

Business Insurance

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

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New Cap Re (Bermuda) losses force a halt to underwriting

HAMILTON, Bermuda—New Cap Reinsurance Corp. (Bermuda) has stopped writing new business, as its statutory capital has fallen below the \$100 million regulatory requirement for its license in Bermuda.

The drop in capital results from heavy losses the reinsurer suffered in 1998. New Cap Re issued a statement last week, saying: "The directors have temporarily suspended writing new business in the Bermudian subsidiary pending a full review of operations. New Cap Re has notified the Registrar of

See Updates on next page

Watson Wyatt to exit defined contribution recordkeeping

By JERRY GEISEL

BETHESDA, Md.—With a shrinking book of business, Watson Wyatt Worldwide is pulling out of defined contribution plan recordkeeping as it continues its strategy of focusing on pure benefit consulting.

Last week, Watson Wyatt disclosed that it will exit the business of defined contribution plan recordkeeping by July, transferring those operations to First Data Investor Services Group, a retirement and mutual fund services unit of payment and information services giant First Data Corp. of Atlanta. Financial terms of the transaction were not disclosed.

As part of a strategic alliance, Watson Wyatt and First Data will absorb any conversion costs for clients that move their defined contribution plan recordkeeping to First Data.

Watson Wyatt's exit comes after years of a steady decline in its defined contribution plan recordkeeping business. Five years ago, defined contribution recordkeeping generated revenues of roughly \$30 million, said Watson Wyatt President and Chief Executive Officer John Haley.

Today, such revenues are about \$4.5 million and slipping. Watson Wyatt provides these services to approximately 200 plans with about 90,000 participants. Its recordkeeping business is a fraction of the size of that of other major benefit consultants, such as Hewitt Associates L.L.C., which provides defined contribution recordkeeping services to 323 plans with 4.3 million participants, and PwC Kwasha, with about 100 plans and 1.5 million participants.

Watson Wyatt's defined contribution plan recordkeeping business has been declining since 1996, when it decided to stop providing daily valuation services to plans and sold that business to Boston-based State Street Global Advisors.

That move out of daily valuation came because Watson Wyatt did not want to compete in that business with State Street, Watson Wyatt's partner in establishing Wellspring Resources L.L.C., a total benefits outsourcing joint venture. Watson Wyatt pulled out of Wellspring last year after incurring steep financial losses (BI, March 2, 1998).

With clients increasingly demanding that vendors offer both daily valuation and recordkeeping services, Watson Wyatt's recordkeeping business was still profitable but steadily shrinking, with little likelihood of a turnaround, Watson Wyatt executives said.

"Business prospects were declining," said Lou Valentino, Watson Wyatt's national practice director of defined contribution administration in New York.

Defined contribution plan recordkeeping also no longer fit into Watson Wyatt's plan to concentrate on benefit consulting.

"Our strategy is to focus on what we do best, and that is benefit consulting," Mr. Haley said.

"Going forward, this decision allows us to invest more of our

See Watson Wyatt on page 27

Size of jury awards up, fueled by EPL claims

By MICHAEL BRADFORD

The size of jury awards in personal injury cases rose in 1997 after several years of relative stability, a recently published report says.

In particular, there was a huge jump in discrimination and sexual harassment cases in 1997, the report finds. The mean compensatory award in those two employment liability cases nearly quadrupled compared with 1996.

The median amount of compensatory damages awarded by jurors in all forms of personal injury cases was up 15% to \$55,000 in 1997, according to "1998 Current Award Trends in Personal Injury," published late last month by Jury Verdict Research of Horsham, Pa.

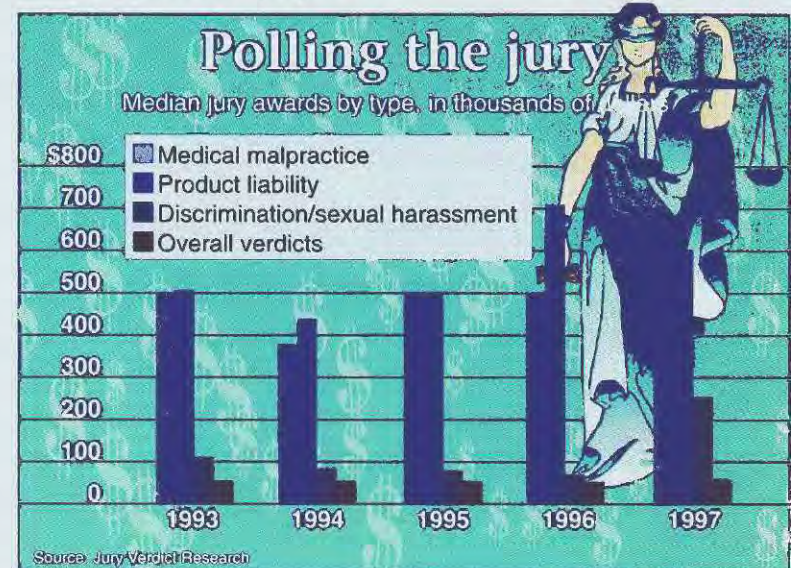
From 1993 to 1995, the median compensatory award stood at \$50,000, declining to \$48,000 in 1996, before 1997's increase.

JVR compiled the information

from its database of 157,000 personal injury cases in state and federal courts. While it does not receive information on every verdict, the research company main-

tains that its database is comprehensive enough to produce a meaningful report. Because it takes time to compile information

See Awards on page 4



GRAPHIC BY MIKE GARVEY

Cardiac recoveries are quicker

Employers, insurers, patients see benefits in early return to work

By ROBERT KAZEL

As vice president of return-to-work programs at Provident Cos. Inc., Ken Mitchell helps employers design programs for bringing workers back to the job despite disabilities.

That experience uniquely prepared him for a personal brush with fate last April, when Mr. Mitchell, 50, suffered a heart attack while walking with his wife near their mountain home. He underwent triple-bypass surgery the next day.

"My research always promoted a transition back to work," Mr. Mitchell said. Now, by closely

working with doctors to develop a return-to-work plan that suited both him and Chattanooga, Tenn.-based Provident, he was able to minimize the time spent at home. Mr. Mitchell was out of work for just three weeks, returning to his job with the disability insurance company on a part-time basis by the beginning of last May and full-time by June 1.

New ways of thinking about recovery from cardiac illness are spurring employees like Mr. Mitchell to return to work much faster than before. And the employer's role in easing cardiac patients back to work sooner is cru-

See Cardiac on page 26



PBGH to reward quality care

By JOANNE WOJCIK

SAN FRANCISCO—One of the country's largest employer purchasing coalitions is using its clout to try and get more money for good doctors and hospitals in California.

The Pacific Business Group on Health initiative is part of a growing trend of health care purchasers seeking better data from providers and health plans to ensure they are getting their money's worth.

"If we really care about quality, let's have it count in the way we pay doctors and hospitals," said Dr. Arnold Milstein, medical director for the San Francisco-based PBGH.

Besides seeking higher bonuses to reward high-quality providers, the PBGH wants to standardize

the formula used to determine which doctors and hospitals are the best performers, he said. The PBGH also will be seeking more and better data from the health plans with which it contracts to track member experience.

The initiative, called "Quality-Based Provider Payment Initiative," is being employed during the coalition's current HMO rate negotiations for the Year 2000.

The California Medical Assn. supports the PBGH effort, said Sandra Bressler, director of professional standards and quality care at the CMA in San Francisco.

"They're really on the side of the employees, who are the ultimate consumers of health care, and the

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Updates

New Cap Re halts underwriting

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Companies in Bermuda of this and has submitted itself for inspection."

The reinsurer is a subsidiary of New Cap Reinsurance Corp. Holdings Ltd., which also has operating units in Australia. The reinsurer was established in 1996 with \$200 million Australian (\$125.3 million) in capital. The majority of New Cap Re's book is property reinsurance, but it also writes liability, marine and aviation, space, and credit reinsurance.

Late last month, the company announced it would have a \$90 million loss for 1998 due to catastrophe losses in 1998 and poorly performing business written in 1997.

Also last week, New Cap Re announced that Craig Deery has resigned as a director of the Bermuda subsidiary. New Cap Re officials did not return phone calls.

Court widens elder care liability

SAN FRANCISCO—California's Supreme Court ruled last week that nursing homes can be forced to pay attorney fees, as well as damages for pain and suffering, in cases where negligence rises to a "reckless" standard.

Under the state's 1975 Medical Injury Compensation Reform Act, plaintiffs cannot be awarded attorney fees in suits alleging medical malpractice. But now, when reckless elder abuse occurs, health care professionals will not be protected by MICRA.

The court ruled in *Delaney vs. Baker* that, in cases of reckless neglect, nursing homes will be subject to California's 1991 Elder Abuse Act, which requires the defense in such cases to pay attorney fees and court costs in addition to jury awards. Defense attorneys had argued that nursing homes had exemptions under the Elder Abuse Act.

In last week's decision, the high court unanimously upheld a jury award of \$150,000 for pain and suffering and \$218,000 in court costs and attorney fees to the daughter of 88-year-old Rose Wallien. Ms. Wallien died in a Clear Lake, Calif., nursing home, where she suffered from advanced bed sores and severely unsanitary conditions, court records show.

\$30 million awarded in accident

CHICAGO—A Chicago jury has awarded nearly \$30 million in damages to a violinist who was severely injured in a 1995 commuter train accident.

Metra, the Chicago commuter rail service, and the former Chicago & North Western Railroad, now part of Union Pacific Railroad, were ordered to pay Rachel Barton \$28.7 million in compensatory damages and \$859,500 in punitive damages.

Ms. Barton, now 24, was dragged by a Metra train after her violin case strap caught on a handrail as she was leaving the train. The accident severed her left leg and badly injured her right leg. At the time, Metra did not have a "second look" policy, in which conductors check for exiting passengers before allowing trains to move.

The jury assigned 62.5% of the blame to C&NW, which owned the railroad and operated the service. Metra, which owns the trains, was assigned 33%, and Ms. Barton was assigned 4.5%.

As a government agency, Metra is responsible only for compensatory damages. Union Pacific must pay the punitive damages. Neither Metra and Union Pacific spokespersons nor the defendants' attorney would comment on insurance coverage.

The plaintiff's attorney, Robert A. Clifford of Clifford Law Offices P.C. in Chicago, said Metra is insured by American International Group Inc. AIG would not comment. Near North Insurance Brokerage Inc. of Chicago is Metra's broker.

Metra, a division of the Chicago-based Regional Transit Authority, is a member of a joint self-insurance fund that provides support to area commuter transit services, according to an RTA spokesman.

In a statement, Metra said, "Reserve funds are adequate for the \$5 million self-insured retention in Metra's insurance policy, while the coverage itself is adequate for the balance of the compensatory awards."

C. Barry Montgomery, partner with Williams & Montgomery in Chicago and counsel for the railroads, said, "Metra and C&NW intend to file post-trial motions and, if they're denied, to take an appeal."

Mr. Clifford said Ms. Barton does not intend to appeal.

NCOIL deregulation proposal

ALBANY, N.Y.—State insurance legislators have adopted more-liberal criteria for defining commercial insurance policyholders that should be exempt from regulation, compared with proposals discussed by state insurance regulators.

The Executive Committee of the National Conference of Insurance Legislators late last month adopted a more-liberal model act to deregulate rate and form requirements for large commercial policyholders, an issue that several state legislatures are considering. NCOIL's model is based on the white paper proposals crafted by the National Assn. of Insurance Commissioners, which is still discussing them.

Specifically, NCOIL proposes lowering several minimum thresholds, two of which a commercial policyholder would have to meet to be exempt from most regulation.

For example, NCOIL supports requiring annual net revenues or sales in excess of \$50 million, instead of the \$100 million stipulated in the NAIC proposal.

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Punitive awards for bias focus of high court review

By MARK A. HOFMANN

WASHINGTON—How bad must an employer's discriminatory behavior be before an aggrieved employee can be awarded punitive damages for violations of federal civil rights laws?



U.S. Supreme Court justices wrestled with that question last week as they heard oral arguments in *Carole Kolstad vs. the American Dental Assn.*

The justices' questions and comments indicated that they might not have an easy time finding an answer. However, the answer they

choose will mean millions of dollars for employers facing suits charging discrimination under Title VII of the Civil Rights Act of 1964, say employment experts.

"If (punitive damages) can be awarded in a garden-variety intentional discrimination cases like this, they can be awarded across the board," warned Robin Conrad, senior vp of the National Chamber Litigation Center Inc. in Washington. The litigation center, which is the legal arm of the U.S. Chamber of Commerce, filed a brief in the case in support of the ADA.

The case stems from changes made to the Civil Rights Act of 1964 by the Civil Rights Act of 1991. The 1991 law allows an award of punitive damages if

See Damages on page 12

Brokers gain ground in '98

Publicly held brokers report higher revenues, profits

By SALLY ROBERTS

Despite continuing tough market conditions, the largest publicly held insurance brokers posted strong results in 1998.

All four of the world's largest brokers reporting year-end results showed increases in brokerage revenues and profits in 1998. While much of the growth was attributable to acquisitions, brokerage executives also point to strong new business growth

as a factor.

Marsh & McLennan Cos. Inc. reported the largest gain with an



brokerage revenue growth, while Jardine Lloyd Thompson

18.6% rise in brokerage revenues to \$4.9 billion. Aon Corp. and Arthur J. Gallagher & Co. also reported double-digit

Group P.L.C. reported a 3% rise.

Marsh and Aon reported huge profit increases between 1997 and 1998. However, comparisons reflect special charges taken in 1997 relating to integration costs. Marsh took a \$297 million charge in 1997 to cover the costs of integrating Johnson & Higgins, while Aon took a \$172 million charge to cover the integration of Alexander & Alexander Services Inc.

See Brokers on page 24

Insurers not state agents: Court

Justices reverse 3rd Circuit ruling in Pennsylvania comp case

By MARK A. HOFMANN and GAVIN SOUTER

WASHINGTON—Workers compensation insurers are not subject to the same constitutional restrictions as government agencies, even when insurers are following state regulations, according to the U.S. Supreme Court.

The high court's decision last week reverses a federal appeals

court ruling that was narrowly focused but could have had much wider implications if upheld, insurers and risk managers feared.

The 3rd U.S. Circuit Court of Appeals had ruled last year that workers comp insurers in some circumstances were actually "state actors" (*BI*, Jan. 11; March 30, 1998). According to the appeals court decision, insurers became agents of the state because

they provided state-mandated workers comp coverage. Therefore, the majority opinion found, insurers were subject to the same constitutional limits that bind government officials as they carry out their duties.

The case, *American Manufacturers Mutual Insurance Co. et al. vs. Delores Scott Sullivan et al.*, dealt with insurers' right to delay

See Reversal on page 25

Need to sue is debated

By MICHAEL PRINCE

NEW YORK—Health insurers would prefer to have treatment decisions reviewed by independent medical panels rather than state court juries, says an official with a national health plan association.

Independent review is "a far-preferred solution," said Richard Smith, vp-public policy and research for the Washington-based

American Assn. of Health Plans. An independent, well-designed review system would resolve coverage disputes better and more efficiently than courts can, Mr. Smith said during a debate on whether patients should be allowed to sue health plans under state laws. The debate was sponsored by the Columbia University Graduate School of Journalism in New York.

Under current law, patients'

suits against health plans generally fall under the federal Employee Retirement Income Security Act. Under ERISA, patients can recover only the value of a denied benefit. But numerous bills before Congress propose changing ERISA to allow individuals to sue plans under state tort laws for claims such as medical malpractice, opening the door for large recoveries for pain and suffering

See Debate on page 4

Inside

• Bipartisan bills soon to be introduced in Congress continue recent legislative moves toward increased pension benefits and eased administrative requirements, this week's editorial says. **PAGE 8**

• Record snowfall has triggered the worst series of avalanches in the Alps in 50 years. **PAGE 19**

• A new Commonwealth Fund study raises questions about why minorities have lower rates of employer-sponsored health care coverage. **PAGE 22**

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Higher work comp rates seen in 2000

By MEG FLETCHER

HARTFORD, Conn.—The continued availability of low-cost workers compensation coverage is good news for employers, though a new insurer survey warns that rate increases may be on the near horizon.

According to a Conning & Co. analysis, workers comp insurers say they need to charge higher premiums to offset growing losses and expenses. Their special concerns include medical cost inflation and possible judicial and legislative erosion of states' previous workers comp reforms.

"For employers, things are still looking just fine," Mary Ann Godbout, assistant vp at Hartford, Conn.-based Conning, said in an

interview. She recently analyzed responses from a survey of the top 100 workers comp insurers and summarized them in a 161-page report, *"Workers' Compensation—Storm Clouds on the Horizon."*

"Rates will pretty much stay at today's levels through the year 2000," she predicted from insurers' responses, which represent 55 private or public insurers that write 78% of U.S. workers comp premium.

Specifically, the soft market that developed in the mid-1990s is expected to continue through this year, as the average rates U.S. employers pay for coverage drop 2.5%, Ms. Godbout said.

Beginning next year though, market changes are predicted to

increase rates an average of 2.6%, which will essentially offset the drop this year, she said.

Rate changes will vary among states, as competition among insurers ranges from "very competitive" to "manageable," according to report data on 29 states (see chart).

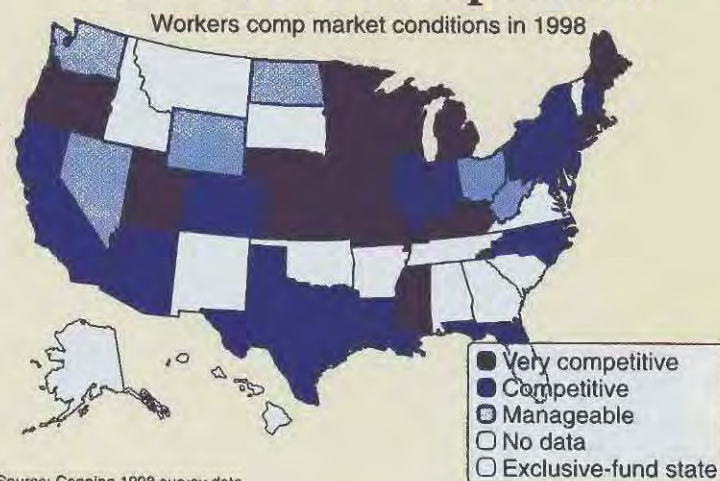
Generally, market conditions in most states in 1999 are expected to remain highly competitive, though competition already has lessened slightly in California, insurers in the survey reported.

The market outlook for next year is similar, though competition is expected to lessen in Kentucky and Oregon and increase only in Virginia, according to the data.

See Comp on page 13

State of the competition

Workers comp market conditions in 1998



Source: Conning 1998 survey data

GRAPHIC BY ADAM DOI



API/WIDE WORLD PHOTOS

Philippe Brugisser, CEO of SAirGroup, the parent of Swissair, last week in Geneva announces the airline's plan for providing immediate compensation to the families of victims of the 1998 Swissair crash near Nova Scotia.

Swissair to pay victims' families

Airline payment not intended to be final

By DAVE LENCKUS

ZURICH—Advocates for airline passenger families applaud Swissair's offer to make an initial, immediate damages payment to the families of each passenger killed in the crash of a jet off Nova Scotia late last summer.

But the offer, made after Swissair consulted a group of victims' families as well as a representative of families engaged in a long legal battle with Korean Airlines, is just part of the obligations the airline has to the families, the advocates said.

The offer of 195,000 Swiss francs (\$133,600) per victim will have no immediate impact on the liability lawsuits that passengers'

families have filed against Swissair, said plaintiffs attorney Marc S. Moller. The families still need to resolve claims for their full value, said Mr. Moller, of Kreindler & Kreindler of New York.

However, the offer, which is not a final settlement offer, probably "makes the families less hostile" toward the airline, he said. Mr. Moller represents many families who lost loved ones in the Sept. 2, 1998, crash of the Geneva-bound flight from New York.

Hans Ephraimson-Abt, chairman of The American Assn. for Families of KAL 007 Victims, agreed. Mr. Ephraimson consulted with the families of the Swissair passengers and with Swissair. Ko-

See Swissair on page 26

PBM makes \$70 million buy

IRVING, Texas—Advance Paradigm Inc. has signed an agreement to buy Foundation Health Systems' prescription benefit management operation in a \$70 million cash deal.

Advance Paradigm's purchase of Foundation Health Pharmaceutical Services Inc., which is the immediate parent company of the PBM, Integrated Pharmaceutical Services Inc., is expected to be completed by the end of this month, said David D. Halbert, chairman and chief executive officer of the Irving, Texas-based company.

Mr. Halbert said the deal, which will add 12 million lives for a total of 27 million to be served by

Advance Paradigm, is expected to move the company up a notch to make it the fourth-largest PBM.

FHS President and CEO Jay M. Gellert said in a statement that the transaction is "another important step forward in our strategic effort to focus on core operations."

In addition, Advance Paradigm signed a 10-year service agreement, which is expected to be effective no later than April 1, to provide integrated PBM services to the approximately 6 million lives covered by Woodland Hills, Calif.-based FSH.

Mr. Halbert said he hopes to make similar arrangements with other managed care companies.

"We're really seeing more of a movement toward outsourcing for the managed care industry and health plans in general, where a service provider like ourselves can provide economies of scale and provide better service for the larger health plans, and provide it at an even lower price," he said.

The deal is the latest in a string of PBM mergers and acquisitions. Earlier this year, Rite Aid Corp. bought PCS Health Systems Inc. for \$1.5 billion. In the second quarter, Express Scripts Inc. plans to complete its acquisition of rival Diversified Pharmaceutical Services Inc. for \$700 million in cash (BI, Feb. 15).

—By Judy Greenwald

Best seeks more uniform data on insurer cat models

By ROBERTO CENICEROS

OLDWICK, N.J.—A.M. Best Co. has teamed up with a computer modeling company to create a nationwide database of insurers' catastrophe loss exposures.

The Oldwick, N.J.-based rating company says the joint project with Paragon Reinsurance Risk Management Services Inc., if successful, will make it easier to compare insurers' catastrophe exposures for more rating purposes.

However, only information about the industry's aggregate exposure will be made available to policyholders and the public. Data on individual insurers'

catastrophe exposures will remain proprietary and protected, said Robin Albanese, assistant vp for Best.

The success of the project will depend largely on insurers' voluntary sharing with Best of their exposure information. The project is seeking from companies the same data they now provide to various catastrophe modeling companies.

Many individual insurers now contract with catastrophe modeling vendors to generate an analysis of their natural disaster loss potential. Catastrophe model outcomes, along with many other factors, such as capitalization, have been important to A.M. Best's rating assessment

ever since 1992, when Hurricane Andrew struck South Florida, said Eric Simpson, a Best vp.

But catastrophe modeling companies each use different underlying assumptions in their systems. Additionally, the vendors are constantly refining their systems, so they regularly change. Comparing one insurer's loss exposure to another's can be difficult if each relied on different catastrophe modeling software for analysis. Even evaluating one insurer using different models can produce dissimilar probable maximum losses.

"So we want to use Paragon as a tool to have comparability," Mr. Simpson explained.

See A.M. Best on page 23

Testimony urges insurers to act on global warming

By MICHAEL PRINCE

NEW YORK—U.S. insurers should do more to address the causes of global warming, a reinsurance executive says.

The U.S. insurance industry faces increased risks as a result of global warming, yet it lags behind its European counterpart in researching the problem and factoring it into underwriting decisions, he says.

Global warming is a reality, and its impact on insurers could be dramatic, warned the executive and others testifying last week during a hearing before the New York Assembly's Committee on Environmental

Conservation and Committee on Insurance.

Despite the threat to their bottom lines, U.S. insurers have not tried to reduce the causes of global warming.

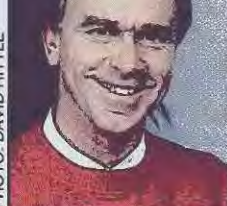


PHOTO: DAVID HITTLE

Mr. Nutter

"The industry as a whole is not doing enough," said Frank Nutter, president of the Washington-based Reinsurance Assn. of America. Insurers, he said, historically have sought ways to

mitigate losses—such as fire safety programs—"but not the underlying causes."

One big difference between U.S. and European insurers, Mr. Nutter noted, is that European insurers typically have staff climatologists, which U.S. companies lack. Also, few U.S. insurers view climate research as a sound business strategy, he said.

Mr. Nutter identified four concerns for insurers from global warming:

- Rising sea levels and increased flooding from storms.
- Droughts of greater intensity causing more wildfires.
- Increased risk of diseases spreading

from tropical areas.

- More-intense storms.

Warmer weather will change the insurance industry in another way, Mr. Nutter predicted. Insurance pricing is based on estimating the probability of future events by looking at historical trends. But warming complicates estimating, and past data will become a less-reliable predictor, he said.

"Then the industry has a dilemma on its hands," he said.

To manage the risks created by global warming, Mr. Nutter said U.S. insurers need to emphasize three areas:

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Awards

Continued from page 1
on verdicts, 1997 is the most recent year analyzed.

While JVR focuses primarily on compensatory awards, some of the study's sections include information on punitive damage amounts.

Proponents of tort reform say the rise in personal injury awards means they have more work to do.

The increase is evidence "of the need for continued vigilance in enacting reasonable reform in our liability system," said Sherman Joyce, president of the American Tort Reform Assn. in Washington.

Mr. Joyce acknowledged that, while most personal injury cases settle before a verdict is reached and not all high awards are uncalled for, there remains a need for laws that balance the rights of defendants and plaintiffs.

The leveling of award amounts in

recent years probably is due in part to tort reforms enacted in the mid-1990s, Mr. Joyce said. Widespread support for legislative reform in recent years "probably is reflected to some extent in these numbers," he remarked.

The median compensatory awards for discrimination and sexual harassment, medical malpractice and premises liability claims rose in 1997. The median in product liability cases, however, declined.

The median compensatory amount for discrimination and sexual harassment awards skyrocketed 286% to \$250,000 in 1997, according to the report. The 1996 figure was \$64,750, down from \$75,000 in 1995 and \$78,592 in 1994. In 1993, the median award was \$110,000.

The report indicates that, for the years 1991 through 1997, punitive damages were awarded in 34% of the discrimination cases and 38% of the sexual harassment verdicts reported to JVR. The median punitive award

for discrimination was \$117,500 and \$100,000 in sexual harassment cases during that time frame.

Plaintiffs in those cases made no claims for wrongful discharge or constructive discharge.

"You can't help but be stunned by the numbers" in discrimination and sexual harassment awards, said Mr. Joyce. "Obviously, sexual harassment is a growing area that indicates the need for greater clarity," he noted. Clear laws, he said, would outline the "rights and responsibilities for all parties" in employment relationships and disputes.

Government entities made up the largest defendant group in discrimination and sexual harassment cases, named in 37% of the cases that resulted in awards for the years 1991 through 1997.

The median compensatory award in cases in which plaintiffs alleged wrongful termination or constructive discharge was \$162,500 in 1997, down

14.7% from 1996.

For the years 1991 through 1997, the median punitive damage amount for wrongful termination was \$200,000 and \$273,250 for constructive discharge claims.

The median compensatory award in premises liability cases jumped 15% in 1997 to \$100,000.

Over the past seven years, the most frequent injury claim in premises liability cases was for spinal disc damage. Nine percent of the verdicts involved plaintiffs with that injury claim, while back strains were claimed in 7% of cases leading to verdicts. The median compensatory award in disc damage cases was \$113,138; it was \$20,800 in back strain cases.

The median medical malpractice compensatory award jumped 10% in 1997 to \$551,750.

The median punitive award in medical malpractice cases was \$150,000 in 1997, significantly lower than the me-

dian of \$397,500 the year before. In both years, punitive damages were assessed in 2% of the cases analyzed in the report.

While the median award rose in some areas of civil litigation, it was lower in products liability cases in 1997, the report says. The amount fell 14.9% to \$600,000.

The JVR analysis revealed that, from 1991 through 1997, 52% of the compensatory awards in products liability cases were for \$500,000 or more. It showed that 35% were for more than \$1 million and 9% were for \$5 million or more, with the remainder for less than \$500,000.

The decrease in award amounts in product liability cases likely is partly due to changes in liability, smarter manufacturing and global competition, said Bruce R. Parker, a defense lawyer specializing in products cases with the Baltimore firm of Goodell, DeVries, Leech & Gray L.L.P.

"Manufacturers over the last 25 years have learned the rules of how to make products consistent with product liability laws," Mr. Parker said. For example, product warnings now serve as liability shields, he said.

Copies of "1998 Current Awards Trends in Personal Injury" are available for \$39.95 plus \$4.50 for shipping and handling. Orders or questions regarding the report should be directed to Jury Verdict Research at 800-341-7874, ext. 307, or by e-mail at cust-serve@lrp.com.

Debate

Continued from page 2
and punitive damages.

Resolving claims disputes in state court won't improve the health care system, and expanding liability "will actually decrease quality and increase costs," Mr. Smith said.

The AAHP executive pointed out that a study sponsored by the organization showed premiums would increase between 2.7% and 8.6% if ERISA were changed so that individuals could sue health plans under state laws (BI, May 4, 1998).

But an independent study conducted by the Congressional Budget Office forecasts only a 1.2% premium increase, countered Ron Pollack, executive director of Families USA Foundation, a consumer health care organization.

"Yes, there is a cost, but the cost will be minimal," he said.

But Mr. Smith dismissed the CBO estimate as unrealistic, though he did not specifically point out its problems.

Mr. Pollack agreed that the best way to resolve coverage disputes is through independent review, but he said that allowing state lawsuits is necessary to keep health plans accountable. ERISA, he said, was fine when it became law in 1974, because plans then were fee for service and coverage disputes concerned paying for treatments after they were provided. But today, under managed care, decisions not to cover treatments occur beforehand, effectively denying patients medical services. Therefore, ERISA should be amended, he said.

Messrs. Smith and Pollack also disagreed on whether expanded liability would hurt or improve the quality of care. Mr. Smith said that quality would suffer if managed care organizations were constantly peering over the shoulders of physicians, questioning their treatment decisions.

But Mr. Pollack argued that quality actually would improve. The threat of suits "creates deterrence against doing the wrong thing," he said. Because managed care plans currently have a financial incentive to deny treatment, holding them accountable for their decisions will place greater focus on quality and deter plans from denying treatment, he said.

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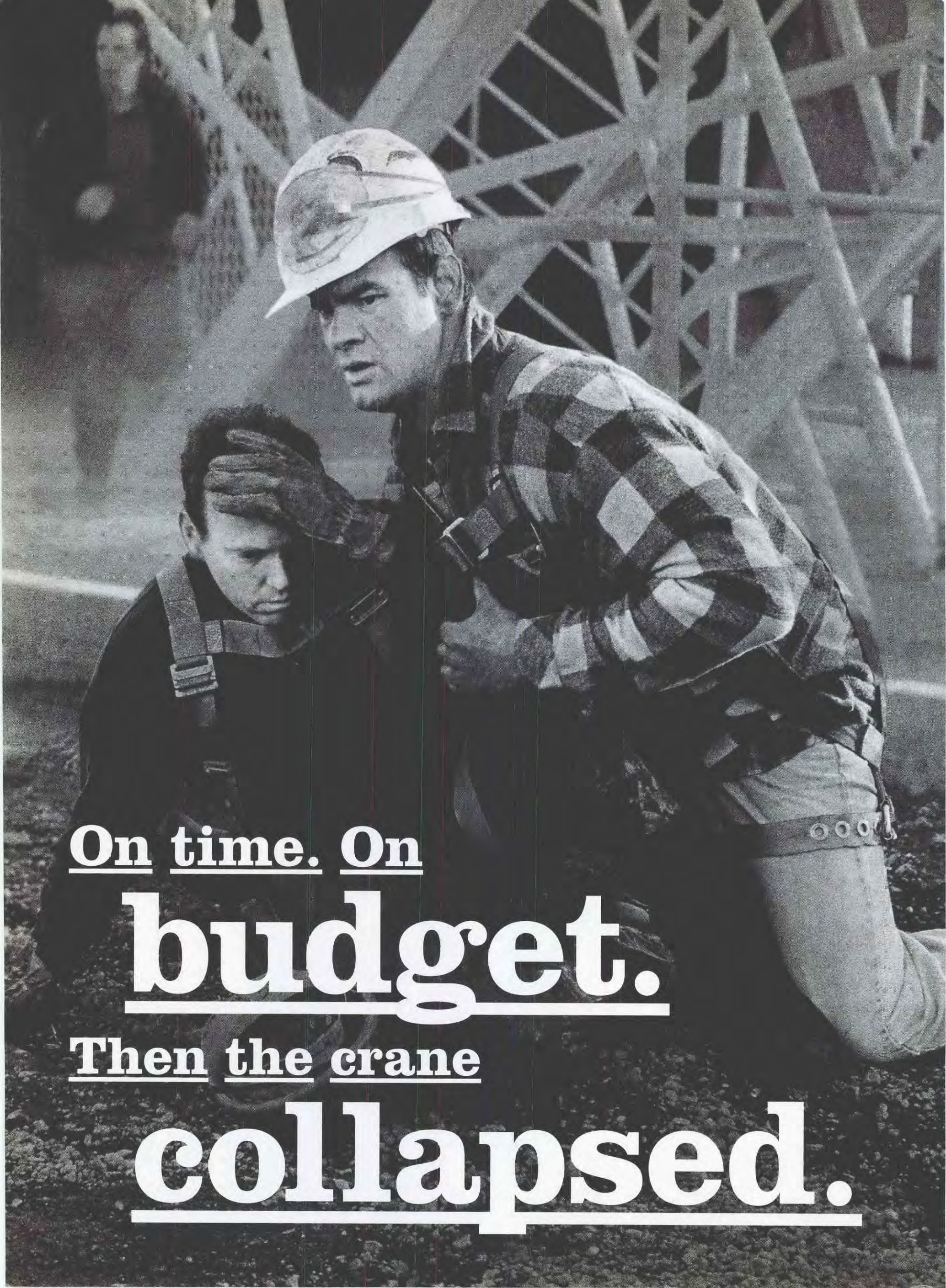
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Opinions

Pension legislation that works

IT WASN'T SO LONG AGO that employee benefit managers used to cringe—and for good reason—whenever Congress considered pension legislation.

However, bipartisan reform legislation expected to be introduced in Congress this week is evidence of how far lawmakers have come in recent years to ease pension administration complexity.

Throughout the 1980s and extending into the early 1990s, pension reform bills considered and passed by Congress almost always added more—sometimes incredibly more—layers of complexity to federal rules employers must follow in administering their retirement benefit plans.

At the same time, federal legislators on several occasions cut the benefits that could be provided through pension plans. Taken together, the administrative burdens and benefit cutbacks have made corporate pension plans much less attractive to employers and employees.

In 1996, however, that approach to pension reform began to change when Congress, in a modest way, for the first time cut away some of the red tape that entangled pension plan administration.

The next year, Congress continued to provide administrative relief by, among other things, exempting employers from filing certain pension reports with the Labor Department—which undoubtedly never read them anyway—as well as allowing employers to remove from their pension rolls employees who had very small accrued benefits when their employment was terminated.

Sweeping reform efforts were introduced in Congress in 1998 that would have boosted employee 401(k) contributions while easing administrative burdens. Time ran out, however, before Congress could act on the proposals.

This year, legislators' pension reform efforts are even more ambitious.

A bipartisan bill scheduled to be introduced in the House this week by Reps. Rob Portman, R-Ohio, and Ben Cardin, D-Md., would significantly increase benefits that could be provided through both defined benefit and defined contribution plans.

The House measure also will contain numerous provisions designed to make it easier and less expen-



sive for employers to administer pension plans.

Similarly, Senate Finance Committee Chairman William Roth, R-Del., is set to introduce legislation that would boost maximum defined contribution plan limits, while Sens. Charles Grassley, R-Iowa, and Bob Graham, D-Fla., by the end of this month should introduce legislation that would boost plan limits while cutting employers' administrative requirements.

The reason behind this change in legislative direction is obvious: For years, employers have warned that adding to their administrative burdens while cutting benefits that can be offered would slowly kill the private pension plan system.

We think that message—coupled with dramatic statistics showing that the number of defined benefit plans today is only one-third of the total in the mid-1980s—is being heard by legislators.

We also think that more legislators are aware that a robust private pension system is necessary to avoid too much dependence on an ailing Social Security program.

These pension reform measures truly are in the national interest and deserve the full support of the employer community.

Letters

Employer-at-Injury Program a quantifiable success

To the editor: At Oregon's Workers Compensation Division, we were pleased with your Dec. 14, 1998, article, "Return-to-work Rewards: Oregon Plan Fails to Catch on Elsewhere," showcasing our Employer-at-Injury Program. This program, funded by cents-per-hour assessments, supports the early return to work of 10,000 Oregon injured workers annually. By providing significant financial incentives to workers' employers, the EAIP has promoted widespread acceptance of light-duty transitional work.

When I spoke with Roberto Cenicerros, I did not have readily available statisti-

cal information directly linking claims cost savings in Oregon with the EAIP. Oregon has, of course, had remarkable results with a broad range of workers compensation reforms that were initiated by a special legislative session in 1990; premium rates have decreased 54.7% and employers have saved \$3.8 billion in direct costs while we've increased workers' permanent disability benefits. Part of the problem in isolating the impact of the EAIP is that we've made significant changes in so many areas—injury prevention, compensability standards, medical cost containment, restrictions on aggravation claims and palliative care, among others.

A department researcher has given me additional data and an analysis that provides empirical support for EAIP. Our researcher estimates that, in 1997, Oregon saved 115,160 time-loss days on disabling and non-disabling claims, directly as a result of EAIP. Using Oregon wage averages from 1997, I calculated the dollar savings of this reduced time loss at \$8,061,200.

Oregon workers are returning to work more quickly than in the past. Average time-loss days paid declined 43% be-

tween 1990 and 1997. The vast majority of the time EAIP is used, workers return to regular or permanently modified work with their employers. While employer clearly save money, a 1995 study by our department showed that workers who returned to their time-of-injury employers had fewer breaks in employment and had higher wages over time than those who did not.

The EAIP remains highly popular. While the program continues to grow steadily, there have been no major calls to curtail it. About one-third of the 2.1 cents-per-hour assessment that Oregon workers and employers pay goes to re-employment assistance, of which EAIP is a part. To date, program expenditures are within projections. We continuously monitor both fiscal data and the ways the EAIP is used. We regularly solicit input from stakeholders. If we make program changes, they will be carefully considered and will balance the interests of workers, employers and insurers.

Mary Hoskins

Manager-Re-employment

Assistance Unit

Workers Compensation Division
Salem, Ore.

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A man and a woman are running on a sandy beach, holding hands. The man is shirtless and wearing red swim trunks, and the woman is wearing a red one-piece swimsuit. They are both smiling and looking towards the camera. The background shows the ocean and a clear sky. Two speech bubbles are present: one from the woman on the left and one from the man on the right.

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Damages

Continued from page 2

the plaintiff demonstrates that the defendant "engaged in a discriminatory practice or discriminatory practices with malice or reckless indifference." The law limits punitive damage awards, however, to a maximum of \$300,000, depending on the size of the company involved.

The case is significant for employers because it revolves around how to define "reckless indifference" for purposes of the law, which could encourage or discourage such lawsuits, depending on how the Supreme Court rules.

"It is a case with high stakes because it will impact not only the way in which employment practices law cases are tried, but also how EPL cases will be evaluated for settlement purposes," said Gerald L. Maatman Jr., a partner in the law firm Baker &

McKenzie in Chicago.

"The plaintiffs bar is hoping for a victory because their side of the argument is any and every garden-variety discrimination case is automatically a punitive damages case, and defendants are routinely faced with elevated settlement demands because of that argument," said Mr. Maatman.

A ruling for the defendant, therefore, would limit increases in the amounts sought from employers in EPL cases, he said.

The ruling also could influence state discrimination cases, Mr. Maatman said. "Most states, in interpreting their own employment discrimination laws, follow the lead of rulings in federal employment cases," he noted.

Kolstad vs. the ADA began when Carole Kolstad, an attorney in the dental association's Washington office, was denied a promotion to the office's No. 2 position in favor of a man with shorter tenure at the ADA. Ms. Kolstad sued under Title VII, claiming

she had been a victim of gender discrimination.

To support her discrimination complaint, Ms. Kolstad claimed in testimony before the U.S. District Court for the District of Columbia that the executive who promoted the other candidate had told off-color jokes and had used offensive language to refer to women. ADA witnesses testified, however, that the man who got the job was better qualified.

Ultimately, a jury awarded Ms. Kolstad more than \$50,000 in back pay, though the judge dismissed her punitive damages claim. Both Ms. Kolstad and the ADA appealed the trial verdict.

In 1997, a three-judge panel of the U.S. Circuit Court of Appeals for the District of Columbia held that the jury should have been able to consider punitive damages under the 1991 act. That ruling was appealed to the full appeals court, which last year ruled 6-5 in favor of the district court

judge's decision (*BI*, May 18, 1998). The majority held that a plaintiff would have to prove that the employer engaged in "egregious" discriminatory conduct before being permitted to seek punitive damages.

Ms. Kolstad then appealed that court opinion to the U.S. Supreme Court.

She argues that the term "reckless indifference"—the threshold required for punitive damages under the Civil Rights Act of 1991—should apply to an employer that knew or "should have known that its conduct was unlawful."

The ADA counters that reckless indifference means a plaintiff must prove "egregious conduct" or "truly outrageous acts of discrimination."

U.S. Solicitor General Seth Waxman joined Ms. Kolstad's attorney, University of Washington law professor Eric Schnapper, in pushing for a more expansive definition of reckless indifference during last week's

Supreme Court arguments. "This is a case of statutory interpretation," Mr. Waxman said.

But the difficulty of interpreting the 1991 law's language was evident last week when Chief Justice William Rehnquist called the statute "simply confusing."

The ADA's attorney, Raymond C. Fay, a partner in the Washington office of law firm Bell, Boyd & Lloyd, argued there is no evidence that Congress ever intended the standard for allowing punitive damages to be any less than that followed in common law. In common law, he said, "reckless indifference is the equivalent of malice."

Associate Justice Stephen Breyer wondered aloud why there should be such a fight over punitive damages in Title VII cases anyway, as juries can always decline to award them and, even when damages are awarded, the federal law caps the punitive awards. **BI**

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Warming

Continued from page 3

- Greater use of computer modeling of catastrophes to help determine rates that better reflect exposures.

- Increased support of scientific research on climate and weather. Although U.S. insurers have made some efforts in this area, such as backing for a Bermuda Biological Station for Research climate research initiative, more action is needed, he said.

- Increased support of research on energy efficiency and existing programs that encourage more-efficient energy use. Reducing energy use can help curtail global warming by reducing the greenhouse gases released into the air, he noted.

Losses from weather events are well known and getting worse, Mr. Nutter testified. In 1998, economic losses from weather events totaled \$90 billion, of which \$11 billion was insured losses in the United States, he said.

Mr. Nutter cited a recent study by Munich Reinsurance Co. that found natural catastrophes in the last 10 years have caused nine times more economic damage and 15 times more insured damage compared with natural disasters of the 1960s, even when adjusted for inflation (*BI*, Jan. 4).

Last year, the mean global temperature was the warmest on record, with 1997's coming in as No. 2, testified David Easterling, principal scientist at the National Climatic Data Center in Asheville, N.C. Global mean temperatures for 1998 stood at 0.6 degrees Celsius above average. "That's quite a bit of warming," he said.

Global warming could cause significant changes, testified Cynthia Rosenzweig, research scientist at National Aeronautic and Space Administration in New York. For example, increasing temperatures will cause ocean levels to rise by a number of inches. Although this by itself may not sound dramatic, this small rise could mean a considerable increase in the height of storm surges, which could increase the frequency and severity of floods in coastal areas, she explained.

During his testimony, Mr. Nutter also speculated on reasons that U.S. insurers have trailed European insurers in addressing warming issues.

For instance, for years U.S. companies—the automotive industry, in particular—have challenged the science behind global warming predictions, a stance that has influenced the views of other businesses. Automakers are modifying their views of warming research, he added.

Also, because one of insurers' greatest weather-related concerns is increased or intensified hurricane activity, and as scientific research to date shows no such occurrence, U.S. insurers have been less concerned about the trends, he explained. **BI**

Comp

Continued from page 3

"Workers compensation costs are the primary cost concern for risk managers," said Anne Allen, director of government affairs for the Risk & Insurance Management Society Inc. in New York. "It's good that rates are predicted to be flat through the year 2000, but employers also are interested in products and services, as well as costs," she added.

"Employers are already getting nervous about possible comp cost increases" because of rises in health-related claim costs, Ms. Allen said. Many of the increases are due to challenges to managed care policies that have helped control costs in the past.

For insurers especially, workers comp has been "a bright spot" in the property/casualty industry in recent years, according to the report. "After the disastrous 1980s, the 1990s—for the most part—have been kind to this business, the result of surprisingly benign loss costs over the past five years," it said.

Several favorable conditions contributed to the positive workers comp

workers comp industry, she said. However, this situation is different from the crisis in the 1980s—when external factors were mostly to blame—because insurers can change the negative outlook for them by raising premiums, she said.

In addition, "the workers compensation industry itself is in a state of flux," Ms. Godbout said.

"There is increasing consolidation and change among leading workers comp insurers, and different products and services will be needed to satisfy customer needs," she said.

For example, large employers are especially interested in integrated benefit products, but the concept continues to be a struggle to implement, many insurers say.

Copies of the study, "Workers' Compensation—Storm Clouds on the Horizon," are available for \$550 each by calling Conning & Co. at 860-520-1521 or at www.conning.com.

'Employers are already getting nervous about possible comp cost increases,' says RIMS' Anne Allen.

results, including sharply lower inflation rates, major system reforms in many states, application of managed care techniques to medical costs, diligent efforts at reducing fraud, a strong commitment to loss prevention and a robust economy, according to the report.

The study concludes, however, that difficult times are ahead.

Loss ratios and combined ratios have been deteriorating since 1995, and profit margins are expected to be severely squeezed. "Over the three-year forecast period, 1998-2000, Conning expects losses to increase an average of 4.5% per year, compared to a 1.5% increase in premiums," it said.

"The deteriorating workers comp outlook results from worsening internal and external conditions," Ms. Godbout said. "Reserves are showing signs of stress, loss costs are expected to outpace premiums, rates continue to decline and expenses remain high."

In addition, there is a concern that system reforms may be eroded by unfavorable judicial or legislative actions. For example, federal and state lawmakers are considering medical record confidentiality provisions that could make it more difficult to quickly treat workers comp injuries. Also, medical inflation is rising, and there is uncertainty about the economy.

"All this does not bode well" for the

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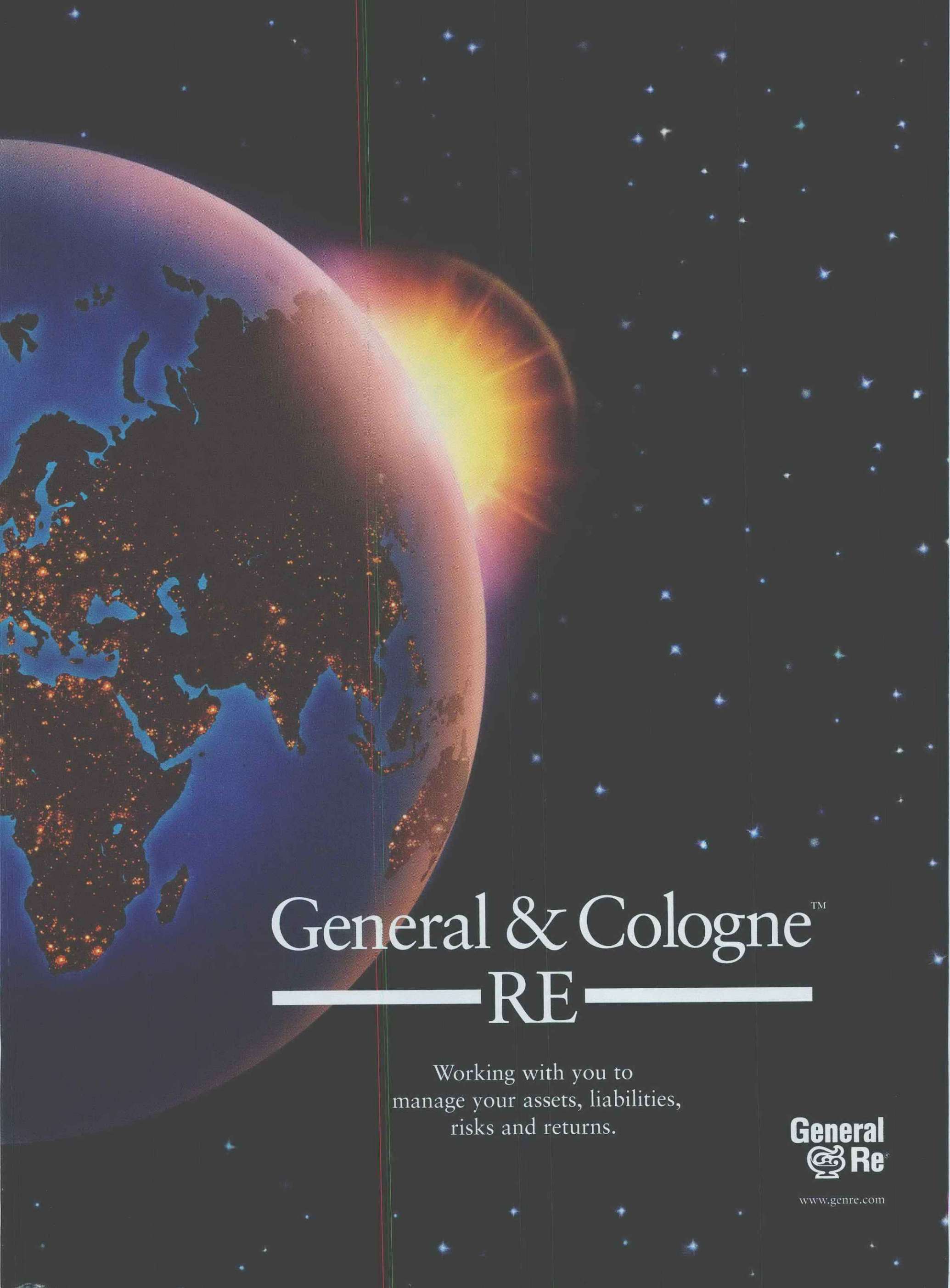
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Sick buildings spell ills for risk managers

By James F. Dorion

IMAGINE YOU ARE a risk manager for a large company and you have been informed that three of your office employees have been hospitalized and that 20 more have gone home sick. The office has been evacuated, and work has come to a grinding halt. Then, just when it appears that the situation couldn't get any worse, those employees become plaintiffs. They allege that they are suffering from "sick building syndrome" and that your company knew the building was making them sick and failed to do anything about it. How likely is this scenario?

The World Health Organization has suggested that up to 30% of new and remodeled buildings worldwide may be the subject of numerous complaints related to indoor air quality. The Environmental Protection Agency studies of human exposure to air pollutants indicate that indoor air pollutant levels are often more than 10 times higher than outdoor levels and that maximum indoor exposures are at least 100 times greater than maximum outdoor exposures. This is problematic, because EPA studies suggest that many people spend as much as 90% of each day indoors.

In addition, comparative risk studies performed by the EPA and its science advisory board have consistently ranked indoor air pollution among the top five environmental risks to public health.

What is sick building syndrome and where did it come from? The energy crisis of the early 1970s caused builders to re-evaluate construction practices and materials in an effort to reduce dependency on foreign oil. As a result, buildings became more energy efficient and, hence, more airtight. In the typical so-called sick building, the windows do not open and a mechanical heating, ventilation and air conditioning (HVAC) system reuses much of the same stale air. As a result, biological contaminants such as pollen, bacteria, viruses, molds and chemical contaminants get recirculated along with the air.

Breathing these contaminants is thought to cause acute health problems in some people. The problems appear to be linked to the length of time an individual spends in a particular building, although his or her physician often cannot identify a specific illness to blame.

Sick building syndrome, or SBS, symptoms range from mild to severe. They include eye irritation, dry throat, runny nose, headache, fatigue, sinus congestion, skin irritation, shortness of breath, cough, dizziness, nausea and mental confusion. The complaints may be widespread throughout the building or localized in a certain area.

In addition to biological contaminants, people are exposed to chemical contaminants through everyday contact with ordinary products and materials. The following is a partial list of chemical contaminants and the items through which most people are exposed to these contaminants on a daily basis.

- Acetone: human breath, cosmetics, fragrances;
- Ammonia: cleaning products, photocopiers;
- Alpha-pinene: deodorants;
- Benzene: laser printers, particle board, paints, tobacco;
- Benzaldehyde: detergents, fragrances;
- Benzyl acetate: air fresheners, fragrances;
- Formaldehyde: particle board, carpets, clothes, glues;
- Limonene: deodorants, disinfectants, fragrances;
- Toluene: glues, laser printers, paints, particle board;
- Trichloroethane: dry-cleaned clothes;
- Trichloroethylene: photocopies, correction fluid;
- Xylene: glues, laser printers, paints, particle board.

Determining whether you have a sick building can be tricky. The symptoms of SBS typically are similar to those associated with colds, allergies, fatigue or the flu. The EPA has outlined several signs of potential indoor air quality problems, including:

- Widespread symptoms, which may indicate a ventilation problem;
 - Symptoms that disappear when the occupants vacate the building;
 - The sudden onset of symptoms after a change is made to the building, such as painting, pesticide application or remodeling;
 - Persons with allergies, asthma or chemical sensitivities have reactions indoors but not outdoors.
- In addition, there may be a problem if flulike symptoms

persist in occupants over a longer period of time than is normally expected. However, a lack of symptoms is no guarantee that the indoor air quality of a building is acceptable. Some long-term health effects have symptoms that do not become evident for many years. One such example is lung cancer from radon exposure.

We all face the risk of exposure to biological and chemical contaminants from a wide variety of sources. To manage this risk, action should be taken to lower the concentrations of indoor air pollutants. The following techniques will help accomplish this goal.

- Source management: includes source removal, such as banning smoking; source substitution, such as selecting less-toxic materials; and source encapsulation, which involves placing a barrier around the source so that it releases fewer pollutants into the indoor air;
- Local exhaust: removing contaminants that originate at specific points before they can be dispersed into the indoor air;
- Ventilation: using outdoor air to dilute the contaminated indoor air;
- Exposure control: regulating the times and locations of

Environmental Protection Agency studies of human exposures to air pollutants indicate that indoor air pollutant levels are often more than 10 times higher than outdoor levels.

contaminant use to reduce the exposure of building occupants;

- Air cleaning: using ventilation equipment to filter certain particles from the air;
- Education: providing information about the sources and effects of contaminants;
- Maintenance: providing regular maintenance of ventilation systems by qualified HVAC contractors;
- Monitoring employee opinions: maintaining a log of employee comments and complaints about indoor air quality and following up on all complaints.

The occupants of a sick building could sue their employer and everyone connected with the building's design and construction. Actions could be brought against current and prior owners of the building, landlords, property managers, general contractors, subcontractors, manufacturers, maintenance contractors, installers, suppliers, designers, engineers and architects.

Such actions often arise soon after a building has been built. However, problems with older buildings can arise if the building's use or number of occupants changes, or if new pollutants are brought into the building. Problems may also arise as building materials age.

Businesses could allege property damage and economic loss due to decreased production or the shutdown of operations. They also could seek damages for the loss of business goodwill or the loss of clients, as well as for moving expenses. Individual plaintiffs usually allege injuries to their person caused by the sick building. They normally seek damages for those injuries and may also seek damages for fear of future injury, increased risk of future harm and medical monitoring costs. Employees may argue that workers compensation laws should not shield their employer because the employer knew that the building was making employees sick and did nothing to remedy the situation.

The diverse theories underlying SBS claims include negligence, strict liability, breach of contract, breach of warranty, fraud, and constructive eviction. To date, negligence has been the most commonly asserted claim. Unfortunately, building owners have few federal or state standards or regulations outlining their duty with regard to controlling many SBS-causing contaminants.

This lack of guidance has fueled SBS litigation and is one of the reasons SBS cases are difficult to resolve. Without a standard of care to look to, judges and juries are free to make their decisions on a case-by-case basis without guidance. Some courts may consider the foreseeability of

the harm, while other courts may scrutinize lease provisions to determine which party is responsible for maintaining indoor air quality.

Will general liability policies respond to an SBS claim or suit? According to most legal experts, the answer usually depends on how the following issues are resolved.

• **Trigger of Coverage:** The long-tail nature of SBS claims makes it possible for a policyholder to have been insured under numerous policies written by various insurers between the time the harm is alleged to have occurred and the time a claim is made. The question of which policy or policies must respond will then arise. The answer depends on the trigger of coverage applied by the court.

A policyholder facing an SBS claim will most likely want to argue that a continuous trigger of coverage should apply. Under this theory, all policies in effect from the plaintiff's first exposure to the alleged cause of harm through the discovery of that harm must respond. However, there are other trigger theories that the court may consider. The "injury-in-fact" theory triggers the policy or policies in effect when the harm actually occurred. The "exposure" theory triggers each policy on the risk at the time the plaintiff was exposed to the harm alleged. Finally, the "manifestation" theory triggers only the policy on the risk when the bodily injury or property damage first manifests itself, such as when a plaintiff is diagnosed with SBS-related injuries.

If multiple policies are called upon to respond, there will then be an issue concerning the amount that the policyholder can recover from each policy.

• **Occurrence:** For coverage to apply under an occurrence-based policy, there must be bodily injury or property damage during the policy period that is neither expected nor intended from the standpoint of the policyholder. The issue here becomes whether the court should apply an objective or subjective standard.

Under the objective standard, the question asked by the court is whether the policyholder should have reasonably foreseen that its conduct would result in the harm alleged. Under the subjective standard, the relevant question is whether the policyholder actually intended for the harm to occur. Obviously, it is far easier for an insurer to establish what the policyholder should have known, as compared to what it intended. The clear overall trend in case law is toward the pro-policyholder subjective occurrence standard.

It is currently unclear whether pollution exclusions apply to SBS claims. A policy may contain a "sudden and accidental" pollution exclusion that provides coverage for contaminant releases only if they are sudden and accidental. If so, the policyholder would want to argue that, as used, the word "sudden" does not have a temporal connotation and take the position that "sudden and accidental" means the same as "unexpected and unintended." The policyholder could then argue that it did not expect or intend to cause the release of contaminants; therefore, the exclusion does not bar coverage.

The insurer is likely to argue that the sudden and accidental exception to the exclusion does have a temporal element and that it applies only to abrupt releases. If the insurer can support this position, it will have a stronger basis upon which to deny coverage for claims arising from regular or continuous exposure to contaminants.

In the alternative, the policyholder could argue that the term "sudden" is ambiguous. Therefore, because insurance contracts are generally contracts of adhesion—meaning only one party, the insurer, drafts the terms—any ambiguities should be construed against the drafter. The policyholder also can argue that the intent of the exclusion was to bar coverage for traditional pollution losses only, not SBS claims. In addition, if the exclusion precludes coverage for discharges "into the atmosphere," the policyholder can take the position that the term "atmosphere" creates an ambiguity when an insurer attempts to apply the exclusion to indoor contamination. Whether the term "atmosphere" refers to the air within a building becomes a critical determination.

Even if the policy contains the more restrictive "absolute" pollution exclusion, all hope is not lost for the policyholder. Many courts recognize that even absolute

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SBS

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pollution exclusions need some limiting principle because, when viewed in isolation, the terms "irritant" and "contaminant" are virtually boundless. After all, almost all substances or chemicals would irritate or damage some person or property. Other courts look to the reasonable expectations of the policyholder in light of the exclusion's general purpose.

There also may be regulatory limits on the application of pollution exclusions to SBS claims. For example, in June of 1997, the insurance commissioner of Louisiana issued an advisory letter strictly limiting insurers' use of pollution exclusions. This limitation was in response to allegations that insurers have abused the absolute pollution exclusion

by using it in ways they assured insurance regulators they never would.

An insurer may attempt to deny coverage by asserting that the policyholder failed to comply with the notice requirements of its insurance policy. Generally, notice of an occurrence must be given "as soon as practicable" or "as soon as possible," and notice of a claim or suit must be given immediately. Compliance with a policy's notice requirements usually is a condition precedent to coverage. Most states require an insurer to prove that it has been prejudiced—suffered irreparable harm—due to the policyholder's failure to give timely notice before it can deny coverage on this basis.

Sick building syndrome can reduce productivity, affect workers' health and increase workers comp and liability claims. The application of general liability coverage to SBS suits and claims will vary greatly depending on the

applicable case law and the factual circumstances of each situation. Therefore, in order to keep exposures to a minimum, any complaints about indoor air quality should be taken seriously and responded to promptly. **B1**



James F. Dorion is a licensed attorney and a senior consultant with Richard Oliver International's claims management practice in Naperville, Ill.

OSHA citations can teach employers a lesson

By Robert K. Tuman

OSHA'S HERE, AN EMPLOYEE whispers sheepishly. "Should I let him in?"

You go out to see what is happening. The Occupational Safety and Health Administration inspector introduces himself and tells you that his office received an employee complaint. As your stomach churns, you ask, "What was it all about?" He tells you and asks to see the area in question.

Fast forward two to three weeks. You receive a citation or multiple citations for workplace safety violations. After a few choice expletives, a number of questions cross your mind:

- Who is the rat who called OSHA?

OSHA cannot divulge the employee's name. However, if you think you are being singled out by a disgruntled former employee, you can provide OSHA with a roster of current employees. If the complainant's name does not appear on the list, OSHA still will allow the complaint but generally will give it less credence.

A hearing officer recently told us that OSHA requires the complainant to give his or her name, address and telephone number but does not independently verify the complainant's identity or whether he or she is actually an employee of that company.

- Should I pay the fines? Is it worth it to waste half a day fighting with people who already have made up their minds?

This decision should be based on whether you feel that the citation or citations have merit, and/or whether you can present facts to convince a reasonable person that you are not guilty. Here are two examples:

In Case A, the inspector observed—and photographed—two employees working over 70 feet in the air without fall protection, putting the two employees in imminent danger. This client was wrong, and the chances of winning this case were slim to none. Despite a lot of kicking and screaming, our client paid the adjusted fine.

In Case B, two employees were washing a wall with water after applying a cleaning agent. Neither was wearing eye protection. However, these two employees had read and signed safety rules mandating eye protection when working with cleaning agents and had been reminded of the rules that day. After the incident, management issued a reprimand to the involved employees for their negligence, as it does whenever a safety violation occurs.

There is no way this employer should be fined for the two employees' lapse. Despite these facts, the hearing officer emphatically said that the violation was symptomatic of management's flawed safety program and refused to drop the fine.

We have appealed the judgment to the next level.

In any case, if you feel you are right and have facts and documentation to prove it, request an informal conference. If you are wrong, pay the fine. OSHA will include an expedited settlement agreement to sign and return with your check. They even have a payment plan.

- If I make waves, will I bring the wrath of OSHA on my company?

As a general rule—and more so recently—OSHA inspectors will spend a great deal of time with you in a closing conference. During this session, the inspector, or "compliance officer," will outline the citations you will receive and will give you documentation to assist you to correct the problems. This closing conference generally does not allow for negotiation, though there is the opportunity for discussion.

The compliance officer also will inform you of your right to request an informal conference or to contest the claim. I have never heard or felt that a compliance officer had discouraged an employer from pursuing an appeal. However, all compliance officers will remind employers that they must come prepared with facts and relevant documentation.

- What are my chances of winning?

This is a hard question to answer, as the probability of prevailing is dependent on a number of variables: the strength of the facts, the hearing officer's perception of your credibility, the nature and magnitude of the safety violation or violations, previous citations, and other factors.

On to the informal conference. At this point, we get a number of questions with some common themes. I will try to provide practical answers and guidelines.

- Is the purpose really to hear what I have to say, or is it an exercise in futility?

This is truly an "informal" hearing, with free-flowing give and take. Based on your presentation of the facts and the documentation you bring, the hearing officer may recategorize the citation, such as from "serious" to "other," and reduce the fine. The probability of this happening comes down to whether the hearing officer believes you, your facts and your documentation. Hearing officers have heard a lot of stories, and their noses are acutely sensitive to the sniff test.

Here are some "don'ts" and "dos" that should guide your preparation and defense:

- Don't go if you can't put together a believable case. Try out your presentation, facts and documentation on one or more impartial individuals. See what they think, and go from there.
- Don't play the victim. If the hearing officer has heard "I might as well close the door and throw away the key" once, he or she has heard it a thousand times.
- Don't argue, confront or accuse—these approaches will backfire on you.
- Do assert the facts and provide relevant documentation. In Case B, mentioned earlier, we produced signed safety rules mandating eye protection and testimony from the operations manager that he had reminded the employees to wear their goggles. In addition, we had asked one of the two employees if he would tell OSHA the truth about what happened that day—that he had simply forgotten to wear eye protection. He gladly came to the hearing and testified.
- Do assert, based on the facts and documentation, that the fines should be reduced or thrown out.
- Do assert, based on the facts and documentation, that the citations should be recategorized to less-severe citations, such as from "willful" to "serious."
- Don't settle if you know you are right. You are

scratching your head and asking, "How do I know if I'm right?" Well, if the facts are overwhelmingly in your favor, contest the citation and take your best shot. The downside is that you'll have to pay the fines.

- Who will be at the informal conference?

There may be some variation within OSHA, but in Massachusetts, for example, the hearing officers are usually managers with concurrent field duties. Presiding over informal conferences is one of their responsibilities. For example, an industrial hygienist recently presided over an informal conference because the area director was otherwise occupied. The hearing officer also can communicate with the inspector, either by telephone or in person.

- What if I decide to settle?

The hearing officer will draw up a settlement agreement for you to sign. You can write a check for the full amount or sign up for a payment plan. Payment plan terms are quite reasonable.

- What happens if I decide to contest?

The hearing officer will tell you the deadline for correcting the perceived problems and the deadline for contesting. He or she may also leave you a proposed settlement agreement to consider. If you decide to contest the citation or citations, you must notify OSHA before the deadline. Within several weeks, you will receive a notice giving the date, time and location of the next hearing.

- If I settle, am I off the hook?

It has been my experience that neither the hearing officer nor the inspector will fully explain your future exposure if you settle.

By settling, you are admitting liability and responsibility. Additionally, the citations become part of OSHA's permanent record. If you are cited for the same violation within 12 months of this citation, OSHA can categorize the citation as willful and repeated, and the fines per citation could start in excess of \$5,000. Please note that they could, in an extreme case, go up to \$70,000 per citation. If you are inspected and cited after a year, the hearing officer will call up your history and remind you of it at the hearing. If you are being cited for the same violation you were cited for as many as nine years ago, your history may adversely affect the outcome. In other words, there is a tendency to hold your past against you.

To conclude, if your facts and documentation give you a reasonable chance of prevailing, request an informal conference. OSHA encourages dialogue, and it is your constitutional right. And if you don't prevail, even partially, you will have participated in an excellent learning experience. **B1**



Robert K. Tuman is president of Compensation Claims Review Corp. in Andover, Mass.

INTERNATIONAL

Global Briefs

An insurance industry protest over a recent legislative proposal in Germany that insurers say would, among other things, raise their taxes by 17 billion deutsche marks (\$9.46 billion) over the next four years has led the government to soften its position. Chancellor Gerhard Schroeder and Finance Minister Oskar Lafontaine last week said the corporate taxes on insurers and reinsurers would not exceed 8.75 billion deutsche marks (\$4.87 billion). Germany's Parliament is expected to vote on the bill this month. . . . Mary Francis has been appointed the new director general of the **Assn. of British Insurers**, replacing Mark Boleat. Ms. Francis, who has spent most of her career in the U.K. Treasury, currently is deputy private secretary to Queen Elizabeth II. . . . French export credit insurer **Coface Group** is opening two new branch offices in Asia. Coface Japan, based in Tokyo, will write domestic market business, while Coface Hong Kong is licensed to write both domestic and export business. . . . Swiss insurer **Zurich Insurance**, part of Zurich Financial Services Group, has joined the International Underwriting Assn. of London. It will use the IUA systems to access international reinsurance business. . . . Profits increased 13.3% to 764 million French francs (\$126.9 million) at French reinsurer **Societe Commerciale de Reassurance** in 1998, despite almost static gross revenues of 15.37 billion French francs (\$2.55 billion). Paris-based SCOR has increased its life, accident and health business, and it is developing its non-traditional reinsurance products business in response to the poor market conditions in property and casualty reinsurance. . . . Chicago rating agency Duff & Phelps Credit Rating Co. has placed a "Rating Watch-Down" on the BBB+ claims paying rating for **New Cap Reinsurance Corp. Ltd.** of Australia and **New Cap Reinsurance Corp. (Bermuda) Ltd.**, both subsidiaries of New Cap Reinsurance Corp. Holdings Ltd. Duff & Phelps made the decision following New Cap Re's announcement last month that it anticipated posting about \$90 million in losses for 1998. . . . American International Group Inc. subsidiary **AIG Otawary Fundusz Emerytalny** has been granted a license by the Polish Board for the Supervision of Pension Funds. AIG OFE will be managed by AIG Powszechna Towarzystwo Emerytalne S.A., which was licensed to transact pensions business in Poland last December. . . . Standard & Poor's in London has placed the BBB+ financial strength rating for **GAN Insurance Co. Ltd.** on CreditWatch with developing implications. The agency's decision comes in the wake of discussions between S&P and GAN management about the company's future following GAN's purchase by Caisse Centrale des Assurances Mutuelles Agricoles last June. . . . Bermuda-based insurer **XL Capital Ltd.** has taken an undisclosed stake in Highfields Capital Management L.P., a global equity investment management firm with headquarters in Boston. XL President and Chief Executive Officer Brian O'Hara said the two organizations will "focus on developing potential synergies." . . . International loss adjuster and claims management company **Cunningham Lindsey Group**, the result of the purchase of the Cunningham Group by Lindsey Morden Claims Services, will now operate as **Cunningham Lindsey Canada Ltd.**, **Cunningham Lindsey USA Inc.**, **Cunningham Lindsey Europe B.V.**, **Cunningham Lindsey International** and **Cunningham Ellis & Buckle**.

Avalanches ravage Alps

By DON LEWIS KIRK

Record snowfall in Western Europe has triggered the worst series of avalanches in the Alps in 50 years.

At least 70 people have died since January in Austria, Switzerland, France and Italy from avalanches. Insured damage from the avalanches totals hundreds of millions of dollars, and uninsured losses are expected to be much greater.

On Feb. 23, the first avalanche in 300 years to hit the small winter-sports resort of Galtuer, Austria, swept down the mountainside and killed 38 people.

No one could have predicted it, said Tirol-based avalanche expert Thomas Huber, who blamed Austria's worst series of avalanches since 1951 on a highly dangerous combination of unusually heavy snowfall and strong winds.

Twelve major avalanches resulting in deaths and several hundred minor avalanches have been reported. The Swiss alpine region of Wallis alone experienced 30 to 50 avalanches on some days.

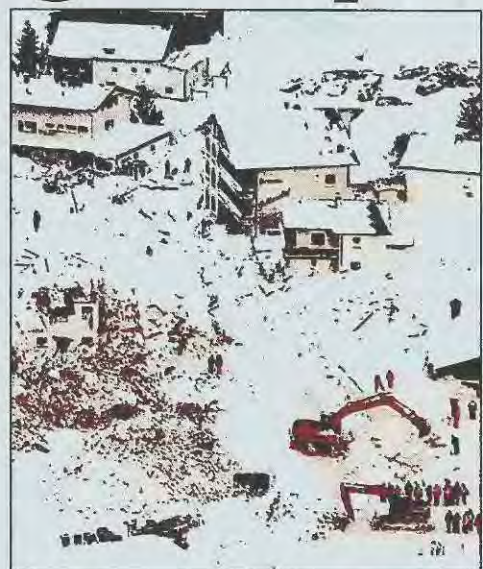
Risk of snow slides closed ski resorts in

regions of Austria and Switzerland and stranded thousands of tourists and local residents in the area of Tirol and the neighboring Voralberg province. Both Galtuer and Valzur, Austria, were evacuated on Feb. 26, except for rescue crews and locals who chose to stay. More than 3,000 tourists were evacuated from surrounding areas.

The Galtuer avalanche was the most severe that Western Europe has seen this winter. Overall, European avalanches have claimed more than 70 lives in the region this year.

At least 14 people have died in avalanches in the French Alps since the beginning of February. One snow slide in Chamonix, France, moving at speeds of up to 60 mph, destroyed several chalets, leaving behind nothing but their foundations. Another avalanche in Italy killed one person and injured three when it swept without warning through the village of Morgex, located about seven miles from Italy's northwestern border with France and Switzerland. The snow slide also buried a major road, isolating the area.

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AP/WIDE WORLD PHOTOS

Backhoes are used in rescue work after an avalanche in the resort community of Galtuer, Austria, killed 38 people.

U.K. tobacco claimants drop lawsuits

LONDON—British tobacco companies are celebrating a decision by two of the United Kingdom's leading plaintiff law firms to drop lawsuits seeking compensation for a group of lung cancer sufferers.

The litigation was dropped following a U.K. High Court ruling last month that most of the 52 plaintiffs had filed their claims beyond the three-year statute of limitations.

In the United Kingdom, a three-year statute of limitations on such claims begins with the discovery of an illness. Although the High Court is able to grant an extension of the statute, it opted not to do so for these cases.

"In the light of the ruling of Mr. Justice Wright and the discussions that we have had with our clients, 46 plaintiffs have decided to abandon their claims against the defendants. We, Leigh Day & Co. and Irwin

Mitchell, have decided not to continue with the litigation," read a joint statement released by the two law firms.

Of the remaining plaintiffs, five filed their claims beyond the three-year limit and one has since decided to withdraw his action, a spokesman for tobacco manufacturer Gallaher Ltd. confirmed last week. The remaining plaintiffs still have the option to appeal the ruling, though they will have to seek legal representation elsewhere.

Gallaher and fellow defendant Imperial Tobacco Ltd. have agreed not to pursue reimbursement from the claimants for the millions of pounds in costs incurred to prepare their defense, said a spokesman for Gallaher. The spokesman added that the tobacco company regarded the money spent as an investment to deter future litigation.

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Risk ownership ideas changing

U.K. risk managers' role in question

By SARAH GODDARD

LONDON—U.K. risk managers may lose ground—or even their jobs—within their organizations if they do not keep pace with the fast-changing business environment, warns a leading risk consultant.

New corporate governance requirements and the convergence of insurance and financial markets products are blurring the boundaries between different parts of organizations, leading to the question, "Who owns risk?" according to Clive Thursby, a risk management consultant with Tillinghast-Towers Perrin in London. Mr. Thursby posed the question in a report the risk management consulting firm issued late last month.

"There is a difference of opinion," Mr. Thursby said in an interview. "There is uncertainty. . . in how different organizations face up to these matters."

Some companies view risk management as the responsibility of the front-line workforce, while others see it as a specialist head office function, he said. At the same time, "there is confusion about what risk management is about nowadays," said Mr. Thursby. He added that organizations' internal structures can further muddy the waters, with what some would view as risk management services falling under the aegis of the internal audit or treasury functions, for example.

As these pressures on traditional risk management increase, risk managers must ensure their role is identified and supported by the board of directors. Mr. Thursby quotes a risk manager whose role was to be outsourced as saying, "I had always been given free rein. Consequently, my bosses never knew what I did."

"Clearly, risk management is not going to prosper as a function if it can't demonstrate it is doing something useful," said Mr. Thursby. This has been difficult, beyond demonstrating

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State insurer to file tobacco suit

Peculiar legal status of tobacco in France makes for a problematic case

By MARIA KIELMAS

SAINT-NAZAIRE, France—In the first case of its kind in France, a local branch of the French state health insurer, Caisse Primaire d'Assurance Maladie, is preparing to sue four tobacco companies for the costs of treating smoking-related diseases.

However, tobacco industry representatives argue that, because of the peculiar legal position of tobacco products in France, the lawsuit merely

amounts to one agency of the French state suing another.

The local office of CPAM, in the city of Saint-Nazaire on the French Atlantic coast, will file a lawsuit at the end of March. The office is, claiming expenses of 50 million French francs (\$8.45 million) annually for an as-yet-undetermined period, according to a CPAM spokesman in Saint-Nazaire. This period could extend to about 10 years, the spokesman confirmed.

The state health insurer oper-

ates as part of the French social security system. The spokesman added that a second CPAM local office in Avignon is considering a similar lawsuit.

The Saint-Nazaire office of CPAM will sue tobacco companies Philip Morris France, Rothmans France, R.J. Reynolds France and the formerly state-owned company La Seita.

The companies will not comment individually on the case. Instead, they are referring all inquiries to the tobacco industry group Centre de Documen-

tation et d'Information sur le Tabac. The Paris-based group represents tobacco growers and retailers as well as the tobacco companies.

CDIT Director Paul Truchot said the lawsuit is an attempt to import U.S. legal practices into France, where the legal code and practice is entirely different. "This is an attempt to hijack a U.S. concept that does not apply to France," he said.

Mr. Truchot added that the plaintiffs are trying to use the

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INTERNATIONAL

Risk

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through some "very crude measures" such as reduced insurance costs, he added.

Richard Reddaway, group insurance manager with U.K. pharmaceuticals company Glaxo Wellcome P.L.C. and a past chairman of the Assn. of Insurance & Risk Managers, said British risk managers now have the opportunity to prove their worth to the company board through a combination of new corporate governance requirements and the millennium bug. "They have been one of the greatest boosts risk management has ever seen," he said.

The 1998 report of the Hampel Committee on Corporate Governance, which states that responsibility for U.K. organizations' risks rests with top management, has helped raise awareness of the risk management role, said Mr. Reddaway. At the same time, dealing with the threat of Y2K problems has given risk managers a "wonderful opportunity" to network with other professionals within their organizations, raising the profile of

the discipline.

As traditional insurance and the capital markets converge, Mr. Reddaway said he sees financial risk management as an opportunity for units that manage different forms of risk to work closer together. "In a lot of companies, people are work-

against internal audit, which often is better equipped and has better business experience," the risk manager said.

To an extent, this turf war has been fueled by the new corporate governance requirements in the United Kingdom, the risk manager

'The traditional risk manager has found himself vying for space against internal audit, which often is better equipped and has better business experience,' says a U.K. risk manager.

ing extremely hard, and life is too short to have territorial wars," he said.

Another U.K. risk manager, however, disagreed.

The risk manager, who works for a U.K.-based multinational company but wished to remain nameless, said that, in his experience, internal audit teams "have been working for a long time to get their hands on risk management."

"The traditional risk manager has found himself vying for space

said, adding that internal audit departments often are "very adept" at identifying broader organizational risks such as treasury and marketing exposures.

Risk managers need to fight back by delivering value, he contended. "Cost-of-risk statements over time certainly show if the risk management function is effective or not," he said, and these can be supplemented using benchmarking techniques.

Tillinghast-Towers Perrin's Mr.

Thursby agreed that risk managers do need to prove their worth to the organization. "As risk becomes a higher priority, people want a cleaner measure of how it is doing," he said. "From the risk manager's point of view, there is an incentive to develop a measure to defend his position."

Some organizations are changing the boundaries, splitting the traditional risk management role and placing each part with a different area of the corporation, said Mr. Thursby.

If risk management is broken down into risk assessment, risk control and risk financing, these can be covered by other departments, he said. For example, risk assessment could be undertaken by internal audit, risk control could become a role for security or engineering professionals, and risk financing could fall within the treasury function. "Having realigned, the organization may not need a risk manager to coordinate all this," he pointed out.

And "if this change in (organizational) style takes root, there won't be too many risk managers around as we understand the term today," he warned. "In terms of where opportunities lie, it's elsewhere, in the

genuine management of risk."

Clive Pracy, an associate partner with Andersen Consulting in London, said there is "no question" that risk management is at a crossroads and agreed the future for risk managers lies in taking a broader view about the risks they have to manage.

As business practices change, particularly with the advent of electronic commerce, risk managers need to be involved in that process in order to understand the changing risk profile of the organization—and they are not there, Mr. Pracy said.

"The risk manager needs reskilling," he said. "The problem is (risk managers) have become pigeon-holed, and it is therefore difficult to get an enlightened attitude into the boardroom."

AIRMIC is helping its risk manager members acquire new skills, said Glaxo Wellcome's Mr. Reddaway. It is "aware of the skill sets of members" and is trying to provide training in the new areas of competency being demanded. And "AIRMIC's record membership is reflecting the fact that people are recognizing they have got to be at the cutting edge." **BI**

Avalanche

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Most insurers in Italy, France and Austria say it is still too early to estimate insured damage. Most insured damage, however, is likely to have occurred in Switzerland, where avalanche risks are typically included in property insurance policies. In Austria, by contrast, avalanche damage is covered only if an extra policy is obtained.

"Property damage from avalanches, which includes damage to cars and buildings, is insured only under special conditions," said Erik Wolf, Vienna-based director of sports insurer ARAG A.G. "Most property is insured against avalanche, but it requires addition-

al coverage. Cars are insured only if they have full comprehensive casualty insurance."

In Switzerland, total insured avalanche losses are likely to exceed 300 million Swiss francs (\$206 million), estimated Swiss Mobiliar S.A., the lead insurer of Zurich-based natural catastrophe insurance pool Elementarschaden Pool. Mobiliar is Switzerland's largest property insurer, with 25% of the market. Mobiliar estimates its own avalanche-related insured losses at 60 million (\$41 million) to 80 million (\$55 million) Swiss francs.

AXA S.A. estimates total French losses will reach 140 million francs (\$23.2 million), although the Paris-based insurer would not estimate insured losses. In France, commercial and industrial companies are

insured against natural disasters through a state-sponsored reinsurance pool called Caisse Centrale de Reassurance. Caisse Centrale, however, refused to give estimates of either total or insured avalanche losses. The French government has promised to provide relief.

In Austria, avalanche damage to property is insured only under special conditions, says Erik Wolf of insurer ARAG A.G.

Helga Werner is a ski sports lawyer and director of the Regensburg, Germany-based Lift Operators Assn. "Unless lift operators or local communities are found at fault, insurance will cover damage," Ms. Werner said, referring to both personal injury and property liability.

"Ski resort lift operators are technically liable for accidents on the slopes and are insured," she said. "In reality, however, a slope is opened only after the approval of avalanche experts commissioned by local authorities. Should experts make a mistake, the community could be liable."

Allegations of negligence have been made against officials after the Galtuer disaster.

Daniela Range-Dietz, a lawyer from Rastatt, Germany, was in Galtuer at the time of the

avalanche. Ms. Range-Dietz is representing herself in a civil lawsuit against the city's mayor, Anton Mattle, who heads the city's avalanche expert commission. She argues that tourists were not sufficiently informed of the risk of avalanche and that dangers were covered up. "Travelers were not informed when the area was closed off (to skiing) on Feb. 17," nearly a week before the Feb. 23 disaster, Ms. Range-Dietz said. "Most would have left had they known."

Ms. Range-Dietz blames authorities for not initiating a "red alert" for the area. "A day before the avalanche, tourists were told 'there is no crisis—it is just winter in the mountains'," she said.

If the community were found negligent, it could be held liable for all damages. However, courts in Austria have seldom ruled against communities.

"It comes down to the fact that no one could honestly expect an avalanche to occur in the area," said ARAG's Mr. Wolf.

There are risk management steps that businesses can take against the threat of avalanche, said Augustin Kroll, managing director of Germany's largest resort lift operation, Nebelhorn Bahn A.G. in Oberdorf, Germany. Ski lift operators employ explosive experts to use detonations to set off smaller, controlled avalanches. "We basically have three methods. Charges are dropped from a lift, they are dropped from an airplane, or laid by hand," Mr. Kroll said.

He said, however, that such steps

would have made little difference in Galtuer. "As far as I can tell, it was an act of God that no one could anticipate. No one is at fault, and I don't expect liability exposures to arise from the disaster," he said.

Even when avalanche risk management measures are in place, hazards still exist, Mr. Kroll noted.

On Feb. 25, an avalanche detonation in the Wallis region set in motion a 350-meter-wide snow slide near the town of Leukerbad, he noted. Thirty people were caught near its path and were nearly killed. It is still unclear who gave the order for that detonation, he said.

The avalanche threat also is creating business losses for hotels and travel agencies. Local businesspeople estimate that hotels in the Wallis region are losing an aggregate \$105 million daily. While commercial operations in Austria have access to "all-risk" policies, no information was available on the number of businesses that have this insurance.

A spokeswoman for the German Travel Agency Assn. said the case for insurance coverage of travel agents' losses is not at all clear.

"There is no precedent for this. A German hotel has no legal basis to demand payment from tourists who book and renege on a trip to what turns out to be an endangered area. Both the client and the travel agent can cancel a contract in such a case. But travel agents can demand compensation for services rendered in advance," the spokeswoman said. **BI**

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U.K. lawyers must settle for SIF

LONDON—Lawyers in England and Wales must continue to buy their primary professional liability insurance from the Solicitors Indemnity Fund, the Law Society Council ruled last week.

In a close vote, council members ruled 32 to 29 against giving lawyers the opportunity to buy primary coverage on the open market. "A mutual fund is in the long-term best interests of clients and the profession," said Law Society President Michael

Mathews, adding that the "commercial insurance market is both volatile and cyclical."

Since 1987, all law firms operating in England and Wales have been required to purchase £1 million (\$1.6 million) in coverage per loss from the SIF, a mutual insurer. Huge losses suffered by the mutual fund in recent years and the resulting premium hikes have led to calls from law firms to be allowed to buy insurance on the commercial market.

In a statement released after

the vote, the Law Society pointed out that the number of negligence claims against lawyers has fallen in the past year by 15%, and that it "is determined to ensure that better risk management will lead to even fewer claims."

However, the decision likely will be tested in the courts later this year, as several lawyers are seeking a court ruling that the restriction violates European laws on competition.

—By Carolyn Aldred

INTERNATIONAL

Tobacco

Continued from page 19

The dropping of the action by two of the United Kingdom's most successful plaintiff law firms is good news for tobacco companies, and it is likely to deter future plaintiffs, noted one plaintiff lawyer who did not wish to be named.

Leigh Day & Co. and Irwin Mitchell had taken on the cases on a contingency-fee basis. As a result, the law firms have incurred

several million pounds in costs to pursue the cases.

Early on in the litigation, the tobacco companies sought a court ruling that would have made the law firms responsible for defense costs should the tobacco companies win the action. The Court of Appeal judges ruled, however, that there was no reason for the law firms to be responsible for a winning defendant's costs just because the law firm was acting under a contingency-fee arrangement.

—By Carolyn Aldred

Cargo ship detained for damage inquiry

LONDON—London-based protection and indemnity club Britannia Steam Ship Insurance Assn. Ltd. faces a substantial liability payout for a shipwrecking member accused of severing an undersea power cable in Indonesia.

Indonesian authorities have detained a 16,332-gross ton cargo ship, the Kota Indah, owned by Pacific International Lines of Singapore. The authorities claim the vessel severed the cable in mid-February when anchoring in a restricted zone near the island of Surabaya. The cable supplied power to another island, Madura, and the damage caused a blackout affecting some 35,000 inhabitants.

Local sources estimated that claims could run into millions of dollars from disruptions to power supplies and telecommunications, business interruption and loss of earnings. A spokesman for the Indonesian government said it is expected to take around six months to

restore full power to the island.

PIL is contesting the allegation, claiming that when the Kota Indah dropped anchor on Feb. 19, it was not in a prohibited anchorage area. It maintains that, at the time, the Kota Indah's crew saw another vessel positioned near the spot where charts showed the two power cables.

A local investigation is under way to determine the cause and amount of damage to the cable.

A spokesman for the Britannia in London confirmed that the Kota Indah was being detained and said the P&I club and PIL are awaiting the results of the local investigation. The spokesman said the incident would not effect PIL's Feb. 20 renewal, as the current year's rates already would have been negotiated at the time of the incident, and the club typically does not take too much notice of one claim.

—By Edwin Unsworth

Heavy losses in 1998 could harden Latin American reinsurance market

By GAVIN SOUTER

NEW YORK—Natural catastrophes and other losses that have hit Latin America over the past year could lead to a harder reinsurance market in the region, a reinsurance executive says.

Already, reinsurers are turning away facultative business from the region, and some rates are increasing, said Keith L. Shroyer, senior vp and chief underwriting officer at Latin American Re in Hamilton, Bermuda.

Over the next year, a general tightening in terms and conditions should occur, Mr. Shroyer said.

While reinsurers will welcome a harder market, other events in the region will not be as well received by foreign reinsurers, he said. In particular, new taxes imposed in Mexico could push up the cost of using foreign reinsurers, he said.

Latin America was hit by some large natural catastrophes, as well as some other large losses, in the past 12 months, Mr. Shroyer said at the International Insurance Council's 1999 Roundtable on Insurance Conditions in Latin America late last month in New York.

In particular, hurricanes Georges and Mitch battered Central America and the Caribbean, and an earthquake caused significant losses in Colombia this year, he said. Hurricane Georges caused an estimated \$3.3 billion in insured losses; Hurricane Mitch, an estimated \$150 million. The Colombian earthquake is estimated to have caused between \$200 million and \$400 million in insured damage, Mr. Shroyer said.

The events have caused changes in the reinsurance market, he said. "A

lot of U.S. reinsurers have significantly curtailed—and in some cases closed their doors to—facultative business."

Also, since November, prices for facultative coverage in Central America have increased by 10% to 30%, he said. "Those prices have held up, but they have not carried over to other Latin American areas."

Since November, prices for facultative coverage in Central America have increased by 10% to 30%, says Keith L. Shroyer.

In recent renewals, catastrophe excess-of-loss rates in the Caribbean have increased by about 20% for program layers affected by the hurricanes and by 10% to 15% for unaffected layers, he said. In the rest of Latin America, prices for most excess-of-loss programs have remained flat, but in some cases brokers had difficulty placing the risks, Mr. Shroyer said.

"We feel that on (catastrophe excess-of-loss), in particular, things have bottomed out, and we may start to see a bit of hardening in terms and conditions," he said. For example, the number of free reinstatements may be reduced for some programs, Mr. Shroyer said.

However, reinsurers are facing new challenges, he said.

On Jan. 1, Mexican authorities increased taxes on foreign reinsurers, he said. Premiums ceded to foreign

reinsurers will be taxed at a rate of 3.5%. There was no tax on these premiums before. "The rationale is that if you assume a 10% profit on a reinsurance transaction, then 3.5 points of that would be a 35% income tax, which is the normal corporation income tax in Mexico," Mr. Shroyer said.

Although foreign reinsurers in countries that have reciprocal tax treaties with Mexico may be able to offset some of the tax against taxes they pay in their home countries, most reinsurance transactions do not generate a 10% profit, he said.

Also, in its 1999 budget, announced on Jan. 1, the Mexican government imposed new taxes on more than 20 "fiscal paradises," including Bermuda, Panama and the Cayman Islands, Mr. Shroyer said. Under the new law, premiums ceded to reinsurers in those countries will be taxed at 40%, he said.

"If you apply the rationale of a 10% profit on reinsurance transactions, then these companies will be charged 400% of their profits," Mr. Shroyer said.

Both taxes are being challenged in court by ceding companies in Mexico and by foreign reinsurers, he said.

Suits challenging the new taxes were filed in Mexican courts last month, confirmed Manuel Aguilera Verduzco, president of the national insurance and surety commission in Mexico, who also spoke at the conference.

The 3.5% tax on premiums is in line with many other countries which impose taxes on foreign or out-of-state reinsurers, Mr. Aguilera said. And the 40% tax was part of a wider Mexican government policy on tax havens, Mr. Aguilera said. **BI**

France

Continued from page 19

case to turn public opinion against the tobacco companies. He said the CPAM wants to prove that the social security deficit is due to smoking-related diseases, even though studies have shown that the state makes a profit from tobacco taxes. "The only winners," Mr. Truchot said, "will be the lawyers."

In France, tobacco products carry a 76.6% tax, compared with a 31.5% tax in the United States. In addition,

'The only winners' of the litigation against tobacco companies 'will be the lawyers,' says Paul Truchot of CDIT.

tobacco advertising has been banned completely in France since 1991.

But, most importantly, said Mr. Truchot, is the different legal status of the tobacco industry in France. "The tobacco industry is controlled entirely by the state," he said. All tobacco products are licensed by a state agency, Laboratoire Nationale d'Essais, and the tar and nicotine levels also are regulated by the state. In addition, the tobacco industry is legally regarded as a public service in France, Mr. Truchot said.

"This is the big difference with the U.S., U.K., Ireland, Belgium and all

the other countries," Mr. Truchot continued. "In France, the tobacco shop is a public service, just like the electricity, railways and water." Mr. Truchot added that tobacco shops are answerable to the customs and excise authority Direction Generale des Douanes.

In addition to France, tobacco retailers in Spain, Portugal, Italy and Austria are regarded legally as public service entities. **BI**

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Fewer minorities in group health plans, study finds

By ROSEANNE WHITE

A new Commonwealth Fund study raises more questions about why minorities—even in comparable jobs with whites—have lower rates of employer-sponsored health care coverage.

The study shows that employer size, the type of company and the type of job may not be the only reasons why minorities—particularly Hispanics—have lower rates of employer-sponsored coverage than whites, said Allyson Hall, lead author of the

Commonwealth Fund study.

Other issues must be examined to determine additional reasons for the disparity, said Ms. Hall, a program officer for the New York-based philanthropic health policy organization. Those issues include whether the employee's culture affects perceptions of the risk of illness and the need for coverage, whether employees are declining coverage offered to them, and whether workers are discouraged by premiums and deductibles, she said.

Hispanic workers lag even fur-

ther than black employees behind whites in the rates of employer-sponsored coverage, the study indicates. Sixty-nine percent of whites have employer-sponsored coverage, compared with 52% of blacks and 44% of Hispanics, according to the study, "Employer-Sponsored Health Insurance: Implications for Minority Workers."

The disparity exists even among workers in job categories where coverage rates generally are higher: full-time, unionized, large employers, and manufac-

turing and government sectors. For example, among workers in the manufacturing sector, 85% of whites, 71% of blacks and 60% of Hispanics have employer-based health insurance, according to the study.

In midsize companies with 100 to 1,000 workers, 84% of whites have coverage, compared with 68% of blacks and 61% of Hispanics.

The disparity exists regardless of wage level and also is found among part-time workers, according to the study.

Benefit managers who find such a disparity among their workforces should try to determine why different groups elect not to have coverage and "to figure out a way to design benefit packages to meet the needs of all kinds of people," Ms. Hall said.

Copies of "Employer-Sponsored Health Insurance: Implications for Minority Workers" are available free by calling The Commonwealth Fund at 888-777-2744 or on their Web site at www.cmwf.org.

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Senate to hold Y2K hearings

WASHINGTON—The Senate Special Committee on the Year 2000 Technology Problem plans to hold hearings on the litigation aspects of the computer glitch later this year.

Y2K-related problems present "an attractive target for abusive lawsuits," according to a report released by the committee last week. The committee's chairman, Sen. Robert Bennett, R-Utah, has not set any timetable for hearings, and the panel did not endorse any of the many pieces of legislation that have been introduced this year to blunt the impact of Y2K-related lawsuits.

The committee's long-awaited report singled out the health-care sector of the economy as lagging "significantly in its Y2K preparations compared to other sectors." According to the committee, 64% of all hospitals—primarily smaller ones—had no plans to test their Y2K preparedness. The report also says that 90% of physicians' offices were unaware of their Y2K exposure.

Overall, however, the United States is much better prepared for Y2K than most of its trading partners, the report says. As he introduced the report, the committee's ranking minority member, Sen. Christopher Dodd, D-Conn., said that about 90% of the U.S. Y2K-related problems "should be remediated or resolved within 72 hours" of being discovered. He compared the probable situation to a "bump in the road" rather than a "crippling" event.

But Sen. Bennett said there is a "high probability of economic impact" elsewhere in the world, notably in parts of South and Central America, Asia and Africa.

Copies of "Investigating the Impact of the Year 2000 Problem" are available at www.senate.gov/~y2k. In addition, single bound copies cost \$16 and can be ordered from the U.S. Government Printing Office, Superintendent of Documents, Mail Stop: SSOP, Washington D.C. 20402-9328 (ISBN 0-16-058162-1).

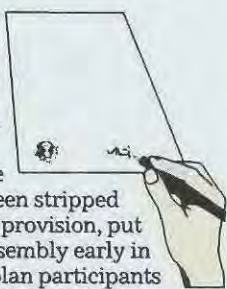
Virginia passes managed care bill

RICHMOND, Va.—Republican Gov. James Gilmore is expected to sign into law managed care reform legislation approved by the Virginia General Assembly on the last day of its 1999 regular session.

Both houses approved S.B. 1235 late last month, but only after the bill had been stripped of its most controversial provision. That provision, put forth by Democratic members of the Assembly early in the session, would have allowed health plan participants to sue their plans if they thought that they had been denied necessary medical services.

Although Republicans killed that provision, the bill still would subject managed care plans to a number of new mandates and regulations. For example, the measure would require that participation in clinical cancer trials be covered and that hysterectomy patients be covered for hospital stays of 24 or 48 hours, depending on the specifics of the procedure, noted Mark Pratt, executive director of the Richmond-based Virginia Assn. of Health Plans.

The measure also calls for the establishment of a managed care ombudsman's office that would handle appeals to health care plans, as well as the creation of an outside review board to issue binding rulings on health care disputes the ombudsman's



office could not resolve. Both new offices would be funded by assessments on health insurers.

Mr. Pratt expressed concern over the added cost of the new review panels, but called the bill a "responsible result" given the tort expansion it initially contained.

Federal claim in insolvency rejected

CHARLESTON, W. Va.—West Virginia's Supreme Court has upheld its state liquidation law, rejecting the U.S. government's attempt to get a higher priority for federal claims.

The state high court ruled regarding the insolvency of Blue Cross & Blue Shield of West Virginia that claims by the U.S. government should receive a lower priority for payment because they were filed late, compared with other claims that were filed on time. The claims include unpaid Medicare and



veterans' bills.

The court cited the McCarran-Ferguson Act, which allows states to regulate insurance, in upholding the procedural process in the state's liquidation law, according to the December 1998 decision.

The decision favoring state regulation is one of several similar outcomes in recent years.

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

However, "the federal government has taken a pretty contentious position" since then, and continues to challenge the issue, said Lenore S. Marema, vp-legal and regulatory affairs for the Alliance of American Insurers in Downers Grove, Ill.

The National Assn. of Insurance Commissioners tried unsuccessfully to resolve the issue last year when it formally adopted a resolution urging Congress to explicitly exempt insurance company receiverships from the federal superpriority law (*BI*, June 29, 1998).

Sears delays benefit commencement

HOFFMAN ESTATES, Ill.—Newly hired employees of Sears Roebuck & Co. will have to wait 60 to 90 days to receive company benefits under a new policy.

Under the new policy, employees receive benefits on the first day of the third month following hiring. The policy, which was announced in December but went into effect Feb. 1, affects benefits such as medical and dental insurance, long-term disability insurance, long-term care coverage, legal insurance and flexible spending accounts, a Sears spokeswoman said. Previously, employees received benefits immediately if they started on the first of the month, or, if not, on the first of the following month.

Sears created the policy because of high employee turnover in the retailing industry, and the move is in line with waiting periods imposed by other retailers, the spokeswoman said.



A.M. Best

Continued from page 3

Best has yet to sign a formal agreement with any insurers or reinsurers that would start the submission of information to Paragon. But several companies have expressed interest during informal discussions, Ms. Albanese said.

Having industrywide exposure data is not unique, says one observer.

Insurers can already obtain industrywide exposure data from catastrophe modeling companies, said Gregg Pope, manager of natural hazard risks for Zurich U.S. in Schaumburg, Ill. The project would likely be of greatest service to Best by helping it obtain a consistent model baseline for making comparisons between insurers. But Mr. Pope stressed he had limited information about Best's plan.

But the insurance industry could benefit from a method to evaluate and compare models, said John Schneider, chief scientist for Impact Forecasting L.L.C. in Chicago, which is majority-owned by Aon Corp.

The rating agency's plan calls for an insurer to voluntarily submit to Best the same data it now provides to its catastrophe modeling company or companies. Best will select comparable portions of that information and submit it to Paragon for an evaluation of the insurer's earthquake and hurri-

cane exposures. Paragon will not know what insurer the information comes from. To ensure confidentiality, no names—only tracking numbers—will identify the data.

From the database that Best and Paragon develop, insurers will gain the ability to benchmark their exposures against the entire industry, Ms. Albanese said.

Policyholders, insurers and regulators could all benefit by better understanding the entire industry's catastrophe exposure, Mr. Simpson said. "We believe it's going to achieve objective No. 1, which is to even the playing field in a rating evaluation when we do comparisons," he said. Best's second objective is to build the aggregate, geographical exposure database on a nationwide basis.

"If we achieve our objectives, and we get good company participation, we believe it would be an exposure database second to none in terms of completeness, in both the large-company arena and the small- (and) medium-size-company arena," Mr. Simpson said.

But even if the project is successful, making comparisons among insurers will remain a tough task, Ms. Albanese conceded. The database will be one more tool among many that analysts have available to them. "It's not the end-all," she said.

Best does not want insurers to abandon the catastrophe model ven-

dors they now contract with, Mr. Simpson said. That's because there is no one "right" catastrophe model, he stressed.

But "there is a need, ultimately, for so-called standardization among these firms," he said. "Not that we will singularly do that, but we might help foster and accelerate movement toward that beneficial goal."

The plan calls for exclusive use of Paragon software CATALYST 3.0 for a full year once the program is operational. Paragon is a unit of Minneapolis-based E.W. Blanch Holdings Inc.

Other modeling companies could later pursue similar arrangements with Best, Mr. Simpson said. "The key is to have comparability company to company through a common benchmark. But the benchmark could widen," he said.

Evaluating insurers on a "level playing field" is a concern among other rating companies.

Standard & Poor's Corp., for example, uses an internally created catastrophe model to evaluate all insurers, said Matthew Coyle, an S&P director in New York. But Mr. Coyle also acknowledged that S&P is not in the business of building catastrophe models, and he would not comment on the sophistication of S&P's model.

Catastrophe modeling firms typically employ a wide range of scientists and various engineers to build their systems.

BI

Grower settles harassment claims

SAN JOSE, Calif.—Tanimura & Antle agreed to pay nearly \$1.9 million to settle a class action sexual harassment lawsuit. The suit was brought by the Equal Employment Opportunity Commission on behalf of two employees and a class of current and former employees.

Under the consent decree, which was approved late last month by a U.S. District Court Judge in San Jose, Calif., the Salinas, Calif.-based produce grower and distributor will revise its existing sexual harassment policy and the handling of harassment complaints. In addition, it will provide mandatory sexual harassment training to all of its employees, including supervisors and managers.

The suit was brought on behalf of a farm worker who alleged she was sexually harassed by a supervisor. Her company then retaliated against for opposing the harassment. Another male employee filed a charge with the EEOC, alleging the company retaliated against him because he was associated with the woman.

Two supervisors have since been terminated from the company, and another has been reprimanded.

The \$1.9 million will provide compensation for the two lead plaintiffs and other employees and job applicants who were harassed, discriminated against or otherwise retaliated against since Sept. 25, 1994. If the awards for the claimants do not exhaust the settlement fund, Tanimura will donate the remainder—up to \$400,000—to women's organizations and employee organizations.

Carmen Ponce, assistant general counsel and vp-human resources for Tanimura & Antle, said that insurance will not cover the settlement, but that the company has since bought an employment practices liability policy.

Information in brief

The Multilateral Investment Guarantee Agency, the World Bank-owned political risk insurer, is increasing its per project limits to \$200 million and its per country limits to \$620 million. The increases were made possible through reinsurance contracts purchased from XL Insurance Ltd. and ACE Bermuda Insurance Ltd. . . **Fireman's Fund Insurance Co.** of Novato, Calif., has agreed to refund \$76.25 million to California policyholders in a settlement reached with the Insurance Department. Fireman's Fund had disputed the profitability formula applied to the company under Proposition 103, a spokesman explained. . . **Kevin Cronin** is leaving the National Assn. of Insurance Commissioners March 26 to become the chief executive officer and president of the International Insurance Council. He is the NAIC's Washington counsel and director of government and international relations. . . **Richard McGahey** has been named assistant secretary at the Labor Department's Office of Pension and Welfare Benefits Administration. Mr. McGahey, who has been the Labor Department's assistant secretary for policy, also was executive director of the congressional Joint Economic Committee. He succeeds Ole-na Berg, who left the department in June for personal reasons. . . **Pauline Thomas** has been elected the first female president of the Society of Risk Management Consultants. The New York-based society is an international professional organization of independent insurance and risk management consultants. Ms. Thomas heads the Irvine, Calif.-based consulting firm of Effective Risk Management. **BI**

PUBLIC NOTICE

It has come to the attention of the Corporation of Lloyd's, the administrative arm of Lloyd's of London, that Eagle County Development Co. (A Limited Partnership) of Texas (USA), principal office located at 9002 Webb Kay Drive, Dallas, Texas 75243, is in possession of a copy of an alleged Lloyd's Surety Bond Guarantee in the sum USD\$60,000,000 (Sixty Million US Dollars).

The Corporation of Lloyd's wishes to inform the public that the Surety Bond Guarantee was not placed with Underwriters at Lloyd's, London and is of no force and effect whatsoever.

Any person who is relying upon the aforementioned Surety Bond Guarantee should contact one of the following people:

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0171 327-5613 (telephone)

0171 327-5988 (facsimile)

Brokers

Continued from page 2

The megabrokers are now busy absorbing other major acquisitions made last year, and some fallout is beginning to take place.

A Marsh spokeswoman said that about 375 jobs are being eliminated in the United Kingdom, as a result of its integration of Sedgwick Group P.L.C. She said that two-thirds of the job eliminations are voluntary.

Aon announced last month that it would take a first quarter 1999 pretax charge of between \$100 million and \$150 million to cover costs associated with reorganization efforts and layoffs in its U.K. brokerage operations, as well as costs associated with consolidating various European acquisitions made in 1998. The charge also will cover costs of an early retirement plan the company is offering about 1,300 of its U.S. employees.

In an effort to ease the concerns among risk managers regarding the clout the megabrokers might wield with insurers, Marsh and Aon both have publicly addressed the issue of contingent commissions.

In January, Marsh reached an agreement with the Risk & Insurance Management Society Inc. and said it will implement a new procedure to let clients receive information on contingent commission arrangements (BI, Feb. 1).

Aon, which said it always disclosed contingent commissions to clients when asked, formalized the procedure in February. The broker said it will begin adding disclosure

language in its routine billing and other statements (BI, Feb. 22).

Meanwhile, all of the world's largest brokers that have reported 1998 results attribute their growth to new business obtained during the year.

"We've always been able to bring in strong new business," said J. Michael Bischoff, vp-corporate development at M&M, "even though the pricing doesn't let us show it on our income statement. If pricing were flat, we'd have 10% to 11% organic growth, and that's what our new business growth is," he said.

Patrick G. Ryan, chairman and chief executive officer of Aon, said that the U.S. brokerage operations were able to develop new business in 1998 as a result of "no major intrusion from any acquisitions" during the year.

"It was the first time in many years that we made no major acquisition in the U.S.," he noted.

JLT attributes new business growth for its 3% rise in revenues to \$373.2 million in 1998. Chairman Ken Carter said that JLT won five major U.K. accounts last year and has just won two major accounts in Asia.

Year-end results of the world's largest brokers follow:

Marsh & McLennan

Year-end brokerage and consulting revenues increased 18.6% to \$4.89 billion at the world's largest broker. Including investment income and revenues from The Putnam Co., M&M's Boston-based investment management company, corporate revenues rose

19.6% to \$7.22 billion. Net income rose almost 100% to \$796 million. Excluding the 1997 special charge, income rose 34%.

"We had a very strong year, an excellent year, and it came from all operations," Mr. Bischoff said. "The growth in operating income from insurance services increased 25%, investment management rose 46%, and consulting rose 36%," he said.

While much of the increases can be attributed to acquisitions, M&M's insurance brokerage operations posted 5% growth organically, he said.

Marsh "has successfully consolidated with J&H," he added. "We said that there would be significant benefits in '98 and '99, and we're seeing those benefits now and more will feed into '99," he said.

On the consulting side, Mr. Bischoff said that growth at William M. Mercer Inc. can be attributed to consolidation savings and a good operating environment.

"It's a good environment with the economic activity," he said. "We've consistently done more than make the most of that."

Roughly \$166 million, or about one month of revenues, in M&M's fourth-quarter results is attributable to its purchase of Sedgwick.

Earlier this year, Marsh announced a new management structure and formed a new holding company for its risk and insurance services business.

Jeffrey W. Greenberg in January was elected president of the parent company and will succeed

A.J.C. Smith as chief executive officer at the end of the year (BI, Jan. 25).

Also, M&M recently announced that it formed Marsh Inc., a new holding company that houses the insurance and reinsurance brokerage and consulting business. The new entity was formerly known as J&H Marsh & McLennan Inc. (BI, March 1).

Aon

1998 brokerage and consulting revenues increased 16.5% to \$4.39 billion at the Chicago-based broker. Corporatewide revenues, which include Aon underwriting operations, increased 12.9% to \$6.49 billion, while net income jumped 80.9% to \$540.5 million.

"We thought it was a very good year," Mr. Ryan said. Revenues from insurance brokerage increased 17.4% and consulting revenues increased 11.3% over the year. While a majority of the growth is acquisition-fueled, Mr. Ryan said that the retail brokerage side grew 4% organically.

"One of the interesting things is that in the past 18 months, we've doubled the size of Aon's employee base from 22,000 to 44,000," Mr. Ryan said. "When you step back and look at that, it's a major change in an organization."

"Oftentimes, we look at revenues and profits and those kinds of changes and don't reflect on the significant demand on people when you double the employee base. It's like adding in a whole city. It was a significant challenge but one that our people rose to," he said.

As part of Aon's ongoing European integration efforts, Mr. Ryan said that the broker plans to blend the U.K. retail and specialty brokerage business "to bring the talent of both organizations to major corporate clients." The effort, Mr. Ryan said, will increase Aon's market share in the region and reduce costs. Aon estimates that about 200 jobs will be eliminated as a result of the consolidation.

While Aon did not make any major U.S. acquisitions during 1998, "we made a major commitment in expanding in Europe," Mr. Ryan said.

During the fourth quarter of 1998, Aon acquired Nikols Sedgwick Group of Milan, Italy. Terms of that deal were not disclosed. In January, Aon Risk Services France S.A., Aon's French brokerage operation, acquired Societe Generale d'Assurance et de Prevoyance of Paris. As a combined operation, Aon and SGAP will have revenues of about \$179 million and 1,200 employees.

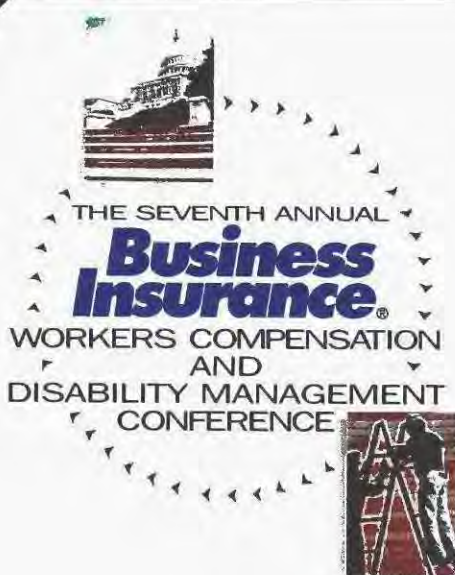
Arthur J. Gallagher

Revenues from commission and fees at Arthur J. Gallagher & Co. rose 11.7% to \$522.1 million in 1998. Adding investment income, corporatewide revenues rose 10% to \$540.7 million. Net income rose 2.9% to \$56.5 million.

"Obviously, we think 1998 is a huge accomplishment," said Michael J. Cloherty, who was named CEO of Gallagher's brokerage services division in January and remains executive vp of the parent company.

See Brokers on next page

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BI #1

Commentary

Settlement sensible in this tragic case

The nearly \$30 million judgment awarded to a talented violinist who was maimed in a 1995 train accident is making news around the world, reinforcing the notion that America's legal system is out of control.

The circumstances of the tragic accident that cost a young woman with a promising career her left leg and damage to her right leg could not have been worse for the defendants: Metra, the government agency that owns the trains; and the former Chicago & North Western Railroad, which owned the railroad and operated the service for Metra.

Rachel Barton suffered her injuries after desperately holding onto the strap of her violin case, which was caught inside the doors of a Metra train rolling out of the station where she had departed the train.

The lawsuit cried out for settlement, but it went to trial anyway. Not surprisingly, jurors rejected the defendants' arguments that appropriate safety measures were in place on the day of the accident and that Ms. Barton should have decided in the 10 seconds she had to remove the strap from her shoulder and release the case containing her prized instrument, which was worth at least \$400,000.

Jurors agreed with the plaintiff's argument that if only the C&NW had looked into prior complaints about the safety system on its doors and if only Metra had required conductors to take a second look for any trapped passengers before the train departed a station, the accident would not have happened. The jurors assessed Metra with 33% of the blame, C&NW with 62.5%, and Ms. Barton with 4.5%.

A Metra press release notes that Ms. Barton's accident is unique in Metra's 15-year operating experience. In my mind, that made it unique for settlement.

Metra says in a press release that it tried to reach a settlement but "that was not

possible, and there was no alternative but to proceed to trial."

We don't know what the defendants offered and what Ms. Barton demanded before the case went to trial or whether it could have been settled for less than the nearly \$30 million the jurors awarded. All we know is that, at trial, Ms. Barton sought about \$65 million in compensatory damages and up to eight times more in punitive damages, while Metra argued that \$5 million was adequate compensation for her injuries.

The jury award is excessive by any standards but, interestingly, less than \$1 million is for punitive damages.

Now the parties have to weigh whether the award will withstand an appeal, and whether they should finally settle the suit.

Even if a defendant believes it should not pay the plaintiff a dime, some cases are better settled than tried. I suspect this may have been one.

Just think, if only President Clinton had settled the Paula Jones lawsuit.

■ **NOW WE HAVE ONLY "MARSH"** among the commercial insurance brokers.

It just doesn't sound right to me. While I hate the alphabet soup this business drowns in, from D&O and E&O to LTD and ERISA, I'm going to miss the old "M&M" and "J&H." But at least we have reduced the opportunities for "McLennan" to be misspelled in *Business Insurance*. While "McLennan" survives in the holding company name, it is gone in the brokerage market. And as Rance Crain, *Business Insurance*'s first editor, recalls, he never could remember how to spell "McLennan." While he always looked it up, too often others have not.

■ **THE HOT GOSSIP** in the insurance industry is the rise to power of the Greenberg sons.

It is intriguing, to be sure, that Jeff Greenberg is becoming CEO of Marsh & McLennan Cos. Inc. at the same time his brother Evan sits at the right hand of Hank Greenberg at American International Group Inc. These are two of the most influential companies in the commercial insurance industry.

Those who look for the sinister seem to imply that somehow the two brothers could one day manipulate the worldwide insurance marketplace.

Such innuendo makes for great cocktail party gossip, but even a good screenwriter would need a lot of imagination to make it plausible as a new series of "Dynasty."

Publisher and Editorial Director Kathryn J. McIntyre's commentary appears fortnightly.



Kathryn J. McIntyre

Brokers

Continued from previous page

Despite the soft pricing environment and industry consolidation, "our strategies are solid and in place," he said. "We're looking to become the insurance broker of choice in the acquisition world and in the personnel world," said Mr. Cloherty, noting that the broker has attracted personnel as a result of acquisitions in the brokerage industry.

In 1998, Gallagher acquired 13 companies, which "says something for the opportunities being brought to us," he said.

During the last two months of the year, Gallagher acquired six agencies: two operations of Gow & Hanna Inc. in Buffalo, N.Y., and Hartford, Conn.; Nelson, Gordon & James Insurance Services Inc. of Tustin, Calif.; Man-Morris Insurers Inc. of Springfield, Mo.; R&R/Select Inc. of Tulsa, Okla.; Robinson, Julianne & Bailey Inc. of Jackson, Miss.; and The Insurance Workshop Inc. of Miami.

Mr. Cloherty said that acquisitions are "a major part of our strategic plan" going forward. Geographically, "we need to see our footprints" in Detroit and Philadelphia. "Other than that, the world is our oyster. We see great opportunities across the country."

The only area that didn't perform for Gallagher during 1998 was investment income, which was down 23.4% to \$18.5 million, Mr. Cloherty said.

Overseas growth, on the other hand, "has been phenomenal," he said.

Gallagher Bassett Services Inc., the broker's third-party administration unit, is the fastest growing business segment overseas for the company, Mr. Cloherty said, adding that, as a whole, it is a small percentage of total revenues because "it's coming off of such a small base." GBS now has 130 offices in six countries.

Gallagher's Bermuda-based rent-a-captive facility, Artex Insurance Co., now has almost \$30 million in premium to date and "is well on its way to its goal of having \$300 million in premium in the next two and one-half years," he said.

Also late in 1998, Gallagher combined its various wholesale church insurance operations into a new division called "Church First."

The division, which provides broad coverage to churches and schools of all sizes and denominations, will initially operate out of three Gallagher sales offices in Tulsa, Okla., Chicago and San Francisco.

Jardine Lloyd Thompson

Britain's largest independent broker finds being an alternative to the two U.S. megabrokers was one of the factors behind a 15% increase in pretax profits last year.

In announcing 1998 results last week, JLT Chairman Ken Carter said many clients are uncomfort-

able with what they see as a "two-horse race" that restricts their choice of brokers.

He said JLT won five major U.K. accounts last year and has just won two major accounts in Asia, showing "we can compete with the big boys." He would not elaborate on the new clients or how JLT acquired them.

New business helped JLT's brokerage revenues rise 3% to £232 million (\$373.2 million) last year despite adverse currency exchange rates and tough market conditions. The 1997 merger of JIB Group P.L.C. and Lloyd Thompson Group P.L.C. to form JLT achieved savings of £8 million (\$12.9 million) in 1998 through consolidated offices and reduced administrative costs. Pretax profits rose 15% in 1998 to £58.3 million (\$93.8 million).

To deliver flexible, innovative services, JLT has been restructuring in 1999 to reflect customer segments, Mr. Carter said in a statement accompanying results.

In January, JLT formed JLT Corporate Risks & Services Ltd. to handle global retail business. On March 1, JLT launched JLT Risk Solutions Ltd. to offer Fortune 500 companies risk management consulting and tailored solutions such as multiline packages and alternative risk transfer. It combines the London market operations Lloyd Thompson Ltd. and Jardine Lloyd Thompson Reinsurance Ltd.

Edwin Unsworth contributed to this report.

Reversal

Continued from page 2

payment to physicians treating workers compensation claimants while reviewing the appropriateness of the treatment or bill. Pennsylvania's 1993 workers comp reform law allows insurers to withhold payment to doctors while performing utilization review.

"The Sullivan case is easily the most important decision the court has rendered in the past decade with regard to the relationship between government and those who are regulated by the government," said Craig A. Berrington, general counsel for the American Insurance Assn. in Washington.

For the first time, the Supreme Court has stated explicitly that a heavily regulated sector does not become an arm of government just because of the regulation, he said.

Insurers warned that the type of state-actor language used by the appeals court could have extended to other types of insurance—such as no-fault automobile coverage—where insurers operated in a state-regulated system, said Joyce Kraeger, a staff attorney with the Alliance of American Insurers in Downers Grove, Ill.

Ms. Kraeger said the decision also "certainly bodes well for the workers comp market" as insurers and self-insurers rely on utilization review to keep some costs under control and to prevent possible fraud.

Risk managers, particularly those who self-insure workers comp risks, also will welcome the decision, said Lance J. Ewing, director of insurance and loss prevention at GES Exposition Services in Las Vegas and chairman of the Risk & Insurance Management Society Inc.'s external affairs team. "It's a great win for employers," he said.

If the appeals court decision had been upheld, the employees of self-insurers could have found themselves subject to the same constitutional rules that govern state and federal employees, Mr. Ewing said.

The case began when 10 injured

Pennsylvania workers sued workers comp insurers and state officials over the utilization review provision of the state's 1993 workers comp reform law (BI, Jan. 25; Jan. 11).

The reform allows an injured worker to go to the physician of his or her choice for the first 90 days of a work-related injury. The provider submits the bill directly to the insurer, which has 30 days to pay the bill or file for UR. The reviewing organization has another 30 days to issue a report. If the treatment is upheld, the insurer must pay the bill plus interest.

The plaintiffs claimed they had been unconstitutionally denied medical benefits because insurers were permitted to suspend payments to

tween an insurer and an employee over whether a treatment is reasonable and necessary, he wrote.

"The most that can be said of the statutory scheme, therefore, is that, whereas it previously prohibited insurers from withholding payment for disputed medical services, it no longer does so. Such permission of a private choice cannot support a finding of state action," Rehnquist wrote.

The chief justice further noted that Pennsylvania law does not say an employee is "entitled to payment for all medical treatment once the employer's initial liability is established" but rather only for "reasonable" and "necessary" treatment. He further noted that the law "requires that dis-

'Action taken by private entities with mere approval or acquiescence of the state is not state action,' Chief Justice William Rehnquist wrote for the majority.

providers during utilization reviews of medical services. The plaintiffs argued that the private workers comp insurers were actually "state actors" when administering workers comp and should thus be subject to the constitutional requirement of due process. In fact, the plaintiffs' attorney later told the Supreme Court that the workers comp system was a "public benefit" system.

A U.S. District Court in Philadelphia dismissed the plaintiffs' claims in 1996, but the 3rd Circuit in the same city reversed the lower court last year. The insurers appealed to the Supreme Court.

Chief Justice William Rehnquist wrote for the majority that "action taken by private entities with mere approval or acquiescence of the state is not state action."

The state law that allows insurers to withhold payments pending review can be interpreted as a decision by the state not to intervene in disputes be-

putes over the reasonableness and necessity of particular treatment must be resolved before an employer's obligation to pay—and an employee's entitlement to benefits—arise."

Chief Justice Rehnquist concluded that, though the plaintiffs had established their initial eligibility for treatment, "they have yet to make good on their claim that the particular medical treatment they received was reasonable and necessary. Consequently, they do not have a property interest—under the logic of their own argument—in having their providers paid for treatment that has yet to be found reasonable and necessary."

Justice John Paul Stevens wrote a partial dissent, saying that the ruling does not address whether the state's procedures were fair.

American Manufacturers Mutual Insurance Co. et al. vs. Delores Scott Sullivan et al., U.S. Supreme Court, No. 97-2000. Decided March 3, 1999.

Cardiac

Continued from page 1

cial, insurers say. Until recently, recovery from heart attacks or heart surgery often required a patient to be hospitalized for weeks and out of work for months, which often leads to feelings of depression that can hamper recovery.

Although that lengthy recovery still is necessary in some cases, the outlook for heart patients has brightened: Less invasive medical procedures combined with well-coordinated case management and accommodations at the work site frequently are getting patients back to work sooner.

A study by Philadelphia-based CIGNA Corp. of its cardiac disability claims between 1994 and 1997 found that the insurer, through a team approach to case management, cut out-of-work time by about 10% over that period. In the case of long-term disability, time off was reduced to 44 weeks from 48 weeks, on average. For short-term disability, average time out of work for cardiac claims was cut to 67 days from 75 days, said Janet Frontera, a CIGNA consultant and registered nurse.

Cutting down on recuperation time and getting workers back on the job more quickly saves employers money spent on short- and long-term disability benefits, as well as on training costs for replacement workers.

About three years ago, CIGNA overhauled the way it handles cardiac claims and brought nurses together in teams with case analysts to better communicate with patients, employers and physicians. The nurses, who form a key point of contact with cardiac patients, discuss lifestyle factors that affect health, such as reducing weight, quitting smoking and getting cholesterol levels in check, Ms. Frontera said. The nurse also acts as an emotional cheerleader, encouraging employees to make small steps toward recovery and monitoring their mood.

"One of the things we do not do is get between the doctor-patient relationship," Ms. Frontera said. "I'm strictly looking at it from a telephonic standpoint."

CIGNA and other insurers also have noted that cardiac patients, especially those with longer recovery times, are prone to depression. The first six months out of work usually represents the best chance to get a patient back in a positive frame of mind and back on the job; after that, the employee may feel like a lost cause. If that happens, a CIGNA nurse usually recommends psychiatric counseling for the patient, said Ms. Frontera, and anti-depressant medication sometimes is advised. Cardiac patients with depression are five times more likely to die than those who are not depressed, she said.

Another insurer, New York-based Metropolitan Life Insurance Co., en-

courages employers to make simple changes in scheduling or to use light-duty work after an employee suffers a heart attack. MetLife shows employers that they can save the expenses associated with hiring and training new employees while a worker is disabled, said David DeCelles, a MetLife vp for disability claims.

"All of those are costs to the employer they may not see initially," he said.

Working with employers to modify their expectations about returning workers is crucial to the success of a cardiac back-to-work program, said Ellen Steel, assistant vp for disability benefits of Portland, Ore.-based Standard Insurance Co.

"Employers should be open to return-to-work options, such as modified work or light-duty options," she said. "Of course, it will benefit the employer, too, because they will get

Teaching doctors about transitional work options is key to the success of cardiac return-to-work efforts, says Greg Miller.

someone trained back on the job."

Ms. Steel said there has been "a real shift in employers willing to accommodate people, and I think it's great. The easiest place to return an employee to work is to their regular employer."

About 17% of Standard's disability claims are cardiac-related, the largest percentage for any type of illness, she said.

Medical innovations in the cardiac care field have allowed many heart patients to return to work more quickly, said Dr. Warren Kantrowitz, corporate medical director of Cambridge, Mass.-based Polaroid Corp. Arteriograms provide pictures of blood vessels leading to the heart for diagnostic purposes, while thallium exercise stress tests can indicate how much exertion an employee is capable of on the job, he said.

"Managed care has proven cardiac patients can ambulate sooner," he said, adding that success back on the job will depend on many variables, including how much patients enjoy their work, whether they are depressed and how strenuous the job is.

"Are companies willing to modify the workplace?" Dr. Kantrowitz asked. "If a guy is in charge of throwing a hundred pound weight off a freight car, that's different from a guy sitting in front of a computer."

The employer's corporate culture—particularly whether it is flexible about job alternatives—will play a role, he said.

"Polaroid always has been famous for agonizing over the individual," he

said. "We are very strong for modifying the workplace."

Greg Miller, manager of health services for Portland, Ore.-based Gunderson Inc., a manufacturer of rail cars and marine barges, said hastening the re-entry of cardiac patients into the workplace depends on the employer teaching doctors about transitional work opportunities.

"Communication with the physician is the key," Mr. Miller said. "The key is the employer needs to tell them what options are available in terms of light duty. If not, the doctor will err on the side of conservatism. . . . If you're a small employer it's harder, of course. If you're a big employer like us, there's jobs in clerical, there's jobs in security. You can build them up slowly."

It is best, however, to attempt to keep the worker in his or her original department, Mr. Miller said. A welder, for example, can be placed in a lighter welding job that requires less lifting.

The employer may also be able to periodically measure the worker's blood pressure and other vital signs on the job, and, if possible, encourage on-the-job exercise such as walking or the use of a treadmill, he added.

Experts in return-to-work issues make the following additional points regarding cardiac patients:

- The psychological impact of a heart attack on a person's self-esteem and self-confidence should not be underestimated. Friends and colleagues should keep in touch throughout the recovery period. In Mr. Mitchell's case, he was able to keep in touch with Provident by e-mail using a laptop computer.

- "If nothing else, it's good for morale for them to see the employer is still looking forward to them coming back," Mr. Miller of Gunderson said.

- The most important person in the recovery process is the liaison between work and the patient's doctor. This may be a nurse with the insurance company, or companies may choose to appoint their own return-to-work coordinator who will be responsible for keeping communication lines active.

- Employers should realize that the vast majority of disabled workers truly want to return to work. Only a small minority will have accustomed themselves to a sedentary lifestyle.

- Employers need to make it clear to group health plans that cardiac rehabilitation is a useful cost control tool and should be a covered expense. Sometimes, unless there is employer intervention, an HMO and a LTD insurer can be at loggerheads because the health plan deems cardiac therapy too costly.

- Because the worker's chances of returning to the job diminish over time, part-time work should be considered as a start. Even a half-day per week can be enough to keep the disabled worker's spirits up.

"Time is the enemy," Mr. Miller said. "Work is the therapy." **BI**

Updates

NCOIL deregulation proposal

Continued from page 2

In addition, NCOIL resolved "one of the most contentious issues" by allowing individual states to establish the annual aggregate premium threshold for exemption, according to Tim Tucker, director of research and education for the Albany, N.Y.-based organization. Meanwhile, the NAIC proposes requiring more than \$500,000 for that category.

NCOIL also formally adopted model laws on codification and multiple employer welfare arrangements.

Concentra to be acquired

BOSTON—Concentra Managed Care Inc., one of the nation's largest utilization management firms serving workers comp, auto and group health insurance buyers, last week announced it would be acquired by a New York investment group.

Concentra said it had reached a definitive agreement to merge with Welsh, Carson, Anderson & Stowe for \$1.1 billion, consisting of about \$800 million in cash and the assumption of \$328 million in debt, which will be refinanced.

Welsh Carson, which already owns 14.9% of Concentra's stock, will control 93% of Concentra's stock after the transaction, Concentra said in a statement. It intends to pump about \$350 million in equity and up to \$110 million of subordinated debt into Concentra.

Welsh Carson manages more than \$7 billion in private equity capital, mostly in the fields of health care and information services. Concentra will retain its name and management after the deal, the statement said.

Wellmark to repay health plans

DES MOINES, Iowa—Wellmark Blue Cross & Blue Shield of Iowa will repay more than \$6.8 million to about 200 self-funded health care plans that it administered as part of a consent agreement with the U.S. Department of Labor.

The Labor Department alleged that Wellmark, which formerly did business as Blue Cross & Blue Shield of Iowa and Blue Cross of South Dakota, between 1990 and 1994 collected hospital billings from plans without taking into account the discounts the Blues had obtained from the providers.

In addition, on administrative-services-only contracts that called for plans to pay service fees based on percentages of paid claims, the company calculated the percentage against the amount billed to the plan, rather than the actual amount the Blues plan paid to hospitals.

Michele Druker, Wellmark's associate general counsel, said the practices alleged in the suit ceased by 1995. She added that customers did receive credits on their service fees based on discounts the Blues plan obtained from providers.

Briefly noted

Approximately 950 women, one-third of them current employees, have filed claims alleging gender discrimination at **Merrill Lynch & Co.** The claims were filed last Tuesday, the deadline stipulated as part of a class-action settlement approved last September. A spokesman for Merrill Lynch said the company plans to review each complaint and respond to each case based on its merits. . . . William J. Kirven III has been appointed **Colorado's new insurance commissioner** by Gov. Bill Owens. Mr. Kirven is currently a principal with the law firm of Oliver & Kirven P.C. in Englewood, Colo., which specializes in health care, administrative and general business law. Meanwhile, outgoing Commissioner Jack Ehnes has taken over as the state's risk and benefits manager. . . . Thomas O'Malley, chief executive officer of Stamford, Conn.-based **Tosco Corp.**, said he would comply with a Contra Costa County, Calif., request to shut down, at least temporarily, the company's Avon, Calif., refinery pending an investigation of the explosion and fire that killed four workers and injured another last month (*BI*, March 1). . . . The **Occupational Safety and Health Administration's authority** would be extended to cover state and local government employees under H.R. 776, the Fairness for State and Local Workers Act, recently introduced by Rep. Robert Andrews, D-N.J. Previous congressional attempts to extend OSHA to local and state government workplaces have failed. . . . Royal & SunAlliance Insurance Group P.L.C. is selling the life insurance operations of its U.S. subsidiary to Swiss Reinsurance Co., allowing **Royal & SunAlliance USA** to focus on property/casualty business. Royal Maccabees Life Insurance Co. and the Royal Life Insurance Co. of New York will be sold for \$380 million to Swiss Re Life & Health, a division of the reinsurer. . . . A bill that would **deregulate commercial insurance rates** and large commercial forms unanimously passed the Arkansas Senate last week and is awaiting Gov. Mike Huckabee's signature. . . . The Senate Banking Committee, on an 11-9 vote, approved **financial services deregulation** legislation that would set new federal rules for banks and insurance companies to enter each other's business. A House committee will resume action on its version of the legislation this week. . . . Several Republican members of the **Senate Labor and Human Resources Committee** are warning the Department of Labor that it would be "regrettable" if its proposed regulations to require health care plans to speed up coverage and claims decisions "undermined" Congress' effort to enact patient protection legislation. . . . In a rehearing, the Louisiana Supreme Court on Feb. 26 affirmed its Jan. 20 ruling that the **absolute pollution exclusion** is not limited to "active industrial polluters" that intentionally pollute (*BI*, Jan. 25). . . . A federal grand jury indicted Richard Van Weir and Elaine Watson Garner, officials of Dallas-based broker **Equipment Insurance Managers Inc.**, on conspiracy and mail fraud charges for allegedly pocketing more than \$2 million in audit premiums collected from policyholders in a crane operators liability program (*BI*, Oct. 2, 1995). Mr. Weir and Ms. Garner pleaded not guilty to the charges last week and were released on bond.

Swissair

Continued from page 3

rean Airlines and the families of passengers killed when Soviet fighter planes shot down KAL Flight 007 in September 1983 still are litigating over crash claims.

"The advance payments seem to have created the perception by some families of the fairness of the air carrier, and they feel embarrassed about going through the legal process in order to settle their claims," said Mr. Ephraimson, referring to some Swissair crash victims' families who have not filed suit against the airline.

Mr. Ephraimson also complimented Swissair as the first airline that "has reached out to victims of other crashes for their advice, and they have taken it."

Swissair, though, is not the first

airline that has extended early payments to families of victims killed in crashes, noted airline attorney George N. Tompkins Jr., special counsel with Rosenman & Colin L.L.P. of New York.

Swissair Flight 111 crashed in the Atlantic Ocean, killing all 215 passengers and 14 crew. The MD-11 crashed while the flight crew was attempting an emergency landing in Halifax, Nova Scotia, after reporting smoke in the cockpit (*BI*, Sept. 7, 1998).

Swissair made its offer against the advice of its attorneys and insurers and even though the airline's ultimate liability has not been determined, a spokesman said. The airline did not want to be bureaucratic and was concerned about its image, he said.

Twenty-five families have accepted the offer so far, the Swissair spokesman said. He could not say

how many of those families had filed suit against the airline.

The Swissair offer meets or approaches the full amount the airline could be held strictly liable to pay as a signatory to an International Air Transport Assn. agreement. That agreement waives airlines' limited liability to passengers on international flights. However, under the agreement, Swissair could be held liable for significant additional damages if the airline ultimately could not prove that it was free of fault in the crash.

Despite the IATA agreement, Swissair technically was not obliged to extend its offer at this time. Under the agreement's strict liability provision, families still must prove the value of their loss.

"But in the real world, no death is worth less than that," said Mr. Moller, referring to Swissair's offer. **BI**

Continued from page 1

providers are on that side, too," Ms. Bressler said of the coalition.

California health maintenance organizations that were asked their opinion of the initiative declined to comment pending further review.

The PBGH also will seek more information from health plans as part of its effort to boost quality.

"We're trying to get more detailed data to get a better understanding of the trends and experience of our members," said Emma Hoo, PBGH senior manager.

PBGH member employers will use their purchasing clout to ensure top providers get the money they need, because employers realize that "it takes resources to re-engineer the way providers do business in order to improve quality," Dr. Milstein explained.

In particular, the PBGH is seeking information on claims processing and quality of care at the provider level.

"Up until now, PBGH and other employers have focused on the plan level, but in markets like California where most plans contract with the same medical groups and hospitals, there's much more likely to be quality differences between the groups and hospitals," Dr. Milstein explained.

Other measurements will focus on how hospitals and medical groups rank in the delivery of preventive care services, patient satisfaction, asthma outcome study scores and how far the provider has progressed in building elec-

tronic information systems, he added.

The latter requirement is part of a three-year-old program called the California Information Exchange Linking Partners for Quality Healthcare, or CALINX, Dr. Milstein explained.

CALINX began in 1996 as a broad-based effort among California businesses, physicians, health plans, hospitals and health care systems to improve their ability to gather and use medical information. The PBGH, the National IPA Coalition and the California Assn. of Health Plans are managing this effort in collaboration with the American Medical Group Assn., the California Healthcare Assn. and the California Medical Assn.

Providers are especially supportive of the PBGH effort to standardize the way quality is measured, according to the CMA's Ms. Bressler.

"It becomes a nightmare for physicians, each of which is participating in 10 or more plans," to keep up with divergent plan quality initiatives, she explained. "We are really supportive of it happening in a uniform way across plans."

The PBGH initiative closely follows another California buyer's focus on health care compensation during plan renewals.

The California Public Employees Retirement System last month released the results of an audit it conducted of Kaiser Permanente's rating data and methodology. CalPERS decided to audit Kaiser after the HMO raised premium rates 10.75% for 1999 (BI, June 22, 1998).

Even though the CalPERS audit found that the process Kaiser used for calculating its 1999 premium rate increase relied on financial data

that "contained inconsistencies, inaccuracies and errors," auditors found no major mistakes that would have suggested that this year's rate hike should have been dramatically lower, according to a CalPERS spokesman.

Kaiser said in its response to the audit findings that the errors were largely a consequence of the HMO not being able to accurately forecast revenue and expenditures as far in advance as CalPERS demands.

"CalPERS' early rate quote requires that we set the community rate before complete data on the prior year's performance can be gathered and analyzed. One consequence of this timing problem was the severe underpricing of our plan in 1998," Kaiser said.

CalPERS requires HMOs to calculate annual premiums in winter or early spring for rates that take effect the following January.

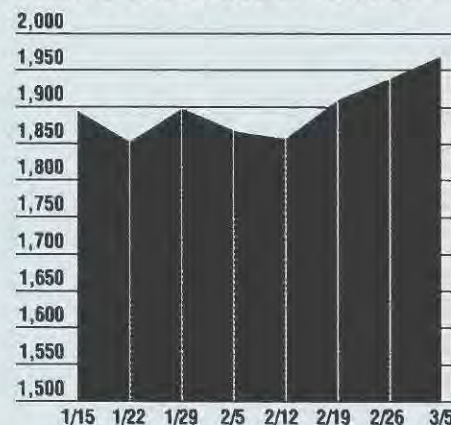
Officials with CalPERS said that other HMOs can expect requests for similar scrutiny of their pricing mechanisms in the months to come, as more companies consolidate and prices continue to rise in the health insurance business.

"It's likely that CalPERS will ask at least one and maybe more HMOs" this year to open their books to auditors "in selective cases where we have some concerns," said Margaret Stanley, health benefits administrator for the Sacramento-based CalPERS.

In fact, Health Net was audited by CalPERS last week in connection with its request for a rate hike in 2000, said a spokesman for the Woodland Hills, Calif.-based unit of Foundation Health Systems Inc.

"This is the first time CalPERS has requested a renewal audit," the spokesman noted. **BI**

BI Insurance Index



Base=100 on Dec. 29, 1978

Source: Nordby International Inc. (nordby.com) Boulder, Colo.

PCS catastrophe options

As of March 5	Call spread	Price bid/ask	Call spread	Price bid/ask
National Annual 1999			California Annual 1999	
40/60	12.0/16.0		60/80	1.2/2.3
60/80	6.0/12.0		80/100	1.0/1.9
80/100	4.0/8.0		150C	0.5/2.5
150C	5.0/6.0		Western Annual 1999	
200/250	3.3/4.0		80/100	0.5/2.2
Southeastern September 1999			Midwest June 1999	
40/60	2.8/—		10/20	1.2/1.4
60/80	2.1/3.0		Florida Sept./Dec. 1999	
80/100	2.0/2.4		100/150	2.6/—

Total volume: 0 Total open interest: 10,999

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

British Issues

Companies	Price pence	P/E	Div. pence	Yield %	52-week high-low
Gdn Royal Exch	357	5.5	4.3	1.2	473-227
Legal & Gen	782	55.3	14.5	2.0	946-500
Royal & Sun	566	18.3	23.0	4.8	825-433

Brokers

Lmbt Fenchurch	70	8.9	4.2	7.3	121-70
JLT	202	9.5	12.0	6.8	236-152

Note: Prices are March 5 closings; other numbers from March 4.

Source: Nordby International Inc. (nordby.com) Boulder, Colo.

Watson Wyatt

Continued from page 1

resources in creating innovative consulting solutions and helping clients with plan design, vendor selection, compliance, non-discrimination testing, communications, and mergers and acquisition services," Messrs. Haley and Valentino said in a memo sent last week to Watson Wyatt employees.

While Watson Wyatt had become a small player in the defined contribution plan recordkeeping arena, First Data Services Group, whose parent is a Fortune 200 company with about \$5 billion in revenues, is a major provider. It currently offers recordkeeping and administration services to about 5,800 plans with more than 600,000 participants. In all, First Data provides services to more than 20,000 retirement plans.

"Watson Wyatt clients will have the ben-

efit of working with a very large, full-service company," said Robert W. Guillocheau, a senior vp in the Westborough, Mass., office of First Data Investor Services Group.

Watson Wyatt and First Data executives say the transition of clients to First Data should be seamless, with the two companies picking up clients' conversion costs. For a select group of clients not transferring recordkeeping to First Data, Watson Wyatt says it will assist them in finding a new service provider.

With such a small and declining share of a competitive market, it is not surprising that Watson Wyatt decided to leave defined contribution plan recordkeeping, outside observers say.

"This is a labor-intensive business" with tight margins, said Donn Bleau, a principal with Global Resources Group, an executive recruiter in San Diego.

When completed, Watson Wyatt's depart-

ture from defined contribution plan recordkeeping will be the third line of business it has exited in the last year. Aside from pulling out of Wellspring, its venture with State Street Global Advisors, Watson Wyatt also exited risk management consulting, selling that unit last year to Tillinghast-Towers Perrin (BI, March 9, 1998).

Financially, Watson Wyatt's strategy of focusing on benefit consulting appears to be working. In the seven-month period ending in January, it reported \$50.7 million in net operating income, up from \$38.3 million for the comparable seven months the year before.

Mr. Valentino says the company does not expect to close any offices as a result of the transaction. The company intends to find other positions within Watson Wyatt or elsewhere for employees now in its defined contribution plan recordkeeping operations. **BI**

BI Industry Stock Report MARCH 1, 1999, THROUGH MARCH 5, 1999

BROKERS

	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
Aon Corp.	NYS	64.00	8.59	14.16	75.56	48.25 2181
E.W. Blanch Holdings Inc.	NYS	49.31	-11.15	5.62	60.00	34.69 538
Gallagher Arthur J. & Co.	NYS	49.19	3.01	12.43	50.63	34.88 208
Hibb, Rogal & Hamilton	NYS	16.38	-5.42	-12.08	19.88	15.38 146
Kaye Group Inc.	NDO	7.63	1.87	5.17	8.06	5.13 24
Marsh & McLennan	NYS	77.56	9.53	31.18	77.56	43.38 4449
Poe & Brown	NYS	34.00	4.82	-2.68	42.50	31.38 47
AVERAGE			0.41	6.61		

INSURERS/REINSURERS

	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
ACE Ltd.	NYS	31.25	14.68	-4.40	43.00	24.38 3178
Accel International Corp.	NDO	2.88	4.55	-4.17	3.50	2.13 11
Acceptance Insurance Cos.	NYS	17.00	-0.73	-14.47	25.63	16.00 260
AEGON N.V.	NYS	101.75	-2.75	-16.56	130.13	56.50 391
Aetna Life & Casualty	NYS	77.63	4.81	-2.74	91.44	60.19 2286
AFLAC Inc.	NYS	47.06	6.66	6.96	50.50	25.13 4298
Allmerica Financial Corp.	NYS	53.00	-0.70	-6.40	75.25	38.38 510
Allstate Corp.	NYS	37.38	0.00	-2.92	52.38	34.75 16325
AMBAC Indemnity Corp.	NYS	56.75	1.34	-5.32	65.94	40.88 1433
American Bankers Ins.	NDO	46.38	-3.39	-2.88	66.06	30.13 2251
American Financial Group	NYS	36.00	-2.54	-12.59	45.75	30.50 290
American General	NYS	73.00	-0.34	-6.71	79.00	52.38 3368
American Heritage Life Ins.	NYS	22.44	1.99	-6.75	26.69	18.63 231
American Indemnity/Fin'l	NDO	13.63	29.76	28.24	15.38	10.25 35
American International	NYS	118.31	3.84	21.50	119.94	64.88 11255
American Safety Insurance	NDO	8.63	2.99	-9.21	15.06	6.75 73
Argonaut Group	NDO	25.56	3.02	6.51	37.00	21.25 98
AXA-JAP Group	NYS	64.00	-3.76	-10.57	80.25	38.25 474
Baldwin & Lyons Inc.	NDO	20.63	-1.49	-11.76	26.00	18.50 81
Berkley W.R. Corp.	NDO	27.19	-5.02	-19.44	49.88	24.63 691
Berkshire Hathaway Inc.	NYS	73000.00	2.67	6.88	84000.00	56900.00 2
Capital RE Corporation	NYS	18.63	11.19	-4.79	38.69	11.94 868
Capitol Transamerica Corp.	NAS	15.50	0.00	-12.37	22.75	14.50 9
Centris Group Inc.	NYS	10.50	-7.69	12.00	14.81	7.94 151
Chartwell Re	NYS	20.94	-3.18	-9.95	34.56	20.38 60
Chubb Corp.	NYS	61.56	2.80	-5.20	88.81	54.00 3270
CIGNA Corp.	NYS	79.75	1.59	2.57	86.44	57.19 3723
Cincinnati Financial Corp.	NAS	37.88	8.02	6.13	45.31	30.50 1698
Citigroup	NYS	61.81	5.44	22.25	73.50	28.50 52541
CNA Financial Corp.	NYS	35.31	4.05	-10.17	53.25	33.00 1036

	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
CNA Surety	NYS	12.44	18.45	-16.74	16.75	10.19 179
EMC Insurance Group Inc.	NDO	11.13	1.14	-12.75	15.88	9.00 31
ESG Re Limited	NDO	16.75	-1.11	-15.46	28.75	12.75 117
Enhance Financial Services	NYS	24.25	2.37	-19.83	37.56	17.31 714
Everest Reinsurance	NYS	34.94	5.27	-4.77	45.25	28.75 1157
Executive Risk Inc.	NYS	72.31	2.94	34.22	74.94	35.50 747
EXEL Ltd.	NYS	61.31	0.10	-14.32	83.25	58.94 1323
Fremont Genera Corp.	NYS	21.06	6.65	-12.69	31.06	18.00 1696
Frontier Insurance Group	NYS	12.50	-4.76	0.00	25.69	11.06 720
Gainsco Inc.	NYS	5.31	6.25	-15.84	10.00	5.00 49
Harleysville Group	NDO	19.75	-3.66	-22.55	28.50	17.25 76
Hartford Steam Boiler	NYS	36.56	-1.18	-9.02	59.56	34.75 255
HCC Insurance Holdings	NYS	17.13	-1.44	1.11	23.94	16.00 473
ING Groep N.V.	NYS	54.63	-2.35	-10.45	76.75	36.06 390
IPC Holdings Ltd.	NDO	20.38	-2.98	-10.44	33.25	19.00 896
Hartford Financial Services	NYS	54.00	-0.12	-3.25	60.00	37.63 4090
LaSalle Re Holdings Ltd.	NYS	18.50	-3.27	-10.30	42.94	17.25 92
Lincoln National	NYS	94.88	0.20	14.48	98.88	67.00 2589
MAIC Holdings Inc.	NYS	27.38	-7.59	-14.45	33.13	23.25 118
Market Corp.	NYS	61.00	0.56	0.42	187.00	132.00 11
MBIA Insurance Group	NYS	18.00	2.34	-5.00	80.94	46.06 2212
Meadowbrook Insur. Group	NYS	16.50	0.76	1.15	35.00	14.94 24
MMI Cos. Inc.	NYS	15.06	1.26	-9.74	25.00	13.75 737
Mutual Risk Mgmt. Ltd.	NYS	42.25	15.56	11.37	43.25	25.38 1075
NAC Re Corp.	NYS	54.19	0.23	16.06	55.88	43.69 831
Navigator Group	NDO	15.25	2.52	0.00	20.75	13.25 13
NYMag Inc.	NYS	14.75	-0.42	-29.34	34.25	14.75 13
Ohio Casualty Corp.	NDO	40.44	0.15	-1.67	51.75	33.75 198
Old Republic Int'l	NYS	19.25	2.33	-10.20	32.25	17.94 1259
Orion Capital Corp.	NYS	32.94	-0.38	-15.95	59.25	28.00 344
Pariner Re Ltd.	NYS	41.50	-4.05	-8.16	52.50	33.63 308
Penn-America Group Inc.	NYS	11.13	0.00	20.27	22.56	8.13 43
PMA Capital Corporation	NDO	20.00	0.31	2.24	23.75	16.63 125
Philadelphia Cons. Holding	NDO	21.94	2.03	3.24	24.50	18.63 382
PXRE Corp.	NYS	21.00	-4.00	-16.83	32.88	19.25 46
Reliance Group Holdings	NYS	9.63	-6.67	-25.60	19.81	9.19 1796
Reliastar Financial Corp.	NYS	42.75	-5.13	-4.47	52.44	29.00 3358
Renaissance Re Holdings Ltd.	NYS	34.31	0.92	-5.02	50.75	31.50 212
Risk Capital Holdings	NDO	19.69	3.62	-6.80	25.50	16.75 60
RLI Corp.	NYS	30.88	4.88	-7.49	45.63	28.00 73

	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
St. Paul Companies	NYS	33.63	3.86	-3.93	47.19	28.06 1996
SCOR	NYS	54.19	5.22	-16.63	72.75	50.06 23
SAFECO Corp.	NDO	41.81	4.04	-1.62	56.00	36.69 3205
SCPIE Holdings Inc.	NYS	29.69	-0.21	-1.25	38.38	26.63 NA
Seibels Bruce Group	NDO	3.25	0.00	-7.14	8.38	3.06 64
Selective Ins. Group	NDO	19.25	5.66	-4.94	29.25	16.69 221
Terra Nova Insurance Co. Ltd.	NYS	24.13	1.05	-1.03	35.00	21.25 259
TIG Holdings	NYS	16.06	0.39	3.63	27.75	11.63 482
Tokio Marine & Fire	NDO	51.13	-4.66	-13.16	61.38	39.00 76
Torchmark Corp.	NYS	33.88	2.26	-2.52	49.81	30.69 1426
Transatlantic Holdings	NYS	74.50	-0.25	-1.49	94.50	73.50 244
Travelers Property Casualty	NYS	36.63	-3.46	19.59	45.94	24.13 999
Trenwick Group Inc.	NDO	28.13	-3.02	-11.07	41.75	26.75 36
Unico American Corp.	NDO	10.13	-6.90	-12.20	18.13	8.88 89
United Fire & Casualty	NDO	29.25	1.30	-12.11	44.50	28.00 28
Unitrin	NDO	67.75	3.63	-4.41	75.47	55.56 121
UNUM Corp.	NYS	44.75	0.00	-25.34	62.50	41.75 7333
Vesta Insurance Co.	NYS	5.06	-4.71	-11.96	59.00	4.94 795
Zenith National Ins.	NYS	25.44	10.90	10.00	30.50	20.31 134

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