers, insurers and third-party administrators. This large number of sources, codes and categories caused us to question the validity of the data as well.

The one bright spot in the reporting process that we found involved the introduction of self-insurance and self-administration in a majority of our locations. Self-insured and self-administered reporting—where the final report of an injury is the one provided by the injured employee's supervisor—had greatly improved data quality over the years; the simplified system tended to eliminate far more misinterpretation of facts. Producing reports using data from those self-insured, self-administered plants helped convince division and corporate safety

managers that it was possible to use the RMIS to produce both safety statistics and financial information.

As for improving the data that was not self-reported, we decided it was necessary to eliminate the multiple entry of data and its "interpretation" to make those reports equally valid and useful for analysis. The accident codes were scrutinized and drastically revamped. We worked closely with our RMIS provider to salvage data already in the system, mapping out where the old codes would fall into the newly revised and greatly reduced codes.

We decided to clean up two years of accident history, with each division being responsible for spearheading the correction of invalid codes and the addition of missing information. Undertaking this cleanup process eliminated the need for extensive programming and the related costs, because our RMIS provider was able to map old codes to the new, more concise ones. It also allowed reports to be run immediately with greater assurance that the information being generated was credible.

The key to making the codes useful was to refine and define their quantity and meaning. In our experience, this could be accomplished only by receiving direct input from the users regarding the manner in which they were to be put to use. While corporate employers can present a list of potential codes, it is only through the feedback of the end users that they can generate meaningful reports and accomplish the ultimate goal of loss prevention.

After going through this process, we refined our list of special analysis codes to:

- **Accident type:** Struck By; Struck Against; Fall or Slip from the Same Level; Fall or Slip from a Different Level; Material Handling—Manual; Material Handling—Mechanical Device; Caught Between; Caught in Machine—Point of Operation; Caught in Machine—Point of Transmission; Exposure to Chemical Agents; Exposure to Physical Agents; Animal/Insect Bite; Over the Road/Passenger Transportation; and Repetitive Motion.

- **Injury type:** Amputation; Burn; Bruise (Contusion); Cut/Laceration/Abrasion/Puncture; Fracture; Hearing Loss; Skin Diseases or Disorders; Respiratory Conditions; Other Occupational Disease; Hernia; Heat Exhaustion/Frost Bite; Allergic Reaction; Strains/Sprains; Foreign Body; and CTD (Carpal Tunnel/Tendinitis).

- **Body part:** Ears; Eyes; Head/Neck; Arm/Elbow/Shoulder; Wrist/Hand/Finger; Back; Chest/Abdomen; Hip/Leg/Knee; Foot/Ankle/Toes; Groin; and Internal Systems.

- **Length of service:** 0-6 months (A); 7-12 months (B); 1-2 years (C); 3-5 years (D); 6-10 years (E); 11-20 years (F); and More than 20 years (G).

- **Experience with task:** 0-6 months (A); 7-12 months (B); 1-2 years (C); 3-5 years (D); 6-10 years (E); 11-20 years (F); and More than 20 years (G).

- **Work shift:** First (1); Second (2); Third (3); and Other (4).

- **Department.**

- **Code.**

- **Optional fields.**

- **Agency.** Machine; Tooling/Fixture/Jig; Conveyor/Elevator/Hoist; Mobile Equipment; Hand Tool; Power Tool; Chemical/Physical Agent; Working Surface/Bench; Floor/Walking Surface; Stairway/Steps; Container/Tote/Box; Material/Part/Product; Pallet; Packaging Material; Scrap/Chips; Furniture; Animal/Insect; and Not Otherwise Classified.

We found that this list has many advantages.

It is concise yet comprehensive. Many lists of special analysis codes contain redundancies, for example, strain or injury by lifting and strain or injury by pushing or pulling. Our goal was to consolidate these codes into a manageable list without sacrificing the detail necessary to adequately code any event that occurs.

Most of the possible choices for each category were reduced to one-fifth of the previous number of choices. The most dramatic reduction was injury agency, which went to 18 choices from 122.

The code list is also consistent. The user selects only

from this limited universe of codes, which allows analysis on different hierarchical levels.

It is easy to use. By placing the RMIS code for the special analysis fields in bold type, the translation from the Accident Investigation Report to the RMIS is simplified. The RMIS code bears a direct relationship to the special analysis factor; e.g., "AMP" for amputation and "RSP" for respiratory conditions.

A previous complaint from the safety area was that the numeric codes previously used to enter data had little meaning when reports were generated and the results were in the same numeric code format.

Following the revamping of the system, once the supervisor has checked the appropriate special analysis code on the Accident Investigation Report, the individual inputting the data into the RMIS need merely select, on screen, the identical description as contained in the Accident Investigation Report.

This, then, avoids the need for the data entry person to interpret a narrative description contained in the Accident Investigation Report. Use of this format in the RMIS also eliminates the need for the claims administrator to interpret the narrative information contained on the employer's First Report of Injury form.

Admittedly, an insurer or third-party administrator may be reluctant to customize a proprietary RMIS to accommodate a single customer, but this is much less of an obstacle for a self-administered program. In fact, to further reduce multiple entry, we hope to eventually have the supervisor input the data directly into the RMIS as part of completing the Accident Investigation Report.

The flexibility of the RMIS is, obviously, a critical component to this process. The ability of the system to accept multiple input sources is invaluable. By customizing the input screen, users—regardless of their experience level—can input data onto a screen that replicates the Accident Investigation Report. As in any such system, training in the completion of the Accident Investigation Report and data entry is critical.

Another advantage of this system is that where errors have been made or fields have been left blank, an error report can be generated and a copy of the Accident Report form sent to the reporting location for completion. The form can then be returned to any data input operator for entry into the RMIS.

Of course, the RMIS should be flexible enough to sort data by any of the special analysis codes to perform the appropriate loss source analysis for prevention purposes.

We believe the benefits of this system lie in its simplicity. Combining the supervisor's Accident Investigation Report with our RMIS data input enables a hierarchical and consistent analysis of occupational injuries and illnesses that remains responsive to local needs. The blank field for department code allows for variations in departments at individual locations. The addition of optional fields allows for locally specific accident analysis.

We are optimistic that this streamlined system will finally allow us to effectively use, for loss prevention purposes, the large collection of accident information contained in our RMIS and, like "Doc," apply appropriate prevention techniques to avoid their recurrence. **BI**



Mr. Pliszka



Ms. Plueckhahn

Walter E. Pliszka is director of workers compensation for Cooper Industries Inc. in Houston. Charlotte A. Plueckhahn is the senior workers' compensation administrator for Cooper Industries.

SHRM

Continued from page 3

ed there are several reasons for buying the coverage. Among them are the ability the insurance provides to budget better and the fact that purchasers currently can benefit from a soft market that features significant capacity. "When you're in a buyers' market, the premiums are soft and you can just about ask for anything," she said.

Despite the current low premiums for EPL coverage, relatively few employers have purchased it so far, Ms. Cortese observed. "It's interesting to note that, even though we've got this buyers' market, less than 10% of employers have purchased coverage," she said.

In evaluating whether EPL coverage is right for a company, some

basic questions must be considered, Ms. Cortese said. Among them are how badly the company needs the coverage, how much it will cost, what it will actually cover and exclude, how its claims will be handled and whether the company should go with a stand-alone product or with one that might wrap around other coverages.

Ms. Cortese noted that policies are available that combine directors and officers coverage with EPL insurance, but that approach isn't for everyone, she said.

"You've got to recognize there are some bad things about it," she said. "There are some endorsements that you can't get in a wrap-around policy that you can get in a stand-alone policy." Employers also need to be aware that policy forms are not standard and have to be cognizant of just whom the policy covers. "You want to

make sure that coverage for the company and its subsidiaries is available," Ms. Cortese said.

discoverable."

"Make your risk manager talk to you," Ms. Cortese said. "And

'Make your risk manager talk to you,' says Vickie R. Cortese. 'And don't put anything in writing that you don't have to put in writing, because it's all discoverable.'

Ms. Cortese noted that, with the division today between HR and risk management in most organizations employment practices policies are often placed by risk management without HR involvement. "And you know what they've attached to the application? Five years of the most sensitive information your department has," she said. "And now it's all

don't put anything in writing that you don't have to put in writing, because it's all discoverable. Don't let anybody tell you it's not."

Employers also must be aware that the results of employment practices audits are also discoverable and that policy elements or coverage scope not yet interpreted by the courts may result in juris-

dictional unenforceability of coverages or coverage gaps.

While she sees EPL coverage as an option companies must consider, Ms. Cortese said there is a downside to purchasing it. She wondered aloud whether the presence of EPL insurance changes workers' attitudes toward suing their employers and makes them more willing to do so.

"I have a very strong personal feeling about what purchasing coverage does to the system," Ms. Cortese said.

"I think we run a major risk of making the system much more expensive than it is now," Ms. Cortese said. Strong risk management guidelines that create good employers are a far better option, she suggested.

On the horizon, the personnel/risk manager said she expects to see a variety of new coverages to address HR-related issues. "I think, in the future, we're going to see coverage for workplace violence, because I think there's a need there," Ms. Cortese said.

She said she also expects to see employment practices policies written on occurrence bases in addition to claims-made bases. Another innovation Ms. Cortese foresees is products to provide coverage for punitive damages in states where such coverage is not now allowed; these products, she said, will become available by using offshore wrap-around coverages underwritten in Bermuda. **BI**

Don't listen if they try to tell you that there's nothing new under the sun. New ideas are being born all the time at First State. New products. New services. New combinations. Ideas born out of a great diversity of experience in professional liability that span the gamut from - architects & engineers to EPLI, from financial services to miscellaneous E&O. Wonder what's new? Take a closer look at First State.

FIRST STATE

NOTHING NEW?

SHRM event attracts 7,000

MINNEAPOLIS—More than 7,000 human resources professionals attended the Society for Human Re-



Society for Human Resource Management
Partners in the Workplace

50TH ANNUAL CONFERENCE & EXPOSITION
JUNE 14-17, 1998 • MINNEAPOLIS, MINN.

source Management's annual conference June 13-17 at the Minneapolis Convention Center.

Titled "Partners in the Workplace," the gathering was Alexandria, Va.-based SHRM's 50th annual conference and exposition. The event featured more than 150 concurrent sessions on various workplace topics and more than 500 different companies exhibiting in the conference's HRM Marketplace Exhibition.

SHRM's 51st Annual Conference and Exhibition is scheduled for June 27-30, 1999, in Atlanta. For conference information, call 800-283-SHRM or 703-548-3440, or visit SHRM's site on the World Wide Web at <http://www.shrm.org>.

Additional coverage of the SHRM conference will appear next month in *Business Insurance*.

INTERNATIONAL

Global Briefs

LIRMA, ILU merger hits snag

Vote delayed until resolution of ILU lease issue

By EDWIN UNSWORTH

LONDON—A technical hitch is not expected to prevent a merger of the London International Insurance & Reinsurance Market Assn. and the Institute of London Underwriters.

The ILU's members have asked that the organization clear up questions regarding their liabilities for lease payments on their current offices on Leadenhall Street before they vote on the proposed merger with LIRMA.

Although no decision has yet been reached on how, or if, the two associations will physically merge their separate headquarters, unspecified liabilities are attached to the lease agreement on the ILU's present premises—for which the ILU members are assessed—and members want these obligations clarified before they vote on the merger at a second extraordinary general meeting yet to be scheduled.

LIRMA expected to be able to announce last week that the memberships of the two groups had voted to endorse the merger. However, LIRMA instead reported that, although its members had voted overwhelmingly in favor of a merger, the ILU members had not put the matter to an official vote until the lease issue was resolved.

When the two organizations do merge, the new association, currently being called the International Underwriting Assn. of London, will become the world's largest representative body for international insurers and reinsurers, with 110 ordinary company members and 80 associate members from 40 countries.

ILU Chairman Steve Redmond emphasized in a letter sent last week to LIRMA Chairman Ken Haddon that ILU members remain convinced the merger "is in the best long-term interests of the company market" and that the

outstanding issue could be dealt with quickly.

Mr. Haddon said he thought it would take no more than five to six weeks for the ILU to clear up the issue to the satisfaction of its members. The two associations had been planning a six-month transition period beginning July 1 before officially merging at the start of 1999. Mr. Haddon said the delay would mean only a shortening of this transition period, with the full merger to be effective at the scheduled time.

Marie-Louise Rossi, executive chairman of LIRMA and chief executive-designate of the IUA of London, said the delay "shouldn't make that much difference to the actual implementation plan." She emphasized that the merger was in the best interests of the London market insurance companies, as she said it will give them a more cohesive representative voice, enable them to deal more effectively with regulatory bodies in the United Kingdom, Europe and the United States, and remove duplication and confusion regarding their roles. **BI**

FDG broker network expands

LUXEMBOURG—U.K. broker Nelson Hurst Ltd. is formally joining the European brokerage network Funk, Diot, GrECo S.A.

London-based Nelson Hurst, acquired in July 1997 by South African broker Forbes Group, previously had a reciprocal agreement with members of the FDG network.

The Luxembourg-based FDG network was set up to coordinate the international operations of insurance brokers Funk Group GmbH of Hamburg, Germany; Diot S.A. of Paris; GrECo International A.G. of Vienna, Austria; and J. Van Breda & Co. GCV of Brussels, Belgium. FDG signed a letter of intent with Forbes Group that will allow its Nelson Hurst subsidiary to join the network.

Lieberecht Funk, chairman of Funk Group and official spokesman for the FDG network, said the link with Nelson Hurst will strengthen FDG's presence in the U.K. market "to complement our client-focus strategy in terms of special services and territorial coverage."

Nelson Hurst brings considerable expertise and complements the continental European focus of the FDG network, Mr. Funk said. The link also gives FDG a relationship with Forbes that will provide the network with access to many countries outside Europe, particularly in Africa, Southeast Asia and South America.

Mr. Funk believes the expansion of the independent broker network—much like the former UNISON network—will provide risk managers with alternatives to the growing dominance of megabrokers worldwide.

FDG hopes the new relationship with Nelson Hurst will allow the network to expand its alternative risk transfer services in Europe. The four FDG partners have offices in 16 countries across Europe, with combined 1997 revenues of more than \$220 million.

Nelson Hurst Chairman and CEO John Percy-Davis said the broker hopes to profit from its expertise in risk engineering and alternative risk transfer and provide services to FDG's clients. "FDG is a means to serve our international clients and an opportunity to distribute our products throughout Europe," he said.

—By Don Lewis Kirk

New forum addresses risk financing options

By DON LEWIS KIRK

GENEVA—Swiss Re New Markets has launched an annual forum in Geneva designed to make the world's top corporations aware of cutting-edge methods of taming corporate risk.

Market Forum '98, held in Geneva last month, sought to underline the impact of new market tools. Two workshops focused on redefining risk to optimize capital productivity and to contain "non-transferable" business risks.

Forum delegates were Swiss Re clients, primarily risk managers from Fortune 500 companies. The delegates also included corporate treasurers, brokers and insurance company executives.

In a keynote address, Daniel Vasella, president and chief executive officer of Novartis, Switzerland's largest pharmaceutical manufacturer, focused on growing liability hazards that confront modern global companies.

"The main risk is uncertainty about the future," said Mr. Vasella. "Losses can be expected and unexpected, covered or not. Such losses can be guided by misfortune or negligence. In the best case, we profit from corporate volatility. In the worst, we face jail or a dissolution of the firm."

Companies face macroeconomic risk, entrepreneurial and strategic risk, and operational risks related to research, production



and products, said Mr. Vasella. In addition, there are long-term technological or societal risks, which can be even more threatening.

Some of Novartis' exposures are created by business cycle fluctuations, foreign exchange markets, financial markets and international trade policy, which include import and export restrictions and tax policy. "All of which influence profitability and growth," said Mr. Vasella.

The driving forces of globalization and deregulation have created greater hazards for companies, which are forcing the creation of new solutions, Swiss Re Chief Executive Officer Walter Kielholz told delegates.

"New techniques can redistribute risk to a larger investor base—a technique characteristic to financial markets. Cooperation

See Risks on next page

Business continuity plans tested by fire Down Under

By YVETTE HIGGINS and KATE TILLEY

SYDNEY, Australia—An Australian city council has learned the hard way the importance of adequate insurance and business continuity planning.

Almost a year ago, a fire destroyed most of the 54,000-square-foot administration center at the Bankstown City Council, 12 miles from Sydney, Australia.

Mark Fitzgibbon, council general manager, said the council had no business continuity plan and that some aspects of its insurance program were insufficient.

So far, the council's insurers have paid \$11.4 million Australian (\$6.9 million) of the expected \$15 million Australian (\$9.1 million) for the total claim, comprised of material damages, increased costs of working elsewhere, and the loss of personal effects. But the council's total claim has not yet been settled because the final costs still are unknown, Mr. Fitzgibbon said. The

council expects the claim to be settled by year-end.

Mr. Fitzgibbon said the council's three Sydney-based insurers, Zurich Australia Ltd., GIO Insurance Ltd. and MMI Ltd., will meet most of the loss, but there are gaps in the coverage.

He said the council's major problem after the loss was its lack of a business continuity plan.

However, the council quickly sought help from people experienced in disaster management, including New South Wales' Knox City Council, which had had a similar experience earlier; contractors; and loss adjusters working with Sydney-based accounting firm Deloitte Touche Tohmatsu.

A spark from a contractor's blowtorch caused the fire, and insurers are "pursuing recovery action" by suing under their subrogation rights to recover payments, Mr. Fitzgibbon said.

The city of Bankstown has a population of 25,000. **See Aftermath on next page**

Aon Risk Services U.K. Ltd. in London has implemented a new organizational structure with Ron Forrest as chairman. Mr. Forrest replaces Geoff Whitehead, who has retired. Mr. Forrest will retain his position as vice chairman of Aon Risk Services Worldwide. Michael Eve, previously executive director-specialty businesses for Aon Risk Services U.K., was named chief executive officer. Along with establishing a core executive committee responsible for the strategic direction of the divisions and of central facilities, the new structure is intended to enable Aon Risk Services to build on its network of 40 regional offices. . . . **Guardian Royal Exchange P.L.C.** has named Roger L. Jean as president and chief operating officer for GRE Insurance Group, the holding company for its U.S. subsidiaries. The appointment will take effect immediately after GRE gets regulatory approval for its acquisition of ING Group N.V.'s property and casualty insurance business in the United States; Mr. Jean currently is chief executive officer for that business. . . . **Whittington Group Ltd.**, the specialist insurance services unit of the Murray Lawrence Group P.L.C., has formed a North American subsidiary to offer services for insurers and reinsurers ranging from underwriting and claims audits to debt collection. Whittington Partners L.L.C. is based in San Francisco and is managed by Ed Tiescher, vp of John Linneman & Co. . . . **A.M. Best Co.** has acquired London-based Financial Intelligence & Research Ltd., an insurance information and software company specializing in the Lloyd's of London and U.K. insurance market. Best said the purchase will strengthen its position in the United Kingdom and continental European insurance information and rating business. . . . **Moody's Investors Service Inc.** and its recently acquired U.K. subsidiary, Syndicate Underwriting Research Ltd., have launched their 1998 "Lloyd's Syndicate Rating Guide." For 155 syndicates doing business this year, the guide has issued a syndicate quality rating on syndicates' ability to perform comparatively over the medium to long term and a volatility rating on the potential variability of their underwriting returns over the insurance cycle. Syndicate quality ratings are single-letter grades ranging from A+, or excellent, to C-, or below average. Volatility ratings range from "extremely high" to "low." . . . **LIMIT P.L.C.**, one of the largest corporate capital investors in Lloyd's of London, reported a pretax profit for the year ended March 31, 1998, of £189.3 million (\$316.4 million), up 64% from the previous year. Chairman Jonathan Agnew said steps had been taken during the year to transform LIMIT from an investment company into an operating insurance business, including LIMIT's acquisition of the Bankside and Janson Green managing agencies. LIMIT supports 28% of the underwriting of syndicates managed by these two agencies, and Mr. Agnew said the investment trust plans to substantially increase this proportion in 1999. . . . **Standard & Poor's Corp.** has raised its insurance financial strength and counterparty ratings of **Trans Re Zurich** of Switzerland to A from A-. The change reflects the reinsurer's improved capital position on a risk-adjusted basis, a selective underwriting strategy, a good operating performance and TRZ's strategic importance to its parent, the Transatlantic Reinsurance Co. S&P said TRZ still has a modest business position given its size, non-leading status and dependence upon traditional proportional reinsurance business.

Forum

Continued from previous page

with financial markets is making it easier to design solutions for new emerging classes of risks," he said.

Insurers are extending the borders of insurability in order to fulfill an urgent market need, said Mr. Kielholz. As a result, risk managers are in a position to contain "non-transferable" business risks, which include fluctuations in commodity prices, foreign exchange rates and stock market prices.

A blend of traditional and non-traditional insurance products, banking instruments and capital market solutions is taking reinsurance into a new

dimension, said Willy Hersberger, Swiss Re New Markets' head of corporate marketing.

"Companies are able, even now, to address a larger share of the risks facing them than they have done previously—if they are willing to cooperate to an unprecedented degree," he said.

The forum sought to define issues surrounding new market products, said Mr. Hersberger, including forms of cooperation among risk managers, insurers, reinsurers and capital markets. "If insurers, reinsurers and their corporate clients are to forge new solutions, they will need to transfer a great deal of detailed and even sensitive information." Companies will have to supply more data about assets to insurers, he said.

It is a leap of faith that not all companies are comfortable making. For Paul Luternauer, who recently re-

'Companies are able, even now, to address a larger share of the risks facing them,' says Willy Hersberger.

tired as director of corporate insurance for a unit of SAirGroup, Switzerland's largest airline, the new dimension in corporate risk financing is also bringing a new role to risk managers.

"Risk management becomes a top management issue," said Mr. Luternauer, who also has served as president of the Swiss Assn. of Insurance & Risk Managers. "We need to cope with (balance sheet) risks, usually in the hands of a treasurer. A change like this takes time and patience."

The limits and possibilities of new market solutions remain a key focus for the future, said Erwin Zimmermann, CEO of Swiss Re New Markets. "More clients understand problems as interrelated and complex. There is a change toward more integrated risk management and a need for sophisticated and tailor-made solutions. The insurance industry supplies a breadth of skills and capital strength with more integrated risk financing solutions and modern tech-

niques of risk modeling," he said.

In an environment where risk management is segregated from other corporate functions, risk managers have a limited role, contends Mr. Zimmermann. "Risk managers can become a focal point for integration," he said. "The ultimate goal of risk management must be a structured package for risk retention, financing and transfer," he said. "Risk management presents the aggregate risk, defines the risk appetite and initiates the orchestration of risk management."

The next forum has not been scheduled yet. For information, contact Swiss Re New Markets, New York, 212-317-5400; Switzerland, 41-285-6868; or London, 44-171-623-3456. **BI**

Council

Continued from previous page

of about 158,000. The council's annual budget is \$120 million Australian (\$73.0 million), and it has a staff of 750.

Mr. Fitzgibbon said the lesson for other councils is to ensure assets are correctly valued and insurance coverage is adequate.

The council had renewed its policies and revalued the administration building and other assets just before the fire but had underinsured the staff's personal effects by \$55,000 Australian (\$33,457), because it purchased coverage only for up to \$5,000 Australian (\$3,042) for the entire staff, he said. Personal effects

coverage is part of the council's overall policy.

The claim for the staff's personal effects totaled \$60,000 Australian (\$36,500). The underwriters paid an extra \$20,000 Australian (\$12,166) which, combined with a council contribution and revenue from fundraising activities, meant 75% of staff losses were covered.

"If not for the goodwill of the underwriters, and the council, there would have been some disappointed people," Mr. Fitzgibbon said.

He recommended that organizations buy a minimum of \$250 Australian (\$152) per employee in cover for personal effects.

Most organizations consider only theft coverage for employees' personal effects, "not cover for anything

like this," he said.

Mr. Fitzgibbon said that, in hindsight, the council should have extended its indemnity period for increased costs of working in a different location for two years.

While the insured property sum of

The City Council had backup data files but no computer to access them, says Mark Fitzgibbon.

\$198 million Australian (\$120.4 million) with a \$5,000 Australian deductible was adequate, its one-year "increased costs of working" indemnity period was insufficient because the council had not realized it would be at least two years before the staff could move back into a permanent administration center.

That means the council will have to pay \$1 million Australian (\$608,300) starting in July 1998 to

fund its temporary accommodation. The council is renting a temporary accommodation until mid-2000, when it can move into a building it owns.

The council's business interruption policy covered only increased costs of working, not loss of revenue, but fortunately the council suffered no losses because it could still issue rates notices promptly, Mr. Fitzgibbon said. Rates are taxes on properties and a quarterly levy homeowners pay for council services.

The council already was printing and distributing its rates notices off-site, which meant the data was not lost. Bankstown collects \$48 million Australian (\$27.4 million) in rates a year. The council receives the remainder of its budget from the New South Wales state government, federal government grants and fees paid for services.

Mr. Fitzgibbon said it was unlikely the loss of profits was considered at policy inception.

"The fire could easily have cost us tens of thousands of dollars in lost income (if rates data was stored on-site)," he noted.

Crisis management should be foremost in an organization's business continuity plan, Mr. Fitzgibbon said.

The plan should spell out recovery management team members and their responsibilities, delegate authority to the chief executive officer to take whatever action is necessary, and provide for a control center from which recovery activities can be coordinated.

Alternative telephone and communication arrangements should be included in the plan and alternate floor space identified, Mr. Fitzgibbon said.

A plan also should clearly outline how an organization can access the necessary computer hardware and software to run backup data.

The Bankstown City Council had backup data files but no computer to access them, he said. The mainframe was destroyed, and another had to be imported from France before the backup data could be read.

"There are many businesses routinely backing up data without realizing they haven't an alternative computer to run it on," Mr. Fitzgibbon said. **BI**

Services Guide

CPCU® and IIA candidates

I guarantee you will learn more in less time with The Burnham System — or your money back
Ray Burnham, CPCU, CLU, ARM
19 Everett Street, Southbridge, MA 01550
Call 1-800-GET-CPCU Now!

**FOR 1998 RATES AND EDITORIAL CALENDAR
CALL 312-649-5340**

Business Insurance's RIMS TV

1998 Tapes Are Available

Three original daily programs include news segments; risk management and employee benefits features; highlights from major conference sessions; interviews with leading corporate and industry executives, RIMS staff, attendees and exhibitors; plus coverage of conference events.

TO ORDER: Dial Rachelle Letersky at BI: 212-210-0229

While supplies last.

\$50 for a set of three programs. \$25 for any single day.

Cost includes standard shipping. Pre-payment required. Make checks payable to Business Insurance or charge to Visa, Mastercard, or American Express. Write to Business Insurance, TV'98, 220 E. 42nd Street, New York, NY 10017. Fax your order to Rachelle Letersky, TV'98, at 212-210-0704.

For advertising information contact: Cheryl Adesko, Classified & Services Guide Advertising, 740 North Rush Street, Chicago, Illinois 60611. Telephone (312) 649-5340 • Fax (312) 649-7937

U.K. pushing workplace health during turn as E.U. president

By CAROLYN ALDRED

LONDON—U.K. regulators are giving health and safety in the workplace a high profile during the country's six-month presidency of the European Union.

The Health and Safety Executive, which is responsible for monitoring employer health and safety standards in the United

Kingdom, has hosted a series of conferences, including an International Conference on Occupational Health that was transmitted via satellite to several other European cities.

The agency's themes were "occupational health, risk assessment and changing patterns of employment," according to a special HSE brochure issued in conjunction

with the U.K. presidency, which runs through June. The six-month terms rotate among E.U. member states.

"The presidency enables the United Kingdom to demonstrate its positive stance toward Europe on health and safety at work issues. Action to maintain or improve health and safety at work is

See Health on next page

"Be sure that you return it."

If you're racing through this issue of *Business Insurance* because you "borrowed" it from a colleague, you should have your own subscription. Then you'll be first on the list. You can take as much time as you like with all of *Business Insurance's* exclusive worldwide news of loss prevention, risk financing and benefit management every week.

To subscribe, use the card in this issue or Call 1 (888) 446-1422 Toll-Free.

Ask about our special 20%-off group subscription rate for five or more subscriptions. A great way to save money. And avoid pass-along problems.

Subscription Rates in U.S. Dollars for 1 year, 52 Issues.

USA	\$87
Canada/Mexico	\$105*
All other countries by expedited air.	\$205
* Price includes Canadian GST.	

Business Insurance.

Subscription Dept.
965 E. Jefferson
Detroit, MI 48207
Outside the USA
Call (313) 446-0450

INTERNATIONAL

Health

Continued from previous page
complementary to the U.K. government's aim of making Europe work for the people," the brochure continues.

"Europe has had a very powerful impact on health and safety lawmaking," said an HSE spokesman.

A raft of European health and safety directives in the late 1980s and early 1990s led to national legislation in member states on managing safety in the workplace; personal protective equipment; display screen equipment; manual handling operations; and work machinery among others.

Although the large volume of European health and safety legislation has subsided, the United Kingdom has been leading discussion during the past few months on several other health and safety issues.

This includes the recent adop-

The United Kingdom has been leading discussion during the past few months on health and safety issues.

tion of a chemical agents directive, which establishes minimum requirements for the protection of workers against risks to their health and safety from chemical agents.

The directive covers all risks from the use of chemicals in the workplace and requires employers to assess and document the risks and to take specific protection, prevention and monitoring and information measures.

E.U. member states have three years to implement the chemicals directive. Implementation will require amendments to the United Kingdom's statutes on the Control of Substances Hazardous to Health, confirmed an HSE spokesman.

The United Kingdom also initiated a debate on the European Union's future policy toward asbestos that could lead to amendments in existing E.U. directives, according to an HSE spokesman. The HSE has published proposals to tighten up existing U.K. legislation on the control of asbestos at work. The deadline for comments on the proposals is the end of June. **BI**

Australia boosts trade credit cover

By YVETTE HIGGINS

SYDNEY, Australia—Australia's federal government-owned Export Finance & Insurance Corp. is continuing to provide trade credit insurance to Australian exporters trading in Indonesia, despite the difficult economic conditions and recent political upheaval.

Australia's industry minister, John Moore, announced recently that the government would extend until September extra funding through EFIC for credit insurance on a case-by-case basis for Australian companies exporting to Indonesia. In February, when the Indonesian rupiah began to

decline in value, the government agreed to provide short-term trade credit insurance funding for Australian exporters.

Chris Wordsworth, media adviser to Mr. Moore, said the Indonesian and Australian governments had signed an agreement in February that guarantees payments to Australian exporters, even if EFIC had to cover the debt. EFIC eventually would recover the money from Indonesia through the guarantee, he explained.

Mr. Moore said the extra funding would allow "essential trade to continue between" Indonesia and Australia.

Private-sector trade credit in-

surers also are continuing to write business for exports to Indonesia but say demand has fallen.

John Rumpler, general manager of Melbourne, Australia-based Trade Indemnity Aust. Ltd., a subsidiary of Sydney-base QBE Insurance Group Ltd., said his company is "very selective" in writing business in Indonesia.

Sydney-based EFIC was established by a 1991 federal government law to provide credit insurance and risk management advice to Australian exporters. The insurer collects premiums, risk management fees and interest on its reserves.

In May, the government allocated an extra \$200 million Aus-

tralian (\$121.2 million) to EFIC to protect Australian exporters trading in South Korea.

The money is in addition to \$300 million Australian (\$181.7 million) allocated Jan. 20, which is available to July.

Graeme Lawless, EFIC managing director, said trade with South Korea traditionally is backed by letters of credit opened through South Korean banks, but credit available to importers in South Korea has dried up. That means Australian exporters' demand for coverage from EFIC has increased, he said.

Industry minister Mr. Moore said the massive drop in value of *See Trade on next page*



Introducing The Perfect Vehicle For Conquering Space.

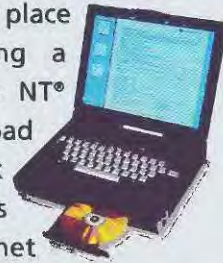


you to the future of document management with the space-saving new CD-4046 Digital Document Recorder. A total desktop solution that allows you to capture and store documents directly onto CDs.

Imagine having the ability to scan 37 letter-size pages per minute — up to 20,000 pages in all — onto one standard recordable CD. Then, being able to copy that CD right on the system itself. With the Canon CD-4046, you can do it all, quickly and efficiently, with touch screen control, at the workstation of your choice.

And the CD-4046 makes accessing documents easy, too. Simply place a CD into any PC using a Windows®95 or Windows NT® standard image viewer. Or load your CDs onto network drives so users can view files over the network, Internet or Intranet.

Look into the CD-4046. And you'll discover just how down-to-earth exploring space can be.



ADVERTISER INDEX

Issue of June 29

ADVERTISER	PAGE #
AIG Corporate	16-17
Aquila Energy Group	19
Burnham Systems	24
Canon Micrographics	25
Carvill America, Inc.	18
Claim Technologies, Inc.	24
First State Management Group	22
General Accident Ins.	6-7
J&H/Marsh & McLennan	20
Liberty Mutual	32
Wm. H. McGee & Co., Inc.	4
Quantum Consultants	18
Tempest Re	9
Wausau Insurance Company	5

©1998 Canon U.S.A., Inc.
All trademarks are of their respective companies.
Windows is a registered trademark of Microsoft Corporation.
Use of the Canon Digital Document Recorder for the collection, storage, retrieval, reproduction, distribution, or other country may constitute a violation of the local, state, or federal laws.
Ensure that you use of this product does not violate the laws of your country.

Canon

1-800-OK-CANON www.usa.canon.com

Trade

Continued from previous page

the South Korean currency, the won, means South Korea is importing less, which contracts the market for trade insurers, but he anticipates the Australian government support for the EFIC would "be of limited duration."

Tim Fischer, Australia's deputy prime minister, said the extra \$200 million Australian funding for Korea included \$70 million Australian (\$42.4 million) for new Australian beef and horticultural exports.

EFIC's Mr. Lawless said coverage for South Korean exports was not limited to any industry sector or commodities, and every risk applying for coverage would be assessed against EFIC's usual underwriting criteria for commercial credit risk.

South Korea is an important trade partner going through a serious but "hopefully short period of difficulty with trade finance," he said.

Ian White, chief operations officer for Brisbane-based Queensland Cotton Holdings Ltd., supports the increased funding. QCH is the state of Queensland's biggest cotton marketer; Australia exports \$350 million Australian (\$212 million) of cotton to Indonesia and \$49 million Australian (\$29.7 million) of cotton to South Ko-

rea each year.

Mr. White said QCH has used the EFIC facility "for several years," and the increased cover for South Korea and Indonesia means "a faster flow of product" to those markets. However, in the past two months, increased economic and political problems have meant "it has been more difficult to come by sales," but QCH still is exporting to Indonesia, he said.

Gordon Cherry, vice chairman of the Australian Cotton Shippers' Assn., said more cotton exporters are prepared to use EFIC's insurance to export to Indonesia and South Korea than in the past.

EFIC's difficult and lengthy approval process, previously a deterrent, has been streamlined, and more exporters are prepared to export to Indonesia because political unrest had eased, he said.

Some Australian exporters are reluctant to use EFIC insurance because it only covers 90% of the value of the export, and they are not prepared to carry the risk of the remaining 10% themselves, he said.

At Queensland's raw sugar export marketer, Brisbane-based Queensland Sugar Corp., a spokesman said the QSC had benefited from the extra funding because it made Australian banks more willing to finance

ventures for Asian markets.

Queensland is Australia's primary sugar producer and, in the year from June 1996 to June 1997, exported 71,000 tons to Indonesia, and 678,575 tons to South Korea.

Meanwhile, private trade insurers say they, too, should be able to access the government money that backs EFIC.

Trade Indemnity's Mr. Rumpler said although it was "admirable" that the government is increasing EFIC's capacity, he thinks all trade insurers should be able to access the additional funds.

Trade Indemnity is the country's largest private-sector credit insurer and holds 25% of the Australian market. EFIC has 70% of the market, and several smaller insurers hold the remainder, he said.

Mr. Rumpler said Trade Indemnity had not reached its capacity limits and is still writing business but that all trade insurers were now forced to "take a more careful approach to underwriting risk."

Trade Indemnity is assessing buyers and risks very cautiously before providing coverage, he said.

The company had investigated the risks created by currency falls in the rest of Asia but still is prepared to write coverage in all Asian countries, Mr. Rumpler said. **BI**

Sentencing ahead Ex-regulator guilty of taking bribes

COLUMBUS, Ohio—David J. Randall, the former deputy director of the Ohio Insurance Department, will be sentenced Aug. 4 after pleading guilty earlier this month to accepting bribes and providing favors to the insolvent P-I-E Mutual Insurance Co. and a lobbyist.

Mr. Randall, who worked for the department from March 1991 to April 1997, faces up to 10 years in prison on the two bribery charges. He also faces a concurrent six-month sentence for "falsification" after lying to the state inspector general, according to Franklin County Common Pleas Court records.

Mr. Randall admitted taking tickets for Cleveland Indians baseball games as well as accepting transportation and lodging in Hilton Head, S.C., from the insurer, said an Ohio Insurance Department spokeswoman. Mr. Randall also golfed as the guest of Larry Rogers, the former P-I-E president and chief executive officer, according to David Buchman, assistant prosecutor for Franklin County.

The favors Mr. Randall provided

included writing a 1997 letter truthfully stating that P-I-E not only met the state's solvency standards but adding incorrectly also could more than meet all its policyholder obligations, Mr. Buchman said. The medical malpractice mutual was insolvent by an estimated \$275 million when it was ordered liquidated in March (BI, March 30).

Mr. Randall also pleaded guilty to taking one bribe from Thomas S. Strussion, a lobbyist with his own consulting firm. The bribes included a \$2,000 payment toward Mr. Randall's wedding reception, a lap-top computer, plane tickets and at least partial payment for four stays in expensive hotels.

In return, Mr. Randall intervened by writing a letter on behalf of Mr. Strussion's client, Genesis Health Care, that helped it obtain approval from the Ohio Department of Human Services to provide Medicaid services, Mr. Buchman said.

"The Ohio Department feels a sense of betrayal because of Mr. Randall's ethical and moral lapses," the department spokeswoman said.

—By Meg Fletcher

The Professional Marketplace

RATES AND CLOSING TIME:

Rates: Display classified is \$171.00 per column inch, minimum of one inch. Straight classified is \$15.50 per line, minimum of 5 lines. Count 34 characters per line (include each space and punctuation as a character). Additional \$25.00 charge for all blind box ads. Only those responses which fit into a business size envelope will be forwarded. Responses are forwarded daily.

Closing: Published every Monday. Copy must be in typewritten form by 5:00 Tuesday, 6 days preceding publishing date. No verbal phone copy accepted. Most major credit cards accepted. Mail ads to, Cheryl Adeszko, Classified Advertising, 740 N. Rush St., Chicago, IL 60611. For more information call 312-649-5340, FAX 312-649-7937, or e-mail cadeszko@craim.com

HELP WANTED

TOYOTA

Toyota Motor Insurance Services, (TMIS) has the following opportunity available at our Southern California corporate headquarters:

COMMERCIAL INSURANCE PRODUCT MANAGER

You will manage the short and long term direction of all aspects of the Toyota/Lexus dealer property and casualty insurance and the TMIS wholesale inventory insurance programs to ensure the success of those programs in line with Company objectives. This includes managing all program requirements with all key departments: Regulatory Affairs, Accounting/Finance, Sales/Marketing, Legal, Systems and Actuarial. Additionally, you will set policies and procedures for the management and administration of all programs.

Requires a minimum of 10 years' property and casualty insurance product management and/or underwriting experience, familiarity with dealership operations and actuarial/underwriting principles, ability to effectively manage the programs across all insurance disciplines, and a Bachelor's degree in Business Administration/related field or equivalent experience. Must be proficient with Lotus Notes, Word and Excel. Previous automotive industry experience and CPCU designation are desirable.

TMIS offers a competitive salary and an outstanding benefits package including medical, dental, vision and life insurance as well as 401k and pension plans. For consideration, please send your resume with salary requirements to: Toyota Motor Insurance Services, Attn: Human Resources, Dept. CP-CIPM, 19001 South Western Avenue, P.O. Box 2991, Torrance, CA 90509-2911, or FAX to: (310) 787-3507. EOE M/F/H/V.

**TOYOTA TMIS
MOTOR
INSURANCE
SERVICES**

Working as one to be #1.

HELP WANTED

INSURANCE

WORKERS COMPENSATION ADJUSTER

Nat'l Co in Nassau City has an excel oppty for a Workers' Compensation Claims Adjuster with 5-7 yrs exp. Responsible for handling claims from start to finish including negotiating reserves and settlements. Good communication skills req'd for contact with nationwide field offices and insurance carrier adjusters. PC proficient a must. Multi-state exp a plus. Good sal + benefits. Fax/mail resume w/cover letter and salary reqmnts to: SH/MD, Fax (516)437-3392, P.O. Box 9006, Woodbury, NY 11797. EOE.

INSURANCE OPERATIONS OFFICER

Strong regional carrier seeks Insurance professional to direct Marketing/underwriting operations. Marketing/underwriting experience in commercial lines a must along with strong management/people skills and computer literacy.

Attractive package including defined incentive compensation formula.

Reply in confidence to:
Business Insurance, Box 3077,
740 N. Rush Street,
Chicago, IL 60611-2590

PROFESSIONAL LIABILITY CLAIMS MANAGER

EmCare, Inc., a national physician practice management company for emergency physicians, is seeking a professional liability claims manager. This job will be based in EmCare's headquarters in Dallas, Texas. Candidates should have experience in managing medical malpractice cases and interacting with physicians. In addition, candidates should have experience in conducting physician risk management seminars. Salary and bonus potential will be commensurate with experience and qualifications. Candidates should send their resumes and compensation history to:

General Counsel
EmCare, Inc.
1717 Main Street
Suite 5200
Dallas, Texas 75201

EmCare, Inc. is an Equal Opportunity Employer

HELP WANTED

RISK ANALYST (PROGRAM SPECIALIST II) \$33,862 - \$55,992 (Career Max)#1

Montgomery County's Dept. of Finance seeks Risk Analyst to assist in managing County's insurance program of commercial and self-insurance. Req. B.A. degree in Bus., Finance, or related field & 2yrs. exp. in underwriting with an insurance broker, agent/company, or 2yrs. exp. in corporate risk mgmt. (An equiv. comb. of educ. & exp. may be subst.) Contact Office of Human Resources at (301)217-2240 (TTY for hearing impaired (301) 217-1094) to receive application which must be submitted by the close of bus. on 7/15/98 to: Risk Analyst, Ann. 08368010, Mont. Co. Office of Human Resources, 101 Monroe Street, 7th Fl., Rockville, MD 20850 EOE M/F/H.

**We're on
the Web**

Business Insurance Online!

www.businessinsurance.com

LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK
IN THE PETITION OF ANTHONY JAMES MCMAHON AND PHILIP WEDGWOOD WALLACE, AS
JOINT PROVISIONAL LIQUIDATORS OF ANGLIO AMERICAN INSURANCE COMPANY LIMITED,
Case No. 97-B-41556 (PCB)

NOTICE IS HEREBY GIVEN that on June 18, 1998, the Bankruptcy Court entered an order (the "Order") continuing the Preliminary Injunction Order pursuant to 11 U.S.C. §§ 105 and 304(b) originally entered in this case on March 19, 1997. The Order shall remain in effect pending a hearing scheduled to be held on December 7, 1998 at 2:30 p.m. before the Honorable Prudence Carter Beatty, in the Alexander Hamilton Custom House, One Bowling Green, New York, New York. Any person wishing to obtain a copy of the Order should contact Mary Ann Elliott at (202)862-2342.

CADWALADER, WICKERSHAM & TAFT
100 Maiden Lane
New York, New York 10038
Tel: (212)504-6000
Fax: (212)504-6666
Attention: Kenneth P. Coleman, Esq.
Lisa C. Dorr, Esq.

LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK
IN THE PETITION OF DAVID LLEWELLYN
MORGAN AND MARK W.R. SMITH, AS
JOINT PROVISIONAL LIQUIDATORS OF
STOCKHOLM RE (BERMUDA) LTD.,
Case No. 95-B-40543 (PCB)

NOTICE IS HEREBY GIVEN that on June 18, 1998, the Bankruptcy Court entered an order (the "Order") continuing the Preliminary Injunction Order pursuant to 11 U.S.C. § 304 originally entered in this case on February 24, 1995. The Order shall remain in effect pending a hearing scheduled to be held on December 7, 1998 at 2:30 p.m. before the Honorable Prudence Carter Beatty, in the Alexander Hamilton Custom House, One Bowling Green, New York, New York. Any person wishing to obtain a copy of the Order should contact Ivy Kepner at (212)504-6402.

CADWALADER, WICKERSHAM & TAFT
100 Maiden Lane
New York, NY 10038
Tel: (212)504-6000
Fax: (212)504-6666
Attention: Kenneth P. Coleman, Esq.
Lisa C. Dorr, Esq.

LEGAL NOTICE

BUSINESS OPPORTUNITY

ATTENTION MEDICAL STOP LOSS MGU'S/PROGRAM ADMINISTRATORS

New York State based MGU/Program Administrator looking to acquire, or develop business affiliation, with an east coast medical stop loss MGU/Program Administrator.

For more information, call or write in confidence to:

Robert W. Menikheim
Stop Loss Concepts, Inc.
5860 Heritage Landing Drive
East Syracuse, NY 13057
(315)449-3406 • Fax (315)449-1921

Business Insurance

Circulation Breakdown Commercial Consumers

Administrative:	
CEO's, Presidents, and Owners	2,710
Vice Presidents, General Managers and Other Administrative Personnel	5,122
Financial:	
Chief Financial Officers and Vice Presidents of Finance	5,429
Secretaries, Treasurers, controllers and other Financial Personnel	4,145
Risk/Employer Benefits:	
Vice Presidents, Directors, Managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	14,748
Sub-total	32,154
Associations	286
Government, Unions and Educational Institutions	1,019
Commercial Consumers	
Sub-total	33,459
Insurance Agents and Brokers	8,083
Insurance Companies	6,933
Accountants, Actuaries, Attorneys & Consultants	2,705
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,578
Others Allied to the Field	757
Total Qualified	53,515
Non-qualified/Paid Subscriptions	14
Single Copy Sales	27
TOTAL CIRCULATION	53,556
★ Source Business/Occupational breakdown of qualified circulation, November 24, 1997 issue, as submitted to BPA for December 1997 BPA Publisher's Statement	

BUSINESS INSURANCE CLASSIFIEDS ASSURE TOP QUALITY RESULTS

Gen Re

Continued from page 3

know if there would have been a material difference if, say in '96, we were willing to put out larger lines or capacity," while last year, not having added capacity "might have had a modest effect."

"It's really more building for the future here," said Mr. Ferguson.

Joseph P. Brandon, General Re senior vp and chief financial officer, said that just by retaining its capital next year instead of paying out money in dividends and stock repurchases, General Re probably will add \$1 billion to its capital base.

"General Re can now withstand considerably more earnings volatility and can reduce some of its cost of retrocessional coverage. It allows General Re to entertain larger, more-complex risks and to put out larger limits," said Weston M. Hicks, an analyst with Sanford Bernstein & Co. in New York.

"I would say it was a deal that was virtually impossible to predict but one that you look at in hindsight and say, 'Why didn't I think of that?'" said Ron Frank, an analyst with Salomon Smith Barney in New York.

"General Re was clearly a company that was laboring to a significant degree under the constraints imposed on its business by the public market and rating agency demands. By bringing Berkshire's total focus on economics vs. reported earnings, as well as its huge and unquestioned AAA balance sheet to the table, Mr. Buffett has in one fell swoop freed General Re from those shackles," said Mr. Frank.

Mr. Frank said General Re is going to be able to do in a macrocosm what Berkshire Hathaway's National Indemnity Co., which has focused on catastrophe coverage, has done in a microcosm, "and that is put down large lines where appropriate, without regard to either retrocessional availability or volatility of earnings."

The deal also will enhance General Re's international presence. During the news conference, Mr. Ferguson said General Re plans to use the new capital to put "more people on the ground." He cited developing nations in particular. General Re already owns or controls 78% of Germany's Cologne Re, which does business from 37 locations in about 150 countries.

General Re has a "very substantial presence" in Europe and the United Kingdom through its Cologne Re affiliation, and it is a significant player in Australia and

South Africa, said Don Watson, director at rating agency Standard & Poor's Corp. in New York. He said he expects the reinsurer to use the deal as an opportunity to grow, particularly in Asia and South America.

"I think what we're looking at is growing the insurance industry on a global basis, and for these players to really be truly serving the markets around the world, you're going to need the kind of financial resources that Berkshire Hathaway brings to the table," said Mark Charron, a principal with Deloitte & Touche L.L.P.-Risk Management Consulting Services in Hartford, Conn.

There will be tax advantages to the deal as well. "There's enough taxable income in the Berkshire Hathaway Group... you don't have to worry about doing suboptimal investment strategies to get yourself in the best tax position," said a Gen Re spokeswoman.

The deal benefits Berkshire Hathaway also, said Russell R. Miller, chairman of San Francisco-based Russell Miller Corporate Finance Inc. "They've substantially reduced the risk that any one catastrophe will diminish their earnings and overall net worth," which is something Mr. Buffett had warned about in his annual report, Mr. Miller noted.

"They also now have a lot more investment capital to marshal for acquisitions if they're investment-minded," he said.

Both Mr. Ferguson and Mr. Buffett emphasized that this deal will not mean any essential change in General Re's underwriting approach. General Re does not intend to change its underwriting and pricing policies, said Mr. Ferguson. "It's an issue of having an appropriate amount of capital and capacity behind you when the deal terms are correct," he said.

Mr. Buffett said: "General Re has been as disciplined as anybody in this business, and it is built into the culture, and we have no worries that the presence of a big piggy bank will cause that to change. I would worry with some other people, but I have no worries about that."

Kaj Ahlmann, chairman, president and CEO of Overland Park, Kan.-based Employers Reinsurance Corp., said, "Warren Buffett is known to buy something and then leave it alone, and if that is the case, I don't see a lot of changes."

"I don't think the underwriting culture and the high business standards of General Re are in any way going to change. It's a very good company; it will remain a very good

company," Mr. Ahlmann said.

"General Re is not a dumb reinsurer. They're not going to sell things cheaper because they're owned by Warren Buffett," said William L. Munson, chairman, president and CEO of Morristown, N.J.-based Toa-Re Insurance Co. of America. "They still have to earn a good return on what they're doing."

Steven Bolland, senior vp of rein-

der to continue to be sensitive to their clients," said Willis T. King Jr., vice chairman-sales at reinsurance intermediary Guy Carpenter & Co. Inc. in New York.

Meanwhile, the extent to which General Re involves other reinsurers in its treaties now will depend on the situation, said Mr. Watson. In combination with National Indemnity, General Re potentially

Pro forma financial summary

Dollars in millions

	Berkshire Hathaway	General Re	Pro forma
Market capitalization (June 18, 1998)	\$98,055	\$16,935	\$119,855*
Cash and invested assets (March 31, 1998)	\$51,501	\$24,931	\$76,432
1997 Net premiums written	\$4,852	\$6,545	\$11,397
1997 operating earnings	\$1,292	\$983	\$2,275

Source: Berkshire Hathaway/General Re

* Following General Re shares' expected conversion to Berkshire stock.

surance intermediary Gill & Roeser in New York, agrees. "Neither the management of General Re nor Warren Buffett are stupid people, and they're not going to push the market down," he said. "What they're going to do is maximize their investment return on the investments they had," which they cannot do if they lose money on underwriting.

General Re clients say they have no problems with the deal.

"I would say that we look at it as a positive move," said David Graham, vp at the Royal & Sun-Alliance U.S.A., in Charlotte, N.C. He is the reinsurance buyer for the U.S. operation.

"We always viewed General Re as a quality company with impeccable security," he said. "I would not doubt that it'll strengthen their ability to broaden their market presence and increase their support of key clients like ourselves."

New York-based Reliance Insurance Group, which has a "huge relationship" with General Re, has been "absolutely assured that this (deal) will only advance the relationship," said Robert M. Steinberg, its chairman and CEO.

However, now that General Re is even bigger, "it'll be interesting to see how their culture changes in or-

will have larger capacity for assuming single risks, and other large reinsurers could possibly be left out.

Royal's Mr. Graham said, "I think it would strengthen their ability to be an even greater presence on many individual insurance company programs, but you could say it's up to the individual insurance company to decide whether that's important for them or not."

Some believe the deal will impact small, broker market reinsurers.

"It's going to pose a real challenge to the broker markets, where risks, especially large risks, tend to be parceled out in pieces," said Salomon's Mr. Frank. "To the extent these companies already faced a 'bigger is better' challenge, they certainly face it now, and one would have to think they will have some greater sense of urgency... about combining in various ways to form larger entities," he said.

This could be a "wake-up call" for broker market reinsurers, agreed Alan Murray, vp at rating agency Moody's Investors Service Inc. in New York. "The capital of the combined entity will exceed that of the rest of the entire U.S. reinsurance industry combined, and (Gen Re's) ability to reduce its dependence on the retrocessional

market to increase its underwriting risk limits will most likely put significant pressure on the remaining competitors," Mr. Murray said.

He added, "Let's not forget that broker consolidation has resulted in a smaller number of powerful brokerage firms, but the degree of fragmentation in (in the reinsurance) market may be unsustainable."

Others say the deal will not have a significant impact on other reinsurers.

"I don't see a lot of problems that aren't already there for the rest of the industry," said William J. Adamson, CEO of CNA Re, a unit of CNA Financial Corp. in Chicago.

The challenges facing this market over what to do with its excess capital are the same as before the deal was announced, said John Smithson, chairman of Philadelphia-based PMA Re Corp.

Reliance's Mr. Steinberg said, "I don't think it will have an impact on the market other than it may lead to more consolidation, which I think would happen anyway."

"It won't kill the broker market. I just think it will further solidify General Re's already-solid position," said John L. Ward of the Cincinnati-based Ward Financial Group.

Tal P. Piccione, president and CEO of reinsurance intermediary U.S. Re Corp. in New York, said he thinks the deal will not have a major impact on the broker market. "People no longer want to put their eggs in one basket," he said. "I don't see a monopoly of power, nor do I see a death knell."

"I don't think it's going to have any impact, because it wasn't consolidation. It's just a company that went private," said Richard E. Cole, chairman and CEO of Stamford, Conn.-based Chartwell Reinsurance Co.

But the deal could lead to fewer publicly held reinsurers, said Michael Smith, an analyst with Bear, Stearns & Co. in New York. He noted General Re will now join American Re Corp. and Employers Reinsurance Corp. in ownership by a bigger entity, and together these three reinsurers alone account for more than 40% of the premium reported by the Washington-based Reinsurance Assn. of America.

Other publicly traded reinsurers now will have to decide whether to continue to try to compete, and see their clients leave, see their stock value decline, or be acquired themselves, Mr. Smith said.

"We could well be seeing the beginning of the disappearance of the reinsurance industry from the stock listings," he said. **BI**

Deal tied to stock prices of companies

STAMFORD, Conn.—The acquisition of General Re Corp. for approximately \$22 billion in stock by Omaha, Neb.-based Berkshire Hathaway Inc. is a good one for both sides, say analysts and others.

General Re shareholders will receive about a 29% premium for their stock. Terms of the deal, which is subject to regulatory and shareholder approval, call for them to have the option at closing, expected in the fourth quarter, of accepting either 0.0035 Class A shares or 0.105 Class B shares of Berkshire for each Gen Re share. That would work out to Gen Re shareholders holding about 18% of newly issued Berkshire stock, Berkshire Hathaway Chairman Warren Buffett said at the news conference announcing the deal.

On Friday, June 19, shortly be-

fore the deal was announced, Gen Re's stock had closed at \$220.25 a share, down \$3.25. Berkshire Class A stock closed up \$1,900 at \$80,900, which would yield General Re holders \$283.15 a share. On Friday, June 26, Gen Re stock closed at \$257.03 a share while Berkshire closed at \$78,005.

On June 19, after the deal was announced, 900 shares of Gen Re stock were traded on the Pacific Stock Exchange at \$275 a share, but the trade was reversed, a General Re spokeswoman said. The transaction apparently was an error, because trading had been halted at that point, she said.

At the news conference, Mr. Buffett said, "By using stock, not a dime of equity is leaving the combined enterprises, and we think that's a significant competitive ad-

vantage and sends a terrific message to clients and potential clients around the world who are thinking who's going to be around to pay

'It's a big premium, but Gen Re was an outstanding operation, so I'm not surprised,' says John L. Ward.

claims 10, 15, 20 years from now."

Gen Re was eager to do a stock deal, said its chairman and chief executive officer, Ron Ferguson. It was "almost a requirement, I would say."

"The 29% premium seems rea-

sonable," said John L. Ward, CEO of the Cincinnati-based Ward Financial Group. "It's a big premium, but Gen Re was an outstanding operation, so I'm not surprised there's a premium on the deal."

Ronald Frank, an analyst with Salomon Smith Barney in New York, said, "I think the General Re deal confirms that genuine franchises, even in a difficult market, can command premium valuations."

Analysts generally do not expect any dramatic changes in the stock price of both companies between now and the closing.

However, "between now and then, I can guarantee the interest rate environment is going to change, there could be more news on consolidation, there could be a big hurricane, so there is some un-

certainty," said Jay Cohen, an insurance analyst with Merrill Lynch in New York.

"It almost doesn't matter" what happens to the share price, however, assuming the parties are committed to the deal, said Russell R. Miller, chairman of San Francisco-based insurance investment bank Russell Miller Corporate Finance Inc.

Most observers say arbitrageurs, who try to profit from changes in the stock price of acquirers and their takeover targets, are not expected to play a significant role between now and the closing.

They are likely to be interested only if the deal is going to break up or another buyer comes in, and neither is expected, said Mr. Cohen.

—By Judy Greenwald

E. coli taint hits deli, park

By GEORG SZALAI

CHICAGO—A Chicago-area delicatessen will face additional scrutiny before reopening, and a Georgia water park may implement additional safety procedures after recent outbreaks of E. coli bacteria were traced to the two entities.

Government health authorities still are investigating the causes of the E. coli outbreak traced to Iwan's Deli & Catering in suburban Orland Park, Ill., said a spokesman for the Cook County Department of Public Health in Chicago. The spokesman said it is the largest E. coli outbreak in U.S. history in terms of the number of the people affected.

Authorities in Marietta, Ga.,

Health officials estimate that 5,400 people in the Chicago area were affected by the food.

are looking into their own series of sudden E. coli infections traced to the White Water Recreation Park.

Health officials said potato salad is the likely source of the outbreak traced to Iwan's Deli. As of Friday, 5,400 people were affected, with the number still rising, the health department spokesman said.

The deli catered the salad to 533 parties and sold it over the counter during the first week of June, the spokesman said.

No one could be reached at Iwan's. "They closed voluntarily the day we got first reports," the spokesman said.

Authorities are analyzing samples from the deli to determine whether the potatoes' handling by Iwan's or by a distributor led to the contamination. "We will recommend specific measures, which Iwan's has to meet to reopen," the spokesman said.

In an outbreak of the more virulent form of the bacteria, E. coli 0157:H7, in Georgia, 10 children were confirmed sick, nine of them after visiting the White

Water Recreation Park on June 11 and 12.

Five of the children were diagnosed with a complication that affects blood and kidneys.

"The outbreak was linked to one or two children defecating into a kiddie pool," said Dr. Virginia Galvin, director of the Cobb County Board of Health.

Tests of the water systems showed that the park met all hygiene standards. "They found we were not negligent in any way," said Marketing Director Deedie Dowdle.

The chlorine levels in the pools met normal standards but were overwhelmed. "At the levels at which chlorine could have prevented this outbreak, it would have harmed children," said Dr. Galvin.

Ms. Dowdle refused to discuss liability coverage, but she said no lawsuits had been filed so far.

After the outbreak, the park asked engineering experts to investigate ways to improve water safety, Ms. Dowdle said. The investigation still is in progress. It also will permanently stop admitting any groups of children not with their families because of the greater difficulty in individually monitoring children in large groups, she said.

Several similar incidents of sudden illnesses have been reported recently.

Last week, during a luncheon at Swissotel New York, 28 lawyers were taken to a hospital with an adverse reaction, most likely to tuna, though lab tests are not complete. A spokeswoman said the hotel had liability coverage, but she refused to give details.

Tests proved the hotel kitchen met all hygiene standards, said a spokeswoman for the New York City Department of Health. "The problem was probably that the fish was not properly refrigerated after it was caught," she said.

Three fish distributors are under investigation, said a spokeswoman for the New York City District Office of the U.S. Food and Drug Administration.

The hotel sees no need to change any procedures. "No faults were made by the hotel. We have no reason to take any measures," the hotel spokeswoman said.

Texas

Continued from page 2

defendants to undisclosed limits by Coregis Insurance Co. and New England Insurance Co. would apply, but "they don't have enough to cover this award," Mr. Castro said.

Defense attorneys could not be reached to comment on the case. As of late last week, no appeal had been filed.

The \$18 million award ranks as one of the largest verdicts in a legal malpractice case, according to Jury Verdict Research, a Horsham, Pa.-based firm that maintains a database of verdicts and settlements from personal injury claims.

The database doesn't include every verdict, so it is not known whether the recent award is the largest rendered. It is the highest among those tracked by Jury Verdict Research, ranking above two other Texas verdicts that each topped \$17 million. And while Jury Verdict tracks the awards made by the jury, it does not track whether awards were later reduced or if cases were settled for a lower amount prior to appealing a verdict.

The lawsuit, originally filed in 1996 in state court in Austin, charged that the defendants advised sisters Tracy Streber and Terry Delony that they owed no taxes on \$1.7 million they each received in 1985 from a real estate trust set up by their father.

In 1991, the Internal Revenue

The suit says the sisters racked up penalties and legal fees for the 10 years their attorneys fought the IRS.

Service won a judgment of \$1.6 million from each of the sisters, an amount representing taxes and penalties owed on the proceeds from the trust.

Mr. Castro said the amount was later lowered to \$1 million each, and the sisters have each paid about \$510,000 of the penalties. Interest continues to accrue on the remainder that is owed, he said.

Mr. Castro said that if the sisters had been given proper advice in the beginning, they could have paid taxes of about \$365,000 each

and pocketed the rest of the proceeds from the trust.

The lawsuit says the sisters were racking up not only tax penalties but also legal fees over the 10 years their attorneys fought the IRS. Mr. Hunter charged them more than \$300,000, according to court papers.

The lawsuit charged that the defendants "failed to tell Terry and Tracy that numerous other alternatives existed" in fighting the taxes. "For example...that they had the option to pay the amount of capital gains tax and sue the government for a refund of the taxes paid," the papers state.

In each of several "misrepresentations and failures to disclose," the lawsuit charges, the defendants "profited from rendering such advice in a manner that was negligent, grossly negligent and in breach of their fiduciary duty" to the sisters.

The jury awarded the sisters \$1.6 million in actual damages and \$16.4 million in punitive damages.

Tracy Parker Streber and Terry Parker Davis Delony vs. Edwin Hunter et al.; U.S. District Court for the Western District of Texas; civil action No. A-96-CA-476SS.

Texas comp accord gets nod; similar suit filed in Georgia

AUSTIN, Texas—Texas employers could get refunds of as much as \$131 million in a settlement with the state's residual market insurers.

The settlement got preliminary approval earlier this month by Travis County District Court Judge John K. Dietz. It calls for 197 insurers that wrote retrospectively rated policies for about 2,000 employers in 1991 and 1992 to refund surplus amounts recorded by the Texas Workers Compensation Insurance Facility in those years.

The facility stopped writing coverage at the end of 1993 and is running off its business. It was replaced by the Texas Workers' Compensation Insurance Fund. The Texas Department of Insurance determined that \$131 million was owed to policyholders.

Scott M. Clearman, an attorney with McClanahan & Clearman L.L.P. in Texas, who represented employers, said, based on information provided to the court by insurers, the settlement may reach only about \$85 million.

Mr. Clearman and other attorneys will collect 10.34% of the settlement amount in fees.

The refunds come on top of those already ordered for surpluses in 1993 and 1994 (BI, March 16; July 28, 1997; July 14, 1997).

Liberty Mutual Insurance Co. and Orion Group are not participating in the settlement but have complied with a Texas Department of Insurance order to refund amounts owed to employers while they continue to litigate the issue.

Once the settlement gets final approval, expected in July, the insurers will have 30 days to make the refunds.

In a similar action, a group of national employers with operations in Georgia is seeking class-action status in their suit against 91 insurance companies they claim defrauded them of more than \$1 billion in workers compensation premiums.

In their suit, filed earlier this month in Richmond County, Ga., Superior Court in Augusta, the employers claim the insurers overcharged them for their retrospectively rated workers comp insurance policies since the mid-1980s. The group is seeking compensatory and punitive damages, legal costs and an end to what they allege are illegal billing and business

practices. The suit also names the National Council on Compensation Insurance, which administers Georgia's residual market pool.

"The allegations against NCCI are clearly without merit and have absolutely no basis in fact," said Terrence Delehanty, vp, associate general counsel for the Boca Raton, Fla.-based association. "Our activities are, and always have been, openly scrutinized and lawful in every respect. NCCI continues to be focused on providing a viable workers compensation environment in Georgia, and we will vigorously defend against such spurious and manufactured claims."

A spokeswoman for Georgia Insurance Commissioner John W. Oxendine's office said the state Insurance Department learned of the employers' complaints only after the suit was filed. "We're currently looking into the matter," she said. "If anybody has a complaint, they should call the commissioner's consumer services division."

"None of these plaintiffs filed a complaint with the commissioner ahead of time," the spokeswoman said. "They didn't involve us at all."

—By Michael Bradford and Rodd Zolkos

Roofing materials, not sprinkler, blamed in casino fire

By DAVE LENCKUS

LAS VEGAS—Fire investigators have "initially determined" that roofing materials caused a blaze that gutted a Las Vegas-area casino earlier this month and no longer think the design of the casino's sprinkler system was a contributing factor.

The system activated and would have controlled the fire at the Gold Strike Inn & Casino had not a fire-ravaged decorative rooftop structure collapsed, causing the system's main water pipe to burst, said John Hall, deputy fire marshal with the Clark County Fire Department in Las

Vegas.

Fire investigators initially were concerned that the system was not designed to throw enough water on the Gold Strike's roof line (BI, June 22).

An early-morning fire at the remote facility on June 16 gutted its 40,000-square foot casino and caused heat and smoke damage to a few of the inn's 178 guest rooms. No one was injured in the blaze. The entire facility, about 25 miles south of Las Vegas, in unincorporated Clark County, has been closed indefinitely.

A fire department spokesman said the Gold Strike's owners estimated property damage and

business interruption losses at between \$20 million and \$30 million. But an official with Gold Strike's property insurer, Affiliated FM Insurance Co. in Woodland Hills, Calif., said that estimate sounds high.

According to Mr. Hall, the fire did not begin on the ground and climb an exterior wall, as fire officials initially suspected based on eyewitness reports. He said the fire began on the roof at the base of a decorative wooden structure simulating a mine derrick.

The department is "95% sure" that roofing repair equipment left on the casino's roof sparked the blaze, he said. Mr. Hall noted that

Gold Strike personnel saw propane-fueled torches that had been used the previous day in a roofing project lying near the structure a few hours before the fire began.

The unenclosed structure was not outfitted with a sprinkler system, but that did not violate local fire codes, Mr. Hall said. A sprinkler system generally would be ineffective in controlling a fire in an unenclosed structure, because not enough heat would build up to activate the system in time to do any good, he explained.

As fire consumed the structure, it collapsed onto the casino's roof. The resulting violent roof vibra-

tion snapped the sprinkler system's three-inch main water pipe, Mr. Hall said.

The sprinkler system had upright heads designed to control roof fires, Mr. Hall said. If the derrick had not collapsed, the sprinkler system would have had "no problem" controlling the fire until firefighters arrived, he said.

Because of the facility's remote location, the response time of the nearest fire department is 15 to 20 minutes. The response time for the Clark County Fire Department, which has primary responsibility for unincorporated areas, is five to 10 minutes longer, a fire official has said.

Seeing signs of a market turn

Risk managers have to know something is up.

The signs should be clear even to those who don't watch "The X Files" or suffer from paranoia. For those of you still in the dark, I'll tell you what the signs point to: a plot by those in the know to take control of the insurance world and raise prices with abandon.

Consider the evidence. Banks chomping at the bit to enter the insurance marketplace, spending their hard-earned money to lobby lawmakers to let them have a piece of the pie. Lehman Brothers forming a reinsurance company in Bermuda, while other investment bankers set up special-purpose reinsurance vehicles in the Caymans. And to top it off, legendary investor Warren Buffett is jumping headlong into the fray with a \$22 billion acquisition of General Re.

These investors aren't in the business of making money-losing business decisions or investments.

Then there are the umpteen mergers and acquisitions roiling the insurance industry as companies jockey to gain ever bigger shares of the market. Look at Travelers and Citibank. Zurich and B.A.T. Winterthur and Credit Suisse.

It seems ludicrous if one looks at the prices being charged in today's market that anyone would want to get into the insurance business. Rates are incredibly low—and have been for years. Even auto insurers like State Farm are rebating hundreds of millions of dollars to policyholders.

Can investing barely break-even premiums be that lucrative? It's quite a gamble to spend billions of dollars to acquire an insurance company on the bet that the stock market is going to continue to scale new heights and keep yielding record investment returns.

So how are they going to make money with all of these new and bigger insurance companies? From you, of course.

The only answer I see is that they somehow know rates are going to go way up. Raising rates is how insurance companies used to make money, in what many an insurance executive no doubt fondly recalls, with a tear in one eye, as "the good old days."

The question then becomes, What will drive rates up?

It can't be that the insurers all suddenly decide to unilaterally raise rates. They tried that in the 1980s and found themselves embroiled in massive antitrust litigation with the states.

It could be that they are in league with the meteorologists and seismologists of the world and have some inside dope on when the Big One will hit. The Big One being any of major natural calamities, such as a big earthquake or hurricane, striking a heavily insured U.S. population center. Or, if one is to lend credence to recent Hollywood fare, a volcano emerging in any of a number of urban centers or big asteroids heading for a planet near you.

Perhaps insurers have been rereading their old liability policies and have stumbled across a ticking time bomb of an exposure that is inevitably going to explode, creating losses of a magnitude that will trigger a hard market. For example, do we really believe that insurers were savvy or prescient enough before the Surgeon General's warning on tobacco to exclude from coverage liability for smoking-related claims? Or that tobacco companies would not even try to tap old liability policies for their hundreds of billions of dollars in liabilities?

Or maybe they know the Year 2000 problem is going to be a lot worse than anyone has imagined and the resulting financial and societal meltdown will create a seller's market.

Maybe it's just as simple as knowing that many insurers after years of low pricing and cutthroat competition are nearing bottom, or will make that hard landing if the stock market turns, and rates will have nowhere to go but up. "Buy low, sell high" is the investor's credo.

Or all of the above.

Whatever the catalyst may be, the signs are there that there is money to be made in insurance. And you can bet you will pay a lot more for insurance in the near future. Because they're betting on it.

Editor Paul D. Winston and Publisher and Editorial Director Kathryn J. McIntyre publish columns on alternate weeks.



Paul D. Winston

Title VII

Continued from page 1
applauded by business groups.

"The court really sets out the framework for litigating these cases, and provides a way for plaintiffs to claim employer liability, as well as defense for employers that have adopted reasonable procedures to prevent harassment. This is an area of law that has been confusing in the courts, and we're thankful that the court has laid down some clear principles to apply," said Quentin Riegel, deputy general counsel for the National Assn. of Manufacturers in Washington.

The *Faragher* case involved a former municipal lifeguard who alleged sexual harassment at the hands of her immediate supervisors but who did not pursue a complaint up the chain of command (*BI*, March 30). Two years after leaving her employment, however, Ms. Faragher sued the city of Boca Raton, Fla., for allowing the creation of a "sexually hostile atmosphere" despite the facts that she had not pursued her claim while employed and that the city had a written policy against sexual harassment.

The *Ellerth* case involved allegations of so-called "quid pro quo" sexual harassment, in which an employee is pressured to submit to a supervisor's sexual advances to avoid retaliation (*BI*, April 27). Ms. Ellerth charges she was crudely approached by her immediate supervisor but rebuffed his advances. She did not, however, suffer negative job consequences and, in fact, was promoted before she left Burlington Industries.

Like Ms. Faragher, she never pursued her complaint up the company's chain of command despite being aware of Burlington's anti-harassment policies. Also like Ms. Faragher, she later sued her former employer, claiming it had violated Title VII.

Writing for the majority in *Ellerth*, Justice Anthony Kennedy wrote that the "terms 'quid pro quo' and 'hostile work environment' are helpful, perhaps, in making a rough demarcation between cases in which threats are carried out and those where they are not or are absent altogether, but beyond this are of limited utility" and noted further that those terms appear nowhere in the Civil Rights Act.

After discussing the nature of principles of vicarious liability, whereby an employer is responsible for the actions of its supervisory personnel, Justice Kennedy spelled out the defense an employer can take in such cases.

"(We) adopt the following holding in this case and in *Faragher vs. Boca Raton*, also decided today. An employer is subject to vicarious liability to a victimized employee for an actionable hostile environment created by a supervisor with immediate (or successively higher) authority over the employee.

"When no tangible employment action is taken, a defending employer may raise an affirmative defense to liability or damages, subject to proof by a preponderance of the evidence . . . The defense comprises two necessary elements: (a) that the employer exercised reasonable care to prevent and correct promptly any sexually harassing behavior; and (b) that the plaintiff employee unreasonably failed to take advantage of any preventive or corrective opportunities provided by the employer or to avoid harm otherwise.

"While proof that an employer had promulgated an anti-harassment policy with complaint procedure is not necessary in every instance as a matter of law, the need for a stated policy suitable to the employment circumstances may appropriately be addressed in any case when litigating the first element of the defense. And while proof that an employee failed to fulfill the corresponding obligation of reasonable care to avoid harm is not

limited to showing any unreasonable failure to use any complaint procedure provided by the employer, a demonstration of such failure will normally suffice to satisfy the employer's burden under the second element of the defense.

"No affirmative defense is available, however, when the supervisor's harassment culminates in a tangible employment action, such as discharge, demotion, or undesirable reassignment," the opinion stated.

The decisions, both of which drew dissents from Justice Clarence Thomas and Chief Justice William Rehnquist, allowed Ms. Ellerth to continue pursuing her case and reinstated Ms. Faragher's case.

In his dissent in *Ellerth*, Justice Thomas blasted his colleagues.

"The court today manufactures a rule that employers are vicariously liable if supervisors create a sexually hostile work environment, subject to an affirmative defense that the court barely attempts to define. This rule applies even if the employer has a policy against sexual harassment, the employee knows about that policy and that employee never informs anyone in a position of authority about the supervisor's conduct. As a result, employer liability under Title VII is judged by different standards depending upon whether a sexually or racially hostile work environment is alleged. The standard of employer liability should be the same in both instances: An employer should be liable if, and only if, the plaintiff proves that the employer was negligent in permitting the supervisor's conduct to occur," wrote Justice Thomas.

Employment law experts, however, tend to view the majority's detailing of the affirmative defense as a significant positive development for employers.

"One important aspect of this case is that it is the first time that the court has placed a burden on the employee to come forward and complain about sexual harassment to the employer," said Susan Mahallati Kysela, labor counsel for the National Chamber Litigation Center Inc. in Washington. "The decisions also encourage employers to implement sexual harassment policies and to take steps to combat sexual harassment in the workplace. The affirmative defense is good for employers because it appears that employers that take action to prevent sexual harassment may not be held liable," she said.

"I don't think it exposes employers to more serious litigation liability," said Cynthia Glass Bivins, chair of the Chicago-based Defense Research Institute's Employment Law Committee.

"I think that most employers currently are very liability-conscious regarding sexual harassment cases. I think most employers already have in place policies and procedures for employees to follow if they believe that have been sexually harassed, and because of that, most employers, I think are in a pretty good position," said Ms. Bivins, who is also a partner in the San Antonio office of Dallas-based law firm Jenkins & Gilchrist.

Another employment law expert, however, said that the opinions will mean new headaches for employers.

"What a gift to the plaintiffs' bar," said Gerald L. Maatman Jr., a partner in the Chicago law firm Baker & McKenzie in charge of the firm's employment law practice.

"I believe it is a gift to the plaintiffs' bar because potentially, the Supreme Court could have adopted positions to dramatically cut back on sexual harassment litigation. I believe it also now makes the jobs of the human resource manager and risk manager even more important than before because of their jobs in disseminating a sexual harassment policy, making sure all employees are aware of it and diligently responding by way of inves-

tigation of any complaints," he said.

In spite of the prospect for increased litigation, Mr. Maatman added, "I think that on the merits and on the facts, employers now will be able to defend themselves in front of the jury if they have good policies and good protocols for enforcing those policies."

The two cases were the third and fourth sexual harassment cases decided by the Supreme Court during its just concluded session. In *Joseph Oncale vs. Sundowner Offshore Services Inc.*, the justices ruled that Title VII applies to same-sex sexual harassment cases as well as cases involving men and women (*BI*, March 9). And, only four days before the *Ellerth* and *Faragher* decisions, the justices ruled in *Gebser, Star, et al. vs. Lago Vista Independent School District*, that school districts enjoy immunity from monetary liability for the sexual misconduct of teachers with students provided that school district officials aren't aware of the conduct.

In another case handed down last week, the high court ruled that people infected with the HIV virus are protected by the Americans With Disabilities Act even if they show no signs of illness. *Randon Bragdon et al. vs. Sidney Abbott, et al.*, stemmed from Dr. Bragdon's refusal to fill a cavity in one of Ms. Abbott's teeth after she disclosed on a patient registration form that she had an HIV infection. Dr. Bragdon said he had a policy against filing cavities of HIV-infected patients in his office but offered to perform the dental work at a hospital at no extra cost, provided Ms. Abbott picked up the cost of using hospital facilities. Ms. Abbott refused, and sued under both Maine state law and the ADA, claiming she had been discriminated against because of her disability.

Four justices joined Justice Anthony Kennedy in the majority opinion upholding Ms. Abbott's right to pursue a claim of discrimination under the ADA.

After discussing the particulars of HIV, Justice Kennedy took up Ms. Abbott's argument that HIV led her to suffer an impairment of a "major life activity"—her inability to bear children—which would therefore qualify as a disability under the ADA. He wrote that "we have very little difficulty concluding" that reproduction is indeed a major life activity.

That finding could give weight to employee claims that group health plans that do not cover infertility treatment are discriminatory.

The high court also agreed last week to take up some cases of interest to employers, though oral arguments have not yet been scheduled.

Ortiz vs. Fibreboard Corp. involves a challenge to a 5th U.S. Circuit Court of Appeals ruling upholding a more than \$1.5 billion class-action settlement of asbestos injury claims. The high court also agreed to review an 11th U.S. Circuit Court of Appeals decision in *Kuhmo Tire vs. Carmichael* regarding standards for the review of expert testimony. Another case the justices will hear—*Humana Inc. vs. Forsyth*—revolves around the question of whether the McCarran-Ferguson Act, which grants regulation of insurance to states, pre-empts a suit alleging fraud against a health insurer brought under the federal Racketeer Influenced and Corrupt Organizations Act.

Beth Ann Faragher vs. City of Boca Raton, U.S. Supreme Court, No. 97-282, Decided June 26, 1998.

Burlington Industries Inc. vs. Kimberly B. Ellerth, U.S. Supreme Court, No. 97-569, Decided June 26, 1998.

Gebser, Star et al. vs. Lago Vista Independent School District, U.S. Supreme Court, No. 96-1866, Decided June 22, 1998.

Randon Bragdon et al. v. Sidney Abbott et al., U.S. Supreme Court, No. 97-156, Decided June 25, 1998.

Privacy

Continued from page 2
administrators or claims investigators.

As a result of the changes, "it will not be the litigation free-for-all it could have been," said John Lennes Jr., vp-workers comp for the Alliance of American Insurers in Schaumburg, Ill.

However, a significant problem remains in the model's overly broad definition of "health information," according to Donald S. Cleasby, assistant general counsel for the National Assn. of Independent Insurers in Des Plaines, Ill.

As a result of that broad definition, property/casualty insurer representatives fear their companies may not be able to shield from a claimant's attorney such information as video surveillance reports of malingering workers, which companies use to prosecute workers comp fraud or to speed return to work.

The proposed NAIC model applies to health and property/casualty insurers and workers compensation self-insurers and health maintenance organizations. Its purpose is to set standards to protect health information from unauthorized collection, use and disclosure by requiring insurers to establish procedures for the treatment of all health information.

If enacted, insurers would have to be more cognizant of claimants' privacy rights, have procedures to track alleged violations of privacy rules and encourage other service providers to follow the privacy guidelines without having to monitor them.

Such activities would likely increase operational costs, though no specific estimates were available, said Bruce C. Wood, assistant general counsel with the American Insurance Assn. in Washington. However, enactment of the model is not expected to interfere with insurers' normal claims-handling procedures, he added.

Four years of on-and-off drafting work ended last week in more than six hours of public sessions in which dozens of specific amendments were considered by the NAIC's

Health Information & Privacy Working Group and its parent, the Regulatory Framework Task Force.

The proposed model then was adopted by the NAIC's Accident & Health Insurance Committee, which will submit it for formal NAIC approval at the organization's fall meeting Sept. 12-16 in New York. Approval is expected, which then would make the model law available for states to adopt.

"I think it's a huge step forward for consumers in the country" and will provide "meaningful protections," said Kansas Insurance Commissioner Kathleen Sebelius, who chairs the Accident & Health Insurance Committee.

Before changes were made at the meeting, though, representatives of several insurer trade associations warned that provisions in the proposed model would be a huge step

Insurers must be able to 'ascertain the legitimacy and extent to which an injury has occurred,' says John Lennes Jr.

backward toward increased litigation in the no-fault workers comp system.

They also warned before the meeting that the measure also would have increased administrative requirements and costs because of the need to establish extensive control procedures to safeguard claimants' privacy rights.

However, individuals' privacy needs must be balanced with property/casualty insurers' special needs, said Mr. Lennes of the Alliance. "To pay claims fairly and effectively, property/casualty insurers must have the ability to ascertain the legitimacy and extent to which an injury has occurred," he said.

Insurer trade group representatives said they faced a special hurdle, because most of the model's drafters were knowledgeable about health insurance but not about the health-related aspects of property/casualty insurance, particularly workers comp.

PBGH

Continued from page 3

The PBGH also gave doctor groups the opportunity to rank the HMOs with which its member companies contract.

Aetna U.S. Healthcare "was perceived as one of the two worst groups across all performance dimensions save quality," the PBGH reported. The health plan appears to have difficulties with consumer education and referral activities, according to doctor groups surveyed by the PBGH.

Across many overall performance categories, doctor groups perceived Blue Cross of California as the second-worst HMO for them to do business with. However, more detailed questions of doctors revealed that Blue Cross was often rated in the top half of HMOs in the state for such factors as working with doctor groups on electronic transfer of enrollment and encounter data, adjusting capitation payments for age and gender, and providing financial incentives for quality performance.

PacificCare and Health Net were ranked as the two best plans across several performance categories.

Surveys such as PBGH's are beneficial and provide direction for improvement, said representatives for both Aetna and Blue Cross.

Although Blue Cross was rated

highly for several factors in several categories, the PBGH summary of its findings focused on the negative aspects, a Blue Cross spokeswoman complained. Additionally, she said it is hard to determine how the PBGH weighted individual performance factors in each category, making it hard for the health plans to understand the overall results. Some of the negative findings, in quality for example, contradict Blue Cross of California's recent accreditation from the NCQA.

In Aetna's case, the health plan knew that its mid-1996 merger with U.S. Healthcare would hamper administration and operations, including doctor relations, an Aetna spokesman said. PBGH's survey results could reflect that, he suggested.

The merger is now complete and Aetna is in a better position to provide member services, compared with a year ago, he added.

In addition, the Aetna spokesman said the PBGH survey may be skewed because it is completed by provider group administrators, rather than practitioners who actually deal with the managed care plans.

In addition to the survey results, the PBGH last week reported 1999 rates it has negotiated with HMOs.

The coalition's member employers will spend 3.8% more on average in HMO premiums in California for 1999, excluding contracts with

Fifteen industry groups—including insurer trade groups, agents associations, the National Council on Compensation Insurance and the Insurance Services Office Inc.—responded by forming a coalition and presenting its own proposed model at the summer NAIC meeting.

Although working group regulators did not adopt the industry draft, it became clear during lengthy discussions that they had read and accepted significant portions of it.

"I think that the industry coming together had a profound impact," said the AIA's Mr. Wood.

But the industry's lobbying effort was constrained by a limited opportunity for comment during the NAIC committee's hearing process. The model's controversial health information definition was not discussed or amended at the meeting, the NAII noted.

"For a model that has had this much attention and controversy, you usually don't see such rapid succession through the parent committee after it gets out of the working group. Usually there is an opportunity for a public hearing or a public forum at the parent committee," said Mr. Cleasby of the NAII.

The NAIC's development of the proposed model was hastened by passage of the Health Insurance Portability and Accountability Act of 1996, which requires that Congress pass privacy legislation by April 1999 or else such standards will be imposed by the federal Department of Health and Human Services (BI, April 27; March 30).

Mr. Cleasby summarized the NAIC's argument as: "Congress is moving on something that could be a lot worse than what you'll see coming out of the NAIC, so we have to get moving."

However, Ms. Sebelius said regulators were primarily motivated by a philosophical desire to bring the four-year drafting process to a close and in accordance with a timetable announced earlier this year.

Consumer representatives were disappointed more was not done to protect their interests in enhancing the privacy of personally recognizable medical information from dissemination to outsiders, including researchers. **BI**

Kaiser Permanente.

Kaiser's rates will be sharply higher due to the HMO's losses and rapid growth, though the PBGH did not disclose its expected rate increase. When Kaiser is included, the PBGH's premiums will increase 8.1% on average, the PBGH reported.

Rising drug costs, health plan financial losses, and the uncertainty of looming health care legislation were major challenges in the PBGH's negotiation process with HMOs.

"In spite of this cost pressure, we were very pleased that most health plans stayed in line" with the medical component of the Consumer Price Index, said Sherrie Matza, chair of PBGH's Negotiating Alliance and senior vp in benefit planning for Bank of America in San Francisco "However, we were especially disappointed with the rate action of our largest carrier, Kaiser."

As a result, some PBGH member employers may freeze Kaiser enrollment in 1999 or add other, lower-cost HMOs to their offerings, the PBGH said.

In Arizona, coalition members will see a 4.2% increase in HMO premiums, where the coalition entered its second year of negotiations.

More information on the PBGH's Physician Group Survey to Assess HMO Performance will be available later this summer on the World Wide Web at <http://www.healthscope.org>.

Updates

Tobacco ruling to be appealed

Continued from page 2

jury award against Brown & Williamson Tobacco Corp.

"We certainly aren't going to just let it stand," said Stephanie Hartley, an attorney with Spohrer, Wilner, Maxwell, Maciejewski & Matthews, the Jacksonville, Fla.-based firm that represented plaintiff Grady Carter.

But if it does stand, Ms. Hartley said the outcome should not affect the more than 100 cases the firm has pending against tobacco companies. The uniqueness of the Carter case means decisions related to it would not apply to other lawsuits, she said.

Brown & Williamson cheered the decision and said in a statement it "will be reviewing the applicability of the Carter decision" in its efforts to overturn a \$950,000 jury award earlier this month in Florida to the family of a smoker who died from lung cancer (BI, June 15).

Ms. Hartley said late last week that plaintiffs attorneys are undecided on what action to take to fight the June 22 decision, but they are considering asking for a rehearing in U.S. District Court.

A three-judge panel was unanimous in tossing out the \$750,000 award, saying in a written opinion that the case should never have been heard because Mr. Carter waited too long to file suit. The Florida statute of limitations gave him four years from the time he became aware of his condition to file an action, the opinion states.

Mr. Carter filed suit in February 1995, charging that cigarettes he smoked from 1947 until January 1991 caused his lung cancer. The judges said he was aware of his smoking-related health problems in February 1991. Ms. Hartley contends that Mr. Carter was not aware of his lung condition until later.

The judges also ruled that plaintiffs attorneys arguments that cigarette warnings were inadequate should not have been allowed. Federal law prohibits state actions claiming that warnings on tobacco products after 1969 are inadequate.

Ms. Hartley said attorneys' failure-to-warn arguments were based on labeling before 1969.

Asbestos settlement approved

PITTSBURGH—A federal district judge and a bankruptcy judge in Pittsburgh have approved a reorganization plan that will create a \$103 million trust fund to pay thousands of asbestos-related claims.

The agreement ends years of litigation and bankruptcy proceedings involving H.K. Porter Co. Inc., a locomotive maker that from 1959 to 1973 had asbestos-related operations.

Porter filed for bankruptcy protection in 1991 under the weight of more than 70,000 asbestos suits, according to court papers. Claimants sued the company's late owner, Thomas Mellon Evans, in 1992, alleging he removed assets from the company to avoid paying those claims. Last week's settlement ends that litigation.

Under the settlement, Evans' estate will contribute \$31 million into the fund and the Pennsylvania Insurance Guaranty Assn. will add another \$25 million, said Philip Milch, an attorney with Pittsburgh-based Campbell & Levine L.L.C. Mr. Milch, one of the plaintiffs' attorneys handling the case, said the guaranty association is contributing to the fund in place of several small insurers that went bankrupt. Combined with \$47 million already in Porter's coffers, these funds will create the pool to pay claimants. At last count, more than 120,000 claims existed, but that figure is expected to rise to more than 500,000, court papers state.

It is estimated that the total value of all claims could exceed \$2 billion. A trustee has been appointed to manage the fund, and due to the large number of claims, it's expected that each claimant will receive about 5% of the value of their claims.

Supermarket roof collapses

NORTH RIVERSIDE, Ill.—A roof of a Dominick's Finer Foods Inc. supermarket in west-suburban Chicago collapsed Friday morning as roofers were repairing part of the roof above the produce section, said a local fire chief.

The North Riverside, Ill., store is part of a mall owned by the Indianapolis-based Simon DeBartolo Group, which also manages the supermarket, a spokeswoman for the developer said. Information about insurance coverage was not immediately available, she said. Dominick's executives, many of whom were on the scene, were not available for comment.

No information was available on the roofing company.

Twelve injured customers were taken to two nearby hospitals, including an 82-year-old woman who needed to be extricated from the rubble. She was in fair condition Friday afternoon. All the other injured were released after suffering minor injuries, hospital spokespersons said.

Briefly noted

The Supreme Court last week declined to review and thus let stand a 4th U.S. Circuit Court of Appeals decision striking down a Maryland regulation that says stop-loss insurance must have at least a \$10,000 attachment point for specific health care claims and an aggregate attachment point of 115% for expected claims. The appeals court said the Maryland regulation was pre-empted by the Employee Retirement Income Security Act (BI, April 28, 1997). . . . The Senate has added its approval to two House measures designed to reform the Occupational Safety and Health Administration. One would prohibit OSHA from using a quota system based on inspections, citations issued and penalties assessed to measure inspector performance. The other would codify the agency's consultation program that assists small businesses in their efforts to improve workplace safety by allowing employers that use the service and improve safety to avoid random inspections for a year. . . . Congressional Republican leaders are promising to take up tobacco control legislation following the recent demise of a comprehensive tobacco bill in the Senate.

Lloyd's

Continued from page 2

considerations rather than enshrined in a regulatory framework."

A recent joint market submission to the U.K. Treasury on broker regulation implied that the status of a Lloyd's broker may be dropped at some point.

In addition to expanding its distribution system, Lloyd's intends to also extend its presence geographically. Speaking at a news briefing after the meeting, Lloyd's Chief Executive Ron Sandler said a study group is looking into prospects for expansion in Southeast Asia, while other areas of interest include Latin America and Eastern European countries.

Lloyd's already has a contact office in Hong Kong, and members of the market have shown interest in developing a Singapore operation.

Lloyd's presence in its target markets will depend on local regulatory requirements, said Mr. Sandler. Lloyd's can enter these foreign countries through a variety of structures, such as opening a local contact office, or having an actual underwriting presence, as it does with its Lloyd's Japan Inc. operation.

"Our worldwide licenses will have been expanded further, and flexible low-cost structures will have been fashioned to reflect local

regulatory requirements overseas," Mr. Taylor told the meeting. Underwriters taking advantage of these overseas offices will be expected to fund them on a "user pays" basis, which is the basis for the charging structure brought into the Corporation of Lloyd's at the beginning of last year.

In addition, captive insurance syndicates are likely to be allowed, and Lloyd's will offer other alternative risk financing products, such as blended financial and insurance products and multiyear contracts, broadening the market's appeal to buyers.

The future also will bring simplified regulation at Lloyd's, partly because of changes Mr. Taylor anticipates in the market's capital structure.

The issue of who will comprise Lloyd's capital suppliers has become "emotive and controversial," Mr. Taylor acknowledged, and he categorically stated that no unlimited liability name will be forced to relinquish his or her preferred form of trading at Lloyd's.

But in the face of "unrelenting" competition in the insurance market, "Lloyd's ability to compete is under threat, and this calls for a vigorous response on many fronts," Mr. Taylor told the meeting.

This means companies in the market "need to take bold steps in order to create sustainable competitive advantage for their members," he said.

The annual joint venture makes it difficult

for entities to make long-term investments in product development and distribution, as well as offer multiyear products, he noted.

In response, many managing agencies are likely to adopt a structure involving continuous capital, dedicated to the syndicates for an undefined period of time.

The trend of capital provided by corporate members aligned with a particular syndicate, already representing about half of 1998's underwriting capacity, will continue and, as a result, these vehicles will start accounting on an annual basis, rather than the three-year system under which Lloyd's now operates.

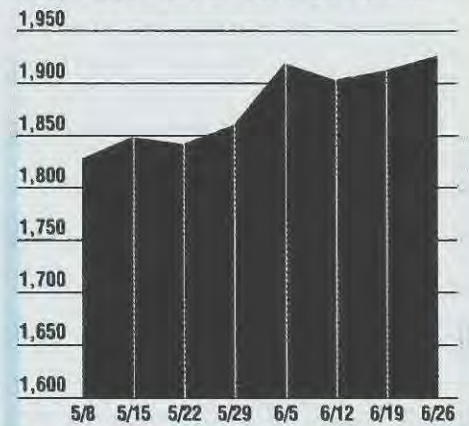
But the Council of Lloyd's is committed to continuing to support the annual joint venture mechanism as long as it is wanted, he said. Welcoming different forms of capital provision is a strength of the market, Mr. Taylor added.

Many of the 485 Lloyd's members attending the meeting were not pacified and said they were still concerned unlimited liability names eventually may be edged out of the market.

Former Council member the Dowager Rona Delves-Broughton demanded a categorical statement that the Council will enshrine the concept of the annual joint venture in regulation, ensuring it will be "set in stone."

Mr. Taylor replied it was not in his power or the Council's to make such a guarantee "in perpetuity" but restated the market's current commitment to individual names. **BI**

BI Insurance Index



Base=100 on Dec. 29, 1978

Source: Nordby International Inc. (nordby.com) Boulder, Colo.

PCS catastrophe options

As of June 26	Call spread	Price bid/ask	Call spread	Price bid/ask
National Annual 1998			California Annual 1998	
40/60	7.5/-		80/100	-1.1
60/80	7.8/9.0		150C	1.2/1.8
80/100	4.0/7.0		Western Annual 1998	
Southeastern September 1998			40/60	-2.2
40/60	2.6/3.3		80/100	-1.7
Northeastern September 1998			150C	1.1/1.8
100/150	0.9/1.4		Eastern September 1998	
Florida September 1998			20/40	2.7/5.5
40/60	1.0/2.4		40/60	2.7/3.5

Total volume: 80 Total open interest: 21,015

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

CIGNA

Continued from page 2

The state Supreme Court's June 23 action means that CIGNA, the Insurance Department and those who oppose CIGNA's reorganization are back to where they have been for more than 14 months: waiting for the court to decide whether it will agree to review the lower court's decision.

As of June 5, the court already had taken twice as long to rule in the matter as called for under its self-imposed guidelines.

CIGNA implemented its restructuring plan shortly after Ms. Kaiser approved it in February 1996. CIGNA used a unique Pennsylvania corporate division law to split its lead property/casualty subsidiary in half to form an ongoing operation and a runoff facility for most of CIGNA's liabilities.

Opponents of the restructuring—about three dozen policyholders and five competing insurance groups—said they had no way to determine whether the runoff facility was adequately capitalized and reserved. And, they said, the restructuring violated state

novation laws nationwide, because CIGNA did not obtain policyholders' approval before moving their liabilities to the runoff facility.

CIGNA officials have said the plan fully funds the insurer's long-tail liabilities three times over. And they have said the restructuring was engineered through a series of mergers that did not require policyholder approval.

After the state Supreme Court's June 5 action, an Insurance Department spokeswoman said the department would determine what impact, if any, the Commonwealth Court's ruling had on CIGNA's structure.

CIGNA says that the litigation concerns departmental procedural matters that do not impact CIGNA's restructuring.

The insurer was not preparing any motion in response to the Supreme Court's June 5 orders, a spokesman said. "We were content to see the matter returned to the Insurance Department, if that's what the court ordered."

The department was in the process of filing a motion with the state Supreme Court when it learned the court had vacated its

earlier orders, the spokeswoman said. The department decided not to file the motion, the nature of which the spokeswoman would not disclose.

Three of the attorneys representing CIGNA's critics said they had never seen the state Supreme Court take such action when no one had filed any motions that complained of any irregularity surrounding a ruling.

Supreme Court officials confirmed that no party in the case had filed any motions since June 5. But the officials said the court's latest action—while unusual—is not unprecedented.

The CIGNA spokesman said, "No matter how the case moves forward, nothing will change the fundamental strength of our restructuring."

A.M. Best Co. last week reaffirmed its A-rating for CIGNA's ongoing operation. CIGNA designed the restructuring to obtain an A rating from Best so the ongoing operation could retain and attract quality risks.

Best also reaffirmed its B+ rating for the runoff operation, noting the facility's favorable runoff trends. **BI**

British Issues

	Price	P/E	Div.	Yield	52-week
Companies	pence		pence	%	high-low
Comm & Gen	NA	NA	NA	NA	NA-NA
Gdn Royal Exch	365	5.3	12.1	3.3	495-263
Legal & Gen	644	16.2	12.7	2.5	785-400
Royal & Sun	618	16.7	22.8	3.6	825-443
Brokers					
Lmbt Fenchurch	103	NA	5.7	7.1	138-101
Lloyd Thompson	180	11.9	10.0	7.0	196-151
Sedgwick Grp	125	11.2	7.0	5.6	171-115
Willis Corroon	152	12.9	6.8	5.6	174-116

Note: Prices are June 26 closings; other numbers from June 25.

Source: Nordby International Inc. (nordby.com) Boulder, Colo.

BI Industry Stock Report JUNE 22, 1998, THROUGH JUNE 26, 1998

BROKERS

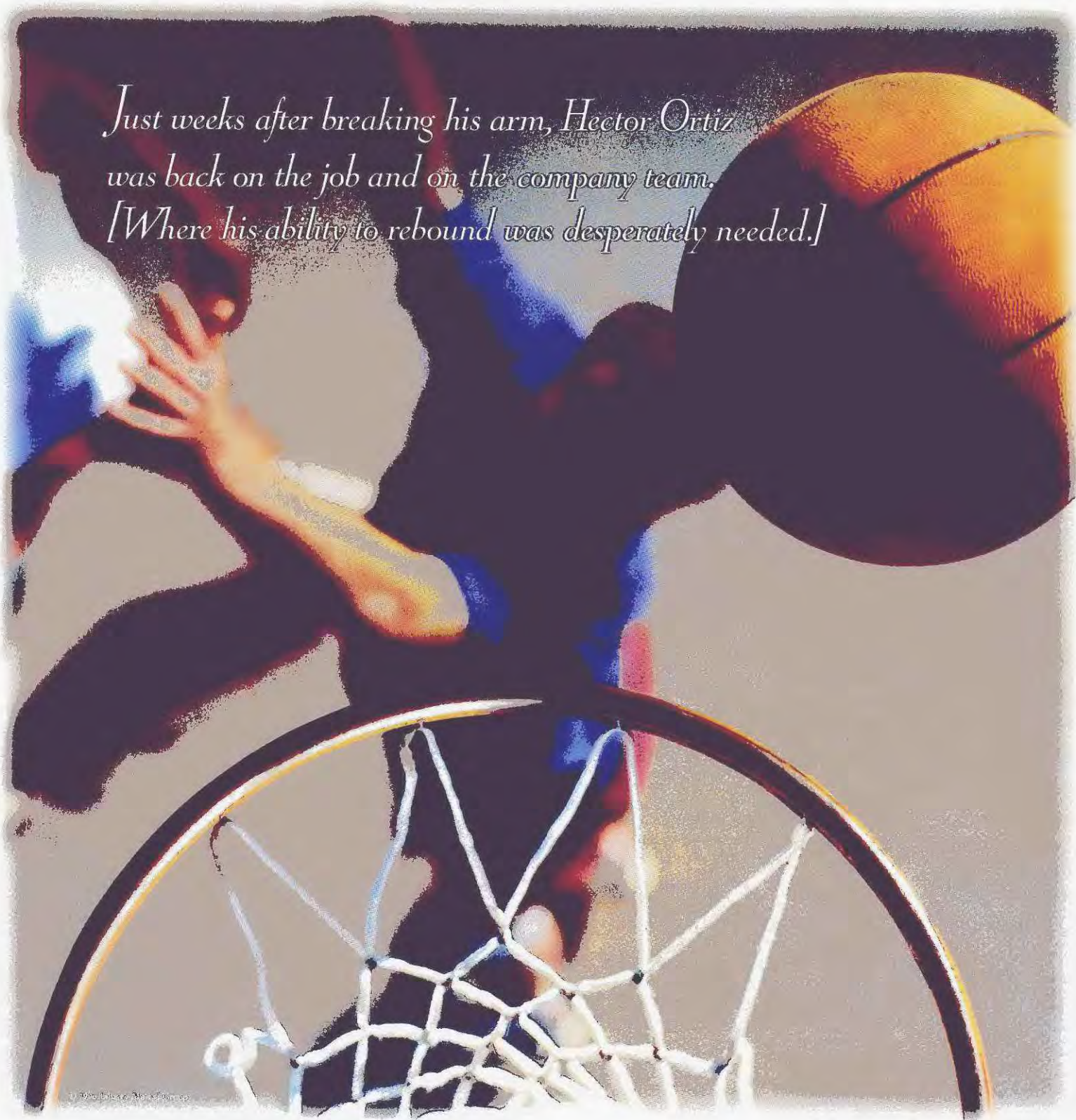
	Price	Weekly % change	Year to date % change	52-week High	Low	Vol.(000)
Aon Corp.	NYS	71.13	7.26	21.32	71.13	50.00
E.W. Blanch Holdings Inc.	NYS	36.75	1.73	6.72	38.75	26.13
Gallagher Arthur J. & Co.	NYS	45.63	7.83	32.49	46.56	33.56
Hibb, Rogal & Hamilton	NYS	15.56	-0.80	-19.42	19.63	15.38
Kaye Group Inc.	NDQ	6.63	-3.64	0.00	9.00	4.88
Marsh & McLennan	NYS	89.94	6.51	20.62	94.88	66.00
Poe & Brown	NYS	37.00	1.20	24.37	39.38	22.00
Sedgwick Group PLC	NYS	10.88	-0.57	-11.68	14.44	9.38
Willis Corroon Corp.	NYS	12.50	-2.44	1.52	15.19	9.75
BROKERS	AVERAGE		1.23	6.83		

INSURERS/REINSURERS

	Price	Weekly % change	Year to date % change	52-week High	Low	Vol.(000)
ACE Ltd.	NYS	38.50	2.84	19.69	42.50	23.38
Acceptance Insurance Cos.	NYS	24.56	-0.25	1.55	28.63	21.13
AEGON N.V.	NYS	79.50	4.61	77.41	84.00	34.00
Aetna Life & Casualty	NYS	74.31	0.08	5.31	118.13	66.31
AFLAC Inc.	NYS	30.94	5.10	21.03	34.50	22.13
Allied Group Inc.	NYS	46.56	0.27	62.66	46.81	25.00
Allstate Corp.	NYS	89.00	-0.21	-1.66	100.25	70.94
AMBAC Indemnity Corp.	NYS	58.50	5.41	27.17	61.00	38.19
American Bankers Ins.	NDQ	59.69	0.53	29.93	66.06	30.38
American Financial Group	NYS	43.19	1.17	7.13	49.25	34.56
American General	NYS	69.44	3.64	28.44	70.56	46.56
American Heritage Life Ins.	NYS	21.88	-0.57	21.53	25.00	15.44
American Indemnity/Fin'l	NDQ	11.63	2.20	-16.22	15.50	9.50
American International	NYS	141.69	5.05	30.29	141.81	93.75
Argonaut Group	NDQ	31.75	2.42	-6.27	38.13	28.63
AXA-UIAP Group	NYS	55.81	4.32	43.11	62.63	30.75
Baldwin & Lyons Inc.	NDQ	23.25	3.91	-3.63	28.75	18.50
Berkley W.R. Corp.	NDQ	40.50	-9.75	-7.69	49.88	35.69
Berkshire Hathaway Inc.	NYS	78005.00	-3.58	69.58	84000.00	30000.00
Capital RE Corporation	NYS	70.63	2.45	13.80	77.44	49.94
Capitol Transamerica Corp.	NAS	20.75	2.47	-2.64	28.13	19.00
Centris Group Inc.	NYS	12.63	-0.98	13.17	14.81	9.69
Charlwell Re	NYS	29.50	1.72	-12.59	36.25	28.25
Chubb Corp.	NYS	80.56	7.78	6.53	83.44	63.50
CIGNA Corp.	NYS	70.13	1.81	22.04	71.75	45.63
CNA Financial Corp.	NYS	46.44	0.41	9.05	53.25	34.44
CNA Surety	NYS	14.63	5.88	-5.26	16.75	12.88
EMC Insurance Group Inc.	NDQ	14.50	-2.11	9.43	15.88	12.25

	Price	Weekly % change	Year to date % change	52-week High	Low	Vol.(000)
ESG Re Limited	NDQ	22.00	0.57	-6.38	28.88	19.88
Enhance Financial Services	NYS	67.44	4.35	13.34	75.19	42.88
Everest Reinsurance	NYS	38.88	6.51	-5.76	45.25	33.00
Executive Risk Inc.	NYS	71.00	9.97	1.70	75.75	49.31
EXEL Ltd.	NYS	76.81	5.31	21.20	81.13	51.19
Fremont General Corp.	NYS	52.81	3.55	-3.54	62.13	36.75
Frontier Insurance Group	NYS	24.00	0.52	4.92	39.25	20.00
Gainsco Inc.	NYS	6.31	5.21	-25.74	10.19	6.00
General RE Corp.	NYS	257.03	16.70	21.24	275.00	182.00
Gryphon Holdings	NDQ	16.38	2.34	-2.24	19.38	14.75
Harleysville Group	NDQ	21.00	-0.59	-12.50	28.50	18.38
Hartford Steam Boiler	NYS	51.25	5.67	39.30	51.25	33.25
HCC Insurance Holdings	NYS	21.31	2.40	0.29	32.69	15.63
ING Groep N.V.	NYS	64.63	0.29	52.73	71.06	38.88
IPC Holdings Ltd.	NDQ	30.31	0.21	-5.83	33.25	26.75
Hartford Financial Services	NYS	108.31	3.40	15.76	116.88	78.56
LaSalle Re Holdings Ltd.	NYS	36.94	3.32	4.42	42.94	29.00
Life Re Corp.	NYS	77.88	5.15	19.46	79.75	46.50
Lincoln National	NYS	89.19	1.49	14.16	94.13	63.81
MAIC Holdings Inc.	NYS	27.56	2.08	2.90	30.38	18.88
Market Corp.	NYS	180.50	3.74	15.61	181.00	127.00
MBIA Insurance Group	NYS	73.69	3.97	10.29	80.94	55.75
Meadowbrook Insur. Group	NYS	27.25	1.87	4.56	35.00	21.88
Mid Ocean Ltd.	NYS	77.31	5.10	42.51	81.63	52.00
MMI Cos. Inc.	NYS	21.25	1.80	-15.42	27.88	20.75
Mutual Risk Mgmt. Ltd.	NYS	35.69	0.71	19.21	37.25	21.63
NAC Re Corp.	NYS	52.63	6.72	7.81	53.88	43.50
Navigators Group	NDQ	18.13	0.69	-3.49	22.50	16.75
Nobel Insurance Ltd.	NDQ	13.56	2.84	3.33	15.38	12.13
NYMAGIC Inc.	NYS	27.50	0.92	-0.23	34.25	20.38
Ohio Casualty Corp.	NDQ	44.88	1.99	0.56	51.75	41.56
Old Republic Int'l	NYS	27.81	1.60	12.18	32.25	20.06
Orion Capital Corp.	NYS	55.38	3.02	19.25	57.75	36.75
Partner Re Ltd.	NYS	50.31	1.77	8.49	52.50	36.88
Penn-America Group Inc.	NDQ	13.50	0.00	-34.15	23.00	12.25
Pennsylvania Manufacturer's Co	NDQ	20.88	6.37	24.63	20.88	16.25
Philadelphia Cons. Holding	NDQ	20.00	-4.19	12.68	24.38	15.50
PXRE Corp.	NYS	30.81	0.20	-7.16	35.25	29.00
Reliance Group Holdings	NYS	18.00	6.27	27.43	19.13	11.63
Reliastar Financial Corp.	NYS	46.81	6.09	13.66	49.94	33.63

		Price	Weekly % change	Year to date % change	52-week High	Low	Vol.(000)
RenaissanceRe Holdings Ltd.	NYS	44.88	1.99	1.70	50.75	37.88	337
Risk Capital Holdings	NDQ	25.00	4.71	12.36	25.50	19.75	173
RLI Corp.	NYS	40.13	1.84	0.69	45.44	27.63	82
St. Paul Companies	NYS	41.50	-4.18	1.14	47.19	36.25	3917
SCOR	NYS	63.63	6.71	33.25	66.00	39.25	50
SAFECO Corp.	NDQ	45.19	3.29	-7.31	56.00	42.50	5562
SCPIE Holdings Inc.	NYS	33.88	1.12	17.06	38.38	24.31	NA
Seibels Bruce Group	NDQ	7.31	2.63	-2.50	8.94	6.63	47
Selective Ins. Group	NDQ	22.56	-1.90	-16.44	29.25	22.56	260
Terra Nova Insurance Co. Ltd.	NYS	31.06	3.97	18.33	33.13	20.69	154
TIG Holdings	NYS	23.50	-0.53	-29.19	36.56	22.63	1080
Tokio Marine & Fire	NDQ	49.44	-5.38	-14.39	66.00	41.25	414
Torchmark Corp.	NYS	44.63	6.09	5.78	49.81	34.81	1705
Transatlantic Holdings	NYS	76.00	1.33	6.29	78.44	66.25	254
Travelers Property Casualty	NYS	41.19	2.17	-6.39	46.06	34.88	1532
Travelers Corp.	NYS	61.50	0.41	14.15	73.50	41.50	18887
Trenwick Group Inc.	NDQ	38.88	11.15	5.98	41.75	33.38	142
Unico American Corp.	NDQ	15.13	0.00	23.47	18.13	10.75	64
United Fire & Casualty	NDQ	39.38	3.28	-11.02	47.00	37.00	4
Unitrn	NDQ	68.25	2.63	5.61	74.13	56.25	127
UNUM Corp.	NYS	56.50	4.03	3.91	59.63	40.69	938
Vesta Insurance Co.	NYS	26.63	5.45	-55.16	64.75	21.56	1101
Zenith National Ins.	NYS	28.31	0.67	9.95	30.50	24.50	23
INSURERS/REINSURERS	AVERAGE		2.53	9.06			



Just weeks after breaking his arm, Hector Ortiz was back on the job and on the company team. [Where his ability to rebound was desperately needed.]

Liberty Mutual's managed care is as fast as Hector's fast break. After his accident, Hector's employer called our 24-hour claims service hotline. We found the right doctor to treat him, at the right price. A rehabilitation nurse coordinated a return-to-work plan. And through our on-site rehabilitation program, a therapist worked to help Hector properly do his job and avoid reinjury, so today Hector is back on the job (and on the boards) leading a safer, more secure life.

➤ *There's more information we'd like to share. So please call John Ryan at (617) 574-5842 or visit our website at <http://www.libertymutual.com>*



The freedom of Liberty