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Updates

Zurich combines reinsurance units, appoints new executives

NEW YORK—The Zurich Insurance Group is restructuring its reinsurance operations into a single global business with four regional headquarters, says Steven M. Gluckstern, chairman of New York-based Zurich Reinsurance Centre Inc. and a member of the group's corporate executive board.

Richard E. Smith, ZRC's president and chief executive officer, will be CEO of the North American region; Dennis Purkiss, CEO of Zurich Re U.K., will be CEO of the London market region; and the group is in

See **Updates** *on next page*

Employers blast 401(k) restriction in tax legislation

By JERRY GEISEL

WASHINGTON—An amendment added without fanfare to tax legislation now working its way through Congress could tarnish the appeal to employees and complicate the administration of 401(k) plans.

The 401(k) amendment would require written approval by a spouse before an employee could take lump-sum distributions, hardship withdrawals or loans from 401(k) plans. Without approval, a 401(k) plan account balance would have to be distributed as an annuity payable over the life expectancy of the participant or over a period of at least 10 years. The provision was added by Sen. Carol Moseley-Braun, D-Ill., earlier this month in executive session when the bill was being considered by the Senate Finance Committee.

The bill, which was approved by the Senate last week, also contains a slew of other employee-benefit related provisions that would shift billions of dollars in costs to employers and retirees from Medicare. Those include proposals that would raise the Medicare eligibility age for future retirees and introduce a new means test to determine the amount of Medicare Part B premiums that retirees pay.

The Senate measure and a companion bill passed by the House also would increase the length of time that employers are the primary payers of medical bills for employees with end-stage renal disease. The bills also would give the government more time to

See **Budget** *on page 25*

High court rejects class formed for asbestos deal

By MARK A. HOFMANN

WASHINGTON—The Supreme Court's rejection of a $1.3 billion class-action settlement of asbestos claims will likely chill future efforts to settle mass tort claims with agreements that bind future claimants.

The result of the Supreme Court's 6-2 decision last week in *Amchem Products Inc. et al. vs. Windsor et al.* will mean more personal injury cases jamming already overcrowded courts, say some observers. That will bring extra pressure on Congress to step in to clarify how such "future-looking" settlements can be structured to meet the needs of claimants as well as defendants.

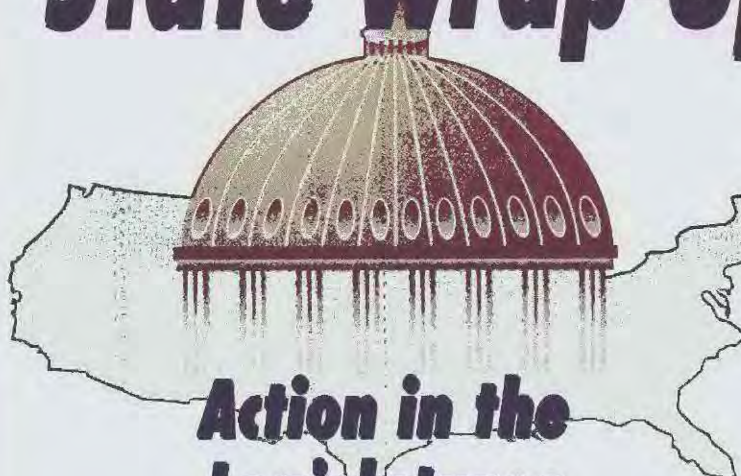
But, says the attorney who argued against the asbestos settlement before the Supreme Court earlier this year, the decision should not hamper Congress' ability to deal with something like the proposed $368.5 billion settlement of liability claims between 40 states and the tobacco industry.

Supreme Court rejects worker's claim for damages for fear of injury. ....page 2

The *Amchem* case turned on the question of whether Rule 23 of the Federal Rules of Civil Procedure, which governs civil cases, allowed the certification of a class for purposes of a global settlement of future asbestos-related claims.

See **Asbestos** *on page 26*

State Wrap-Up 1997



Action in the Legislatures

Tort reforms less sweeping

States enacting more targeted reforms

Tort reform and risk management-related legislation met a decidedly mixed reception in statehouses this year.

The pace of comprehensive tort reform has slowed, in part because so many states have already enacted wide-ranging measures. More targeted reforms have come into play, as lawmakers attempt to deal with such matters as circumscribing employers' liability when asked for job references or protecting physicians who volunteer their services at clinics for the poor.

"The trend in the last couple of years has been to deal with employer reference liability. That's continuing right now," said Sherman Joyce, president of the American Tort Reform Assn. in Washington.

Mr. Joyce pointed out, however, that at least three states—Alaska, Iowa and Montana—enacted major reforms during the most recent legislative sessions.

"I think it turned out to be a pretty good tort reform year," said Anne Allen, legislative counsel for the Risk & Insurance Management Society Inc. in New York. She added that legislative action on environmental and other risk management-related issues has been a "mixed bag."

Also, both Mr. Joyce and Ms. Allen pointed to continuing attempts to roll back tort reforms as cause for concern. Ms. Allen noted unsuccessful attempts to do so in Tennessee as "a warning to us not to let down our guard."

"We are clearly seeing that when broad-based civil justice reform is enacted, there's an immediate challenge in the courts," said Mr. Joyce. Such a challenge already has been launched in Illinois, with similar action expected in Ohio and elsewhere, he said.

"Most of our focus is on the Illinois Supreme Court, which will rule on the constitutionality of the major reforms passed in

See **Tort** *on page 13*

Workers comp stable

Major changes in fewer states

Many states continue to fine-tune their workers compensation statutes, while only a handful of states have passed major reform packages in recent legislative sessions.

A few of those states—Kentucky, Ohio and Oklahoma—in the past year adopted major workers comp system reforms, while some others—Colorado, Connecticut, Maine and Massachusetts—faced efforts to undercut previously enacted reforms.

Most states, though, have continued to focus on general workers comp system changes.

For example, in multiple states legislation was introduced to abolish second-injury funds and to establish premium credits for drug-free workplaces. In addition, managed care proposals—which can affect workers comp medical care—have been advanced in several states.

Still, the degree of legislative activity on workers compensation issues is not great as it was a few years ago when workers comp rates were soaring in many states.

"We are now in a period of relative stability," said Bruce Wood, assistant general counsel with the American Insurance Assn. in Washington.

"It is not surprising that in an environment of rate decreases that there is less interest and

See **Comp** *on page 10*

Managed care targeted for restrictions, mandates

Reforms of mastectomy coverage, emergency care

The backlash against managed care and some of its practices remains the hottest health care-related issue for state legislators.

Bills requiring health care plans to offer hospital coverage to women undergoing mastectomies was introduced in more than 30 states and passed by 10. Typical of these are bills passed in Rhode Island and Maine that require managed care plans and insurers to offer at least 48 hours of hospitalization after a mastectomy and coverage of at least 24 hours after an axillary lymph node dissection.

Those proposals are a direct response to public anger after reports surfaced that managed care plans in some cases were attempting to force women to undergo mastectomies on an outpatient basis.

States also are moving to stop other practices associated with managed care. For example, seven states have passed measures mandating coverage for emer-

See **Health** *on page 15*

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NEWSPAPER

Updates

Zurich restructuring units

Continued from previous page

the final stages or recruiting a CEO for the Zurich-based operation. Plans are still being developed for an Asian regional headquarters as well, said Mr. Gluckstern, who is responsible for Zurich's global reinsurance business and is overseeing its reinsurance strategy.

The strategic focus is on the development of a "truly global business as opposed to an isolated geographic business," with skills, talent and expertise to be shared globally, said Mr. Gluckstern.

The intent of the restructuring is to "put our arms around the business" under a single leadership, while continuing to be a major player, particularly in "non-commodity reinsurance," said Mr. Gluckstern.

Underwriter, exec sentenced

NEW YORK—United States Aviation Underwriters Inc. was fined $20.5 million, and its former chairman, John V. Brennan, was sentenced to nearly five years imprisonment last week in a criminal fraud case involving insurance allocation.

If the convictions are upheld on appeal, all insurers will face stringent new operating requirements and will have to rethink what formerly were routine business decisions, said Harold J. Clark, USAU's current chairman.

"The application of federal mail fraud laws to business decisions is alarming," Mr. Clark said.

The sentencing follows a trial in the U.S. District Court for the Eastern District of New York last year in which a federal jury found USAU, the underwriting manager of U.S. Aircraft Insurance Group, and Mr. Brennan guilty of 43 counts of mail fraud (*BI*, July 8, 1996).

The case centered on the allocation of claims after the crash of Pacific Southwest Airlines Flight 1771 in December 1987. The crash, which killed all 39 passengers, occurred after a disgruntled former employee smuggled a gun on board and shot his former supervisor, both pilots and himself.

USAIG was the lead insurer for both PSA's parent, USAir Group Inc., and Ogden-Allied Corp., the ground checkpoint security firm. The USAir coverage was completely reinsured, and at last year's trial prosecutors argued that USAU saved USAIG at least $7.5 million in claims by allocating all of the loss to the US-Air insurance contract.

At last week's sentencing, Mr. Brennan also was personally fined $100,000 and USAU was ordered to continue a special compliance program established after the trial last year that established an independent monitoring committee, including two outside lawyers, to oversee USAU claims handling.

The case will be appealed to the 2nd U.S. Circuit Court of Appeals in New York. USAU is a wholly owned subsidiary of General Reinsurance Corp.

Zenith to buy Riscorp book

WOODLAND HILLS, Calif.—Zenith National Insurance Co. will purchase Sarasota, Fla.-based Riscorp Inc.'s workers compensation insurance and managed care business for at least $35 million in cash.

Zenith officials said they see the acquisition providing their company "profitable workers compensation business, additional geographic diversification and state-of-the-art managed care capability."

After the purchase, Riscorp executives will "go about trying to resolve (the company's) contingent liabilities, in essence, the lawsuits it faces," a company spokesman said. "Once those are resolved, the shareholders will receive any remaining cash and assets." Financially troubled Riscorp recently announced plans to close offices, lay off workers and restrict its underwriting (*BI*, June 16).

The final purchase price paid by Woodland Hills, Calif.-based Zenith, a unit of Zenith National Insurance Corp., will be the difference between the book value of the assets purchased and the liabilities it assumes from Riscorp on the deal's closing date, subject to the $35 million minimum. Zenith will finance the purchase with bank financing and internal funds.

Zenith will not purchase the stock of Riscorp, which closed at 15/16ths June 26, or its affiliates, or assume their corporate liabilities. The deal's closing is subject to the review of state and federal authorities and Riscorp shareholders. Until the deal closes, Zenith will reinsure all new and renewal Riscorp workers comp policies.

Tribe to form comp system

MASHANTUCKET, Conn.—In an effort to increase its autonomy and efficiency in handling workers compensation risks, Connecticut's Mashantucket Pequot Tribal Nation will begin operating its own workers comp system this week.

MPTN, which employs about 12,000 people, operates Foxwoods Resort Casino and other businesses in eastern Connecticut. As a sovereign nation, under rights granted by Congress, MPTN is free to operate independently of the state workers comp system.

The MPTN formerly participated in the state system, and the tribal council is modeling its workers comp code after that of Connecticut so that the change will be easier for employees, said Richard Paton, chief risk management officer for the MPTN.

The MPTN already operates its own court system and is looking to hire its own workers comp commissioner. Efficiency is the ma-

See **Updates** *on page 26*

No future illness damages

Broad private sector impact seen from high court ruling

By MARK A. HOFMANN

WASHINGTON—The U.S. Supreme Court's unanimous denial of damages for a worker's fear of contracting a future illness extinguishes what business groups feared could have been an explosion of new litigation.

The case, *Metro-North Commuter Railroad Co. vs. Michael Buckley*, involved a pipe fitter who sued his employer for negligence after being exposed on the job to large amounts of white pipe insulation dust containing asbestos. He and his colleagues were so coated with the dust they were dubbed "snowmen."

According to the Supreme Court, the employer "conceded negligence" but disputed that the worker—who has not become ill—had suffered emotional distress because of his fear of developing an asbestos-related disease. The employer, Metro-North Com-

See **Ruling** *on page 20*

AP/ WIDE WORLD PHOTOS

A claim by pipe fitters who worked at Grand Central Station was rejected by the Supreme Court last week.

Canadian company stakes out global reinsurance role

Fairfax buys Sphere Drake

By EDWIN UNSWORTH

LONDON—Canadian insurance holding company Fairfax Financial Holdings Ltd. is making strides in the world reinsurance market with its latest acquisition, Sphere Drake Holdings Ltd.

Toronto-based Fairfax's announcement last week of the Sphere Drake deal is the latest in a series to build a global reinsurance empire. Bermuda-based Sphere Drake is the third reinsurer Fairfax has acquired since May 1996.

Analysts think Fairfax's purchase of Sphere Drake for about $420 million, which is expected to be completed in the fall, is a wise move for both companies. The deal not only will quickly make Fairfax one of the world's major reinsurance groups but also will strengthen Sphere Drake's financial security.

Sphere Drake will be merged into Odyssey Re Group, a reinsurance unit that Fairfax formed after the acquisition last May of Skandia America Reinsurance Corp. of New York, which changed its name to Odyssey Reinsurance Corp. in September. Also last September, Fairfax purchased Paris-based Cie. Transcontinentale de Reassurance to be Odyssey's international operation

See **Fairfax** *on page 4*

EMLICO deal in limbo

Judge wants court to decide redomestication issue first

By DOUGLAS McLEOD

BOSTON—A state Supreme Court judge has refused to rule on the Massachusetts Insurance Division's proposed settlement with Electric Mutual Liability Insurance Co. until the entire court can decide whether EMLICO's redomestication and the settlement deal itself are legal.

In a setback for state regulators and sole EMLICO policyholder General Electric Co., Justice John M. Greaney last Thursday put off ruling on the settlement, which would continue EMLICO's Bermuda liquidation while making the Massachusetts division ancillary receiver.

Justice Greaney ruled that the full court should first decide whether Insurance Commissioner Linda Ruthardt had the authority to allow EMLICO to move to a foreign country in the first place and whether state law allows her to act as EMLICO's ancillary receiver.

EMLICO reinsurers, which have charged that the redomestication was illegal and part of a fraud by EMLICO, hailed the ruling as a victory.

"Clearly, in his opinion he sees the merit of what the reinsurers are saying," said Joseph T. McCullough IV, a lawyer with Lovell White Durrant in Chicago, representing Kemper Reinsurance Co. "What he is saying is it's not good enough to just approve this settlement and not dig into it."

Representatives of the In-

See **EMLICO** *on page 25*

Lloyd's still faces U.S. suits, despite refusal to hear case

By STACY SHAPIRO

WASHINGTON—Lloyd's of London is not yet out of the woods when it comes to avoiding litigation over alleged securities law violations from recruiting U.S. members.

The U.S. Supreme Court last week declined to review a decision by the 4th U.S. Circuit Court of Appeals that member disputes should be heard in U.K. courts. Although that was not bad news for Lloyd's, an opinion by the 9th U.S. Circuit Court of Appeals allowing such a suit to proceed remains to be resolved.

Altogether, the Supreme Court has refused to hear four cases involving choice of law and forum, and federal appeals courts have upheld five such cases, said a Lloyd's spokesman. These decisions have upheld clauses in members' contracts maintaining that U.K. laws and courts should govern any membership disputes.

However, as long as the 9th Circuit's decision stands, Lloyd's can't breathe a sigh of relief.

In March, the 9th Circuit ruled in *Alan Richards vs. Lloyd's* that choice of law and forum clauses in members' contracts are void

See **Lloyd's** *on page 6*

Inside

• We generally applaud states' legislative efforts in tort reform and workers compensation but are less enthusiastic about health care legislation, this week's editorial says. **PAGE 8**

• Union Pacific Corp. will cover the $7.7 million in damages from a train crash last week in Texas without calling on its insurers. **PAGE 6**

• Europe may take a lead from the proposed U.S. tobacco settlement. **PAGE 21**

• A Spencer Educational Foundation Inc. program will send risk managers on visits to four colleges. **PAGE 27**

Departments

Advertiser Index........24

Classifieds........22

Global Briefs........21

Insurance Services Guide........20

International........21

Letters........8

Opinions........8

Ticker........27

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Hong Kong change greeted with optimism

Insurance industry doesn't foresee drastic changes from Beijing

By MICHAEL BRADFORD

HONG KONG—Members of Hong Kong's insurance community see no need to cross their fingers during the pomp and ceremony of tonight's transition to Chinese rule.

Insurance companies, brokers and risk managers are expressing confidence that it will be "business as usual" after 155 years of British rule ends at midnight and the People's Republic of China begins to put its imprint on the Special Administrative Region of Hong Kong.

While the population waits nervously for coming restrictions on civil liberties—limits on the right to demonstrate, for example—the business community is putting on an optimistic face.

The insurance industry's main concern is that the Chinese eventually could make changes to the region's legal system that would make it an inhospitable and unpredictable place to operate.

That uncertainty, however, is not scaring away Hong Kong-based corporations.

In fact, the number of insurers is increasing as the region becomes part of the vast Chinese market.

Businesses operating in Hong Kong do expect some changes in the legal system. But, how far the Chinese government might go in rewriting civil and commercial law is a matter of speculation.

"That's the wild card," according to Joseph A. Graziano, executive vp and managing director of international operations for Reliance National Insurance Co. in New York.

"The British system was one that everyone was real comfortable with," Mr. Graziano said.

Under the Joint Declaration that China and Britain agreed to in 1984, a 50-year transition begins this week, during which Hong Kong will enjoy autonomy in most areas.

Hong Kong will retain its legal system, which is based on English Common Law, rather than adopt Chinese law, which has different applications and procedures for review.

One change calls for Hong Kong to have a Court of Final Appeals that will hear appeals on commercial and civil matters. The court is instructed to adjudicate matters on common law

See **Hong Kong** *on page 23*

AP/WIDE WORLD PHOTOS

A royal yacht waits to transport Hong Kong Gov. Chris Patten and Prince Charles after ceremonies returning the former British colony to Chinese control.

Fear and loathing in managed care

Plan satisfaction remains high, yet public casts a critical eye on HMOs

By ROBERT KAZEL

CAMBRIDGE, Mass.—For employers that want to move more workers into managed care, a curious paradox exists.

Survey after survey shows most employees are happy with their treatment in health maintenance organizations. But the public remains increasingly skeptical about whether the HMO industry is trustworthy.

So says Robert J. Blendon, professor of health policy and political analysis at Harvard University in Cambridge, Mass. Mr. Blendon said an analysis of survey research conducted over the past few years shows people form impressions of managed care based on worst-case scenarios of HMOs that have denied care or made mistakes with tragic results.

For benefit managers, such industry dynamics are important, because persuading employees to move from traditional indemnity health plans to managed care plans—and to stay in them—depends both on their satisfaction with their own plan and with managed care generally.

Mr. Blendon's presentation came at a seminar for the media, HMO executives and medical directors sponsored by the Washington-based American Assn. of Health Plans and Harvard's John F. Kennedy School of Government.

Regardless of people's own routine or pleasant experiences with HMOs, highly publicized cases of people being injured or dying as a result of HMO treatment have created lasting, negative images in the public's mind, Mr. Blendon said.

He cited a survey prepared by Louis Harris & Associates this year that showed only 51% of the public thinks HMOs and other managed care networks "do a good job" in serving customers, one of the lowest of all

See **AAHP** *on page 24*

Lilly writedown of PCS not unexpected

By DEBORAH SHALOWITZ COWANS

INDIANAPOLIS—Eli Lilly & Co.'s $2.4 billion writedown of its investment in PCS Health Systems Inc. is not symptomatic of widespread financial problems in the prescription benefit management industry, experts agree.

Drug manufacturer Lilly, which bought PCS in 1994 for $4 billion, last week announced the second-quarter non-cash charge, which devalues the asset on Lilly's balance sheet to $1.6 billion. PCS is the largest PBM in the country.

Indianapolis-based Lilly has no plans to sell the unit, according to a company statement. Charles E. Golden, executive vp and chief financial officer, said in the statement, "PCS remains a key part of Lilly's pharmaceutical strategies and holds significant potential for us."

The writedown "was pretty well expected by Wall Street," said Richard Vietor, a senior analyst specializing in the drug industry with Merrill Lynch & Co. Inc. in New York. Lilly's announcement is not indicative of broader problems in the PBM industry, he added. It simply reflects that PCS is "operating at a far lower level than they had anticipated."

Edward Kaplan, vp in the New York

See **Lilly** *on page 27*

Comp study links claims to outreach

By MEG FLETCHER

Employer communication with workers—both before and after a workplace injury—can reduce the costs of workers compensation claims, a new survey reports.

Communication, concern and caring have "a halo effect" on the entire workers comp experience, according to a recent national study conducted by the Chicago office of The Gallup Organization.

Those approaches help a worker develop a positive frame of mind that produces optimal outcomes, summarized researchers of the Princeton, N.J.-based organization.

Specifically, workers who said they received pre-injury communications from their employers about workers comp policies and procedures were more satisfied with their treatment, recovery and experience in returning to work, the study said.

Employers' communication efforts and demonstrations of concern after an injury—through calls, visits and even flowers—also had a positive impact on worker satisfaction. Those workers returned to work sooner and were less likely to seek out a lawyer for help with pursuing a claim, according to the study, which was sponsored by Intracorp, a Philadelphia-based managed care company.

Conversely, workers who received no prior communication were out of work longer, had significantly lower satisfaction levels and were more likely to seek out a lawyer, the study reported.

"This study further reinforces the need for all of us—employers, providers and managed care organizations—to begin thinking of injured workers as a primary customer in the workers comp equation," Maddy Bowling, Intracorp's senior vp of workers compensation managed care, said in a statement.

Gallup's 1997 study was based on 514 interviews with workers who had experienced job-related injuries or illnesses within the past three years. The sample was drawn from a group of 8,500 workers in 10 states.

A typical respondent was a man, who had not completed college and was working in a service or labor job for a midsize company with 101 to 499 employees, often for four years or less. His average annual income was $36,670.

See **Workers** *on page 27*

Blast rocks Shell plant

By BRUCE KELLY

DEER PARK, Texas—Shell Chemical Co. could face tens of millions of dollars in property, business interruption and liability losses following a June 22 explosion at an olefins unit at a Shell plant in Deer Park, Texas.

Last week, adjusters were investigating and processing more than 800 claims filed since the explosion, a spokeswoman said. A majority resulted from property damage to homes and businesses in the surrounding community.

Shell provided little information last week about the cause and potential cost of the explosion, though in a statement said the blast caused a fire that burned throughout the day.

"It is too early in the investigation to make any estimates on damages," said Ron Leftwich, assistant treasurer and risk manager for Shell Oil Co., parent of Shell Chemical.

But, some observers say that replacement of one or more of the olefins processors could cost the company as much as $40 million.

Mr. Leftwich refused to comment on Shell's insurance.

An executive for Oil Insurance Ltd. confirmed that Shell Oil Co. is a member of the Bermuda-based property insurance captive. OIL provides $225 million in all-risk property insurance. OIL policies carry a minimum $5 million deductible, though OIL documents say $10 million is a typical deductible.

The explosion in Deer Park occurred in the plant's olefins manufacturing unit. The olefins unit produces ethylene and propylene, which are then used in the manufacturing of such items as plastics and detergents.

The force of the explosion knocked in windows and doors of businesses and homes in the northern section of Deer Park, said Ronald Crabtree, Deer Park's City Manager.

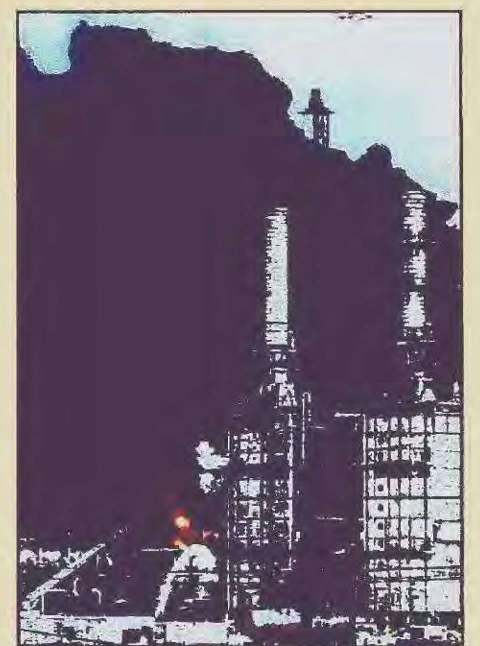
Sources watching the investigation said the cause for the explosion likely is mechanical.

"There's speculation there was a problem in the unit's cracked gas system or cooling system," said Steve Zinger, a consultant for Chemical Marketing Associates Inc. in Houston, who specializes in olefins.

Without knowing the extent of the damage, Mr. Zinger said it is almost impossible to estimate costs. But if one or more of the unit's systems have to be replaced, the cost could be $30 million or $40 million, he said.

"I've been out there 20 years, and I've never seen one this totaled," said Alan Barnes, Secretary and Treasurer for Local 4-367 of the Oil, Chemical and Atomic Workers Union, whose members work at the plant.

He said the accident was probably due to hydrocarbon released from the unit, which formed a cloud that exploded when "it hit an ignition source."



AP/WIDE WORLD PHOTOS

Hundreds of claims have been filed following an explosion last week at a Shell Chemical Co. plant in Texas.

This is the fourth explosion at a Shell plant since January 1996. The most recent occurred at a plant in Woodbridge, N.J., last June (*BI*, June 24, 1996).

Fairfax

Continued from page 2

(BI, Sept. 23, 1996).

The purchase of Sphere Drake will enhance Odyssey Re in several areas, said Andrew A. Barnard, president and chief operating officer of Odyssey in New York.

"The benefits for the Odyssey Re group will be the addition of London and Bermuda underwriting outlets; the diversification of product lines; access to a network of relationships that will enhance group activities; and the addition of $300 million in capital that will bring the total reinsurance capital of the Odyssey Re group to $900 million," he said.

With the addition of Sphere Drake's $288.6 million in net premiums, Odyssey Re Group should rank third among the broker-market reinsurance companies in the United States and rank among the 20 largest reinsurers worldwide, with net premiums of more than $750 million and surplus of approximately $900 million.

Fairfax is a financial services holding company whose subsidiaries are engaged in property/casualty and life insurance, reinsurance, investment management and insurance claims management. In 1996, Fairfax's group net premiums totaled more than $700 million, and revenues were about $1.1 billion.

The addition of Sphere Drake's $288.6 million in net premiums should rank Odyssey Re Group third among U.S. broker-market reinsurance companies.

The price Fairfax will pay for Sphere Drake includes $220 million, or $7.50 a share, in cash or Fairfax stock, which has yet to be decided. On Friday, Sphere Drake stock closed at $8.13 a share.

In addition to buying out shareholders, Fairfax will assume about $100 million of Sphere Drake's debt and has committed to making deferred payments of $9.86 per share payable in 10 years to all shareholders, subject to a reduction in Sphere Drake's claims reserves and provisions for unrecoverable insurance.

Sphere Drake underwrites reinsurance for insurers and alternative risk financing vehicles as well as specialty insurance, with an emphasis on U.S.-based clients. The company's results have suffered as a result of increased competition in the global reinsurance market and falling premium levels. Sphere Drake's pretax profit in the first quarter this year fell to $2.6 million from $9.6 million a year earlier.

Michael Watson, Sphere Drake's president and chief executive, said last week that the takeover by Fairfax is "entirely consistent" with an ongoing strategic restructuring of Sphere Drake's operations in Bermuda and London.

This includes a focus on reinsurance, specialty insurance lines and excess and international property, and a withdrawal from marine insurance.

While "economies of scale would be looked for" from the merger, Sphere Drake does not plan any large staff reductions, he added. The company is expected to stick to its target of about 250 staff by the end of the year, compared with 275 employees currently and 400 at the start of 1996. Mr. Watson will become president of Bermuda-based operations.

Mr. Watson also said the acquisition "enhances our franchise in our current markets and offers access to additional markets and products," especially in the United States, continental Europe and Asia.

He also acknowledged that it would "materially improve" Sphere Drake's financial security, "which is what our customers require."

Rating agency Standard & Poor's Corp. in New York agreed, and just after the takeover was announced put its BBB claims-paying ability and counterparty credit ratings of Sphere Drake Insurance P.L.C. and Sphere Drake Insurance (Bermuda) Ltd. under review for a possible upgrade.

S&P said it thinks the acquisition by Fairfax will help address concerns about the quality of Sphere Drake's balance sheet and limited financial flexibility by stopping the erosion of Sphere Drake's business and providing a foundation to regain business momentum.

S&P also affirmed its BBB+ senior debt rating of Fairfax, saying the acquisition "is consistent with Fairfax's strategy of building a global reinsurance business."

The rating agency pointed out that apart from the enhanced position the acquisition of Sphere Drake would give Fairfax in the ranks of global reinsurers, it would create a reinsurance group with offices in major markets: New York, Paris, Singapore, London and Bermuda.

New York-based Moody's Investors Service also confirmed its Baa3 rating on Fairfax's senior debt, saying the takeover "should enhance Fairfax Financial's Odyssey Re operations."

Moody's noted that Fairfax's acquisitions since 1992 have increased its group premium volume nearly tenfold, adding that it does have some concerns about the risks associated with such rapid growth through leveraged acquisitions.

However, S&P said it expects financial management at Fairfax to remain strong, as the company intends to keep sufficient cash resources at the parent level to meet holding company expenses.

Although the takeover of Sphere Drake still is subject to regulatory approval, Fairfax already has received support from Sphere Drake's management and from investors Centre Capital Investments, Electra Investment Trust and Dai-Tokyo International, which hold a combined total of 40% of Sphere Drake's stock. BI

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Lloyd's

Continued from page 2

because investors cannot waive U.S. securities law under Securities and Exchange Commission regulations (*BI*, March 17). That cleared the way for 350 members to sue Lloyd's for alleged securities violations.

As a result of that ruling, some members who have had their claims against Lloyd's rejected in other U.S. courts are looking to see whether they can have their cases reheard in light of the 9th Circuit decision, according to Richard S. Rosenblatt, chairman of the American Names Assn.

Lloyd's and California Insurance Commissioner Chuck Quackenbush recently filed petitions to the 9th Circuit panel to get the case reheard or to get it reheard en banc, court papers show.

If the 9th Circuit decision stands, Lloyd's says the lawsuit would impair its insurance business, according to court papers. Lloyd's argues that allowing such a lawsuit would contravene federal policy against interference with the insurance business.

Lloyd's and Commissioner Quackenbush also predict in their petitions to the 9th Circuit that if the U.S. members are allowed to proceed with their securities claims, they ultimately could rescind their obligations under their Lloyd's contracts, which "would have catastrophic consequences" on policyholders, third-party claimants and ceding insurers.

The SEC, however, argues that the 9th Circuit's decision should stand.

Lloyd's doomsday predictions may have some merit, the SEC acknowledges in a brief filed with the court. However, "the proper solution is not to be found in ignoring the antiwaiver provisions (in securities law), upholding the choice clauses, and preventing the assertion of securities claims," the SEC states.

Such a decision could deprive investors in any foreign insurance company the right to protection under federal securities law, argues the SEC.

It is up to a U.S. court to decide whether Lloyd's membership can be considered a security, the SEC says. Although the SEC has not issued an opinion on whether Lloyd's membership may be considered a security, as alleged, it contends the case must be heard under U.S. law, as there is nothing similar under British law that offers the same protection.

Indeed, the 9th Circuit's decision is almost in direct conflict with the 4th Circuit's decision on choice of law that the Supreme Court declined to review last week.

The 4th Circuit overturned a district court judge's decision in *Louis F. Allen vs. Lloyd's* that the case should be heard under U.S. securities law.

The 4th Circuit concluded—contrary to amicus briefs filed by the SEC in the proceedings—that the case should be thrown out because "the contractual provisions among the parties selecting the law of, and a forum in, the United Kingdom should be enforced."

Although the Supreme Court declined to review the 4th Circuit decision, it might hear the 9th Circuit case because it would be petitioned on different grounds, according to Mr. Rosenblatt.

Any appeal on the 9th Circuit case would be on the choice of law issue, whereas in the 4th Circuit case the 93 plaintiffs unsuccessfully petitioned the Supreme Court on the grounds that the appeals court usurped its judicial power by throwing the case out. The plaintiffs contend that the 4th Circuit had been asked only to hear an emergency motion to stay a preliminary injunction and not asked to decide on the merits of the district court's decision at all.

The plaintiffs had filed a preliminary injunction to block Lloyd's reconstruction and renewal program—scheduled to be completed on Aug. 28, 1996—until they received more financial information required by SEC regulations. On Aug. 23, a federal judge granted the injunction, and set a Nov. 4 trial date.

Lloyd's appealed to the 4th Circuit, which ruled in Lloyd's favor on Aug. 27, the day before R&R was to be completed.

Meanwhile, Lloyd's awaits another forum selection decision from the 5th U.S. Circuit Court of Appeals in regard to *Charles Robert Leslie vs. Lloyd's and R.W. Sturge & Co.* In that case, Lloyd's is appealing a decision by the U.S. District Court in Houston that the Leslie case could be heard in the U.S. because Mr. Leslie signed the members contract under fraudulent pretenses (*BI*, Sept. 18, 1995). BI

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Union Pacific Corp. to retain crash losses

By BRUCE KELLY

DEVINE, Texas—Union Pacific Corp. will pay the $7.7 million in property and cargo damage caused by last week's head-on collision of two freight trains outside Devine, Texas.

Union Pacific will "assume the risk for the whole thing. It won't involve insurance coverage," a spokesman for the Bethlehem, Pa.-based transportation company said. Union Pacific owns both trains and the track on which the crash occurred.

Union Pacific has insurance for major catastrophes, the spokesman added. Bermuda-based X.L. Insurance Co., which last year purchased RAIL, a mutual insurer owned by 12 transportation companies, including Union Pacific, confirmed that it writes coverage for the railroad, but provided no details (*BI*, Sept. 16). X.L. writes property and liability coverage for railroads.

The trains collided June 23, shortly after midnight near Devine, which is 30 miles southwest of San Antonio. Four men were killed and two injured in the collision and resulting diesel fuel fire. Of the four men killed, one was an engineer, one a conductor and two were transients illegally aboard the trains.

Another Union Pacific spokesman said damage had been done to its equipment, including the destruction of four locomotives, as well as freight, train track and a bridge. Union Pacific hopes to salvage one locomotive damaged in the collision, he said. The northbound train carried mixed freight, and the southbound train carried auto parts, he added. The estimated $7.7 million in damage includes the damaged cargo.

Although the cause of the accident has not been determined, "human error" was both "likely" and "possible" in causing the collision, a spokesman said.

The National Transportation Safety Board and the Federal Railroad Administration are investigating the accident. Both agencies sent investigators to the collision site in Texas and to Omaha, Neb., where a Union Pacific dispatching center is located. The trains were traveling between San Antonio and Laredo when they collided in an area without signals or a signal system. Such areas are common and known as "dark territory."

Engineers rely on dispatchers to guide them through dark territory, a spokesman from the Federal Railroad Administration said. "The Federal Railroad Administration is interviewing dispatchers and investigating the dispatcher facility in Omaha," the FRA spokesman said.

Two "event recorders" that recorded the communication between the northbound train's engineer and dispatcher were recovered at the crash site and carried by investigators to Washington, said a spokesman from the National Transportation Safety Board.

After rerouting trains throughout Monday, Union Pacific opened the San Antonio/Laredo route at 7:30 a.m. on Tuesday.

Laredo, which is approximately 150 miles southwest of San Antonio, is a gateway for Union Pacific's freight to Mexico.

Approximately 10 Union Pacific Trains cover the route each day.

The collision of two freight trains last week in Texas killed four people and will cost Union Pacific Corp. nearly $8 million in property and cargo damage, which the company will retain.

AP/ WIDE WORLD PHOTOS

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Opinions

Keeping states on course

AS WE SURVEY state legislative activity on the tort reform, workers compensation and risk management fronts, we generally are very pleased with what is going on.

Health care legislative developments, though, are not as encouraging.

As we report this week, states continue to reform their workers compensation statutes—albeit at a more modest pace than a few years ago. States also are continuing to enact tort reform measures. Just as important, business groups are fighting legal challenges aimed at weakening or overturning reforms enacted years ago by several states.

At the same time, risk managers are in the trenches actively lobbying for more alternatives to the traditional market. That effort succeeded in Maine with the enactment of legislation to allow employers to establish captive insurers there. In North Carolina, they're fighting to assure that fronting arrangements aren't saddled with expensive and unnecessary new regulatory burdens.

On the health care front, however, managed care plans are under attack. They're passing measures that, if continued, eventually could undermine the ability of managed care plans to keep costs under control.

Looking at those three main areas of legislative activity, we're most encouraged about workers comp reforms at the state level. As we report, two states—Ohio and Kentucky—have passed major reform statutes. Just as significantly, several states—Connecticut, Maine and Massachusetts—beat back efforts that would have undermined previously enacted workers comp reforms.

In the tort reform area, no one would confuse the rate of legislative activity this year with the mid- to late 1980s, when state legislators responded to the liability insurance crunch of that period with dozens of bills intended to bring more balance and certainty to the civil justice system.

Still, Alaska, Iowa and Montana enacted comprehensive tort reform bills so far this year, while other states enacted smaller reforms. We think that is a decent record, especially given the fact that many other states have already enacted broad-based meaningful reforms in the past few years.

Of course, tort reform is not a one-shot deal. Business has to continue push for additional reforms as well as defend what already has been enacted.

The situation in health care is different. States continue to pile benefit mandates on insurers and health maintenance organizations. As we have said many times, those measures have more to do with the power of special interest provider groups than good health care policy.

States also are trying to undermine the efforts of managed care plans to hold down costs, such as by allowing patients to go directly to specialists rather than primary care physicians, who are supposed to coordinate care. Legislators also are mandating how much coverage health care plans should provide for specific health conditions.

To be sure, some managed care practices, such as forcing women out of the hospital within a day of delivering newborns, are outrageous and thus invite a legislative response.

Still, we're somewhat encouraged that state lawmakers are defeating other attempts to restrict sound managed care practices as often as they are passing them. We hope that's a sign that some legislators are beginning to understand that they would be better off not trying to micromanage the health care system. It's up to the business community to make every reasonable effort to persuade lawmakers that that's indeed the right approach.

Letters

Golden Eagle opinion is uninformed

To the editor: I feel compelled to comment on the inaccurate and irresponsible editorial, "Who's in Charge in California?" in the June 16 issue, relating to the conservation of Golden Eagle Insurance Co. Your editorial is unfair, uninformed and biased.

You say that "in looking at the Golden Eagle case, one has to wonder what Commissioner Quackenbush intended to accomplish." There is no need to wonder; the commissioner intended to accomplish exactly what he has accomplished, including:

- Golden Eagle was underreserved by approximately $289 million as of Dec. 31, 1996. Those same policies will now be fully reinsured up to an additional $420 million by Liberty Mutual Insurance Co., with its $40 billion in assets and $5.8 billion in policyholder surplus.
- The jobs of almost 1,300 employees were in jeopardy, but now *all* employees will be retained.
- The economic value of the Golden Eagle business and its role as a key competitor in the California market were in serious jeopardy; now *both* are being fully preserved.
- Most important, policyholders were in a hazardous circumstance; now they will be *completely* safe.

These are admirable goals and it is extraordinary that they have been accomplished in such a short time.

You, however, have chosen to ignore the facts; instead you assert that the process that has occurred is both unusual and inappropriate. You are wrong on both counts.

Among other things, you assert the commissioner initiated his bid process after "backing away from an early deal with Zurich Centre Group." This is utter nonsense. First, the agreement with Zurich Centre was an "agreement in principle," not a deal. This means that it was subject to substantial preconditions, including due diligence, and the deal may or may not have come to fruition. Second, terms of the agreement in principle expressly acknowledged that an alternative transaction process could be required by the conservation court.

If you did not know that the bid chosen by the commissioner would be subject to approval by the conservation court, and that this process might result in a further round of bidding, then you need to read some of your own back issues. Everyone actually involved in the process knew it, however. Indeed, almost every similar receivership in California over the past decade has involved an overbidding process.

Your claim that the commissioner somehow made a "hasty retreat" from the American International Group Inc. deal and that this "leaves him open to questions about the integrity of the process" is absurd. First, there was no hasty retreat. This process has flowed forward quickly, it has proceeded in a well-precedented fashion, and it has resulted in the rehabilitation of a substantial property/casualty company.

You seem not to care about the results; instead, you carp about the process. AIG did win the original bid, but at a subsequent court hearing *both* AIG and Liberty Mutual entered into a new series of bids and overbids. In the end, the Liberty Mutual bid was selected as the best bid.

As a result, there has been a substantial improvement in the protections and benefits for policyholders, creditors, the general public and the shareholder.

Your opinion that "to allow bidding in two separate forums is absurd" ignores that this is a very common occurrence. It is a byproduct of "due process" concepts and of the checks and balances built into the insurance insolvency statutes by the Legislature.

These things, and other aspects of your editorial, are incorrect and unfair. But you transgress to the irresponsible when you declare that the current situation "guarantees more uncertainty for policyholders." This makes your editorial a "scare piece" and a false one at that. Golden Eagle's policyholders are completely safe under all scenarios.

Karl L. Rubinstein
Deputy Conservator
and Chief Executive Officer
Golden Eagle Insurance Co.
San Diego

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Comp

Continued from page 1

less pressure to further reduce costs," Mr. Wood said. "It doesn't mean that there aren't problems with those workers comp systems that need to be addressed, it just means costs have aligned—however temporarily—with the employer community's willingness to pay."

"The bills this year are smaller—literally and figuratively," said Nancy Schroeder, director of workers compensation for the National Assn. of Independent Insurers in Des Plaines, Ill.

She noted a few exceptions to that trend, including Ohio, which passed some major changes; Indiana; Kentucky, which enacted changes in late 1996; and unsuccessful proposals in Oklahoma.

Three northeastern states—Connecticut, Maine and Massachusetts—essentially staved off isolated efforts to undercut previous reforms.

"Bills that seem to have the most life are those that affect attorneys' fees," Ms. Schroeder said.

However, "there was virtually no gain that the trial bar made this year," said the AIA's Mr. Wood.

Other unsuccessful legislative efforts, he said, included efforts to reinstate a broad cost of living adjustment in Connecticut and to give workers more say in choosing treating physicians in Maine.

"The memories of the workers compensation financial crisis in recent years are still pretty fresh, and I believe those memories serve to give legislatures pause in moving ahead to undo what was enacted to restabilize workers comp systems in recent years," Mr. Wood said.

One movement gaining support nationally is the trend to abolish second-injury funds, which the AIA also is lobbying to eliminate.

Legislatures in Florida and Nebraska this year voted to abolish such funds. Second-injury funds were developed in the early 1900s to encourage employers to hire disabled workers by providing them economic relief if the worker had a second injury rendering him or her totally disabled.

The Florida and Nebraska actions bring to 10 the number of states that have passed such legislation in recent years, Mr. Wood said. The other eight states are: Alabama, Colorado, Connecticut, Kansas, Kentucky, Minnesota, New Mexico and Utah.

In addition, Delaware passed legislation this year that would allow self-insured employers, such as Wilmington-based E.I. du Pont de Nemours & Co., to opt out of the second-injury fund, Mr. Wood said.

The trend of abolishing second-injury funds concerns the AFL-CIO, however.

"I don't think the argument that the Americans with Disabilities Act made second-injury funds obsolete has any basis in fact," said James Ellenberger, assistant director for the union's department of occupational safety and health in Washington.

Such funds have been "misused and abused" by employers and insurers that "like dumping their problem cases on a second-injury fund, but no one likes paying for it," Mr. Ellenberger said. Supporters of abolishing such funds "are really transferring risk back on an injured person with a disability," he said. This is "real transparent" and "despicable," he said.

Another trend seen in several states is adoption of laws encouraging drug-free workplaces, often by allowing insurers to provide workers comp premium credits to employers (*BI*, June 2).

This year, Mississippi and Virginia passed laws mandating premium credits and Georgia and Tennessee expanded their programs, Ms. Schroeder said.

While employers and legislators tend to favor the programs, the NAII has some concerns about whether actual savings from the programs are going to match the discounts insurers are required to provide, she said.

Insurers are also concerned about the indirect, negative impact that anti-managed care legislation may have on workers compensation.

"The general anti-managed care environment will erode acceptance generally of controls on workers comp medical care delivery through managed care networks," the AIA's Mr. Wood said.

That could make workers comp medical care more expensive and reduce insurers' ability to manage claims, he said.

In addition, legislative proposals designed to increase the privacy of medical records may particularly hamper workers comp insurers if states begin adopting legislation that would apply to comp cases, Mr. Wood said. "From the property/casualty industry's viewpoint, these would be antithetical to evaluating claims, protecting against fraud and carrying on the business of insurance," he said.

From labor's perspective, dubious trends in recent workers comp legislation include growth in the number of states restricting compensation for repetitive stress cases and states using only American Medical Assn. impairment guidelines to determine compensation.

In addition, Mr. Ellenberger is cautious about praising what he called "low benefit states" when they significantly increase benefits, as Indiana did this year. "Are these gains or are we making long overdue corrections?" he asks.

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

The **Maine** Legislature passed two bills relating to workers comp in its session that ended June 2, though the governor vetoed one.

The vetoed proposal would have removed from existing law a provision that gives an employer the right to select a health care provider for an injured employee for the first 10 days of care. The governor vetoed the measure June 10. The Legislature failed to override the veto.

Another measure signed into law by the governor directs employee advocates to assist employees through mediation and hearings and raises the cap on assessments and adds an allocation to fund additional employee advocates. The new law also says that health care practitioners submitting sworn statements are not subject to cross examination at hearings with respect to medical evidence.

In **Massachusetts**, legislation is being considered by the House Commerce and Labor Committee that would effectively repeal workers comp reforms made in Massachusetts in 1991. Those reforms sharply cut back benefits.

The bill would: increase the average comp wage loss compensation rate to 66.66% from 60%; extend the payment period for temporary total disability benefits to five years from three; and increase the period for paying temporary partial disability benefits to 11 years from five.

There was no significant workers comp legislative activity in **Connecticut, New Hampshire, Rhode Island** or **Vermont**.

While **Pennsylvania** did not make any changes to its workers compensation law this year, sweeping reforms enacted last year have resulted in rates being cut by 25% this year.

In **Delaware**, Gov. Thomas R. Carper was expected to sign a bill last week that would allow large employers, such as Wilmington-based E.I. du Pont de Nemours & Co., to opt out of the state's second-injury and contingency funds.

There was no significant workers comp legislative activity in the **District of Columbia, Maryland, New Jersey, New York** or **West Virginia.**

Florida reforms introduced changes to the state's guaranty funds. The measure, which became law without Gov. Lawton Chiles' signature and is effective June 1, merges the Florida Self-Insurance Fund Guaranty Assn. into the workers comp account of the Florida Insurance Guaranty Assn. to create the Florida Workers Compensation Insurance Guaranty Assn.

The self-insurance fund, known as "Little FIGA," was designed to pay accident claims on behalf of insolvent self-insurers. A number of insolvencies and an overall decline in the number of self-insurers has the left the fund short of what is needed to pay claims. The new fund will be created by Oct. 1 and will assess self-insurers and insurers to pay claims of insolvent self-insured plans.

The legislation also eliminates the state's Special Disability Trust Fund, or "second-injury fund," which reimburses insurers and employers for a second injury to a worker with an existing impairment. The fund had incurred unfunded liabilities of $4.05 billion.

The second-injury fund will not accept claims for accidents occurring on or after Jan. 1, 1998.

Georgia Gov. Zell Miller signed a package of workers comp changes submitted by the state's Board of Workers Compensation and passed by the Legislature.

Among other things, the new law provides protection against civil and criminal liability to any person who provides information to the board about workers comp fraud or noncompliance.

The new law also gives the state's workers comp board the authority to regulate third-party administrators and servicing agents that deal with self-insured workers comp plans.

The **Louisiana** Legislature has passed several workers comp bills. Among them is a bill that would define who is responsible for workers comp coverage of temporary workers. The bill would make both the "special employer" that hires the temp and the "general employer" that makes the worker available jointly responsible for comp benefits. Each employer could seek contribution from the other for payment of benefits when there is no contract between them specifying how the liability should be shared. Both employers are entitled to statutory exclusive remedy protection under the bill. The new law only affects cases arising after its effective date.

Other bills include a measure that would allow lump sum settlements of workers comp benefits earlier than six months after termination of temporary total disability. The bill would overturn a state appeals court ruling that invalidated one such early settlement and that jeopardized the validity of hundreds of similar settlements.

Another bill would allow a hearing officer to impose a civil fine of $500 to $5,000 against a person making a fraudulent workers comp claim.

All three bills became effective on signature by the governor earlier this month.

A new law enacted this spring in **Mississippi** will make it possible for employers to earn workers comp premium reductions by qualifying as drug-free workplaces.

The law creates a system of certification for employers that implement programs aimed at preventing substance abuse in the workplace. Certified employers can earn a 5% workers comp premium reduction. Participation is voluntary for both employers and insurers.

The new law, which takes effect July 1, directs the state's Department of Insurance to write the appropriate regulations for the new drug-free workplace program.

The program is not based on employee drug-testing but instead focuses on education, with workers comp administrators at qualifying employers required to receive two hours of drug-free workplace training yearly and employees to receive one hour of such training annually.

The **North Carolina** General Assembly, though still in session until early July, passed no major workers comp legislation other than a revision of the hospital fee schedule for workers comp-related services, which was subsequently signed into law.

See **Comp** *on page 12*

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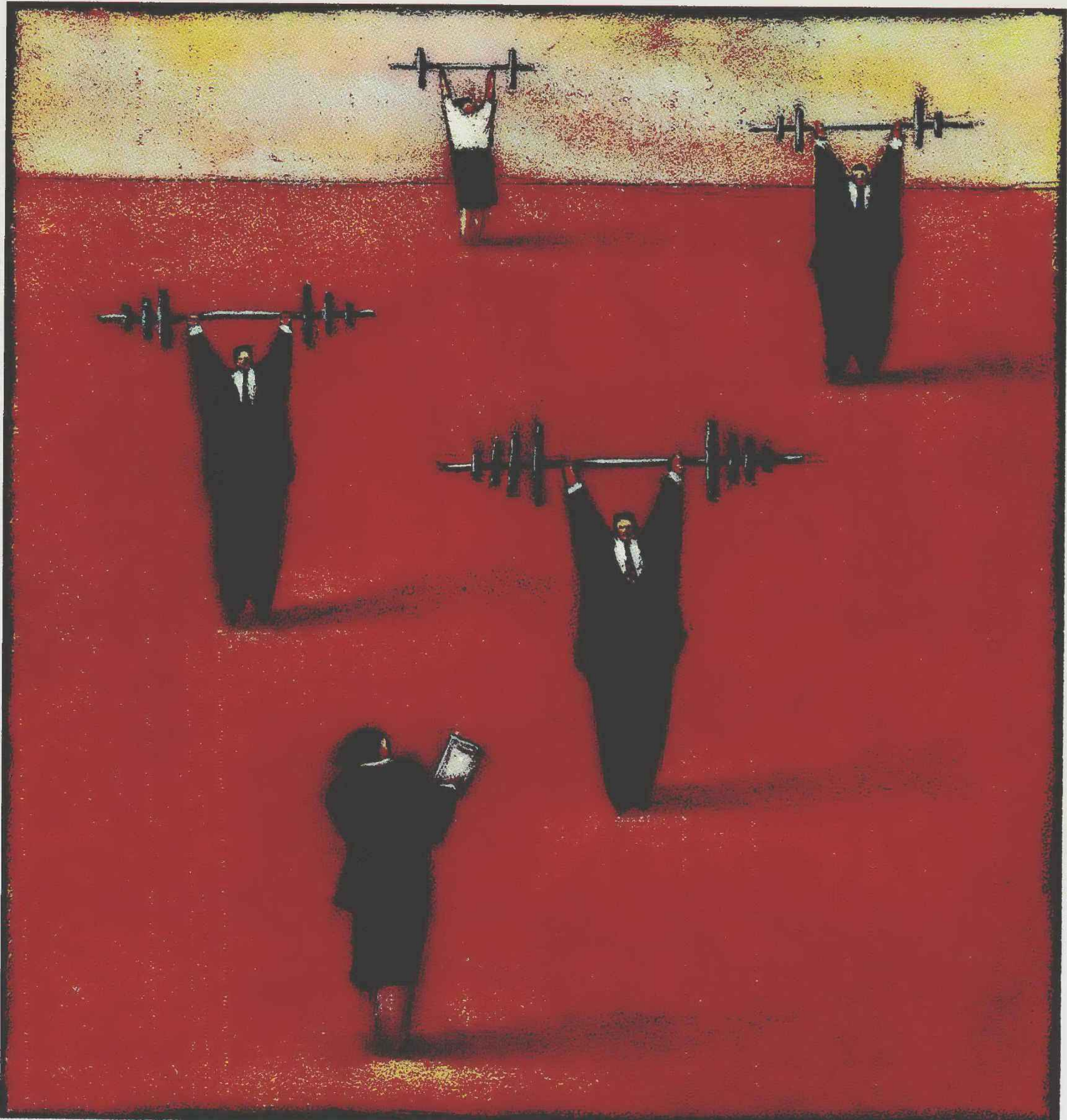

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Comp

Continued from page 10

The **South Carolina** Legislature approved legislation that would require "actuarially sound" discounts for employers that maintain a "drug-free" workplace. The governor signed it into law June 10 and it will take effect in October.

In addition, before adjourning earlier this month, the Legislature carried over for consideration a measure that would require workers comp insurers that write in the voluntary market to also participate in the residual market.

Technical amendments to **Tennessee**'s Workers Compensation Reform Act of 1996 include one that will require the state's insurance commissioner to approve variations in rates of more than 20%. The amendment was included because of concern that some insurers were pricing coverage at low rates that could not be sustained, according to Charles Fentress, state director of the National Federation of Independent Business in Nashville.

The measure, which was included as part of a bill that Gov. Don Sundquist signed, states that such deviations cannot be approved if they do not reasonably reflect projected losses, including loss adjustment expenses, or if they would result in a cost that is "excessive, inadequate or unfairly discriminatory."

Under other legislation that has been signed into law, all construction-related businesses except sole proprietors now must carry workers comp insurance. Previous law required coverage only if a company in the industry had five or more employees.

Another bill that became law without the governor's signature allows lawyers a non-voting representative on the state's workers comp advisory council, which was established by 1996 reforms. The council, made up of seven voting members that represent employers and employees, studies workers comp issues in the state and makes recommendations for changes to regulators.

The **Virginia** General Assembly approved a number of workers comp-related measures, most of which were very targeted, before it adjourned. The most significant piece of workers comp legislation to emerge from the General Assembly is a measure signed by Gov. George Allen and effective July 1 that defines hearing loss and carpal tunnel syndrome as "ordinary diseases of life" for purposes of compensability. Under Virginia law, ordinary diseases of life are compensable through the workers comp system only if a claimant establishes by "clear and convincing evidence" that the conditions arose out of and in the course of employment. The new law spells out the specific conditions that must be met to establish such proof.

Alabama passed no workers comp reform measures. **Kentucky**'s Legislature is not in session in 1997.

A proposed ban on so-called "balance billing" is stalled in the **Illinois** Legislature, after passing the state's House of Representatives last month (*BI*, May 26).

The bill would outlaw the practice of medical care providers directly billing injured workers for payments in excess of the amount paid by a comp insurer or self-insured employer. Nearly all other states ban this practice (*BI*, Feb. 3). Illinois employers, labor unions and insurers have been unsuccessful in urging legislators to pass such a ban in previous legislative sessions.

The bill could be discussed again in a veto session this fall.

A bill awaiting Gov. James Edgar's signature would set a variety of standards for employee leasing companies, including requiring them to provide workers comp coverage.

Indiana Gov. Frank O'Bannon called the General Assembly into a special session in May and presented a package of bills designed to finance a new sports arena that also contained unrelated provisions to increase workers comp benefits.

Although there was staunch business opposition to the workers comp provisions in the package, the legislation's key provisions to pay for a new sports arena for the Indiana Pacers and expand the Indiana Convention Center to appease the Indianapolis Colts drew support. The governor refused to break up the package and it cleared the Legislature May 28 and was signed into law in June.

Business analysts estimate the higher comp benefit costs will raise costs by 13.7%, or $42.6 million, over the next three years.

Minnesota workers will receive workers comp benefit payments on an interim basis, even if current and former employers are disagreeing over who is liable for payments, under a bill signed into law May 9.

Ohio employers' concerns over the timeliness, duration and delivery of lost-time and impairment-based benefits are the focus of new workers comp reform that was signed into law in April and takes effect July 21.

However, the severity of the cutbacks prompted a coalition of trade unions, injured workers and trial attorneys—called the Coalition for Workplace Safety—to draft a petition for a referendum to repeal the measure and begin collecting signatures to place it on the November ballot.

Major provisions of the new law will change operations of the state's exclusive state compensation fund by:

- Reducing or eliminating claims for aggravation of pre-existing conditions, except where the aggravating incident can be shown to have substantially worsened the pre-existing disease or condition.
- Limiting cumulative trauma claims by classifying them only as occupational disease—instead of injury—claims and generally excluding from compensability most diseases to which the general public is exposed unless they specifically arise from an occupational exposure.
- Limiting the life of most claims to five years, excluding claims for some ongoing medical benefits and some occupational diseases. Currently, the state fund has a backlog of more than 3 million claims because medical-only claims can remain open for six years from the date of injury and a lost-time claim can remain open for 10 years from the date of the last payment of benefits, including medical expenses.
- Giving the Ohio Bureau of Workers' Compensation the authority to require that any claimant submit to a vocational rehabilitation evaluation.
- Creating the presumption that an injury to a claimant, found to have excessive levels of alcohol or any controlled substances in his system during a post-accident test, was caused by intoxication. However, the employer is required to have reasonable cause before it can require the test.
- Encouraging prompt payment of benefits in a variety of ways, including eliminating a 40-week wait to apply for permanent partial impairment compensation.
- Requiring use of the American Medical Assn.'s guides to evaluating impairment for determining applications for permanent partial impairment.

The new law also impacts employers in several ways, such as by:

- Stating that employers that make false or misleading statements concerning payroll or manual classifications, forge or alter certificates of coverage or fail to obtain coverage for the purpose of defrauding the bureau will be guilty of felony workers comp fraud.
- Creating a religious exemption for workers comp coverage for primarily an Amish employer and worker, if they are members of a recognized religious sect that is conscientiously opposed to acceptance of workers comp benefits.

The AFL-CIO views the Ohio law as "a disaster for injured workers," said Mr. Ellenberger. "Employers basically got everything they wanted," he said.

There was no significant workers comp legislative activity in **Michigan** or **Wisconsin.**

In **Iowa**, the ability of professional athletes to collect workers comp benefits has been limited with the passage of legislation signed into law April 18. The law ends benefits when the injured athlete is well enough to perform whatever job he or she was doing before becoming a professional athlete, rather than until he or she can compete as an athlete once more. The bill also changes how benefits are calculated for athletes. Instead of being based on weekly earnings in the job they were injured in, for professional athletes compensation is equal to one-50th of total earnings over the last year.

Iowa also enacted a measure that requires individual or group health insurers to begin paying all medical bills relating to an injury or illness arising out of employment, even if the employer disputes the validity of the claim.

Kansas lawmakers enacted a workers comp bill, effective July 1, that makes a number of changes to the workers comp act and statutes governing the operation of the second injury fund.

The bill will remove a statutory reference to the National Council on Compensation Insurance as the approved rating organization for workers comp pools.

It also expands the workers comp act to apply to subcontractors in certain situations; increases the amount of any award that can be allocated to attorneys' fees; and clarified that the 10 days in which one can appeal an award to the state's workers comp board exclude Saturdays, Sundays and legal holidays.

The new law also will allow the insurance commissioner or director of workers compensation to dismiss complaints filed against the second injury fund for lack of prosecution. The dismissal is considered final and not subject to appeal. The new law also states that reimbursement from the second injury fund for overpayment must be sought within one year of the date of final order.

A **Missouri** bill that the governor signed last week exempts from workers comp law any community service work performed as a condition of probation for a criminal conviction.

The **Nebraska** Legislature voted to eliminate its second injury fund during the recent legislative session and Gov. Ben Nelson signed it into law earlier this month.

North Dakota legislators passed a number of workers comp measures in the biennial session that ended in April that were subsequently signed into law.

Among them, one measure requires the state's Workers Compensation Bureau to adopt administrative rules setting maximum allowable costs to compensate an injured worker's attorney. Another new law allows the director of the Workers Compensation Bureau to choose not to participate in a claimant's health care malpractice action, waiving the bureau's subrogation interest and obligation to pay attorney fees or costs related to the action.

Other new legislation requires the North Dakota auditor to appoint an independent audit firm every two years to prepare a performance audit of the workers comp bureau. The firm must have extensive expertise in workers comp practices and standards.

Another measure requires that workers comp wage-loss benefits be suspended if a claimant is confined in a penal institution for more than 72 hours. It also broadens the wage reporting requirements of injured workers to include any work activities regardless of whether wages were received. The bill also allows the bureau to pay pre-acceptance disability benefits and changes medical information requirements by requiring doctors to report on the extent of the injured worker's abilities and restrictions.

Under another new law, an injured worker's failure to take a drug or alcohol test could result in the forfeiture of workers comp benefits. The final piece of legislation changes the definition of "permanent impairment" by no longer considering whether disfigurement diminishes the ability of an employee to obtain employment.

South Dakota Gov. William J. Janklow on March 11 signed a bill that makes volunteer emergency medical technicians and other volunteer rescue workers eligible for workers comp benefits. The bill became effective immediately.

Previously, rescue workers' injuries largely were covered by their employers' health plans.

Arizona Gov. Fife Symington earlier signed into law legislation that allows two or more employers to establish a self-funded workers comp insurance pool. Under the law, effective July 21, the employers have to be members of a pre-existing group, such as an industry association. Pool members also must have been in business for at least five years, and their pool premiums must total at least $750,000.

The law prohibits pool members from adopting managed care for injured workers.

Two other workers comp proposals died in the Legislature. One would have allowed the state to implement managed care for state employees who are hurt on the job. The other would have prohibited insurers from factoring into employers' experience modifiers the losses that employers paid as part of their deductibles, especially under large-deductible programs.

Before this year's legislative sessions, nine other jurisdictions that allow large deductible programs had enacted similar statutes, said Samantha Fearn, Arizona state director of the National Federation of Independent Business in Phoenix. Insurers in the 30 other jurisdictions that allow large deductible programs have been able to base experience modifiers in part on losses that employers pay, Ms. Fearn said. The bill likely will resurface next year, she added.

An **Arkansas** workers comp law that took effect May 21 eliminates offsets against permanent total disability benefits for Social Security, retirement and pension benefits for workers 65 and older. For permanent partial disability benefits, the retirement offset is reduced to 50% of the amount of benefits that the injured workers is receiving or is eligible to receive from other sources.

The bill also extends the durations of permanent partial schedule benefits for the amputation of arms, hands and fingers, but retains the current durations for other scheduled injuries.

A number of other workers comp bills were introduced during the session but were subsequently defeated. One such bill would have provided employees whose claim for workers comp was denied the option to commence a civil action in circuit court to recover damages against the employer as a result of the injury. The other measure would have removed carpal tunnel syndrome and other repetitive motion injuries and back injuries not caused by a specific incident from the definition of compensable injury for purposes of workers comp.

In **New Mexico**, a bill that would have clarified in what situations construction workers could sue their employers for injuries failed to pass the Legislature but is expected to be reintroduced next year, said J.D. Bollington, vp at the Assn. of Commerce & Industry of New Mexico in Albuquerque.

An ambiguity under New Mexico law concerning contractors and subcontractors now allows employees to sue their employers under certain circumstances, in spite of the exclusive remedy doctrine, said Mr. Bollington.

The bill would have closed this loophole by clarifying definitions involved.

Oklahoma's Senate and House could not work out most of their differences over two major workers comp reform bills. Instead, on May 29, a conference committee agreed on a compromise measure that did not include most of the cost-saving measures the bills originally contained.

The original version of the bill would have cut Oklahoma workers comp system costs 2.4% to 5.9%, according to the NCCI.

Any savings under the final version—which Gov. Frank Keating signed into law this month and becomes effective Nov. 1—will depend on how the workers comp court interprets the law and on the regulatory process, according to the American Insurance Assn.

Among other things, the new law:

- Trims to 156 weeks from 300 weeks the duration of compensation payments for temporary total and temporary partial disabilities that occur after Nov. 1.
- Defines permanent impairment as an anatomical or functional abnormality that exists after the employee has achieved "maximum medical improvement" rather than "reasonable medical improvement."
- Limits the compensability of heart-related injuries to those caused only by stress that exceeds the normal amount of stress workers experience as part of everyday living.
- Increases the permanent partial disability benefit for loss-of-eye injuries occurring prior to Nov. 4, 1994, to 250 weeks from 200 weeks.
- Increases survivor benefits for families of workers killed on the job.

See **Comp** *on next page*

Comp

Continued from previous page

The surviving children benefit rises to 30% from 25% of the state's average weekly wage. The surviving spouse benefit rises to 70% from 50% of the average wage.

• Bars coverage for injuries resulting from "horseplay" or other "willful behavior," unless the injured worker is "an innocent victim."

• Allows employees to seek medical treatment on their own but at their employer's expense if the employer does not arrange treatment within three days of an injury. Previously, employers had to arrange treatment "within a reasonable time."

• Directs the state's workers comp administrator to develop a new medical fee and treatment schedule that would have to be effective by Jan. 1.

The NCCI expects that the Legislature will attempt to pass additional reforms with even greater cost-saving potential next session.

Workers comp reform legislation in **Texas** calls for a State Office of Risk Management that will administer the state's workers comp program and help state agencies implement loss control programs.

The measure, which cleared the Legislature, calls for the new office to establish an allocation program that charges state agencies for workers comp costs based on claims' experience. State agencies that accounted for 90% of the costs during the previous two fiscal years would pay into the self-insurance fund while the remaining 10% would not be charged.

Agencies that pay into the fund will get back a portion of allocations not used to pay claims but would be required to make up the shortfall if claims exceed the allocation.

The risk management office, which replaces the division of risk management in the Texas Workers Compensation Commission, will be headed by a six-member board appointed by the governor. The members must have "demonstrated experience in the field of workers' compensation and risk management administration," according to the legislation.

Gov. George W. Bush signed the bill, which will become effective Sept. 1.

Other legislation the governor signed included a measure that will require utilization review of health care services in workers comp cases. The bill takes effect Sept. 1.

But he vetoed a bill that would have clarified that the burden of proof is with an employee who charges he or she is being discriminated against in the workplace for filing a workers comp claim.

Despite lobbying by insurers, **Colorado** Gov. Roy Romer vetoed insurer-supported legislation that would have reversed recent state court rulings that liberally interpreted the state's 1991 workers comp reform law.

The measure would have reversed a Colorado Court of Appeals decision in *Mountain City Meat Co. and Colorado Compensation Insurance Authority vs. the Industrial Claim Appeals Office and Emiliano Oqueda*. The court ruled in that case that when an injured worker sustains both scheduled and non-scheduled injuries, the losses must be measured as a whole-person impairment.

However, in a letter to the governor, Ronald Cobb, a vp with the American Insurance Assn., wrote that this was not the intent of the Colorado General Assembly when it passed the 1991 reform law. Those reforms, he wrote, intended that scheduled injuries remain on the schedule and that non-scheduled injuries be compensated as medical impairment benefits.

The bill also would have prohibited workers comp claims for mental or emotional stress to be combined with a schedule injury.

The governor explained in a letter accompanying his veto of that bill and a companion measure that the legislation would have reduced benefits to injured workers who have mental impairment arising from on-the-job injuries.

"Since the passage of Senate Bill 91-218 six years ago, I have worked with business, labor organizations and the Legislature to craft workable solutions to ensure a workers comp system that is equitable and fair to both employees and employers. We need to continue working together in the future to make any changes to the workers compensation system," Gov. Romer wrote.

The governor also pointed out that neither bill had been reviewed by the workers comp review group he had appointed to analyze the situation (*BI*, May 12).

Montana's governor has signed into law two workers comp-related bills passed by the Legislature.

The first bill makes several changes, particularly to the state compensation fund, including: allowing the state workers comp fund to provide dividends to policyholders beginning July 1, 1998; authorizing the fund to contract with licensed insurance agents to sell workers comp insurance; and authorizing the state fund to provide additional coverage for employers with multi-state operations.

The bill also clarified that an insurance company has to respond to a claim within 30 days or it may be fined.

Another reform law raises the workers comp hospital reimbursement schedule to better reflect the true cost of treating workers compensation injuries.

In **Utah**, lawmakers approved a bill that creates a "Blue Ribbon Workers' Compensation Commission" to study the possible privatization of the Workers Compensation Fund of Utah, the statutorily designated insurer of last resort in the state.

Other issues the 15-member commission will study and report on by November include a proposal for the fund to expand its insurance activities and how the fund should serve the residual market. The legislation provides that members of the commission include the insurance commissioner, legislators, insurers, employers and employees.

The **Wyoming** Legislature passed several reforms related to workers comp, most of which were minor technical amendments to existing laws.

There was, however, one significant reform measure that clarifies that the Wyoming Workers Compensation Act applies in situations where the injury or death:

• Occurs in Wyoming and the employment is principally localized in the state.

• Occurs outside of Wyoming but the employment is principally localized in Wyoming.

• Occurs outside of Wyoming but the employee was hired in Wyoming for work that is not localized in any state but is in the United States, Canada or Mexico and the employer has a principal place of business in the state.

• Occurs outside of Wyoming, the employer has a principal place of business in Wyoming, the employee was hired in Wyoming for work that is localized in another state or Canada or Mexico, but the laws of the jurisdiction where the work is localized do not require workers comp coverage in that state.

All the Wyoming legislation was signed into law.

There was no significant workers comp legislative activity in **Idaho** or in **Nevada**, where the Legislature is still in session.

Alaska enacted reforms that, in some cases, deny workers comp benefits to an employee who knowingly makes a false statement about a physical condition in response to a medical inquiry or examination after a conditional offer of employment. The law took effect with the governor's signature on May 27.

In **California**, both insured and self-insured employers are coming out against legislation that would increase workers comp disability benefits.

The bill, backed by the state Federation of Labor, would:

• Increase maximum temporary total disability benefits; permanent partial disability benefits; and life pension benefits, which are paid to people with 70% or greater disability after permanent partial disability awards have been exhausted.

• Provide full death benefits for the rest of their lives to dependent widows or widowers of employees whose deaths are caused by employment-related activities.

The bill passed the Assembly June 4. Similar legislation passed the Senate the same day. Both bills now are in committees in the opposite houses.

Californians for Compensation Reform, a coalition of employers, and the California Self-Insurers Assn. both have come out against the measures.

Other workers comp measures being considered in California include bills that would:

• Pay workers comp benefits in the case of the death of a health worker or public safety employee due to HIV-related disease. The bill is currently before the Senate Committee on Industrial Relations, having passed the Assembly.

• Include painters in both the private and public sectors among those for whom cancer is presumed to be compensable. This bill is awaiting vote by the Senate Appropriations Committee.

• Entitle an employee who does not speak or understand English proficiently to receive the services of a qualified interpreter when the employee submits to an examination by a designated treating physician. This bill passed the Senate and now is in the Assembly's Industrial Relations Committee.

• Permit a greater percentage of the $4,500 in annual vocational rehabilitation service benefits to be used for job placement services. It also would increase the number of days that might be used to assist in placement to 90 days from 60 days with the possibility of 60 more if the parties agree. This bill has passed the Senate and now goes to the Assembly.

• A bill that would change the distribution of money to fight fraud to a 40%-40% distribution to the district attorneys' offices and the Insurance Department has passed the Assembly and is in the Senate Industrial Relations Committee. The remaining 20% would be distributed based on the Insurance Commissioner's discretion. Currently the district attorneys and the Insurance Department split the money 50%-50%. The bill was introduced because the district attorneys requested more money than the Insurance Department, and there was no mechanism to respond to that request.

Hawaii's governor signed into law a bill that requires workers comp insurers to provide employers with at least a 5% premium discount if the employer maintains an effective safety and health program.

Oregon legislation awaiting the governor's signature would overturn a court ruling that forces employers and insurers to appeal compensation determination orders issued by the Workers Compensation Division if the division awards permanent partial disability for conditions not specifically accepted by the insurer.

Failure to appeal an award was held to imply that the employer and insurer accepted their obligation to compensate those conditions in the future, according to the court ruling. As a result, the ruling prompted excessive litigation as employers and insurers sought to limit future exposures for conditions that may never require further treatment.

The legislation would clarify earlier court rulings so that employers and insurers would better understand which cases may require treatment.

Washington's governor signed into law a measure allowing public hospital districts to self-insure their workers comp exposures. The law takes effect July 27. BI

Tort

Continued from page 1

1995," said Ed Murnane, president of the Illinois Civil Justice League in Chicago.

There have been a few minor and not very serious efforts to repeal the tort reform measures or expand them, though none has gotten very far, he said.

In Ohio, the focus is now on state trial courts where several lawsuits are challenging provisions of that state's new tort law, said Roger Geiger, the Columbus, Ohio-based director of the Ohio Chapter of the National Federation of Independent Business and president of the Ohio Alliance for Civil Justice.

"There will not be too many broad challenges to the tort reform law, but rather a whole bunch of individual challenges to specific provisions," he speculated. That approach will be "much more difficult for us to defend," he said.

"I suspect that there is no appetite for wholesale rewriting of tort reform," though lawyer-legislators have said they may temper what they have done, he added.

"We first and foremost are an advocate of legislative reform," said ATRA's Mr. Joyce, who called the state constitutional challenges "a very troubling development."

Elsewhere, on the risk management front, Ms. Allen said that an ongoing legislative attempt in North Carolina to set new reporting requirements in certain insurance fronting arrangements is of particular concern to RIMS. The measure passed the Senate but is currently stalled in a House committee.

She pointed out that several other states are "looking at deregulation," while the North Carolina proposal would increase regulation.

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

Maine became the newest U.S. captive domicile this month under a bill signed by Gov. Angus King. The new law also allows captives to write insurance "for controlled unaffiliated business," which is defined as business that has a contractual relationship with the parent of an affiliated company and follows certain risk management guidelines (*BI*, June 23). Maine's minimum capitalization requirements are $250,000 for single-parent captives, $500,000 for industrial insured captives and $750,000 for association captives.

The Maine Legislature did not pass any tort reform bills this year. But a measure that addresses insurance fraud includes a provision awarding attorney's fees and costs to the prevailing party in certain civil actions.

A major tort reform measure is currently being considered by the Joint Judiciary Committee of the **Massachusetts** Legislature. Provisions in the bill include: changing the joint and several liability system to a proportional system; tying judgment interest rates to U.S. Treasury bond rates instead of the current flat 12% rate; a requirement that in suits against professionals another professional in the field certifies that the case has merit; a 15-year statute of repose for product liability actions that incorporate a "state of the art" defense; standards for expert witnesses in medical malpractice actions; and a reduction of the statute of limitations in slip and fall cases to one year from three years.

There was no significant tort reform legislation in **Connecticut, New Hampshire, Rhode Island** or **Vermont**.

A tort reform bill moving through the **New York** Legislature would permit non-economic damages for survivors in a wrongful death suit. Currently, only damages for financial losses may be awarded. The measure has passed the Assembly and is awaiting action by the Senate Rules Committee.

Another Senate bill would allow policyholders to sue insurance

See Tort on next page

Tort

Continued from previous page
companies directly for unfair claims settlement practices. This measure passed the Assembly and is pending in the Senate Rules Committee.

Another bill being considered by the Senate Rules Committee and the Assembly Insurance Committee would permit the establishment of captive insurance companies in the state.

Governor George Pataki has not taken a position on any of these bills. Any bills not acted on when the session ends in early July will be held until the Legislature reconvenes in January.

Medical malpractice legislation was enacted in **Pennsylvania** late last year. The law limits punitive damage awards to two times the compensatory award, requires an expert to certify the defendant deviated from the appropriate standard of care, institutes pretrial conferences for discovery and allows defendants to certify they were not involved in the care of the defendant, which allows them to be dismissed from the case.

The law also makes changes in the state's catastrophic loss fund. The rate physicians pay into the fund is now based on the scheduled rate set by the insurance commissioner, and not the discounted rate commonly paid by providers for their primary layer of coverage. Also, the attachment point for the fund was raised and a committee was created to investigate the total elimination of the fund.

Another bill awaiting the governor's signature would allow banks to sell insurance.

There were no significant tort reform measures enacted in **Delaware**, the **District of Columbia, Maryland, New Jersey** or **West Virginia.**

Tort reform efforts fell short in **Florida** but discussions regarding a package of reforms will continue this summer. Former House Speaker James Harold Thompson will act as a mediator in talks between a coalition of Florida business and insurance interests and the Florida Academy of Trial Lawyers as the two sides negotiate over reforms to be introduced in 1998.

Florida businesses and insurers pushed for legislation drafted by the House Financial Services Committee. The bill, which failed to gain final approval before the session ended May 2, contains a number of reforms, including barring lawsuits in product liability cases involving products more than 12 years old; eliminating vicarious liability of a company or person because of the intentional tort of another. The legislation also would eliminate vicarious liability against the owner of a product if a user injured by the product has insurance coverage that will indemnify; and clarify that punitive damages are only to be awarded for intentional misconduct or conduct for which it is highly probable an injury was caused. The bill called for allocating 75% of punitive awards to the state's Public Medical Assistance Trust Fund and the remainder to the plaintiff.

Insurers in Florida are required to follow standards under the National Assn. of Insurance Commissioners model acts on risk-based capital and material transactions as a result of the passage of a measure this year, which was allowed to become law without the signature of Gov. Lawton Chiles. The legislation is effective July 1.

Insurers will be subject to financial examinations by insurance regulators whenever it is deemed necessary under the new law. Previously, insurers were examined at least once every five years.

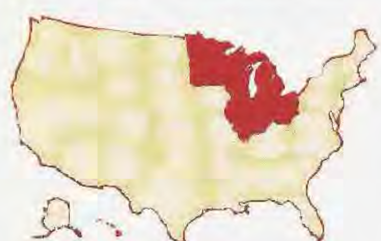
Several tort reform measures were approved last week but not signed in **Louisiana**, where the legislative session ended on June 23.

One bill provides that lawsuits filed but not pursued for three years would be considered abandoned, a reduction from the five-year period in current law.

Another sets out a clearer definition of what would constitute a certifiable class action lawsuit and set procedural requirements for class actions. Another measure would require that service of lawsuits be requested within 90 days of the filing of the suits. Current law provides no time limit.

Attention in **North Carolina** centered on an attempt by the Insurance Department to persuade the General Assembly to approve legislation that would subject certain fronting arrangements to new reporting requirements. The measure, which was opposed by RIMS and other business groups, won Senate approval but is currently stalled in the House. Little tort reform legislation has been considered during the current session other than competing House and Senate measures that would provide employers with some relief from liability when making employee references. The session is expected to conclude early next month.

There was no significant tort reform enacted in **Alabama, Georgia, Mississippi, South Carolina** or **Virginia. Kentucky** is not in session.



In **Illinois**, a bill that would expand the scope of the tort immunity act for local governments and their employees is still pending in a Senate subcommittee. Another measure that would provide damage recovery for an individual injured by a youth under 18 years of age is now pending in the House Rules Committee. The Illinois Legislative session will resume in the fall after a summer hiatus, and run until December.

In **Indiana**, an environmental insurance bill that would have enabled insurers to clarify policy language defining pollution risks was vetoed. That bill was a response to a May 1996 state Supreme Court ruling that held the state's standard insurance pollution exclusion was ambiguous and shifted liability to insurers (*BI*, March 10). Gov. Frank O'Bannon's surprise veto of the House bill last month enraged insurers, which had anticipated his support. They now say the veto will have a chilling, destabilizing effect on the writing of liability policies in the state.

No significant tort reforms were enacted in **Michigan** in the current session to date, which runs through the fall. A proposed bill would set July 13, 1995, as the starting point for the statute of limitations for product liability suits involving blood products and HIV/AIDS.

In **Minnesota**, a bill enacted on April 11 created civil immunity for alternative dispute resolution personnel.

The attention of **Ohio** employers is focused on preserving the major tort reform gains made in legislation signed last October, which went into effect on Jan. 27.

The law significantly limits noneconomic and punitive damages (*BI*, Oct. 7, 1996). For example, it abolished joint and several liability for non-economic damages. However, joint and several liability for economic damages would be maintained for defendants more than 50% responsible for a plaintiff's harm. Defendants less than 50% responsible for a plaintiff's harm would be severally liable for economic damages and only pay damages in proportion to their share of liability.

The law also capped non-economic damages in severe injury cases, limited punitive damages assessed to large employers and limited the statute of repose to 15 years for most product liability claims and six years for most medical malpractice claims.

Thus far, no other major tort reform bills have been introduced into the Legislature.

Wisconsin legislators are considering a measure that would repeal a $350,000 cap on non-economic damages in medical malpractice cases established under a 1995 law. The bill is currently in the Senate Judiciary Committee, which has already conducted a public hearing on the measure. This year's session of the Wisconsin Legislature began Jan. 6 and continues through the end of the year.

Iowa Gov. Terry Brandstad signed a multipronged tort reform bill on May 29. The law establishes a 15-year statute of repose for product liability lawsuits—except in the case of certain silicon gel implants, asbestos, dioxins, tobacco, polychloride biphenyls and substances posing an unreasonable risk of injury; sets the interest rates on judgments equal to U.S. Treasury bills; limits future damages to present value. The law also establishes limits on how much a plaintiff can collect for loss of consortium and eliminates the traditional rule of joint and several liability for non-economic damages. The existing joint and several liability rule is preserved for actual damages when defendants' fault is between 50% and 100%

One provision of the legislation limits the ability of a minor who was under the age of 8 when an alleged act of medical malpractice was committed to bring legal action later than the child's 10th birthday.

Now, minors can bring personal injury suits until age 19. As a result, the new law treats minors over age 8 the same as adults; they have two years from the discovery of an injury, or up to six years from occurrence of an injury, to file suit.

Under the law, defense counsel would have greater access to relevant medical records in all malpractice cases, with some safeguards for patient rights.

North Dakota legislators approved several tort reform measures in the biennial session concluded April 29. Gov. Edward Shafer subsequently signed them into law.

One law requires a medical malpractice case to be dismissed without prejudice when the plaintiff fails within three months to obtain an admissible expert opinion to support the allegation of malpractice.

Another raises the state's maximum liability for claims against it to $1 million per occurrence from $750,000 per occurrence. The law also requires that the state will indemnify and hold harmless state employees acting within the scope of employment for any claims or judgments as long as the employees provide complete disclosure and cooperation in the defense of the claim.

Two new **South Dakota** laws that become effective July 1 are designed to discourage frivolous actions by plaintiffs and defendants in civil lawsuits.

The first creates a cause of action for frivolous or malicious claims or defenses in civil cases. The other requires courts to order the party whose actions were found frivolous to pay at least some court costs and reasonable attorneys fees.

Gov. William J. Janklow signed both measures March 11.

Kansas, Missouri and **Nebraska** did not pass any tort reform measures during the 1997 legislative session.

Arkansas Gov. Mike Huckabee signed one tort reform measure during the 1997 legislative session, which ended April 17. One bill extends volunteer immunity for any civil damages to physicians and health care professionals who are licensed by the state and render medical services free of charge to people unable to pay, or provide medical services for a nominal fee. The immunity does not apply if the act or omission was the result of gross negligence or willful misconduct.

But another reform bill, which would have limited punitive damages to the greater of three times the amount of compensatory damages awarded in an action, or $250,000, died during Arkansas' legislative session.

Arizona Gov. Fife Symington signed into law three bills that will reduce the financial burden of parties that are at least partially liable for creating hazardous waste sites. All become effective July 21.

One eliminates joint liability for the cost of cleaning up hazardous waste sites.

Another eliminates joint liability for related third-party bodily injury and property damages. The law applies to pending as well as future claims because it clarifies the Legislature's intent under a 1987 tort reform law.

That law eliminated joint and several liability in tort cases except those involving hazardous substance or waste sites. The Legislature's intent, though, was to preserve joint and several liability only under a 1986 statute that created a fund to clean up contaminated surface and ground water.

Under both laws, responsible parties now can be held liable only for their degree of fault. A state fund financed by several taxes will pay for the cleanup costs and third-party damages attributable to parties that are out of business or are financially unable to pay.

An environmental law in Arizona creates a pilot project designed to encourage the first 100 eligible owners of underutilized property with soil contamination to clean up their sites and make them economically attractive for development. Once a site has been remediated, the state will release the property owner from liability for any further action to remediate the known contamination at the site.

The state also anticipates the project could be the first step in developing a program that would release participating property owners from federal Superfund actions. Property owners who currently are embroiled in civil or criminal litigation with state or federal environmental regulators are ineligible. In addition, owners of property with groundwater contamination and owners with leaky underground storage tanks who have sought coverage from a special state UST cleanup fund are ineligible.

Another new Arizona law that provides insurers some regulatory relief could help standard lines insurers prevent some unusual risks from moving to the surplus lines market. Under the measure that becomes effective July 21, insurers no longer will have to go through the costly and time-consuming process of filing with the state Insurance Department so-called "A rates" for unusual risks that do not fall within a normal rating category.

On June 13, **Oklahoma** Gov. Frank Keating signed a bill that gives the insurance commissioner authority to determine which of about two dozen rating criteria are applicable to each line of coverage. The law, which becomes effective Nov. 1, also allows the commissioner to promulgate regulations that would allow insurers not to refile rates every four years if, for example, the rates are unchanged.

The Legislature killed several bills that it determined would reform tort laws. In 1995, it agreed to a three-year moratorium on tort reforms from 1996 through 1998.

Venue shopping will be restricted under a new law that makes it more difficult for residents of other states to file some types of lawsuits in **Texas.**

The legislation, signed by Gov. George W. Bush, allows courts to dismiss asbestos-related personal injury or wrongful death suits filed after Jan. 1, 1997, if defendants show that the action "would be more properly heard in a forum" outside Texas.

Asbestos suits filed between Aug. 1, 1995 and Jan. 1, 1997 can be heard if plaintiffs agree to certain stipulations, including limits on damage awards.

The act also applies to suits filed against railroad companies under the Federal Employers Liability Act and in cases alleging injuries caused during air transportation to or from Texas.

New Mexico enacted no significant tort reform legislation.

The **Colorado** Assn. of Commerce and Industry was successful in defeating a trial lawyer-supported bill,

See **Tort** *on next page*

Tort

Continued from previous page

which would have allowed plaintiffs to recover from "deep pocket" defendants, regardless of their proportionate share of liability. Existing Colorado law places limits on such joint and several liability.

Despite heavy opposition from business interests, however, lawmakers did pass another Colorado Trial Lawyer Assn.-backed bill that provides for increasing damage awards to reflect the effects of inflation. The measure, which is awaiting Gov. Roy Romer's signature, applies to compensatory damage awards in cases involving social-host liquor liability, dram shop liability and wrongful death. It also applies to non-economic damage awards in personal injury and wrongful death cases.

The **Montana** Legislature approved several tort reform and risk management-related measures during the session that ended April 23. Gov. Marc Racicot signed all of the bills into law.

One requires a unanimous jury verdict before punitive damages can be awarded. Another law states that in determining liability in a lawsuit, the fault of parties that have settled their portion of the lawsuit or those that have been released from the suit can be considered. A companion bill will become effective only if the first one is ever found unconstitutional by the state Supreme Court. The companion bill repeals joint liability but retains the new modified comparative fault liability system signed into law.

Still other reforms include allowing jury costs to be assessed against parties filing frivolous lawsuits; and allowing companies to do environmental audits of their own operations to achieve some level of immunity from administrative fines. The immunity does not apply if the company knowingly violates the law or if its action would be a criminal rather than a civil offense.

Another measure that passed establishes criteria for drug and alcohol testing of employees and prospective employees and provides for the confidentiality of test results except in certain circumstances.

A bill signed into law in **Nevada** requires the deposition of certain persons before holding the settlement conference required in medical and dental malpractice claims. The law becomes effective July 1.

In **Utah**, the Malpractice Against Health Care Providers Amendments law establishes a 180-day time limit within which the required health care provider pre-litigation panels must be conducted. The law, which went into effect in May, also provides that these panels need not be held if both parties agree to dispense with them.

No tort reforms were passed by the **Idaho** or **Wyoming** legislatures.

Alaska legislators met Jan. 13 through May 11. A comprehensive tort reform bill was passed that caps punitive damages at the greater of three times compensatory damages or $500,000. However, in cases involving commercial activities, the punitive award would be capped at the greater of $7 million, four times the amount of financial gain that resulted from the defendant's misconduct, or four times compensatory damages.

Punitive damages are to be established at a separate proceeding, and 50% of any punitive award goes to the state's general fund.

In cases of unlawful employment practices, punitive damage awards against employers are to be determined by a scale based on the number of employees working for the employer within the state.

Non-economic damages are limited to the greater of $400,000 or the injured person's life expectancy in years multiplied by $8,000. However, for specified injuries the limit rises to the greater of $1 million or life expectancy multiplied by $25,000.

The bill also establishes a 10-year statute of repose, expert witness qualifications, and disallows damages if the plaintiff was involved in the commission of a felony when the injury occurred. The law was sponsored by an employer group, Alaskans for Liability Reform. It takes effect Aug. 7.

Other legislation establishes two incentives for business to conduct voluntary self-audits of their compliance with environmental laws and regulations. The legislation provides immunity from civil penalties for violations if the noncompliance is discovered through a self-audit and reported promptly to the appropriate regulatory agency. The law also makes certain voluntary compliance reports privileged and not admissible as evidence or subject to discovery. The legislation was first vetoed by Gov. Tony Knowles, but he was overridden. The law takes effect Aug. 9.

Other legislation could provide protection for employers with established drug and alcohol testing programs. For example, an employer could not be sued for failing to test for a specific drug. Employees could not sue for damages resulting from test results unless the employer acts on results the employer knows are false positive. Gov. Knowles has until July 2 to return the bill to the Legislature.

In **California**, a bill that would have permitted third-party bad faith lawsuits against insurers was placed in the inactive file when supporters realized they didn't have enough votes to move it out of the Assembly.

The bill, which had the support of both the California Assn. of Consumer Attorneys and the California Applicants Attorneys Assn., also would have permitted injured workers to file bad faith suits against their employers' workers compensation insurers.

Named the Royal Globe bill after a controversial 1979 court decision, the bill could be resurrected next year (*BI*, March 17).

Meanwhile, case law set by the 1988 California Supreme Court decision in *Moradi-Shalal vs. Fireman's Fund Insurance Cos.* continues to bar such suits in the Golden State.

A bill that would lift the $250,000 cap on medical malpractice pain and suffering awards also was placed in this year's inactive file.

An effort by the California Assn. for Tort Reform to place limits on punitive damages also failed to reach a vote. A measure that would have given judges the authority to set punitive damage awards never passed out of committee.

Hawaii legislators passed four bills backed by the Hawaii Captive Insurance Council. Two became effective in April. One allows reciprocal insurance groups to set up association captives or risk retention groups. The HCIC hopes this law will attract non-profit organizations that now go to the Cayman Islands. The other new law liberalizes a captive's ability to write credit life disability policies.

The two other bills are awaiting action by the governor, who had until July 1 to act on them. One would broaden the insurance commissioner's latitude in adopting rules for the financial oversight and regulation of captive insurers. Another would create a full-time insurance administrator within the Insurance Division who would be responsible for monitoring and regulating the captive insurance industry. The legislation also would provide funds for support staff.

Gov. Ben Cayetano also signed a bill that changes the state's modified no-fault automobile insurance system. This new law makes an automobile accident victim's health care plan—rather than an automobile insurance plan—responsible for covering accident medical expenses above $10,000.

Oregon lawmakers were trying to wrap up their legislative session at press time. Legislation to make insurance fraud a crime of theft passed the Senate and moved on to the House. But as of June 23 it had not passed the House. The bill also would provide immunities for people reporting fraud and require insurers to provide information about fraud to government agencies.

In **Washington**, the Washington Liability Reform Coalition, representing a broad group of employers and associations, is backing a legislative package that attempts to restore the state's 1986 Tort Reform Act. Portions of the act have been eroded by court decisions, such as a health care statute of limitations that supporters believed applied to minors as well as to adults. But the state's Supreme Court eventually diminished the statute for minors.

The legislation also calls for early dispute resolution, and proposes that contingency fees not be charged against any amount offered in settlement by the defendant prior to the personal injury plaintiff obtaining an attorney.

Defendants in personal injury cases could make early settlement offers, and if made within 60 days of receipt of a demand for compensation, and accepted, then plaintiffs attorneys' fees would be limited to hourly rate charges or capped at 10%. If early offers are rejected, contingency fees could only be charged against net recoveries in excess of those offers.

For professional negligence or product liability cases, plaintiffs would have to obtain a certificate of merit within 90 days of filing a lawsuit. The certificate would establish that a qualified expert has determined the merits of the claim and that the reported negligence caused the plaintiff's injuries.

Current law imposes joint and several liability, but the legislation would allow defendants to be held liable only for their proportionate share of fault. The legislation was not adopted this year, but it will be automatically reintroduced next year.

Also in Washington, the governor vetoed portions of a bill sponsored by insurers attempting to strip Insurance Commissioner Deborah Senn of certain rule-making authority, such as her ability to adopt unfair practices rules.

However, insurers were successful in their bid for a use-and-file law, allowing them to begin using new rates or forms for commercial accounts before submitting them to the commissioner for review. The commissioner still will retain the ability to disapprove rates found to be excessive or inadequate. The law takes effect July 27.

Another measure signed by the governor requires all licensed insurers—except health, life, title, medical malpractice and credit—to institute and maintain an antifraud plan. The law takes effect July 27. BI

Health

Continued from page 1

gency room services that a "prudent" user believes are necessary.

In addition, states are trying to force employers to give employees in health maintenance organizations an alternative to providers in the HMOs' networks.

For example, Oklahoma and Iowa have enacted legislation that requires employers with at least 50 employees that only offer an HMO to offer a point-of-service option also. That requirement, though, may violate the pre-emption provisions of the Employee Retirement Income Security Act, some benefit experts say.

Under a POS, enrollees can go outside the HMO network each time they need to use health care services. But HMOs impose more cost-sharing requirements for services delivered outside the network. Other states are requiring HMOs to offer POS options, with the District of Columbia, Idaho, Montana and New Jersey considering such legislation.

States are taking other approaches to improve services delivered by managed care plans. For example, a new Virginia law requires HMOs to offer enrollees 24-hour telephone access to a physician or licensed health care professional.

The wave of bills aimed at curbing what the public perceives as managed care abuses isn't surprising given the dominant role managed care has assumed in delivering health care services.

"Managed care is now the establishment. It is not the alternative delivery system," says Susan Laudicina, director of research in the Washington office of the Blue Cross & Blue Shield Assn.

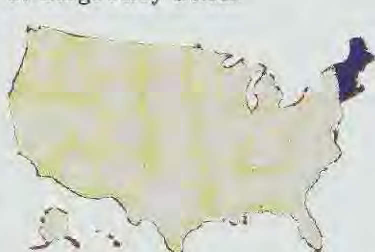
Other legislative measures appear intended as a way for specialists to maintain their revenue base as managed care grows.

For example, 10 states have enacted measures that give patients direct access to specialists without first having to see an HMO's gatekeeper. A Minnesota measure, for instance, gives managed care enrollees direct access to obstetricians and gynecologists, while a new Florida law lets enrollees see a dermatologist directly, without a referral from a primary care physician.

"Every licensed medical group is trying to get a direct stream of patients. Ultimately, you lose coordinated care, because there will be nothing left to coordinate," Ms. Laudicina noted.

Meanwhile, states continue to follow the decades-long practice of requiring insurers and managed care plans—typically in response to special-interest provider groups—to offer specific benefits, such as coverage for diabetes.

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:



Connecticut Gov. John Rowland this month signed sweeping managed care legislation. The new law, which the Legislature passed in May, establishes an external appeals process in which the insurance commissioner or an independent panel of health care experts appointed by the commissioner can rule on coverage disputes. The law also requires managed care organizations to set up internal complaint review procedures; bars gag clauses in which physicians are prohibited from discussing non-covered treatment options with patients; and requires the commissioner to develop an annual "consumer report card" on managed care organizations starting in 1999.

Maine Gov. Angus S. King Jr. signed several health care-related bills during the legislative session that ended June 2.

The new laws:

- Require health care payers to calculate copayments or deductibles based on actual costs rather than percentages.
- State that a beneficiary has no duty to pay back a health insurer for benefits received until the beneficiary has received full payment from other sources. In addition, health insurers recovering payments must reduce amounts recoverable to reflect beneficiaries' attorneys' fees and costs.
- Require HMOs that offer mental health services to cover services performed by a counseling professional.
- Prohibit removing high-risk participants from group health care coverage and forcing them to buy individual coverage.
- Mandate coverage for 48 hours of inpatient care for a mastectomy and 24 hours of inpatient care for a axillary lymph node dissection for treatment of breast cancer.

In **Massachusetts**, legislation that proposes new regulations is pending in the House's Health and Insurance committees. Among its many provisions, the bill would require health insurers to disclose more information so the state can issue report cards on providers, and it adopts a reasonable lay person provision for the coverage of emergency services.

The **New Hampshire** Legislature passed and Gov. Jeanne Shaheen signed a bill that will give the Department of Insurance power to set rules on: managed care networks' procedures in resolving complaints about coverage denials; utilization review processes that networks must develop; credentialing of network health care professionals; ensuring the adequacy of provider networks in managed care plans; and outlining policy on the quality assurance and quality improvement programs that networks should implement.

Meanwhile, the Legislature has agreed to study external review of managed care decisions.

In **Rhode Island**, the House passed a bill that would require health insurers to permit women

See **Health** *on next page*

Health

Continued from previous page

to make an annual routine visit to a gynecologist without a primary care physician's referral. The Senate also passed the bill, which now goes to the governor.

Earlier this month, Gov. Lincoln Almond signed legislation that mandates a 48-hour minimum hospital stay for a mastectomy and a 24-hour stay for axillary lymph node dissection.

The House and Senate also have passed separate bills broadening coverage for cancer treatments. The two bills would require insurers to cover more experimental cancer treatments. Each bill must be approved by the other chamber before going to the governor.

Gov. Almond in April signed a measure requiring health insurers to pay all medical claims relating to an injury or illness arising out of employment, even if the employer disputes the validity of the claim.

Vermont Gov. Howard Dean signed a measure June 10 requiring health insurers to provide the same level of benefits for mental illnesses as for physical ailments. The measure includes alcohol and drug addictions and bars insurers from setting lower lifetime coverage caps for mental illnesses than for physical conditions.

Several bills were still in committee last week in **Delaware**, whose legislative session ended today. Among other things, the bills would require:

• Direct access to obstetricians and gynecologists and would let qualified Ob/Gyns apply to be primary care gatekeepers.

• Coverage of childhood immunizations for 11 conditions.

• Coverage by state-regulated health plans of equipment and supplies for treatment of diabetes.

• Coverage of annual mammograms for women 40 and older.

A comprehensive managed care consumer protection bill now in committee calls for, among other things: a state-appointed oversight agency for managed care plans; sufficient primary care providers and specialists and 24-hour telephone access for plan members; a specific waiting time for appointments; and allowing special-needs patients to select a specialist as a primary care provider.

Late last year, the **District of Columbia** enacted the HMO Act of 1996. The measure forbids HMOs from imposing so-called "gag rules" and requires HMOs to offer a point-of-service option to employers.

Maryland enacted legislation that will require coverage of necessary medical equipment, supplies and outpatient self-management training for people with diabetes. The governor also signed into law measures that will require insurers and HMOs to provide coverage for prostate-specific antigen tests for men aged 40 to 75 and bone mass measurement for diagnosis and treatment of osteoporosis. The laws take effect Oct. 1.

A new law in **New Jersey** requires insurers to cover hospital stays for 72 hours for a radical mastectomy and 48 hours for a simple mastectomy. Also, legislation approved by the full Senate and the Assembly Health Committee would require HMOs to offer a point-of-service option.

Legislation is pending in the **New York** Senate that would give managed care organizations the same liability as physicians for medical malpractice suits. An identical bill is pending in the Assembly.

If the bill is not passed by the time the session adjourns in early July, it will remain active in the next session beginning in January.

A new law in **West Virginia** that goes into effect July 11 bars life and health insurers from denying, canceling or not renewing coverage for victims of abuse. The law also prohibits adding surcharges or rating factors to policies covering victims of abuse.

Pennsylvania did not enact any significant health care legislation.

Alabama enacted several reforms during its legislative session, which ended May 19. Gov. Tony Knolls signed the measures, which:

• Repeal the mandates making federal and state funds available for early intervention services for all eligible infants and toddlers with disabilities and their families.

• Give the insurance commissioner authority to issue regulations to create a high-risk health insurance pool and to promote the availability of coverage to small employers, regardless of worker health status or claims experience.

• Require health plans that offer coverage for mastectomies to cover mammograms at least every two years for women ages 40 to 49 and annually for women age 50 and older.

• Subject HMOs to the same premium tax rates as health insurers.

• Prohibit genetic testing of enrollees for cancer risks.

A **Florida** law sweeps aside one of the "gatekeeper" functions of primary care physicians. Under a "direct access bill" that became law without Gov. Lawton Chiles' signature, managed care subscribers may visit a dermatologist up to five times a year without a referral from a primary care physician.

Other Florida reforms:

• Prohibit HMOs from including "gag clauses" in provider contracts.

• Require HMOs to respond promptly to complaints, advise subscribers of their rights to file a written grievance and establish a procedure for addressing urgent grievances.

• Provide that HMOs inform patients of the organization's quality assurance program and procedures for determining provider credentialing and when services are deemed medically necessary.

• Require insurers to cover prosthetic devices and reconstructive surgery in some cases after mastectomy. This law, which goes into effect Oct. 1, bars insurers from denying or canceling coverage for policyholders who have had breast cancer. The law also gives physicians authority to determine hospital stays after mastectomies.

Lawmakers also passed legislation that brings Florida into compliance with the federal Health Insurance Portability and Accountability Act of 1996.

The **Louisiana** Legislature earlier this month narrowly passed the "Rural Hospital Preservation Act," which includes a hotly contested "any willing provider" provision. The bill would require managed care organizations to contract with all hospitals and the providers who work in those hospitals in parishes with 65,000 or fewer residents. The law would cover most of Louisiana's 64 parishes, excluding only New Orleans, Baton Rouge and a handful of other cities, according to the Louisiana Managed Healthcare Assn. The bill was sent to Gov. Mike Foster last week.

Another bill the Legislature approved and that Gov. Foster is expected to sign would let the state Department of Health and Department of Insurance set standards for provider and consumer complaint resolution and utilization review.

Louisiana lawmakers also considered a proposal to require managed care organizations to meet several mandates already imposed on insurers, including requiring payment within 30 days of claims from participants in point-of-service plans. That measure was passed last week and is awaiting the governor's signature.

The **North Carolina** Senate, which is still in session, approved three managed care bills. The most sweeping would require insurers to provide coverage for mental illness and chemical dependency equal to that for physical ailments. If passed by the House, the measure would take effect with policies issued or renewed beginning Jan. 1, 1998. Another managed care bill would prohibit gag rules and require that health benefit plans provide coverage for emergency room services under specified circumstances. The third bill would require that both patient and physician be consulted before a mastectomy patient is discharged from the hospital. All three measures are before a House committee.

Tennessee Gov. Don Sundquist signed a bill requiring insurers to cover the cost of equipment and supplies such as syringes and blood glucose monitors needed by diabetes patients. The law also requires insurers to cover the cost of training and education to help patients manage the disease.

The **Virginia** General Assembly approved three managed care bills that were signed into law by Gov. George Allen and take effect July 1.

One will require HMOs to provide 24-hour member access to medical care or 24-hour telephone access to a physician or licensed health care professional. The new law also will require HMOs to reimburse hospital emergency facilities and providers for initial screenings and other specified services when a member was referred to the emergency room by a participating physician.

Another law requires the commissioner of health to examine HMOs' quality of services and will require HMOs to inform members of the grievance system.

The third law will require plans that cover prescriptions to offer coverage for contraceptives.

No significant health care legislation was enacted in **Georgia**, **Mississippi** or **South Carolina**. The **Kentucky** Legislature was not in session this year.

In **Illinois**, Gov. Jim Edgar signed a measure passed by the Legislature that bans health insurers from using genetic testing in coverage decisions.

The governor earlier this month also signed legislation requiring insured health plans to provide coverage of Pap smears, prostate exams and naprapathic services, or therapy that uses manipulation of the body without drugs.

Indiana enacted legislation that requires insured health plans to pay for diabetes care, services, equipment, appliances and education. The law bars annual deductibles or copayments that exceed those for similar benefits covered by the insurance plan.

Gov. Frank O'Bannon also signed a bill establishing parity for mental health coverage that closely mirrors federal legislation. The Indiana law, though, only applies to employees covered under the state's health insurance plan.

Other reforms the governor signed require insured plans to pay for reconstructive breast surgery after mastectomies and require managed care plans to maintain written grievance procedures and appeals policies.

Michigan legislators have introduced many bills relating to managed care that are pending in committee. Among them are measures that would: allow obstetrician/gynecologists to become primary care physicians at the request of women in managed care plans; prohibit "gag rules"; ban genetic discrimination by insurers; require HMOs to allow 48 hours of care after mastectomies; and mandate that HMOs cover emergency services, in and out of their networks.

Other pending bills include one that would expand HMO member access to boards of HMOs through creation of a health care consumer advocacy department within the state Health Department.

In **Minnesota**, a reform bill signed earlier this month expands eligibility for a program that provides coverage for low-income residents. The measure also eliminates a 1% premium tax on Blue Cross & Blue Shield plans and HMOs and cuts provider taxes for physicians who serve low-income populations. Another approved measure requires managed care plans to pay for self-education and training for patients with diabetes, while yet another reform requires managed care plans to provide direct access to obstetrician/gynecologists.

Ohio became the first state to give its Insurance Department regulatory authority over all health plans engaged in insurance, even if physicians own or operate them.

The Managed Care Uniform Licensure Act went into effect June 4 after Gov. George Voinovich signed it.

Under the law, managed care entities will be known as "health insurance corporations," or HICs, which pay for, provide or otherwise make available health care services through a panel of physicians.

The new law also places HMOs, health care corporations, dental care corporations and prepaid dental plans under the same regulatory umbrella with all other managed care entities. Previously, preferred provider organizations and physician hospital organizations were unregulated.

Solvency standards for the health insurance corporations are based on the types of services provided. Minimum net worth requirements for HICs vary from $1.2 million to $1.7 million.

Wisconsin legislators are considering a measure that would allow private employers to seek lower health insurance costs by joining with their public sector counterparts in the managed care programs run by Wisconsin's Group Insurance Board. The measure is pending in the Senate Health Committee.

A new **Iowa** law effective July 1 mandates that employers with more than 50 employees and managed care plans provide a point-of-service option. The law also will require managed care plans to make available a POS plan option to employers with two to 50 employees.

The **Kansas** Legislature passed and Gov. Bill Graves signed several health care-related reforms this year, including the Patient Protection Act, which contains provisions effective July 1 that:

• Bring the state into compliance with the federal Health Insurance Portability and Accountability Act of 1996. Group health insurance provisions included adopting the federal definition of "pre-existing conditions." The legislation also extended, to 63 days from 32 days, the gap permitted between prior health coverage and a new group plan to get credit against the pre-existing condition limits. Small-business policies also must be guaranteed available and guaranteed renewable, and the definition of a "small employer" was revised to cover businesses from two to 50 employees.

• Establish a "prudent person" standard for payment of emergency room services.

• Prohibit gag clauses in provider contracts and "negative incentives" that reward providers for not utilizing certain services or specialty care.

• Bar the use of genetic screening or testing in underwriting health insurance.

• Require parity between medical and mental health benefits in all group policies except those for small groups.

Other reforms also effective July 1 will repeal a requirement that HMOs buy medical malpractice insurance and will require, among other things, that employers provide coverage from the date an adopted child is placed in a home.

Missouri Gov. Mel Carnahan last week signed a comprehensive bill that would require organizations that deliver or pay for health care services to maintain an "adequate" provider network, disclose

See Health on page 19

Regulators confront online issues

By Brooks White

THE OPPORTUNITY TO CIRCUMVENT insurance regulation in the United States, through the marketing and distribution of insurance via the Internet, has yet to be tested.

Apart from ongoing study by the National Assn. of Insurance Commissioners, many state insurance departments have not formally confronted this problem. Many find comfort in their state's excessively broad jurisdictional laws, which, if enforced, could probably ensnare the legitimate offshore markets. Even if these laws overcome constitutional challenges, enforcement may still be problematic for the departments if the perpetrators operate from countries with no treaties with the United States.

The California Insurance Department, having an older and narrower law, has formally taken a position on part of the issue. Under California's Bulletin No. 96-4, issued on May 30, 1996, the solicitation of insurance via a Web site of a non-admitted insurer was analogized to be the equivalent of a non-admitted insurer advertising in a magazine of general circulation and including a pre-stamped, self-addressed return mailer for the prospective policyholder.

The California department's position is that if the Web site reasonably would be expected to reach, or is purposefully directed at prospective California policyholders, then the Web site must have a disclaimer of the insurer's unlicensed status in California. If these applicants can obtain an executed policy in California via the Web site, then the policy must be procured through a California surplus lines broker.

Given that this was outlined in a bulletin, the department recognizes that this is its viewpoint and did not cite any statutory authority for its position.

The analogy of a Web site to a magazine ad of general circulation is well-intentioned but inaccurate. Reliance upon the surplus lines laws is also misplaced.

Unlike a magazine that is physically in California, a Web site on a non-admitted insurer's server located outside the state is not soliciting in California. Like any direct placement initiated by the policyholder, it is there to be solicited.

It is the distinction that takes the Web site transaction outside the statutory predicate for the regulation of insurance. The "transaction of insurance," which is the basis for all state insurance regulation, requires, in part, solicitation, negotiation or procurement of insurance within the state.

If there is no solicitation of insurance by a non-admitted insurer because the applicant has dialed an out-of-state server, the next criterion for insurance regulation is negotiation of insurance within the state. If the Web site merely contains a program or template for the inputting of data from California, it would be questionable whether this would constitute negotiation of insurance. The insurer's underwriting and rate quote would be done outside the state and would be merely available to the prospective insured by again accessing the out-of-state server.

The California Insurance Department seems to have recognized this fact, as its focus is on the final criterion for insurance regulation: the procurement of the policy.

In this regard, California agrees that if the policy is delivered to a California resident who is not in the state, then a California surplus lines broker need not be used. The department does not address the issue of the policy being electronically delivered to an out-of-state location or computer, but I believe the result would be the same. It also does not address the possibility that the policy might be kept electronically by the insurer in a book entry format rather than delivered. This would permit a policyholder to access its policy through the Web site, at any time, via a policy number. While I do not believe any insurer has done this to date, the possibility exists that this could be done for standard forms and ultimately save insurers considerable expense. It also would offer the policyholder, who elected book entry when applying for the insurance, an opportunity for permanent record retention.

As it is feasible for a non-admitted insurer through its Web site not to solicit, negotiate or procure insurance in a state other than where its server is located, insurance regulation can be avoided in a state such as California. If the non-admitted insurer's server is offshore, then all U.S. insurance regulation conceivably could be avoided.

Although surplus lines business is exempt from certain licensing and other regulation, it is still within the definition of the "transaction of insurance." It is this distinction that undermines the California department's application of the surplus lines laws to electronic insurance.

Of broader implication is that because such electronic insurance would not be the "transaction of insurance" as currently defined in some state statutes, the independent procurement laws would not apply. This seems to be an incongruous result, as such transactions are clearly direct placements. The fact that most states do not have independent procurement laws is ill considered in light of electronic commerce.

Assuming that the definition of "transaction of insurance" is broadened to include direct placements through any medium—or, as in many other states, be premised upon the location or performance of the risk within the state, regardless of where the insurance transaction directly occurs—the most difficult question of all remains: How will insurance regulation be enforced and premium tax collected if a policyholder can directly obtain insurance electronically from an offshore insurer, bank or other institution?

Because large and middle-market commercial insurance buyers already have found numerous ways to legally circumvent the insurance laws, this is primarily an issue that will become the focus of the small commercial lines market, select specialty lines and personal lines that are based upon standardized product and price. State insurance departments do not have the resources to monitor or prevent such transactions, so enforcement ultimately may have to be through direct placement and financial responsibility laws and through criteria set by commercial participants in their business transactions.

While the industry is cognizant of the susceptibility of the insurance regulatory system to electronic commerce, it has not yet exploited the opportunity. This is partially due to the development of companies' own electronic marketing and internal systems, the incomplete development of electronic signature laws, the limitation on non-admitted insurer defense rights and good citizenship. Rogue insurance markets will not be as charitable. BI

Brooks White is associate general counsel with Reliance National Insurance Co. in New York. The views in this article are Mr. White's and do not reflect those of Reliance Group Holdings Inc. or any of its affiliates.

Workers comp only remedy for injured prisoner

Legal Briefs

Workers compensation is the exclusive remedy for prisoners injured while working on prison jobs, according to the Supreme Court of North Carolina.

Percell Richardson, an inmate at the Caledonia Correctional Institution, was operating a tractor with an attached silage harvesting machine at the prison farm. The farm superintendent directed Mr. Richardson to operate the harvester. During the operation, Mr. Richardson's legs were caught in the silage cutter. His right leg needed to be amputated below the knee. His left leg was permanently and severely injured.

Mr. Richardson filed a claim against the Department of Correction with the State Industrial Commission, alleging negligence due to inadequate training and supervision. The Department of Correction asked the court to dismiss the claim on the ground that workers comp was his exclusive remedy. The trial court ruled for the department.

On appeal, Mr. Richardson argued, in part, that the limitation of prisoners to workers comp as their exclusive remedy constituted a violation of the right to equal protection under both the federal and state constitutions. However, the court concluded that the limitation met constitutional scrutiny because there was a rational basis for the limitation. According to the court, numerous legitimate state interests were rationally addressed by the exclusive remedy effect of the law, including suspending compensation to prisoners during incarceration because their needs are met by the state and limiting the liability of the state in the same way as that of private employers by tying compensation to wages. The trial court decision was affirmed.

Richardson vs. North Carolina Department of Correction, Supreme Court of North Carolina, Dec. 6, 1996 (*BI*/01/July.-$10).

Court bars coverage of assault

An intentional-act exclusion in an employers liability insurance policy bars coverage of an employer's assault on his employee, according to the Supreme Court of Iowa.

At issue in this case was whether the employer's mental state deprived him of the ability to intend the assault he perpetrated. Allied Mutual Insurance Co. and AMCO Insurance Co. provided employers liability insurance coverage to William L. Costello and his business, Costello Insurance Agency Inc. The policies contained an exclusion for "bodily injury intentionally caused or aggravated by you (the insured)."

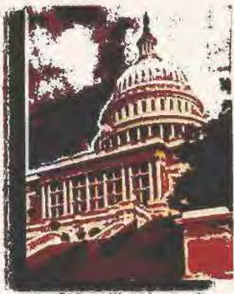
In March 1994, Mr. Costello assaulted his secretary at his business office, causing her severe injuries. The assault occurred after Mr. Costello lost his temper during a dispute with her. He was charged and found guilty of assault. Thereafter, the secretary sued Mr. Costello for damages resulting from the assault. One of the insurers brought this action, seeking a declaration from the court that it did not have a duty to defend him because of the intentional-act exclusion. The trial court found Mr. Costello did not intend to cause injuries to his secretary and that the exclusion did not apply. The insurer appealed.

The appellate court concluded that Mr. Costello was not mentally ill, only that he experienced difficulty controlling his temper. "His assault could scarcely be considered rational, but it does not follow that it was unintentional."

The appellate court was not persuaded that the anger caused a lack of understanding on his part. Thus, the court said the intentional-act exclusion applied and the policy did not provide coverage here. The trial judgment was reversed.

Allied Mutual Ins. Co. vs. Costello, Supreme Court of Iowa, Dec. 18, 1996. Rehearing denied Jan. 23, 1997 (*BI*/05/July.- $10). BI

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



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Health

Continued from page 16

all plan benefits and limitations on care, prohibit "gag clauses," keep mental health records confidential and standardize grievance procedures.

In addition, the bill would:

• Require coverage of off-label uses of federal Food and Drug Administration prescriptions and emergency services based on the opinion of a "prudent lay person."

• Permit medical malpractice suits against managed care organizations and appeals of health care coverage denials.

• Require the Insurance Department to establish and disclose provider credentialing standards and impose fines for violations.

Nebraska Gov. E. Benjamin Nelson recently signed The Managed Care Patient Protection Act, which prevents health plans from imposing "gag clauses" on physicians or offering "unreasonable" incentives to physicians or other health care providers, though that term is not defined. The act also prevents a health plan from imposing unreasonable limits on emergency room care that a "prudent" lay person may seek.

North Dakota enacted numerous health-care related laws that will become effective Aug. 1. Provisions of the legislation will:

• Bar insurers from interfering with communication between health care providers and patients or from retaliating against providers.

• Prohibit third-party administrators from requiring health care providers to indemnify the TPA for any negligence or to waive the right to bring actions against the TPA.

• Extend group coverage for mental health disorders to include residential treatment.

• Establish a minimum post-delivery coverage requirement of 48 hours for mothers and newborns after normal vaginal deliveries and 96 hours for normal Caesarean deliveries.

South Dakota Gov. William J. Janklow signed into law a measure that prohibits health plans from denying benefits to participants who are injured while operating a motor vehicle under the influence of alcohol or drugs. The law becomes effective July 1.

Also effective July 1 is a law that requires health care plans to cover a worker's injury if the worker's employer determines the injury is not work-related. If the health care plan denies coverage without a full explanation, the state's insurance director may determine that the coverage denial is an unfair trade practice. If the injury later is determined to be work-related, the employer must reimburse the health plan and the worker with interest.

Gov. Janklow signed another bill that generally prohibits all insurers from refusing to issue or renew policies based solely on the age, race, color, creed, national origin, ancestry, occupation, marital status or residence of applicants. However, life, health and annuity insurers may deny coverage because of an applicant's age. And, life and disability insurers may use an applicant's occupation to deny coverage.

The **Arizona** Legislature passed and Gov. Fife Symington signed several measures designed to protect the rights of health care recipients. All of those laws become effective July 21.

Provisions of the measures:

• Prohibit managed care plans from barring providers from fully disclosing to patients their medical needs, treatment options and benefits. The legislation also requires utilization review agents and insurers that use their services to adopt written UR plans. And, it establishes procedures for appealing UR decisions.

• Prohibit health, life, disability and long-term care insurers from requiring genetic testing as a condition of coverage.

• Require health care providers to obtain verbal and written consent from their patients before they can practice telemedicine.

Arkansas Gov. Mike Huckabee signed several health care bills during the legislative session, which ended April 17. The measures:

• Require health insurers to cover the diagnosis and treatment of mental illnesses and developmental disorders.

• Require insurers to cover diabetes self-management training and certain equipment, supplies and services for treatment of diabetes.

• Set minimum maternity hospital stay coverage requirements of 48 hours after a normal vaginal delivery and 96 hours for a Caesarean section. In addition, the legislation sets minimum hospital stay coverage of 48 hours for mastectomies, allows women in managed care plans that require a primary care physician to also choose an obstetrician/gynecologist and go directly to the Ob/Gyn without a referral, and prohibits the use of gag clauses.

Oklahoma Gov. Frank Keating signed a managed care patient-protection measure that, among other things, calls for employers to offer a point-of-service plan.

The law requires employers that previously had offered only a health maintenance organization health plan to offer a POS plan as well. The law, which applies to employers with 50 or more employees, became effective immediately.

The chief intent of the law is to direct the State Board of Health to develop rules to protect managed care plan patients. For example, the law calls for rules that:

• Prohibit physician gag orders.

• Require plans to provide clear explanations of benefits.

• Prohibit plans from excluding from their networks physicians who have practices with a substantial number of patients requiring high-cost care.

The **Texas** Legislature passed a sweeping package of reforms, including legislation that allows managed care patients to sue their HMOs. One of the first of its kind, the law exposes HMOs to new civil liability for denying or delaying treatment. Similar legislation is pending in Missouri and New York.

Gov. George W. Bush allowed the bill to become law without his signature. It takes effect Sept. 1. The law requires that, before suing, a patient must appeal the case to an independent physician reviewer selected by the Texas Department of Insurance. The reviewer will determine whether the HMO should have paid for treatment.

Among reforms Gov. Bush has signed are measures that:

• Amend the Texas HMO Act to transfer oversight functions to the Texas Department of Insurance from the Texas Department of Health, establish complaints and appeals procedures and require disclosure of information to patients.

The law also requires referrals to non-network providers for medically necessary covered services not available through network providers and directs the Office of Public Insurance Counsel to produce HMO report cards for consumers.

• Establish standard utilization review procedures and require that personnel performing UR functions must be licensed physicians, nurses or physician assistants.

• Allow women direct access to their obstetrician/gynecologists without a referral from a primary care physician.

• Require HMOs to cover breast reconstruction after mastectomies.

• Mandate coverage for minimum hospital stays of 48 hours after childbirth.

Managed care laws enacted in **New Mexico** during the 1997 legislative session included the Health Insurance Portability Act, which brings the state into compliance with federal law that allows for the portability of health coverage when a person changes jobs, according to Blue Cross & Blue Shield of New Mexico. The law is effective immediately.

In addition, the Provider Service Network Act, among other provisions, creates a guaranty fund association for provider service networks in case of insolvency.

The Minimum Hospital Stay for Mastectomy law, effective July 1, requires hospital coverage to include 48 hours of inpatient coverage for mastectomy and 24-hour inpatient coverage after a lymph node dissection for treatment of breast cancer.

Among the health care-related legislation that was vetoed was the Patient Protection Act, which would have given the state Department of Insurance authority to implement managed care regulations.

Bills that were killed included an any-willing-provider proposal that would have required managed care plans to accept any provider willing to meet the requirements to be a primary care physician. Also killed was a bill that would have required managed care plans to provide unlimited mental health services.

Colorado lawmakers passed legislation that, among other things, would bring the state into compliance with the federal law creating health care benefit portability.

Two companion measures concerned treatment and coverage of "intractable pain" or chronic, incurable pain. The bills would allow plan physicians to prescribe treatment for such conditions and require indemnity plan underwriters to stipulate in contracts beginning Jan. 1, 1998, whether there is coverage for such treatment. Treatment could be provided by a primary care physician or by a pain management specialist.

A controversial section of **Idaho**'s Managed Care Reform Act, which was approved by the 1996 Legislature and signed into law in March, requires managed care organizations to offer a point-of-service option to patients. The law takes effect July 1 and allows enrollees to choose non-network providers for a higher copayment or deductible. Other provisions include benefit disclosure requirements, utilization review protections, grievance procedures and provider contract provisions.

Montana enacted several health care-related bills, including legislation that:

• Requires insurers to cover hospital stays of any duration, as determined by a doctor and patient, and mandates that patients receive written material about their medical conditions and procedures.

• Combines two National Assn. of Insurance Commissioners model acts on network adequacy and quality assurance. The law allows Montana to set minimum standards based on the Health Plan Employer Data & Information Set standards that all managed care companies must meet. It also prohibits managed care companies from requiring prior authorization for emergency care but allows them to decline to reimburse emergency care if it is determined that the care was not really an emergency. The law is effective in phases beginning Oct. 1, 1999.

• Mandates maternity hospital stay coverage of at least 48 hours for a vaginal delivery and 96 hours for a Caesarean delivery.

• Requires HMOs to offer a point-of-service option, though employers may decide whether to buy that option for its employees.

• Allows an obstetrician/gynecologist to be designated as a primary care physician and provides women direct access to an Ob/Gyn.

• Prohibits underwriting discrimination against domestic abuse victims.

In **Nevada**, the Legislature approved and Gov. Bob Miller signed comprehensive managed care legislation that will take effect Oct. 1. The legislation defines managed care and provides oversight for all managed care organizations as well as limits their ability to deny covered health services.

Among its provisions, the law also requires written policies and procedures for utilization review, prohibits managed care organizations from reprisals against physicians who act as advocates on behalf of patients and forbids financial inducements that limit medical services. The law also has provisions for emergency services in managed care plans and requires each managed care organization to develop a quality assurance program.

Managed care organizations also must file with the state and make available to the public financial reports as well as descriptions of any complaints that lead to legal proceedings. A complaint resolution procedure also is required.

Utah enacted legislation that prohibits the use of gag clauses in provider contracts. The law became effective in May.

The **Wyoming** Legislature passed a measure that requires the life and health insurance guaranty association to include coverage of policies sold by Blue Cross & Blue Shield organizations.

California lawmakers have launched an attack on managed care following the defeat of many similar measures at the ballot box last November (*BI*, Nov. 11, 1996; Oct. 14, 1996).

More than 60 bills have been introduced in both houses that, among other things, would prescribe coverage for hospital stays and limit HMO mergers.

Lawmakers are taking aim wherever they suspect California HMOs and other managed care plans are cutting costs at the expense of patient welfare.

But, some of these reforms may be misdirected given the change that has occurred in California health delivery over the past few years, suggested Alan Tomiyama, vp of public affairs for the California Assn. of Health Plans in Sacramento.

"The delivery system in California is vastly different today than it was in 1993, 1994 or even 1995," he said.

While in the past, health plans were blamed for dictating patient care to keep their costs low, "in 1997, hospitals and doctors are capitated," he explained.

As a result, much of the legislation directed at health plans and HMOs will have little or no effect on patient care, Mr. Tomiyama said. "All it's going to do is create more regulation and more paperwork," he said. "It just doesn't make any sense."

While it is unknown at this point how many of the bills Gov. Pete Wilson will sign, he has shown increased interest in health care regulation. His task force of consumer, health care and insurance experts is investigating how best to reform HMO regulation in the state.

Bills that have passed at least one house of the California Legislature include measures that would:

• Compel a managed care network intending to dismiss a doctor to explain its decision and submit disputes to binding arbitration.

• Require managed care organization authorities who make coverage decisions to be licensed physicians in California. The Department of Corporations, which has regulated HMOs in California since 1975, has come under sharp criticism lately as too lax.

• Transfer state regulation of managed care organizations to other state agencies, or to what would be a newly created Department of Health Care Oversight, from the Department of Corporations.

• Require coverage for certain minimum hospital stays for patients who undergo breast cancer surgery or a lymph node exam.

• Mandate maternity hospital stay coverage of 48 hours after a normal vaginal delivery and 96 hours after a Caesarean section.

• Require prior state approval of HMO mergers, in an attempt to curb monopolies and encourage competition.

Oregon Gov. John Kitzhaber signed legislation that would require health insurers to disclose a broad variety of information to plan enrollees. The law also bars insurers from penalizing providers over their communications with plan enrollees, gives enrollees a two-level grievance review process and requires insurers to provide enrollees detailed information on treatment policies for particular conditions.

In addition, the legislation requires insurers to reveal financial risk-sharing arrangements between the insurers and health care providers.

Other health care-related measures have been introduced but still are pending in the Oregon Legislature. They include bills that would:

• Allow school districts to self-insure their health care benefits.

• Require insurers to allow any pharmacy willing to abide by the insurer's reimbursement contract to fill prescriptions.

• Mandate that health plans reimburse enrollees for services rendered by marriage and family counselors.

Washington Gov. Gary Locke vetoed legislation approved by lawmakers that would have blunted several health care reforms created in 1994. Legislators approved a bill that would repeal requirements that insurers offer coverage to all applicants regardless of their medical history, limit waiting periods to no longer than three months and restrict insurers' ability to cancel coverage.

No significant health care legislation was enacted this year in **Alaska** or **Hawaii**. BI

Ruling

Continued from page 2

muter Railroad Co., argued that under the Federal Employers Liability Act, which governs the rail industry, there was no cause for a worker with no physical injury to recover damages.

The high court agreed, to the relief of employers.

Although the decision focused on federal employers, the case was seen as having broad implications for the private sector, as well.

"We're thankful that the court took steps to limit unpredictable liability," said Quentin Riegel, deputy general counsel of the National Assn. of Manufacturers in Washington.

"RIMS is pleased to see that the Supreme Court refused to expand the breadth of the tort of negligent infliction of emotional distress," said Paul Brown, general counsel and director of government affairs for the Risk & Insurance Management Society Inc. in New York.

"We applaud the court for taking such a stand. To have found otherwise would have subjected employers and others to a potential flood of new litigation," said Mr. Brown.

But the justices did not fully answer the question of whether employers in such cases may be liable to pay for medical monitoring of employees, which the worker in this case sought.

Michael Buckley worked as a pipe fitter in Metro-North's Grand Central Terminal project in the late 1980s. Mr. Buckley sued his employer under FELA for $1 million, claiming that the exposure to the dust caused him mental distress. He also asked that Metro-North be required to pay for periodic medical monitoring to detect any sign of asbestos-related disease.

But Mr. Buckley showed no sign of having contracted any disease, and the U.S. District Court ruled in favor of Metro-North. Mr. Buckley appealed the case to the 2nd U.S. Circuit Court of Appeals, which ruled in his favor.

Metro-North then appealed to the U.S. Supreme Court, which heard oral arguments in the case in February (*BI*, Feb. 24) and handed down its decision last week.

Although the justices ruled unanimously that Mr. Buckley was not entitled to any damages for emotional distress, two justices filed a partial dissent on the matter of medical monitoring.

The unanimous court found that Mr. Buckley could not recover emotional distress damages "unless, and until, he manifests symptoms of a disease."

"Common law courts do permit a plaintiff who suffers from a disease to recover for related, negligently caused emotional distress," wrote Justice Stephen Breyer for the court. "Some courts permit a plaintiff who exhibits a physical symptom of exposure to recover."

But "with only a few exceptions, common law courts have denied recovery to those who, like Buckley, are disease and symptom-free," he added.

The majority was more sympathetic to Mr. Buckley's claim that he should receive compensation from the employer for the cost of periodic medical monitoring.

"We do not deny that the dissent paints a sympathetic picture of Buckley and his co-workers; this picture has force because Buckley *is* sympathetic and he *has* suffered wrong at the hands of a negligent employer," Justice Breyer wrote. "But we are more troubled than (the dissenting justices) by the potential systemic effects of creating a new, full-blown, tort law cause of action.

"Tens of millions of individuals may have suffered exposure to substances that might justify some form of substance-exposure-related medical monitoring. And that fact, along with uncertainty as to the amount of liability, could threaten both a 'flood' of less important cases—potentially absorbing resources better left available to those more seriously harmed—and the systemic harms that can accompany 'unlimited and unpredictable liability'—say, for example, vast testing liability adversely affecting the allocation of scarce medical resources.

"The dissent assumes that medical monitoring is not a 'costly' remedy. . . .But Buckley here sought damages worth $950 annually for 36 years; by comparison, of all claims settled by the Center for Claims Resolution, a group representing asbestos manufacturers, from 1988 until 1993, the average settlement for plaintiffs *injured* by asbestos was about $12,500, and the settlement for non-malignant plaintiffs among this group averaged $8,810."

In her partial dissent, in which she was joined by Justice John Paul Stevens, Justice Ruth Bader Ginsburg said: "The court's anticipation of a 'flood' of less important cases and 'unlimited and unpredictable liability' is overblown. The employee's 'injury' in the claim at stake is the economic burden additional medical surveillance entails; if an employer provides all that a reasonable physician would recommend for the exposed employee, the employee would incur no costs and hence have no claim for compensation. Nor does the FELA claim Buckley states pave the way for 'tens of millions of individuals' with similar claims," she wrote for the dissent. "It is doubtful that many legions in the universe of individuals ever exposed to toxic material could demonstrate that their employers negligently exposed them to a known hazardous substance, and thereby substantially increased the risk they would suffer debilitating or deadly disease. Withholding relief, moreover, is dangerous, for lives will be lost when grave disease is diagnosed too late," the dissent added.

'RIMS is pleased to see that the Supreme Court refused to expand the breadth of the tort of negligent infliction of emotional distress,' says Paul Brown.

Justice Ginsburg also called the majority decision denying medical monitoring "enigmatic" and wrote that by her reading of the decision, Mr. Buckley could "re-plead a claim for relief and recover for medical monitoring" provided that he received the relief in some form other than a lump sum.

Despite the ambiguity over liability for medical monitoring, business and insurance groups applauded the decision.

"We're quite pleased with the decision," said Craig A. Berrington, senior vp and general counsel of the American Insurance Assn. in Washington. "We always believed that the case had ramifications beyond FELA. That was one of the reasons we were so intent on getting our views before the Supreme Court in an amicus," he said.

"While the decision addresses only FELA, it sends a very strong signal to courts dealing with the so-called fear of future injury issue in other contexts on how they should address that issue," Mr. Berrington said.

"They provided for everyone a rule that can be easily understood and easily followed: Essentially an individual has a right to bring a tort action if that individual has suffered an injury; not just because the individual has been exposed or come in contact with elements that might cause injury in the future," he said.

Mr. Berrington added two caveats, however. The first is that the decision applies specifically to a FELA case, and there is no obligation for other courts to follow it in similar cases not governed by FELA, he said.

The second caution is that while the court expressed "substantial concern" about medical monitoring claims, it "did not rule that medical monitoring claims were, especially when there were symptoms that actually existed, could never be properly brought," he said.

"You've got to prove your case is what they're saying," said Robin Conrad, vp of the National Chamber Litigation Center Inc. in Washington.

She noted that the U.S. Chamber of Commerce had been concerned with the "potential spillover effect" to the private sector of allowing damages for emotional distress and medical monitoring presented by the *Metro North* case. But the decision shows that "the court is very cautious about entertaining the idea of a separate medical monitoring tort," she said, calling it a "very pragmatic" and "thoughtful" opinion.

She pointed out that Justice Breyer noted tens of millions of people have been exposed at one time or another to toxic substances, in and out of the workplace. She said those concerns show "that the court is thinking beyond the scope of FELA. I think the court is seeing the potential for recovering for exposure only is really tremendous."

Despite the fact that the case addressed only liability under the FELA, NAM's Mr. Riegel said: "It's going to be very important nevertheless, because the Supreme Court generally does not get into interpretations of state product liability issues unless they reach constitutional dimensions. To the extent that the court is interpreting a statute at the federal level, that is very likely to be persuasive at the state level. I think it will have a significant impact on state court product liability cases and workplace safety claims."

Separately, the Supreme Court last week ruled 5-4 in another liability case that guards at private prisons do not enjoy the same legal immunity from civil actions that some guards at state-operated prisons have. The case, *Richardson vs. McKnight*, began when a 300-pound inmate at a privately run Tennessee prison sued guards at the facility. He claimed that his rights had been violated by being placed in tight bodily restraints when he was being transported to the prison.

Metro-North Commuter Railroad Co. vs. Buckley, U.S. Supreme Court, No. 96-320, June 23, 1997.

Richardson vs. McKnight, U.S. Supreme Court, No. 96-318, June 23, 1997. BI

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Global Briefs

Bermuda-based reinsurer **Mid Ocean Ltd.** has offered to acquire the 49% it does not already own of Brockbank Group P.L.C., owner of one of the largest managing agencies at Lloyd's of London. The offer, at 696 pence per share, values Brockbank at £85.5 million ($142.4 million) and values the 22% stake of Chief Executive Mark Brockbank at about £19 million ($31.6 million). . . . U.S. medical malpractice insurer **MMI Cos. Inc.** is acquiring Unionamerica Holdings P.L.C., which through its London company, Unionamerica Insurance Co. Ltd., is a specialty property/casualty reinsurer and insurer. The share-for-share offer, which has been approved by the boards of both companies, values Unionamerica at about $165 million. After the acquisition announcement, Standard & Poor's Corp. affirmed its "A" claims-paying ability rating on Unionamerica Insurance Co. Ltd. . . . **Royal & SunAlliance Insurance Group P.L.C.** is acquiring AMEV (General), an Irish non-life subsidiary of Fortis Group, for £12 million ($20 million). The takeover of AMEV (General), which in 1996 had net premiums written of £23 million ($38.3 million), will raise Royal & SunAlliance's share of the Irish non-life market to around 15% . . . .The British government last week rebuked 24 pension providers or sellers for failing to compensate victims whom they allegedly wrongly advised to switch to individual pension plans from company pensions. The government singled out **Sedgwick Group P.L.C.** and **Legal & General Group P.L.C.** as the worst offenders in failing to meet its timetable. . . .**Liberty ART**, the Argentinian workers compensation subsidiary of Boston-based Liberty Mutual Group, has acquired Argentinian commercial lines insurer Sul America ART from its parent company, Sul America of Brazil. Acquisition of Sul America ART, the sixth-largest workers compensation insurer in Argentina, will make Liberty ART the third-biggest writer of workers compensation in Argentina. . . .**Commercial Union P.L.C.** has doubled to £2 million ($3.3 million) its standard limit for most public liability and product liability policies without increasing rates for policyholders. The increased limit will apply to both existing and new business. . . .**The Institute of London Underwriters**, which represents non-Lloyd's marine insurers operating in the United Kingdom, has tightened its financial requirements for membership. Saying it also would like "universally recognized" membership criteria, the ILU has ruled that members must achieve a Standard & Poor's Corp. credit rating of "BBB" or better, or its equivalent from another credit rating agency. . . .British lawyers face an 80% increase in annual premiums payable to their mutual indemnity insurer, the **Solicitors Indemnity Fund**, because of a fund shortfall estimated at almost £454 million ($755.9 million). The SIF provides all solicitors with at least the first £1 million ($1.7 million) of their indemnity cover, but ended with a shortfall after apparently underreserving for exposures facing some law firms. . . .London-based specialist loss adjusting company **IRISC Technical Services** has expanded further into North America with the opening of regional offices in Houston and Pittsburgh. Simon Severne, ITS business development director, said the opening of the U.S. offices is part of the company's strategy "of providing adjusting services in regions with strategic importance to the product lines in which we operate." . . .Standard & Poor's Corp. has said the impact of **Japan's "Big Bang"** financial liberalization should be "generally positive for the insurance sector over the long term." However, over the short term there is likely to be considerable pressure on some companies, its analysts said at a press conference in Tokyo last week.

U.K. health officials consider action against tobacco firms

By SARAH GODDARD

LONDON—The proposed $368.5 billion settlement between the tobacco industry and state attorneys general in the United States is attracting the attention of health authorities in the United Kingdom.

At least one tobacco company, however, contends that the settlement will not be duplicated elsewhere.

"This is a U.S. solution to a U.S. problem," said a spokesman for B.A.T Industries P.L.C., one of the tobacco companies involved in the proposed settlement.

At the same time, liability insurers in London are not expressing undue concern about their potential liability under the proposed settlement.

Immediately following news on June 20 of the proposed settlement in the United States between state attorneys general and the tobacco industry (*BI*, June 23), several U.K. health authorities started looking into an attempt to recoup from tobacco companies the costs they have incurred over the years treating patients with smoking-related illnesses. Within a week, the authorities agreed to work together on the issue.

The British Medical Assn., an organization

representing all medical practitioners in the United Kingdom, last week issued a statement supporting the principle of "poisoner pays." Tobacco companies should pay for the damage caused by cigarette smoking, which annually costs the U.K. health system around £610 million ($1.02 billion), said the statement.

Dr. Sandy Macara, chairman of the BMA, said that he strongly supports the principle of health authorities and hospital trusts suing tobacco companies to recoup the costs of treating smoking-related diseases.

Also at the end of last week, The NHS Confederation, an association of health authorities and hospital trusts, at its annual conference in Brighton passed a motion stating "That a working group be established. . .to consider the potential contribution of the tobacco companies to the costs to the NHS of smoking-related diseases."

In addition, the confederation authorized the working group to make recommendations on the U.K. government's anti-smoking strategy.

That strategy includes a "smoking summit" of European health ministers called by British Minister of Public Health Tessa Jowell to be held in London next month.

Meanwhile, liability insurers in London are showing little concern that they will have to pay much toward the proposed settlement in the United States.

A spokesman for Equitas Ltd., the reinsurer for Lloyd's of London's pre-1993 liabilities, said, "We don't think this is going to be a

See **Tobacco** *on next page*

European insurers in need of change: Exec

By SARAH GODDARD

COLOGNE, Germany—The traditional arms-length relationship between insurance companies and policyholders is outdated and likely to change, a European insurer executive says.

In Europe, insurers "hardly ever hear what is said" because of the involvement of intermediaries in the business relationship, contends Willi Suter, deputy general manager of Winterthur Swiss Insurance Co. and head of the Winterthur, Switzerland-based insurer's international division. In the future, insurers must "solve the problems of customers better than before" by talking with them, he said.

Although some markets in Europe are trying to keep the traditional arrangement, they likely will be forced to change if they want to survive, predicted Mr. Suter during a keynote address at recent conference on Risk Management & Risk Financing in Europe, sponsored by London-based Risk & Insurance Research Group Ltd.

> **Although some markets are trying to keep the traditional arrangement, they will be forced to change if they want to survive, says Willi Suter.**

Brokers already are seeing their traditional roles eroded as customers become more sophisticated and professional, he said. Instead, brokers are placing greater emphasis on their consulting practices and will survive only if they "stand for added value."

In addition to closer relationships between buyers and underwriters, Mr. Suter identified several other trends that affect European insurers and risk managers.

Globalization is increasing, he said, pointing out that if a company is active throughout Europe, it is already international.

More and more European companies are moving their manufacturing facilities to Asia, noted Mr. Suter, and Latin America is growing in importance as well.

"Europe will continue being important, but the trend will be that Europe will lose a bit of the weight it has been holding," he predicted.

As a result, he said, the commercial insurance market must become more international—in terms of the makeup of its workforce as well as where it locates offices.

The European insurance market has already reached a saturation point in terms of demand for its products, according to Mr. Suter. At the same time, he said, it faces competition not only from other insurers but also from other types of financial services companies.

To remain competitive, the insurance industry needs to enhance its profile in the business world, Mr. Suter said. Risk managers and brokers are in a similar position, he contends.

The insurance industry currently is "not held in high esteem" and does not attract the best people, he said. Talented employees instead are snatched up by banks, which also are offering higher salaries, he said.

Looking to the future, Mr. Suter predicted that the trend toward consolidation and globalization, particularly within the commercial insurance industry, will result in just eight major global insurers and four major global reinsurers by the end of the century. Four of the 12 major players could come "from the German-speaking world," he added.

"There is a certain process of fusion taking place, particularly in the capital of reinsurers," Mr. Suter said.

A key reason the industry is going through these "concentration processes" is that insurance transaction costs are too high, he said.

Competing globally also means that insurers need to invest in international communications networks to exchange data worldwide, Mr. Suter said. However, the high investment costs required could force some players out of the market. "Not everybody is going to be able to afford to be playing the game," he said.

For those that remain, business relationships will be different. "There is going to be a certain bond between the first insurer, the reinsurer and the investment bank," predicted Mr. Suter.

One result of such integration, he said, could be that insurers may require less capital and therefore carry lower financial ratings and still be competitive.

"AA could be good enough," Mr. Suter said of an insurer's rating. An AAA rating requires more than double the amount of equity capital, which investors may not see as being a worthwhile return, he said. BI

Insurers good allies in fighting liability

By SARAH GODDARD

COLOGNE, Germany—Insurance buyers must arm themselves with a battery of defenses against growing liability exposures in Europe, a German insurance executive warns.

The best defense is for the risk manager and insurer to "stick together in tough times," according to Herbert Schilling, a member of the board of Cologne, Germany-based Gerling-Konzern Allgemeine Versicherungs A.G. A company's risk management department should make sure it has fully analyzed potential risks and that the company and the insurer share the same risk management strategy, Mr. Schilling said. "They should become real friends."

Liability exposures have increased over the past four decades as legal systems have become stricter worldwide, he said.

"The claimant is always seen as a good boy who needs help," Mr. Schilling said in a presentation to delegates at the Risk Management & Risk Financing in Europe conference earlier this month. "There is an assumed empty pocket to be filled from an assumed full pocket, though it can drive companies to bankruptcy."

Public opinion also has put pressure on companies from both media and politicians, he said.

At the same time, contradictory expert opinion on assessing causes and effects of potential risks is muddying the waters further.

"Scientists have left insurers in limbo with respect to risks," said Mr. Schilling, giving the example of electromagnetic fields. "No one until recently regarded (EMFs) as a risk," he explained, and while there may be no basis for a bodily injury claim, the fear of injury alone may be enough to create problems.

As these types of issues grow, people will see health risks everywhere,

See **Schilling** *on page 23*

INTERNATIONAL

Tobacco

Continued from previous page
really big event for us."

Tobacco-related claims were factored into the Equitas reserving model, said the spokesman, adding he is confident that the reserves are sufficient.

Tobacco exclusions were added to policies in London in the mid-1960's, at the behest of the tobacco companies, according to a spokesman for Royal & Sun Alliance Insurance Group P.L.C. The tobacco companies wanted the exclusion to allow them to conduct their own legal defenses, he said.

"If we have exposures, they are extremely limited," said the spokesman. He did add, however, that there was always the possibility of "some old policy" lurking that pre-dates the exclusion.

Royal & Sun Alliance is monitoring the situation on a worldwide basis, rather than solely focusing on the U.S. exposure, he said, but is "satisfied that we are adequately reserved for all liabilities."

Some insurance experts suggest that any policies lacking the exclusion might have been voided by the tobacco companies' decision to broker a deal directly with the state attorneys general without any insurers at the negotiating table. Those policies would have included provisions for insurers to lead any legal defense or negotiations, according to market sources.

Another possible defense by the insurance industry includes whether tobacco companies withheld from insurers information about possible health effects of smoking.

Some insurers also think the tobacco companies are unlikely to file

> **Tobacco exclusions were added to policies in London in the 1960's at the request of the tobacco companies.**

claims against their policies because the proposed U.S. settlement includes the provision that 80% of any successful claims against insurers must be put into the settlement fund rather than retained by tobacco companies.

But Paul Hodges, an analyst with Schroders Securities Ltd. in London, has warned that the U.K. insurance industry may be underestimating its exposures. Although he agreed that the 80% rule could stave off claims against insurers, he pointed out that the inclusion of this provision in the settlement showed that state attorneys general thought tobacco companies could have valid claims against their insurers.

Insurers will not know what their potential exposures are until the settlement is ratified by Congress, and then whether tobacco companies will seek coverage.

Indeed, the spokesman for B.A.T, which also owns U.K. insurer Eagle Star Insurance Co., said that whether there was coverage, and how much, depends upon the wordings of "countless different exclusions spanning decades."

The U.S. tobacco settlement may spur more anti-smoking activity in other countries.

German politicians hope that the proposed settlement will help them to pass legislation that would limit smoking in public places in Germany, though product liability laws in Germany make it unlikely that tobacco companies would face litigation, according to Roland Sauer, a member of the German parliament.

At the same time, state governments in Australia are looking at outlawing smoking in certain public places, while local courts are expecting an increase in the number of smoking-related cases brought by Australians exposed to passive smoke. BI

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INTERNATIONAL

Schilling

Continued from page 21

even where they don't exist, resulting in increased claims and increased costs, he said.

Insufficient scientific knowledge of product-related diseases also is contributing to the increased liability problems.

"Science cannot keep track" of product-related risks, said Mr. Schilling, and "the public cannot accept that uncertainty leads to the disadvantage of claimants" rather than strengthening their cases.

Mr. Schilling criticized the increasing "claims consciousness" in society, noting that he thought it is "approaching claims aggressiveness." There is a "decline in assuming personal responsibility," he added.

While the public is looking to shift responsibility, top management is proving weak both financially and psychologically in the face of such claims, Mr. Schilling contends.

Corporations don't like to be publicly criticized, he said. Consequently, management's main concern is "to get rid of the uproar and media and save the company."

As a strategy, this may lead the organization to make larger settlements than necessary, which in turn could make it uninsurable in the future, he said.

And if the worst does happen, Mr. Schilling said, both insurer and risk manager need to show "nerves of steel."

Individually, the risk manager can use several weapons to fight the liability exposure, he said. First in the risk manager's armory is creating a strong public image for the organization, an image of safety and consideration. This will lend less credibility to liability claims.

Mr. Schilling also recommended strength in the face of public criticism, with no signs of nervousness or trembling lips.

In fact, Mr. Schilling advised that risk managers should destroy paperwork that indicates a possible liability problem such as product defects. Documents relating to product development and manufacturing processes should be kept if possible, though, particularly because of the long-tail nature of some of these issues, he said.

He also suggested that risk managers learn how to fight unfounded claims and the increasingly large numbers of claimants, class actions and lawyers. Crisis management techniques and legal training can help the risk manager in these situations, he said.

Finally, Mr. Schilling suggested that insurance buyers ensure they are using the most qualified and solvent insurers available.

Insurers also have a role to play in dealing with the increasing liability problems. They must be certain they have the best internationally experienced staff, said Mr. Schilling, and they should develop close contact with the policyholders. This means not just the insurance buyer, but the legal department, the technical department and top management, he said.

The insurer constantly should be monitoring technical, legal and scientific trends, and develop alternative strategies to defend claims.

The insurer also must play a role assisting its client with political and marketing issues relating to liability problems. And where claims need to be fought, they should be fought strongly, he said. BI

U.K. adjusts to recycling rules

By CAROLYN ALDRED

A European Commission directive expands corporate responsibility for recycling packaging products to reduce waste sent to landfills.

In the United Kingdom, which implemented the directive with new regulations earlier this year, companies that fail to comply with the law risk fines.

Risk managers should keep an eye on the regulations concerning waste packaging, according to Hilary Gallagher, coordinator of health, safety and the environment at Courtaulds P.L.C., a London-based diversified manufacturer.

The regulations are likely to become a major financial issue for some companies, Ms. Gallagher warned.

The U.K. law requires companies to ensure that ever greater amounts of packaging are recycled or retrieved to be reused. The legislation applies almost universally, from manufacturers of raw packaging materials to packaging manufacturers, as well as to users and retailers of any packaged goods.

Despite the potentially heavy fines, which have not yet been determined, companies may join programs that help industries comply with the law.

Under the British regulations, which were passed in March, all companies that handle more than 50 metric tons (110,000 pounds) of packaging materials a year or have revenues exceeding £5 million ($8.3 million) a year must register with the government-funded Environment Agency by the end of August and report how much packaging they use a year.

Companies must then ensure that they help meet the national targets for recovering used packaging and recycling established for each type of packaging material in the regulations. Materials include paper, glass, metals, plastic and wood.

The regulations "are immensely complex, and a lot of businesses have no idea what it means for them," noted Simon Paul, environmental issues manager for British Telecommunications P.L.C. in Swindon, Wiltshire.

"Many companies are only just waking up to the regulations and discovering that compliance with them is going to be very costly," said Allan Rickmann, environmental director at consulting firm Willis Corroon Ltd. in Abingdon, Oxfordshire.

The next few years, in particular, will be particularly burdensome in costs and management resources as companies "get to grips" with the regulations, said Mr. Rickmann.

But, in the long term, the regulations likely will be "effective in that they will make industry use less packaging," he predicted.

Others are more skeptical of the long-term benefits. Mr. Paul called the regulations "unworkable" and said they will be very costly for British industry. The regulations call for companies to ensure that used packaging is either recycled by the consumer or recover it themselves.

Most companies do not consider recycling of packaging a pressing environmental issue, such as energy use, he said. Trucks "trundling up and down the country collecting used packaging" may be more environmentally damaging than the packaging itself, he argues.

The U.K. regulations are exceptionally complex because they allocate differing levels of responsibility along the packaging chain. For example, companies that make components used in manufacturing a box would have a lesser obligation than those that sell the finished containers.

In many other European countries, responsibility lies chiefly with the manufacturers of consumer products. The consumer also undertakes a greater role in many European countries.

"The U.K. approach is different as we have put the onus on the whole chain, from raw material suppliers to manufacturers of packaging to the packaging fillers to the consumer," said Mr. Rickmann.

"Other E.U. countries have focused on a specific sector and have simpler regulations," agreed a spokesman for London-based Incpen, the Industry Council for Packaging & the Environment, an industry-backed special-interest group.

Under the U.K. regulations, the amount of packaging a company must recycle and retrieve—from customers or disposal areas, if necessary—depends on its role in the packaging chain as well as increasing national goals as stated in the E.C. directive.

The E.C. regulations set overall recycling and recovery targets for packaging that each country should reach by certain dates. By 1998, 38% of all packaging should be recovered and 7% recycled. These levels increase to 43% recovered by the year 2000 and 11% recycled; and in 2001 to 52% recovered and 16% recycled.

A formula accounting for companies' role in the packaging chain determines what percentage of packaging must be recycled and recovered according to its "activity obligation," or role in the chain.

Each year, starting this August, every company that handles more than 50 metric tons of packaging or has revenues exceeding £5 million ($8.3 million)—this threshold will be lowered to £1 million ($1.7 million) in 2000—must notify the Environment Agency of the estimated tonnage of packaging, broken down into different packaging materials, it uses/produces in a year.

The company's recycling obligation is then worked out by multiplying the amount of packaging handled by its activity obligation by the U.K. recycling target. Recovery obligation is assessed by the same method. The complexity of the regulations has left "people still scratching their heads despite endless seminars" on the subject, the Incpen spokesman said.

Traditional insurance coverage is not available for companies' exposure to fines, though companies can join "compliance programs." For a fee, these programs assume members' responsibility for meeting the recovery and recycling obligations.

Mr. Rickmann, whose company offers seminars and advice on the regulations, believes that most companies plan to join a compliance program.

Joining a program frees members from the risk of prosecution for noncompliance and represents the "lowest cost, least worry solution for most businesses," according to John Bell, chief executive of London-based Valpak Ltd., the largest compliance program, which has about 750 U.K. member companies.

The Labour government already has recognized the complexity of the rules and pledged to review the obligations as soon as data has been collected from companies later this year.

New Environment Minister Michael Meacher announced in June a modification and review of the Packaging Waste Regulations to ensure that the "share of the responsibility between the sectors in the packaging chain is fair."

He also warned industry that failure to take early action to achieve recycling and recovery would result in a tougher approach. BI

Hong Kong

Continued from page 3

precedents. Under British rule, judicial appeals were heard by the Privy Council in the United Kingdom.

"There is genuine concern about the legal system," said C.J. Steggles, general manager-China/East Asia for Hong Kong-based HSB Engineering Insurance Ltd. "As we go forward toward the 21st century, what's going to happen with statutes, with legal cases? Decisions that were precedents before, will they remain intact?"

"What if a foreign firm gets into a disagreement with a Chinese firm?" Mr. Steggles asked, noting there are questions over how arbitration matters in such cases might be handled under the new regime.

Mr. Steggles emphasized, though, that the Chinese are aware that the rest of the world is closely watching their moves in Hong Kong. "They could reverse themselves a number of years if they take a wrong turn."

"I think the Chinese want Hong Kong to succeed," agreed Mr. Graziano. "If it's badly handled, it will be noticed around the world."

The Joint Declaration means the legal system must be retained during the 50-year period and likely will remain indefinitely, according to George F. Lazovsky, Hong Kong-based chairman of J&H Marsh & McLennan-China.

In a faxed reply to questions about the implications of this week's changeover, Mr. Lazovsky suggested there likely will be a "substantial convergence" between Hong Kong and Chinese law during the 50-year transition period.

But, he added in his response, "As a practical matter, if the legal system were to change abruptly in 50 years, commerce would be seriously interrupted. It is very unlikely that an interruption is in anyone's interest."

Hong Kong's continuing autonomy and preservation of most of its legal system means risk managers, brokers and insurers have little concern for the moment, Mr. Lazovsky suggested. "No wild cards in the commercial deck," he noted.

Risk managers with Hong Kong operations for the most part will be buying the same coverages under the new regime that they purchased when the British were in control. There appears to be little concern over political risks that could leave businesses exposed to losses.

Hong Kong businesses aren't concerned with currency risks because there will continue to be no exchange controls and the Hong Kong dollar will remain fully convertible.

Mr. Steggles pointed out that there is little incentive for insurrection to brew among a population that enjoys the kinds of amenities Hong Kong provides.

"People are still receiving a good education," he said, and have available a fine transportation system, top-notch telecommunications and other comforts.

Some worry that crime could increase if Chinese mainlanders have easier entrance to Hong Kong.

Mr. Steggles pointed out that while the Chinese have stated that entry will be controlled, the lure will be great for illegal immigrants. "It's what Miami is to the Cubans. The streets are paved with gold; everybody has a car. That's what they see here."

If border crossings aren't controlled, "We potentially could see an increase in crime," he said.

There likely will be limits on press freedoms and the citizens' rights to demonstrate, Mr. Steggles said. "But that shouldn't surprise us," because those restrictions exist in other parts of China.

"On a personal basis, people are apprehensive," said Clyde Fritz, a J&H Marsh & McLennan senior vp in New York with clients based in Hong Kong. "On a professional basis, I don't sense that many are overly concerned."

"We're not concerned," said David Herratt, insurance and claims manager at China Light & Power Co. Ltd. in Hong Kong.

China Light & Power hasn't sought out any new coverages for risks that could emerge as a result of the changeover, Mr. Herratt said, and the utility has no plans to add coverage for operations that include a $2.5 billion project in China's Shandong Province.

Although pro-democracy protests are almost certain to be held this week, they are not expected to trigger a harsh response from the Chinese. Mr. Herratt said there is little risk of serious disruption because the new rulers want the world to view the transition favorably.

Said Dean R. Jobko, risk management principal at The Southern Co. in Atlanta, "There may be some changes in the way things are done, but we don't anticipate any big changes." The Southern Co. earlier this year acquired Hong Kong-based Consolidated Electric Power Asia, a utility with power plants in China and the Philippines.

"I think people outside of Hong Kong are more torqued out about it" than those who do business there, Mr. Jobko said.

Mr. Herratt pointed to the influx of insurers to Hong Kong as a show of confidence in the stability of the region. "There are new risk-takers coming in," he noted, from China and other nations.

Mr. Graziano of Reliance National said his company soon will release details of a joint venture it is entering with a Hong Kong insurer. The operation will write professional liability, surety bond and other coverages.

"We don't have any significant concerns about Hong Kong," Mr. Graziano said. "As with any change, it's difficult to look into the future," he added, but it is hard to imagine the Chinese making changes that would derail one of the world's major financial centers.

"A lot of insurers are interested in doing something in Hong Kong," Mr. Graziano noted, and the regulatory climate is favorable for them to locate there.

While licensing requirements in China mean only about one foreign insurer per year is able to locate in that country, it's much easier for a company to join the 276 insurers doing business in Hong Kong. A Hong Kong insurer can be capitalized at about $2 million, while it takes about $100 million in China.

Insurers also can rely on terms of the Joint Declaration that continue separate insurance regulation in Hong Kong.

American International Group Inc. has done business in Hong Kong for nearly 70 years and expects to be there for many more years.

In a written response to a query on the impact of the changes, Maurice Greenberg, chairman of AIG, lauded Hong Kong's infrastructure, "sophisticated financial markets and a talent pool as good as any in the region."

Mr. Greenberg wrote that AIG does not expect "any changes of significance in the business or regulatory environments. In fact, we believe Hong Kong has a brighter future once the transition takes place." BI

AAHP

Continued from page 3

industries rated. That level of confidence was far below those expectations of good service from physicians, at 83%; drug companies, at 79%; and hospitals, at 77%. Health insurance companies drew a 59% favorable response.

According to Mr. Blendon, other surveys show that a majority of Americans believe their ability to get good health care is worse now than three years ago; that the U.S. health care system is partly good but needs some fundamental changes; and that government has a role in protecting consumers from unfair treatment at the hands of managed care plans.

Ironically, however, when questioned about their own experience with managed care, most people—especially those who have been healthy—give the system high marks, he said. Mr. Blendon said the cause of the discrepancy is plans that have fallen outside normal industry experience by becoming involved in outrageous controversies involving denials of care or allegedly poor treatment.

Mr. Blendon drew an analogy between recent HMO experience and the crash of ValuJet Flight 592 in the Florida Everglades in May 1996. Regardless of passengers' personal confidence in air travel before and after the accident, negative news about alleged ValuJet cost-cutting and its supposedly lax inspection record cast a shadow over the entire discount airline industry for a time, he said.

Mr. Blendon's remarks were echoed last month by David Mechanic, director of the Institute for Health, Health Care Policy and Aging Research at Rutgers University in New Brunswick, N.J. Writing in the Journal of the American Medical Assn., Mr. Mechanic noted the public's "growing ease of attributing dissatisfactions and perceived failures to clearly identifiable targets (indeed, an entire industry) than to a single professional, service, or institution."

With HMOs, Mr. Mechanic wrote, "the culprit is now more easily definable and each observable misdemeanor is a signal for what is wrong with managed care."

Part of the answer, Mr. Mechanic wrote, may be for managed care plans to regain respect by working more closely with physicians, increasing flexibility, and easing the "formal explicit rules" of capitation that are causing the public to mobilize politically against managed care. BI

Experts endorse newest HEDIS tool

By ROBERT KAZEL

SEATTLE—The managed care industry is entering a new era of accountability when increasing numbers of employers will use the latest generation of standardized quality measures to decide which plans to bring to the negotiating table and which to ultimately select.

That conclusion was reached by three speakers at last week's American Assn. of Health Plans annual conference in Seattle, though each presented a different perspective on why the industry will turn to the third version of the Health Plan Employer Data & Information Set for guidance.

HEDIS, a collection of standardized performance measures intended to allow the comparison of one health plan to the next, is being marketed by the Washington-based National Committee for Quality Assurance, a non-profit research organization.

The new version of HEDIS aims to give buyers and consumers more information on managed care plans by including a broader scope of performance measures and setting up a process for introducing new measures, as needed, into the next century.

The sole employer in the panel discussion, Thomas J. Davies of Stamford, Conn.-based GTE Corp., said incorporating HEDIS data into employees' selection of medical coverage will allow them to choose the best value for their money. GTE gives financial incentives to those employees who make cost-efficient choices within a range of managed care options.

Mr. Davies, who is manager of GTE's 13-state West managed care region, said in the past five years his company has increased the proportion of employees in health maintenance organizations to two-thirds from one-third.

"We discovered about five years ago, or a little longer than that, that we could no longer from a business point of view tolerate the out-of-control escalating health care costs. Our goal is to move folks up this continuum, toward higher levels and opportunities for care management and cost effectiveness (in HMOs)," he said.

To do that, he said, HEDIS data will be essential to act as a beacon to better health care values.

HEDIS data are powerful for three

purposes, Mr. Davies said: to empower consumers to differentiate among health care plans; to help HMOs improve themselves by showing them their own weak spots; and to help payers design a financial incentive and reward program with true backbone.

"The question always comes up for employers: 'Why are you asking about quality? We know you're just in it for the money.' And the last part really is true. We are in it for the money. But we're very much aware that in our competitive arena quality costs less," he said.

The emphasis that HEDIS places on quality, as opposed to cost, will be welcomed by buyers if employers look at the large picture and not next year's bottom line, he said, praising the Ford Motor Co. slogan "Quality is Job One."

"This is especially true in medicine, and we've known it a long time,' Mr. Davies said.

GTE collects and publishes HEDIS data in five categories: surgical/medical quality; women's health; satisfaction; access; and preventive services. Plans are given one to three diamonds in each category to aid workers in choosing their network. In addition, GTE has used HEDIS periodically as an educational tool by bringing together representatives from health plans in a region and displaying one another's performance ratings.

Such an effort has gone on between GTE and plans in Portland, Ore., in the past two to three years, with an outcomes study on breast cancer treatment supplying the market with data on each HMO's quality. The report was released in May.

HEDIS data can be particularly valuable for use by HMOs for self-diagnostic purposes, said Dr. George Isham, medical director and chief health officer of HealthPartners Inc. in Minneapolis.

"In addition to measurements for accountability and external performance, we can think about measurement in terms of internal usage—the use of measurement for quality improvement," he said.

But Dr. Isham, who is co-chair of the NCQA committee that developed the HEDIS 3.0 measurements, cautioned that there will be hurdles in the successful use of HEDIS measurements in the buyers' marketplace.

"There are tremendous gaps in our ability to measure," he said.

The need also exists to measure quality and outcomes for traditional fee-for-service medicine in addition to managed care, as well as ways to determine just what employers should do with the data after it is obtained.'

An unusual perspective on HEDIS importance came from the third member of the panel, Rep. Lee Greenfield, a state representative from Minnesota who has been instrumental in health care reform there and generally supportive of managed care.

Data must be collected to prove that managed care plans are doing an effective job, he argued, or state legislatures will continue to attempt to regulate them. Outcome measures are the way for HMOs to keep hold of their own destiny.

And even with data, lawmakers sometimes will ignore facts on outcomes, he warned.

"It is the case that no matter how much data you have, one anecdote will wreck it all," he said. "If somebody can talk about somebody's mother in (Minnesota), I don't know how much data you have to show that that's an anomaly."

As for NCQA's managed care accreditation program, which at present is separate from the HEDIS program, Mr. Greenfield was blunt and said he saw little value for consumers.

"Having NCQA accreditation is of about zero interest to the general public," he said. "Nobody cares out there other than members of your own organizations."

Mr. Davis of GTE responded: "For us it (accreditation) is a threshold requirement. . . . We only select from among those plans that have stood for accreditation, and we think those that have tried and failed are a darned sight better than those that decide not even to apply." BI

HMOs urged to focus on satisfying patients

By ROBERT KAZEL

SEATTLE—Managed care plans must replace their desire for short-term market advantage with long-range strategies for pleasing consumers or face an age of intense, sustained regulation by Congress and state legislatures, a federal health official and a leading consumer advocate warned HMO executives last week.

Bruce Merlin Fried, director of the Office of Managed Care at the Health Care Financing Administration, and Ron Pollack, executive director of Washington-based Families USA, told those attending the American Assn. of Health Plans' annual meeting in Seattle that even more massive regulation of managed care than is now taking place may be imminent.

"I suspect we're going to see a whole new array of consumer protection provisions that will come out of this Congress," said Mr. Fried, the administrator for Medicare and Medicaid beneficiaries enrolled in managed care plans. "All of this is a government response to a market that has failed to provide those things that society feels are important."

Although Mr. Fried praised the

quality rules that AAHP has imposed on member plans (see story, page 24), he called the initiative "a baby step, only the first step."

"The challenge is to move beyond short-term objectives to major investments in quality aimed at patient satisfaction," he said. "This is an industry in an adolescence. So much of your efforts go to capturing market share."

HMOs as an industry have the opportunity to avoid severe regulation, but he hinted that their existence may be changed dramatically and involuntarily if they don't mature soon.

"If you can see the vision, if you can see the opportunity of that kind of strategy, you can become an institution as powerful and important and worthy of consideration as consumers, as government, and as the other institutions in society," he said. "If you don't, society will find other ways to get what it wants, and if you can't be there at that table, there's not going to be a table for you to be at."

Mr. Pollack predicted new regulation of managed care plans is inevitable. Although Americans are mostly satisfied with HMO care, he said, they firmly support legislation reining in HMO decisions on patient care.

"I believe the American public actually believes they are at risk even at the same time that they believe they are receiving good care from the HMOs they are in," he said. He especially detects "a new receptivity among state legislators to go further and faster" in regulating the industry.

Heightened regulation will come in may forms, including continued tinkering with HMO operational rules, such as policies on emergency room care and bans on so-called gag clauses in physician contracts.

But the "new frontier of liability" may be the realm of the courtroom, as state legislators give the public power to sue managed care plans for malpractice or other torts, he said. Texas has enacted a law allowing malpractice suits against HMOs, while Missouri and New York lawmakers are considering such proposals.

However, laws that regulate treatment of specific illnesses should be avoided, he said. "Consumers should no more welcome rigid rules about care from legislators than from insurance or HMO executives." BI

AAHP tries to shake up health plans

SEATTLE—For a year, the American Assn. of Health Plans has been trying to convince its more than 1,000 member companies of the gravity of adopting the group's new quality standards.

Last week, at its annual AAHP Institute in Seattle, the association's message got some added emphasis from Mother Nature.

An earthquake hit the city at about 12:15 p.m. on the conference's first day, causing floors to sway underfoot, presenters to stop dead in mid-sentence and audiences to gaze at the ceiling of the Washington State Convention & Trade Center in eerie expectation. Fortunately the temblor, which measured 4.9 on the Richter scale, caused no injuries and only slight damage in the region.

More dramatic for the industry was a vote by the association's board of directors the previous

evening. The board gave its official imprimatur to initiatives, announced over the past year, designed to prod plans to improve care and safeguard the rights of patients.

The board approved a requirement that all existing and new members must abide by "Putting Patients First" policies, which include:

- Member plans cannot require patients to undergo outpatient mastectomies.
- Patients should be fully informed about how their health plan operates and should be able to talk freely with doctors about any treatment option.
- Care denials should be in clear English, and the appeals process should be timely.

The AAHP, formed last year when the Group Health Assn. of America and the American Managed Care & Review Assn. merged, named this year's conference "Patients, Providers & Plans: Effective Partnerships That Work." Emphasizing the need for plans to be conciliatory and conscious of public opinion, the conference attracted a record 3,445 people.

The Institute included a keynote address by Bill Gates, president and chief executive officer of Redmond, Wash.-based Microsoft Corp., and a speech from Washington via satellite by former Surgeon General Dr. C. Everett Koop. Educational seminars covered medical management, health policy, business and communication challenges for health plans, marketplace issues and trends, new health care delivery partnerships, and consumer issues.

More than 300 companies, from diagnostic test manufacturers to drug companies to software firms, displayed exhibits.

Next year's AAHP Institute will be held June 14-17, 1998, at the John B. Hynes Veterans Memorial Convention Center in Boston.

ADVERTISER INDEX

Issue of June 30

ADVERTISER	PAGE #
Bell Atlantic	11R
Business Insurance	11, 18
Carvill America, Inc.	10
Chubb Group of Insurance Co's	9
Conning & Co.	4
Liberty Mutual	28
Wausau Insurance Co.	5
World Captive Forum	6
World Insurance Network	7

Budget

Continued from page 1

bring suit against employers to recover hospital and doctors' bills that they—not Medicare—should have paid for workers age 65 and older.

In addition, a potentially far-reaching amendment in the Senate bill would mandate that group health care plans in which dependents' premiums are subsidized by the states would have to provide full mental health care benefits parity to children.

While the health care provisions could shift enormous costs to employers from Medicare, employer groups last week were concentrating their fire and anger on the 401(k) plan amendment.

Benefit lobbyists are angered because of the damage they say the proposal would wreak on 401(k) plans and their participants.

"While the provision is advertised as helping women, it isn't going to help those who contribute to 401(k) plans. The assumption that spousal consent rules favor women is based on an outdated view of the workforce," said Pam Scott, a principal at The Kwasha Lipton Group in Fort Lee, N.J.

Requiring written spousal consent before loans, hardship withdrawals or lump sum distributions can be made "is the death knell of electronic processing of many 401(k) transactions," said Lynn Dudley, director of retirement policy at the Assn. of Private Pension & Welfare Plan in Washington.

Benefit lobbyists also say the proposal, which is intended to protect women from husbands depleting 401(k) plan assets, could result in lower-paid women cutting back on their 401(k) plan contributions.

While no doubt there have been situations in which husbands withdrew and then squandered 401(k) account balances, benefit consultants and lobbyists say there is no evidence that such a problem is widespread.

"No doubt there are horror stories, but this kind of requirement seems like real overkill," said Fred Rumack, director of taxes and legal services at Buck Consultants Inc. in New York.

Scenarios far more likely to develop if the amendment becomes law are that working women who are covered by 401(k) plans and need immediate access to 401(k) funds, such as for medical emergencies, could find that access blocked by husbands who have abandoned them.

"The woman is going to need the consent of her husband, and the husband is likely to demand a share of the distribution. The amendment is going to put women in a worse position than they are under current law," said Mark Ugoretz, president of the ERISA Industry Committee in Washington.

With immediate access to 401(k) funds conditioned on spousal approval, the APPWP's Ms. Dudley predicts that women, especially the lower-paid, would cut back on their contributions to the plans.

"We really think it will hurt participation levels and we are madder than heck about it," she said.

No comparable measure was included a tax bill passed by the House last week. Benefit lobbyists are gearing up to convince congressional conferees, who will meet next month to iron out differences in the House and Senate tax bills, to drop the Mosley-Braun amendment.

"We are trying to get rid of it," said the ERIC's Mr. Ugoretz.

The 401(k) plan provision is just one of numerous provisions in the House and Senate tax bills affecting employee benefit programs. Standing at the top in terms of financial impact, though, is a provision in the Senate bill that would raise the eligibility age for Medicare to 67 from 65 over a 24-year period beginning in 2003.

While an exact dollar estimate is not available, raising the eligibility age for Medicare would mean a multibillion-dollar cost shift to employers that offer retiree health care plans, as well as to future retirees. The most hard hit would be employers that provide health care coverage to early retirees and continue those programs until the former workers are eligible for Medicare.

"For employers and future retirees, this is the single most important provision in the Senate bill," said Frank McArdle, a consultant at Hewitt Associates L.L.C. in Washington.

A comparable provision does not exist in the House-passed bill and whether to keep, modify or drop the provision will be one of the most contentious issues in the conference committee, benefit experts say. The Clinton administration says it is opposed to a higher eligibility age for Medicare.

But other Medicare provisions in both House and Senate bills, while having a significant cost impact on employers and plan administrators, are non-controversial and will be approved by conferees. Those include proposals that would:

• Increase to 30 months the amount of time employer plans are the primary payer of health care bills for employees who develop end-stage renal disease, or kidney failure. Under current law, employer plans are liable to pay medical bills of those with ESRD for 18 months after which the responsibility shifts to Medicare.

While even very large employers may have only a handful of employees with ESRD, the cost of treatment is expensive, typically in the range of $50,000 a year per individual.

• Give the government more time to file suit to recover funds from employers, insurers and third-party claims administrators for health care claims group health care plans—not Medicare—should have paid (*BI*, Feb. 17; March 27, 1995).

Under this provision, which would end years of litigation on the issue, the government would have up to three years after a health care service was delivered to an employee to bring an action against employers or others for payments Medicare improperly made. This provision would have the effect of overturning a 1994 federal appeals court decision that gave the government in many cases only a year after a service was delivered to bring a legal action.

The provision is directly tied to the federal government's huge Medicare Data Match program, in which the Health Care Financing Administration has been auditing employment records and medical bills to determine if Medicare paid bills that were the responsibility of group health care plans and then has tried to recover the funds for Medicare.

This problem chiefly involves workers who have stayed on the job after 65 and hospitals that incorrectly sent those older workers' medical bills to Medicare rather than to employer plans.

• Allow the government to sue and recover Medicare overpayments from third-party administrators that administer group plans. This provision also would overturn the 1994 appeals court decision, which said the government only could sue TPAs if they actually insured an employer's plan.

However, the provision would let TPAs off the hook if they had no means to recover from their clients, such as if an employer went bankrupt.

And late last week, benefit experts were poring over a surprise amendment by Sens. Pete Domenici, R-N.M., and Paul Wellstone, D-Minn., that would expand—via a backdoor—a 1996 law that calls for limited mental health care benefits parity.

Under the 1996 law, which doesn't go into effect until next year, group health care plans have to offer the same annual and lifetime limits on mental health care benefits as they do for physical disorders. The 1996 law, though, contains numerous loopholes, including one that says group health care plans do not have to upgrade their mental health care benefits if the upgrade would increase employer costs by at least 1%.

The latest provision applies to a new program—called for in the Senate bill—under which the federal government would give states several billion dollars a year in grants to design programs to reduce the number of children without health insurance.

One of the ways states could cut down on the number of uninsured children would be to subsidize premiums for lower-income employees who opt for dependent coverage. If an employer plan enrolled children with funds from a state's grant, the employer would have to provide the same coverage for mental health care benefits for children as they do for physical disorders. However, treatment for substance abuse and chemical dependency would not be considered mental health care services.

The new amendment is a sign that the 1996 law is only a first step in the drive of advocates to achieve complete mental health care benefits parity.

"This is a signal that the proponents of mental health care benefits parity will continue to advance that issue at every opportunity," said Mr. McArdle of Hewitt.

On the pension side, except for the 401(k) provision, the House and Senate bills generally would ease employers' administrative costs and taxes on employees.

For example, both bills would allow employers to give workers terminating employment the present cash value—up to $5,000—of their pension benefits and remove the workers from their plans. That's an increase from the current $3,500 limit on so-called cash outs.

Raising the threshold for cash outs means more participants can be terminated from the plan, which reduces employer overhead costs incurred for such items as sending out annual reports to those individuals and paying Pension Benefit Guaranty Corp. premiums for them, noted Henry Saveth, a principal with William M. Mercer Inc. in New York.

The Senate bill also would exempt employers from filing certain pension reports—the summary plan description and the summary of material modifications—with the Department of Labor and opens the door to electronic transmission of employee benefit materials to employees.

The two bills also would exempt public pension plans from non-discrimination rules—now scheduled to go into effect in 1999—while the Senate bill would protect the tax-favored status of pension plans if they accepted benefit rollovers from new employees' former pension plans, even if the former plans ran into trouble with the Internal Revenue Service.

The Senate bill also contains an amendment—proposed by Sen. Barbara Boxer, D.-Calif.—that would bar employers from requiring employees to invest more than 10% of their 401(k) plan deferrals in their companies' stock.

In addition, the Senate bill would subject all public employers to the 1.45% Medicare payroll tax. The measure also would increase the tax deductions the self-employed can take for health insurance premiums they pay. **BI**

Differing tax treatments

How the House and Senate tax bills would affect employee benefits

Provision	Senate	House
• Higher Medicare eligibility age	X	
• Linking Medicare premiums to retiree income	X	
• Expand employer liability for ESRD	X	X
• Government recoveries for Medicare overpayments	X	X
• Spousal consent on 401(k) distributions	X	
• Repeal of 15% excise tax on big pension payouts	X	
• Increase in pension benefit cash-out limit	X	X
• Reduced pension reporting requirements	X	
• Educational assistance benefits	X	X

GRAPHIC BY ADAM DOI

EMLICO

Continued from page 2

surance Division, EMLICO's Bermuda liquidators and GE, meanwhile, downplayed the ruling.

"We are still confident that on the basis of the facts the settlement will be approved," a GE spokesman said.

Even if Justice Greaney had ruled on the settlement itself, one side or the other would have appealed for review by the full Supreme Judicial Court, added Ian Crawford, a lawyer with Todd & Weld in Boston, representing EMLICO's liquidators. He declined to comment on whether the delay threatens the settlement.

The agreement gave EMLICO's liquidators the option of backing out if the court didn't approve the settlement by May 12. In his ruling, though, Justice Greaney ordered the parties to submit new filings over the summer and said the full court would hear oral arguments in September or October.

"We were hoping to have a quicker resolution," Mr. Crawford conceded.

But the liquidators have not discussed the impact of the delay, and "no decision has been made" regarding the settlement, he said.

EMLICO, a longtime GE liability insurer, won Insurance Division approval to move to Bermuda in 1995. Within four months of the move, it declared itself massively underreserved for GE pollution and asbestos claims and insolvent by more than $500 million. The collapse triggered a storm of litigation, with reinsurers charging that EMLICO engineered its move in a fraudulent scheme with GE to take advantage of Bermuda liquidation laws that would accelerate its reinsurance recoveries.

State regulators launched their own investigation of charges that EMLICO had concealed its insolvency but dropped the inquiry in March when they announced their proposed settlement with EMLICO, a Massachusetts-based former EMLICO subsidiary and GE (*BI*, March 17).

Under the settlement, the Insurance Division would become EMLICO's ancillary receiver and GE environmental claims settlements negotiated by the Bermuda liquidators would be reviewed in Massachusetts by a court-appointed special master recommended by the Insurance Division, GE and EMLICO's liquidators.

Reinsurers labeled the deal a sham and, in a May hearing before Justice Greaney, attacked it on several grounds, including that the settlement and the redomestication itself violate Massachusetts law.

In his ruling last week, Justice Greaney refused to approve or reject the deal, instead agreeing with reinsurers that the full court should review it.

At issue are two sections of Massachusetts law. One, known as section 49A, allows redomestication of an insurer "to any other state." The other, section 180C—the basis for the settlement deal—provides for the court-approved liquidation of an insolvent "domestic company."

Kemper Re and other reinsurers argued that the word "state" in section 49A does not include a foreign country like Bermuda and that EMLICO's redomestication was illegal. On the other hand, if EMLICO's move was legal, it ceased to be a "domestic company" under section 180C and the court has no authority to approve a settlement creating a Massachusetts ancillary receivership, reinsurers argue.

"I conclude that a question exists as to whether the requirements of (section 180C) have been satisfied so as to enable the petition to be considered on its merits," the judge ruled.

He said this issue also raises two other questions: whether a domestic insurer such as EMLICO can, under section 49A, be allowed to redomesticate to a foreign country; and the effect of an invalid redomestication on the legal sufficiency of the commissioner's petition under section 180C.

"I view resolution of the questions to be important for other reasons as well," the judge added. "If the petition is approved, the case could establish a precedent for other insurers to seek to redomesticate to Bermuda or to another foreign country and, in the event of an ultimate insolvency, use Massachusetts as an ancillary site to deal with local or United States claims.

"Any such procedure, in my opinion, should be on firm legal ground," he wrote.

In a footnote, the judge also noted a recent scathing legislative report on the Insurance Division's handling of EMLICO and Ms. Ruthardt's response noting her own "frustrations" with the redomestication.

"In my view, this is not a happy state of affairs and emphasizes the need for careful examination of the petition in view of the precedent that may be set," he wrote.

In another footnote, Justice Greaney invited the parties to consolidate appeals of other EMLICO-related rulings by lower Massachusetts courts. Reinsurers, for example, may try to consolidate their appeal of a state judge's April ruling that they have no standing to sue the Insurance Division to reverse the redomestication (*BI*, April 7).

Separately, the Bermu[illegible] of Appeal has given Ker[illegible] leave to appeal a ruling [illegible]ocked its [illegible]dicial review efforts to ob[illegible]ernment orders allowing [illegible] of Bermuda [illegible]edomestication (*BI*, June 23).

Asbestos

Continued from page 1

As Justice Ruth Bader Ginsburg wrote for the majority, "the class proposed for certification potentially encompasses hundreds of thousands, perhaps millions, of individuals tied together by this commonality: Each was, or some day may be, adversely affected by past exposure to asbestos products manufactured by one or more of 20 companies."

The 20 former asbestos manufacturers had formed the Asbestos Claims Facility, which was the forerunner of the Princeton, N.J.-based Center for Claims Resolution, to handle claims made against them by people exposed to asbestos. The consortium offered to compensate future victims according to the diseases they manifested (*BI*, Jan. 25, 1993). The agreement also allowed compensation for some claims that did not fall into the four categories of compensable diseases. Everyone who had been exposed to asbestos but who had not filed a claim against any CCR member could either opt out of the class formed for the settlement purpose or remain in the class and agree to use the settlement to resolve any future claim.

A federal district court judge approved the settlement in 1994, but a three-judge panel of the 3rd U.S. Circuit Court of Appeals in Philadelphia overturned it in 1996 (*BI*, May 20, 1996). The appeals court held that the $1.3 billion settlement violated Rule 23 because disparity among the claimants' illnesses was greater than their commonality. The judges also said classes formed for settlement purposes had to meet the same standard as classes formed for litigation.

The CCR members appealed to the Supreme Court, but a 6-2 majority agreed with the lower court. Writing for the majority, Justice Ginsburg said that what she described as the "sprawling class" did not meet the requirements of Rule 23. The named parties in the class "with diverse medical conditions sought to act on behalf of a single giant class rather than on behalf of discrete subclasses. In significant respects, the interests of those within the single class are not aligned. Most saliently, for the currently injured, the critical goal is general immediate payments. That goal tugs against the interest of exposure-only plaintiffs in ensuring an ample, inflation-protected fund for the future," she wrote.

The justice also wrote that "many persons in the exposure-only category, the Appeals Court stressed, may not even know of their exposure, or realize the extent of the harm they may incur. Even if they fully appreciate the significance of class notice, those without current afflictions may not have the information or foresight needed to decide, intelligently, whether to stay in or opt out."

The majority did note, however, that "the argument is sensibly made that a nationwide administrative claims processing regime would provide the most secure, fair and efficient means of compensating victims of asbestos exposure. Congress, however, has not adopted such a solution." Rule 23 "cannot carry the large load CCR, class counsel and the District Court heaped upon it," the opinion said.

In a partial dissent in which he was joined by Justice John Paul Stevens, Justice Stephen Breyer wrote that, "I believe that the need for settlement in this mass tort case, with hundreds of thousands of lawsuits, is greater than the court's opinion suggests."

After detailing his concerns about the case, Justice Breyer wrote: "The issues in this case are complicated and difficult. The District Court might have been correct. Or not. Subclasses might be appropriate. Or not. I cannot tell. And I do not believe this court should be in the business of trying to make these fact-based determinations."

Justice Sandra Day O'Connor did not participate in the case.

Lawrence Fitzpatrick, president and chief executive officer of the CCR, said the immediate impact on the facility would be slight.

"With one possible exception, I don't expect any change in the membership. The exception is the trust created as a result of the National Gypsum bankruptcy, and that trust is currently weighing its options, and may or may not continue as a center member. I personally feel that they probably will," he said.

"We are in discussions to try to restructure the settlement," he added.

But the impact on similar attempts to create forward-looking settlements will be considerable, said Mr. Fitzpatrick.

"Obviously what the court did in our case was to set up some fairly stringent road maps that settlements must follow in order to obtain judicial approval, and I think it's going to be difficult in some instances to structure settlements that meet all of the court's criteria."

Said Steve Bokat, executive vp of the National Chamber Litigation Center in Washington: "It's unfortunate. I think it may leave room for some settlements in some of these cases, but it clearly will make it harder to settle. I think it's unfortunate for the companies settling, the plaintiffs, and I think it's unfortunate for the courts, because I think these cases are going to continue to clog the courts." The center had filed a brief supporting CCR's position with the Supreme Court.

On the other side of the debate, a self-described public interest law group called the decision a "huge victory for millions of asbestos victims and all Americans.

"It creates important safeguards against class-action abuse, establishes critical limits on the use of class actions to settle personal injury claims, and raises serious doubt as to whether class actions can ever be used to eliminate future victims' rights. This court's ruling truly enhances our system of justice," said the Washington-based Trial Lawyers for Public Justice in a statement issued shortly after the decision.

But Laurence Tribe, the Harvard Law School professor who had argued against the CCR before the Supreme Court, said the decision won't hamper another high-profile proposed mass-tort settlement, that between state attorneys general and the tobacco industry (*BI*, June 23).

"Nothing in this decision casts a shadow over the authority of Congress to approve something like the tobacco settlement," said Mr. Tribe.

"The asbestos decision underscores how indispensable the role of Congress is, because in the absence of the asbestos ruling, it might have been possible, at least in theory, for the people who negotiated the tobacco settlement to obtain the blessing of one or more courts around the country in order to impose that settlement on the nation without bothering to have the matter debated and perhaps changed in Congress."

Mr. Fitzpatrick and Mr. Bokat agreed that Congress should examine how such mass-tort settlements can be carried out.

"I think there was an understandable backlash in the judiciary to what I call sham class-action settlements," said Mr. Fitzpatrick. He described sham settlements as those class-action suits where individual members of the class receive very little compensation while the attorneys walk away with millions of dollars in fees.

"I think it's time for Congress to step in and do something that eliminates the bogus class-action settlements but still makes it possible to use the class-action settlement mechanism as a tool to solve serious and vexing social problems that cannot really be solved any other way," he said.

Mr. Bokat agreed.

"I think the chamber would support some kind of congressional action" that would protect such future-looking settlements, he said.

"If they want to have a specific rule about asbestos, that should be tailored by Congress," said Victor E. Schwartz, counsel to the Arlington, Va.-based Product Liability Coordinating Committee. "For legislation for asbestos to pass in this Congress, you would probably have to have the trial lawyers, the principal defendants and the unions to agree," he said.

After its *Amchem* ruling, the court declined to review a proposed mass-tort settlement between Fibreboard Corp. and thousands of people who could file asbestos-related injury claims against the company.

Late Friday, the high court ordered the case—*Flanagan vs. Ahearn*—back to the 5th U.S. Circuit Court of Appeals for review in light of the Amchem decision, even though the two settlements raised different legal questions. A second asbestos-related case, *Ortiz vs. Fibreboard*, was also remanded to a lower court for further review.

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Amchem Products Inc. et al. vs. Windsor et al., U.S. Supreme Court. No. 96-270. June 25, 1997.

House bill offers med mal reform

WASHINGTON—Tax legislation passed by the House of Representatives last week would cap medical malpractice damages.

The House tax bill would place a [illegible]50,000 cap on non-economic dam[illegible]in medical malpractice suits. [illegible]would not apply to other [illegible]ury awards. The House [illegible]would limit medical malpractice [illegible]in other ways as well. Those include:

• Punitive damage a[illegible]rds limit. The amount of punitive [illegible]mages that could be awarded could no[illegible]exceed the greater of $250,000 or three times the amount of economic damages.

In order to win punitive damages, a plaintiff would have to prove by clear and convincing evidence that the conduct "manifested a conscious flagrant indifference to the rights or safety of others" or was specifically intended to cause harm.

Also, manufacturers of medical products generally could not be held liable for punitive damages if their products were approved for use by the Food and Drug Administration.

• Periodic payments. Court awards mandating periodic payments of medical malpractice awards of more than $50,000 generally could not be reopened or contested. However, courts still would have the discretion to award lump-sum payments.

None of these medical malpractice reforms, eagerly sought by medical groups, are in the Senate bill. That will leave it up to a congressional conference committee to resolve this and numerous other differences in the two bills.

—*By Jerry Geisel*

Updates

Tribe to form comp system

Continued from page 2

jor advantage to creating an independent system, Mr. Paton said.

Other advantages include greater flexibility in managing claims and a more convenient hearing and adjudication process for workers, he said. The tribal nation will self-insure its risks.

The Navajo Tribal Nation of Window Rock, Ariz., operates its own workers compensation system and self-insures its risks.

Punitive award overturned

SPRINGFIELD, N.J.—A New Jersey appellate court threw out as excessive an $8 million punitive damage award ordered in 1994 against Schering-Plough Corp. in an age discrimination case.

Calling the punitive damage award "manifestly outrageous," a three-judge panel of the Superior Court Appellate Division in New Jersey ordered a new trial to determine punitive damages. The appeals court upheld the lower court finding of age discrimination and $435,000 in compensatory damages.

Salesman Fred Maiorino, a Schering-Plough veteran with 35 years' experience, was fired in 1991 at the age of 63. He alleged that the firing was due to his age, while the Madison, N.J.-based pharmaceutical company contended it was due to poor performance.

Reading from a statement, a spokesman for the company said Schering-Plough was "gratified" by the June 25 ruling but was "disappointed" the court affirmed the compensatory damages.

Aetna sues over Texas HMO law

HOUSTON—Aetna Health Plans of Texas Inc. is suing to block implementation of a Texas law that would allow medical malpractice lawsuits against managed care plans.

The Houston-based health maintenance organization filed the suit earlier this month in U.S. District Court in Houston, charging that the law scheduled to take effect Sept. 1 would drive up health care costs and make care less accessible for many Texans.

The suit claims the law is pre-empted by the federal Employee Retirement Income Security Act of 1974 and the Federal Employees Health Benefit Act.

The Texas Department of Insurance and Insurance Commissioner Elton Bomer are named as defendants because of their authority to enforce the act.

The Texas law is the first to allow such suits, though similar laws are pending in Missouri and New York.

Travelers repurchases stock

HARTFORD, Conn.—Travelers Property Casualty Corp. has agreed to repurchase 6.6 million shares of its common stock held by various investors, increasing the Travelers Group's ownership of the unit to 83.4%from about 82% said a spokesman.

Hartford, Conn.-based Travelers agreed to pay a total of $240.8 million for 20%of the holdings of each of the private investors: Aetna Services Inc., J.P. Morgan Capital Corp., Fund American Enterprises Holdings Inc. and The Trident Partnership L.P. The shares purchased will be used to issue stock for various compensation plans and for other corporate purposes.

Robert I. Lipp, chairman and chief executive officer of Travelers Property Casualty Corp., said in a statement, "These repurchases are a solid investment and represent our continuing positive outlook for the company."

Briefly noted

London-based broker **C.E. Heath P.L.C.** on Friday agreed to a management buyout of the company. The offer, which is valued at approximately £98 million ($163.2 million), would pay 143 pence ($2.38) per share for Heath stock, which was trading at 129 pence ($2.15) as of last Friday. Heath, which ranks among the world's largest brokers, announced the buyout negotiations May 30 (*BI*, June 9). The management bid was backed by DLJ Phoenix Private Equity Ltd. . . .HCC Insurance Holdings Inc. of Houston is acquiring all outstanding shares of **Managed Group Underwriting Inc.**, a Kansas City, Mo.-based managing general agency specializing in medical stop-loss insurance. . . .The House Banking Committee has narrowly approved a **financial services reform bill** that would allow affiliations between commercial banks and insurance companies and other non-banking businesses. The measure—H.R. 10—is expected to be taken up by the Commerce Committee later this summer. . . .CIGNA Corp. said its **CHC Acquisition Corp.** subsidiary has completed its $21.75 per share cash tender offer for the outstanding common stock of Healthsource Inc. CIGNA announced in February it planned to acquire Healthsource for about $1.7 billion, including the repayment of about $250 million in outstanding Healthsource long-term debt (*BI*, May 12, March 3). . . . **Sen. James Jeffords**, R-Vt., said he intends to introduce legislation that would gradually increase the lifetime benefits employers and insurers would have to offer in their health care plans. The minimum limit would be set at $5 million in 1998 and then would be increased to $10 million in 2002. However, the lifetime cap requirement would not apply to employers with fewer than 20 employees. Typically, employers now include limits of $1 million to $2 million in their health care programs. . . .Edgar "Sandy" Clark has resigned as executive director of the **Surplus Lines Assn. of California**. Mr. Clark joined the association in 1995 after numerous years in the brokerage side of the insurance business, most recently with the former Alexander & Alexander Services Inc. in San Francisco. No replacement has been named yet, and Mr. Clark could not be reached to discuss his plans.

Lilly

Continued from page 3

ffice of The Segal Co., said the writedown will make the pharmaceutical manufacturers a lit- le more hesitant" to acquire PBMs.

Lilly and others outlined several reasons PCS as not lived up to expectations.

They include "the collapse of government-ini- iated plans for large-scale health care overhaul, ndustry concerns about the Federal Trade Com- nission focus on the Lilly-PCS combination and he slowing of the industry trend toward strict nanaged health care," Randall L. Tobias, Lilly's hairman and chief executive officer, said in a tatement. "These factors and the competitive nvironment that has limited the ability of cer- ain PCS services to contribute to operating profits at anticipated levels have adversely affected our anticipated return from our investment in PCS. Therefore, we have determined that it is appropriate to make this adjustment."

Said Mr. Kaplan, "PCS certainly has a lot tougher competition now than it did five years ago."

Also, after Lilly acquired PCS, it unsuccessfully looked for some other company to buy into the PBM's ownership, which would have offset the hefty price Lilly paid for PCS.

Mr. Vietor noted that PCS' late entry into the mail-order prescription business also is a factor. Mail-order is "where the money is," he said, but PCS only last September launched a mail-order pharmacy.

In the wake of Lilly's acquisition of PCS, the FTC indicated it would continue to review the issue of drug manufacturers purchasing PBMs.

In a separate development in the PBM industry last week, the FTC last week informed Rite Aid Corp. that it has closed its investigation into the refusal by Rite Aid and other pharmacy chains to participate in a Maryland State Employees prescription drug plan managed by Merck/Medco Managed Care Inc., a PBM.

The retail drug chains balked at the plan, saying Medco's intended reimbursement rate for state employees was too low (*BI*, Jan. 1, 1996).

Martin Grass, Rite Aid's chairman and chief executive officer, said in a statement: "Rite Aid Corp. is seeking a fair price on the pharmacy services it provides. If our analysis of a prescription drug plan leads us to conclude that we are not being offered a fair price, then we will not participate."

A lawsuit filed by Merck Medco against Rite Aid in federal court is still pending. BI

BI Insurance Index

1,480 / 1,460 / 1,440 / 1,420 / 1,400 / 1,380 / 1,360 / 1,340 / 1,320 / 1,300 / 1,280 / 1,260 / 1,240 / 1,220

5/9 5/16 5/23 5/29 6/6 6/13 6/20 6/27

Base=100 on Dec. 29, 1978
Source: Nordby International Inc.

Workers

Continued from page 3

Approximately 25% of the respondents had ack injuries, 11% had broken bones, and 10% ad cuts. The most common work-related ill- esses were stress, 45%, and allergies, 17%.

Researchers found some key differences com- ared with results of a 1994 study. The number f employers offering injury-prevention pro- rams increased to 52% in 1997, up from 43% in 994. Also, return-to-work programs increased 41% from 33%. A return-to-work program ut in half the likelihood that a worker would be out one month or longer and reduced the likelihood that he would hire an attorney.

The number of employers that kept in touch with workers during their recovery dropped to 32% in 1997, down from 50% in 1994.

"These findings suggest that employers are increasingly likely to understand the need for injury prevention and return-to-work programs in workers comp," Robert Schussel, vp and managing director of research for The Gallup Organization in Chicago, said in a statement. "However, in the process, employers are forgetting the 'human element'—letting injured workers know that they are concerned about their recovery and return to work."

The study also points to some opportunities for employers. For example, only 19% of respondents said their employers recommended doctors or hospitals to use for treatment, even though 76% viewed such recommendations as positive or neutral.

This finding represents "a huge opportunity," especially because workers comp outcomes "are most positive when treatment is provided by occupational health specialists with track records of achieving positive, sustained return-to-work results," Ms. Bowling said.

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For a free copy of the 1997 Injured Worker Study Report, call Intracorp at 215-761-7144.

PCS catastrophe options

As of June 27

Call spread	Price bid/ask
Eastern September 1997	
40/60	3.2/3.8
60/80	2/—
80/100	1.5/1.9
National Annual 1997	
80/100	3.5/5
120/140	—/5
June Midwestern 1997	
10/20	.1/1.6
California Annual 1997	
40/60	.6/2
60/80	—/1.5
Western Annual 1997	
40/60	.8/2.6
60/80	—/2
Southeast September 1997	
40/60	2.5/3.5
60/80	2.2/—
80/100	.5/1.9

Total volume: 307 Total open interest: 13,822

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.
Source: Chicago Board of Trade

Risk managers head back to campus

By SHANNON GALLAGHER

NEW YORK—A few of the nation's top risk managers will be heading back to college as the Spencer Educational Foundation Inc. introduces its Risk Manager in Residence Program.

"With the current flow and downsizing of business, it would be an opportune time to teach the risk management discipline as very much a part of the corporate world," said Angela Sabatino, secretary and administrator of the New York-based foundation, which promotes risk management education.

The program, which will be rolled out as early as November with a risk manager lecturing at each of four universities, is the brainchild of the late Anita Benedetti, who was president of the foundation from 1985 until 1996, and James V. Davis, chairman of the foundation's Education Committee and chairman and chief executive officer of Willis Corroon Advanced Risk Management Services in Nashville, Tenn.

For the two to three days the risk managers are on campus, undergraduates majoring in business and finance will meet them through a series of lectures, question-and-answer sessions and informal dinner discussions. Topics will be selected jointly by the universities and the risk managers in an effort "to share what the real day-to-day, hands-on experience (of a risk manager) is," Ms. Sabatino said.

Georgia State University in Atlanta, Northeastern University in Boston, Southwest Missouri State University in Springfield and the University of Georgia in Athens were chosen from more than 100 universities throughout the United States and Canada, based on proposals that Ms. Sabatino described as "appearing the most productive and all-inclusive." Each university was granted $3,500 for travel, housing and other expenses related to the Risk Manager in Residence program.

These universities will assist in selecting risk managers, which should be completed by the end of the summer and announced in September. The foundation is looking for risk managers with at least 10 years' work experience who ideally have teaching experience in the Chartered Property & Casualty Underwriter or Associate in Risk Management programs and good communication skills. Participants also must be able to spend two to three days on a college campus.

Resumes or recommendations of potential qualified candidates are due July 18 to the Education Committee, Spencer Educational Foundation Inc., 655 Third Ave., 2nd Floor, New York, N.Y. 10017. Address all resumes to Angela Sabatino.

British Issues

June 26 Companies	Price pence	P/E	Div. pence	Yield %	1 week high—low
Comml Union	664	10.4	30.3	5.7	764—550
Genl Accident	883	6.4	34.3	4.9	978—614
Gdn Royal Exch	276	5.7	10.0	4.5	311—227
Independent	838	10.4	13.3	2.0	847—456
Royal & Sun	450	13.4	19.0	5.3	529—357
Brokers					
Bradstock	83	11.9	6.4	9.9	90—54
CE Heath	129	15.6	4.5	4.4	135—74
Lmbrt Fenchurch	112	NA	8.4	9.9	138—101
Lloyd Thmpson	176	NA	10.0	7.1	206—163
Nelson Hurst	133	12.1	8.6	8.1	206—121
Sedgwick Grp	124	10.6	8.9	7.2	144—115
Steel Brl Jones	31	10.6	1.5	6.1	44—22
Willis Corroon	130	11.1	6.6	6.4	165—117

Source: Nordby International Inc.

BI Industry Stock Report JUNE 23, 1997, THROUGH JUNE 27, 1997

		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
BROKERS							
Acordia Inc.	**NYS**	**39.88**	**0.00**	**37.50**	**40.00**	**27.25**	**32**
E.W. Blanch Holdings Inc.	NYS	26.38	-1.40	31.06	27.13	17.75	34
Gallagher Arthur J. & Co.	NYS	35.31	1.62	13.91	35.50	29.13	104
Hilb, Rogal & Hamilton	NYS	16.94	6.69	27.83	17.00	11.38	151
Kaye Group Inc.	NDQ	4.88	0.00	-7.14	7.00	4.38	180
Marsh & McLennan	NYS	146.25	-1.85	40.63	150.50	88.00	1400
Poe & Brown	NDQ	35.50	6.37	33.96	36.50	23.50	41
BROKERS	AVERAGE		1.63	25.39			
INSURERS/REINSURERS							
ACE Ltd.	NYS	74.63	6.80	24.12	74.63	40.88	722
Acceptance Insurance Cos.	NYS	21.56	-3.09	9.18	23.13	16.63	169
AEGON N.V.	NYS	69.38	-3.31	9.68	76.63	42.25	3776
Aetna Life & Casualty	NYS	103.94	-3.87	29.92	112.75	55.38	3480
AFLAC Inc.	NYS	50.75	1.00	18.71	51.38	28.25	1067
Allied Group Inc.	NYS	38.69	0.16	18.58	41.25	22.38	84
Allmerica Prop. & Casualty	NYS	33.13	0.76	9.05	33.13	25.63	198
Allstate Corp.	NYS	74.13	-0.34	28.08	77.00	40.88	4456
AMBAC Indemnity Corp.	NYS	78.38	-4.86	18.08	84.50	47.00	525
American Bankers Ins.	NDQ	61.44	-9.73	20.17	69.13	39.50	776
American Financial Group	NYS	42.19	3.85	11.75	42.19	28.63	505
American General	NYS	48.56	-0.38	18.81	49.63	34.00	2691
American Heritage Life Ins.	NYS	31.31	1.01	19.29	31.63	19.00	194
American Indemnity/Fin'l	NDQ	12.50	0.00	21.95	14.00	9.50	1
American International	NYS	150.06	-0.12	38.63	150.63	90.13	3195
Aon Corp.	NYS	52.06	-0.36	25.70	53.38	31.75	1756
Argonaut Group	NDQ	29.63	0.42	-3.66	32.25	26.75	99
Baldwin & Lyons Inc.	NDQ	20.13	-1.83	9.52	20.75	17.38	22
Berkley W.R. Corp.	NDQ	57.75	5.12	13.79	59.25	40.25	552
Berkshire Hathaway Inc.	NYS	47600.00	1.28	39.59	48600.00	30100.00	1
Capital RE Corporation	NYS	53.50	3.38	14.75	54.31	33.00	72
Capital Transamerica Corp.	NAS	26.63	21.02	-13.41	27.38	12.13	102
CapMac Holdings Ltd.	NYS	33.38	-3.96	0.75	36.88	22.50	1079
Capsure Holdings Corp.	NYS	12.63	2.02	9.78	18.88	8.00	117
Centris Group Inc.	NYS	21.25	2.41	8.28	21.25	14.88	23
Chartwell Re	NYS	29.63	3.04	10.75	29.63	21.00	135
Chubb Corp.	NYS	67.56	-0.09	25.70	68.50	40.88	2162
CIGNA Corp.	NYS	179.25	-4.27	31.20	187.25	105.50	856
CNA Financial Corp.	NYS	104.88	1.70	-1.99	114.75	95.88	187
EMC Insurance Group Inc.	NDQ	13.25	6.53	10.42	13.50	10.13	86
Enhance Financial Services	NYS	43.75	1.16	19.86	45.19	26.13	100
Everest Reinsurance	NYS	37.88	5.94	31.74	37.88	22.50	872
Executive Risk Inc.	NYS	52.38	-0.95	41.55	56.38	33.38	26
EXEL Ltd.	NYS	51.88	-2.12	36.96	53.25	31.75	731
Fremont General Corp.	NYS	38.69	3.86	24.80	38.75	21.50	805
Frontier Insurance Group	NYS	64.75	1.57	69.28	65.50	32.63	310
Gainsco Inc.	NYS	9.00	1.41	-6.49	10.88	8.13	278
General RE Corp.	NYS	185.06	-2.08	17.31	189.75	140.75	912
Gryphon Holdings	NDQ	15.25	-1.61	7.96	16.25	12.00	20
Guaranty National Corp.	NYS	24.63	-1.50	47.01	25.75	13.50	112
Harleysville Group	NDQ	37.88	0.00	24.18	38.38	24.50	95
Hartford Steam Boiler	NYS	53.00	0.00	14.29	53.88	42.75	147
HCC Insurance Holdings	NYS	27.00	-4.42	12.50	32.75	21.50	933
IPC Holdings Ltd.	NDQ	27.00	-2.70	20.67	28.13	19.50	700
ITT Hartford Group	NYS	83.88	-1.18	24.26	86.88	50.50	1235
LaSalle Re Ltd.	NDQ	29.88	3.91	2.14	30.75	21.00	370
Lincoln National	NYS	64.81	-4.34	23.45	68.63	40.75	1645
MAIC Holdings Inc.	NYS	40.38	-2.12	19.19	41.38	28.25	36
Markel Corp.	NYS	129.00	0.78	43.33	132.00	83.00	22
MBIA Insurance Group	NYS	116.00	-3.73	14.57	122.00	73.00	471
Meadowbrook Insur. Group	NYS	24.88	0.00	18.45	32.00	15.25	34
Mid Ocean Ltd.	NYS	53.50	-2.73	1.90	56.38	38.13	217
MMI Cos. Inc.	NYS	26.13	1.46	-18.99	33.38	20.75	379
Mutual Risk Mgmt. Ltd.	NYS	45.38	4.61	22.64	45.38	26.88	633
NAC Re Corp.	NYS	46.19	-3.27	36.35	48.00	30.25	298
Navigators Group	NDQ	17.75	5.97	-2.74	20.25	15.75	50
Nobel Insurance Ltd.	NDQ	15.00	0.84	19.40	15.38	11.00	136
NYMagic Inc.	NYS	20.38	-1.81	13.19	21.13	17.00	11
Ohio Casualty Corp.	NDQ	44.50	-3.65	25.35	47.50	30.00	349
Old Republic Int'l	NYS	30.38	-0.41	13.55	31.25	20.63	653
Orion Capital Corp.	NYS	74.75	0.50	22.29	75.25	47.88	111
Partner Re Ltd.	NYS	38.00	-0.65	11.76	38.88	25.63	488
Penn-America Group Inc.	NDQ	15.50	4.20	44.19	15.50	9.63	43
Philadelphia Cons. Holding	NDQ	33.38	-3.96	43.55	35.25	16.75	35
PXRE Corp.	NYS	31.38	5.02	26.77	31.38	22.25	115
• Reliance Group Holdings	NYS	12.06	-0.52	32.19	12.75	6.50	1820
Reliastar Financial Corp.	NYS	72.31	0.61	25.22	73.50	40.00	713
RenaissanceRe Holdings Ltd.	NYS	38.00	-1.62	15.15	41.25	26.75	1792
Risk Capital Holdings	NDQ	20.75	3.75	7.10	21.00	15.88	115
RLI Corp.	NYS	35.38	-1.05	5.99	36.63	23.38	99
St. Paul Companies	NYS	77.38	-2.52	31.98	80.25	50.63	1000
SCOR	NYS	40.59	1.72	18.36	43.50	34.00	11
SAFECO Corp.	NDQ	47.00	-3.59	19.18	49.38	32.00	2379
Seibels Bruce Group	NDQ	7.63	-1.61	-7.58	11.25	5.88	3
Selective Ins. Group	NDQ	48.75	1.56	28.29	49.13	31.00	126
Sphere Drake Holdings	NYS	8.69	-10.90	-2.11	10.50	8.13	455
TIG Holdings	NYS	31.94	5.14	-5.72	38.00	26.38	2211
Titan Holdings, Inc.	NYS	23.56	8.33	42.80	24.25	12.75	825
Tokio Marine & Fire	NDQ	64.38	4.25	38.07	66.75	42.00	113
Torchmark Corp.	NYS	72.25	-0.52	43.07	72.94	40.25	1016
Transatlantic Holdings	NYS	100.00	-2.79	24.22	104.00	65.00	130
Travelers Aetna Property	NYS	39.13	-1.88	10.60	40.38	23.13	516
Travelers Corp.	NYS	63.75	-3.41	40.50	66.13	29.13	7202
Trenwick Group Inc.	NDQ	38.38	9.64	24.46	38.38	30.75	162
Unico American Corp.	NDQ	10.88	6.10	0.00	11.25	7.13	27
Unionamerica Holdings	NYS	20.69	6.09	16.55	20.94	14.75	239
United Fire & Casualty	NDQ	37.50	-1.96	6.38	40.00	29.75	16
Unitrin	NDQ	62.31	3.64	11.77	62.31	44.25	367
UNUM Corp.	NYS	43.75	-3.31	21.11	46.50	28.38	1372
USF&G Corp.	NYS	24.06	-2.78	15.27	25.00	15.00	1490
Vesta Insurance Co.	NYS	45.44	-4.84	44.82	49.00	24.50	168
Washington National	NYS	28.13	-1.32	2.27	30.75	25.13	89
Zenith National Ins.	NYS	27.06	-1.14	-1.14	28.88	24.63	62
Zurich Reinsurance Centr.	NYS	39.25	0.00	25.60	39.38	28.38	56
INSURERS/REINSURERS	AVERAGE		0.26	18.51			

Note: AVEMCO merged w/HCC Holdings, GCR Holding acquired by EXEL, USLIFE merged w/American General.

HEALTH MAINTENANCE ORGANIZATIONS		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
Healthsource Inc.	NYS	21.81	0.87	66.19	21.88	9.75	991
Humana Inc.	NYS	22.88	-4.19	20.39	24.75	15.00	3733
Oxford Health Plans	NDQ	73.00	-0.51	24.65	75.75	27.69	6383
Pacificare Health Sys.	NDQ	59.38	-27.31	-26.92	86.25	59.38	2892
Safeguard Health Enter.	NDQ	10.56	-3.98	-39.64	22.50	9.63	139
Sierra Health Services	NYS	30.75	-2.77	24.87	34.88	22.38	246
United Healthcare Corp.	NYS	52.50	-4.33	16.67	56.75	30.00	8141
Wellpoint Health Networks	NYS	46.00	-3.66	33.82	51.25	23.38	1728
HMOs	AVERAGE		-5.74	15.00			
ALL COMPANIES	AVERAGE		-1.28	19.64			

Top advancing issues: Capital Transamerica Corp., Trenwick Group Inc., Titan Holdings Inc. Leading decliners: PacifiCare Health Sys., Sphere Drake Holdings, American Bankers Ins. Most active issue: United Healthcare Corp. The *BI* Index dropped 1.6%; the Dow Jones 30 Industrials dropped 1.4%; the S&P 500 decreased 1.3% and the NYSE Composite dropped 1.0%. Average P/E: Brokers, 19.9; Insurers/reinsurers, 43.3; HMOs, 31.1.

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Risk manager Theresa Baer was not only impressed by how we reduced her insurance cost by 15%, but by how we gave her the courage to take another risk. A two-week vacation.

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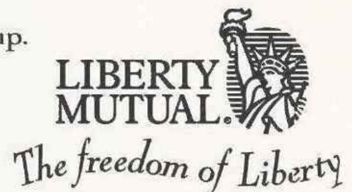
➢ *There's more information we'd like to share. So please call John Ryan at (617) 574-5842 or visit our website at http://www.libertymutual.com*



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