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update

Fire-gutted DC-10 insured for $17 million

CHICAGO—An unoccupied DC-10 jetliner destroyed by fire at O'Hare International Airport last week is insured for $17 million by its owners, American Trans Air Inc. of Indianapolis.

New York-based broker Marsh & McLennan Cos. Inc. placed the $17 million in hull coverage, with Associated Aviation Underwriters Inc. in New York leading the U.S. por-

Continued on next page

Insurer owes D&O defense: Appellate court

By STEPHEN TARNOFF

SAN FRANCISCO—In a victory for policyholders, a federal appellate court says a directors and officers liability insurer must pay defense costs as they are incurred.

Furthermore, the court says that under Hawaii law, all D&O insurance policies carry a "duty to defend," which greatly expands the indemnity coverage provided under D&O insurance policies.

In *Okada vs. MGIC Indemnity Corp.*, the 9th U.S. Circuit Court of Appeals affirmed by a 2-1 vote a U.S. District Court decision that held MGIC owed defense costs as they came due to three directors of an insolvent Hawaii savings and loan sued by its shareholders.

It is the highest court in the country to rule on this issue, which is a growing controversy between policyholders and D&O liability insurers.

However, the court plowed new ground in its ruling that D&O policies carry a "duty to defend" unless that duty is expressly excluded in the insurance contract.

The dissenting judge, Cynthia Hall, called the ruling the "worst form of judicial activism by a federal court."

Last week, an attorney for MGIC said the insurer was "greatly disappointed" with the decision and will seek a rehearing with the entire 9th Circuit.

The July 31 decision also upheld the District Court ruling that the savings and loan's insolvency included more than one potential "loss" that could trigger the policy's $1 million limits more than once.

But the court reversed the District Court's ruling that MGIC had acted in bad faith because there is still a factual dispute over MGIC's actions.

The appellate court's ruling affirms a U.S. District Court of Hawaii decision handed down in April 1985.

And, the decision comes less than two months after a similar decision by the U.S. District Court for the Southern District of New York. That ruling, in a suit involving Pepsico Inc. and Continental Casualty Co., also held that defense costs must be paid as they are incurred (*BI*, July 14).

The MGIC case arose out of the 1980 insolvency of the First Savings & Loan Assn. of Hawaii, which subsequently was taken over by the Federal Savings and Loan Insurance Corp.

In 1982, First Hawaiian Bank and FSLIC, as assignees of various shareholders' direct and derivative claims, filed lawsuits in federal court against the savings and loan's eight directors and officers. The suits included allegations that the directors' and officers' negligence caused the savings and loan to become insolvent.

Earlier this year, those claims against all eight directors were settled out of court and dismissed, according to W. Gregory Chuck

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Brokers' results continue to boom Page 3

Tort reform explodes

34 states enact laws to help solve liability crisis

By JERRY GEISEL and STEVE TARAVELLA

Galvanized by the liability insurance crisis, an unprecedented drive to reform the nation's civil justice system is sweeping state legislatures.

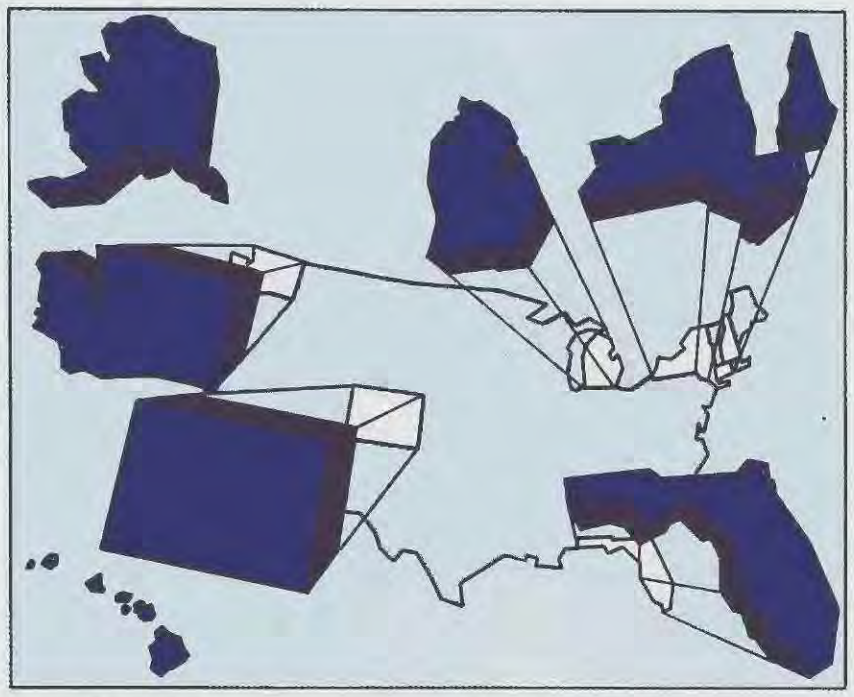
Thirty-four states have enacted tort reform measures to reduce liability exposures and make insurance more available and affordable for businesses, professionals, governmental entities and non-profit organizations, a six-week *Business Insurance* survey of legislatures found (see chart, page 22).

The scope of the tort reform activity is unprecedented.

"This is an historic year," said James K. Coyne, president of the American Tort Reform Assn. in Washington, D.C. "Never before has civil justice reform been addressed by so many legislatures. I'm awed at what has been done."

"This has been a significant start in the tort reform movement," adds John Waligore, an attorney and analyst with the Alliance of American Insurers, a Schaumburg, Ill.-based insurance trade association.

In all, 36 state legislatures have passed tort reform measures. But, Arizona Gov. Bruce Babbitt vetoed a four-bill package and Illinois Gov. James Thompson has yet to sign the legislation passed in that state.



However, only nine states—Alaska, Colorado, Connecticut, Florida, Hawaii, Michigan, New Hampshire, New York and Washington—have passed what experts say is significant reform legislation. And, in one of those states—Florida—insurers are protesting the linking of reforms to insurance rate rollbacks and the legislation appears to be decreasing the availability of insurance.

Implored by businesses and insurers alike to curb the rise in multimillion-dollar court awards, 16 states responded by capping non-economic damage awards, although half apply the cap only to medical malpractice awards.

Almost as popular a reform as capping non-economic damages was amending the application of the doctrine of joint and several liability, a legal theory that can force a defendant to pay an entire damage award even if it is only slightly at fault. The doctrine has been abolished or modified in 14 states, sometimes governing both economic and non-economic damages, other times governing only non-economic damages.

The most popular reform, however, was imposing new penalties if a suit or defense is judged to be frivolous. Seventeen states enacted such legislation, most often requiring the losing party to pay the other side's legal costs.

In addition, 13 states have passed legislation requiring or encouraging structured settlements or periodic payments for large awards.

Reforms in 11 states include modification of the collateral source rule so that payments made to plaintiffs from other sources, such as medical insurance, may be introduced as evidence and/or used to reduce an award.

Another 10 states have placed limits on punitive damages, for example by linking the awards to a multiple of compensatory damages that are awarded or by narrowing the conditions under which such awards can be made.

Governments clearly gained the most in tort reform in 1986. Sixteen states enacted reforms that specifically limit the liability of governments and public entities, either in addition to other reforms applying to all torts or as the only reform enacted.

In addition, 13 states enacted legislation addressing the liability of liquor servers.

Only six states addressed contingent fees, but 16 states passed other reforms, including limiting or abolishing the liability of directors and officers of non-profit organizations.

Yet, the degree of reform enacted varies considerably. "Not all tort reform is equal," said Mr. Waligore.

Caps on damage awards, considered one of the most significant reforms, range from as low as Michigan's $225,000 for non-economic damages in medical malpractice cases to the $1 million cap for all damages in medical malpractice cases in Kansas and South Dakota.

And, looking at just the dollar caps can be misleading. For example, Michigan's $225,000 malpractice cap contains so many exceptions that there are questions on how effective it will be in halting big awards. By contrast, there are no exceptions to Mary-

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Courts to decide if Prop 51 applies to pending suits

By ROBERT A. FINLAYSON

LOS ANGELES—When California voters overwhelmingly approved Proposition 51 in June, did they intend for the tort reform initiative to affect pending lawsuits?

This question is the center of a legal battle in California's courts, the outcome of which will affect literally thousands of third-party lawsuits and potentially millions of dollars in non-economic damages sought in these suits.

More specifically, the question is: Does the repeal of joint and several liability as applied to non-economic damages affect cases pending trial when Proposition 51 took effect June 4?

Officially known as the "Fair Responsibility Act of 1986," Proposition 51 protects defendants from having to pay non-economic damages in excess of their percentage of fault if other defendants cannot pay their share of an award.

Non-economic damages include awards for such injuries as pain and suffering, inconvenience, injury to reputation, humiliation, mental suffering, emotional distress and loss of society, companionship and consortium.

"There are thousands of cases in this state that will either be exempted from the sweep of Prop 51 or brought within it, based on how the courts resolve this one issue," says Fred Hiestand, counsel to the Assn. for California Tort Reform, one of the groups that spearheaded the campaign for the initiative.

"If you take the amount of non-economic damages that gets awarded in cases, it's millions of dollars," he says.

How much of those damages may be assessed against those who can't pay is not known.

The legal battle over whether Proposition

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update

Jet destroyed by fire insured

Continued from page 1

tion of the coverage, sources say. About 30% of the coverage is placed in London through Lloyd's of London broker C.T. Bowring & Co. Ltd. The London coverage is led by The Orion Insurance Co. P.L.C.

Cleaning and maintenance workers preparing the jetliner for an early morning flight to Jamaica discovered the fire about 7:15 a.m. Aug. 10. The plane had just completed a flight from Los Angeles to Chicago about 6 a.m.

The National Transportation Safety Board is investigating the cause of the blaze.

Bonds finance insurance pool

NEW YORK—The Louisiana Public Facilities Authority sold $280 million in tax-exempt bonds last week to establish the nation's first bond-financed self-insurance pool for public entities, according to attorneys, brokers and bond underwriters.

The authority will use proceeds from the 10-year revenue bonds to loan money to qualifying municipalities, school districts and parish governments so they can purchase liability coverages through the pool. Those coverages are either unavailable through the commercial insurance market or too costly, officials say.

The Local Government Liability Insurance Program is expected to offer at least general liability and auto coverages, but details are still being worked out, according to Lary Stromseld, an attorney with the law firm of Orrick, Herrington & Sutcliffe in New York, which represents the bond underwriters.

The program also is expected to seek reinsurance support, its developers say.

The program was organized by insurance broker Johnson & Higgins, which will help administer the insurance pool; Paine-Webber Inc., which led the offering; and Orrick, Herrington & Sutcliffe, said J&H Vp James G. Smith of Houston, Texas.

Great Global rehabilitation 'on'

SCOTTSDALE, Ariz.—The on-again, off-again rehabilitation of Great Global Assurance Co. is on again.

The Arizona Insurance Department in April had petitioned Maricopa County Superior Court in Phoenix for a liquidation order against Great Global, but withdrew that petition late last month.

Roy E. Gill, an assistant insurance director, explained that the department sought liquidation because it appeared after two months of rehabilitation that the insurer's losses would be much greater than originally expected. Great Global was put into rehabilitation in February.

However, while preparing for a July 30 hearing on that petition, the department determined that "rehabilitation is a very real possibility," Mr. Gill said.

That rehabilitation hinges on securing, through legal action, an infusion of capital from the sale of Great Global's parent company, BSP Holding Inc., to Texergy Corp. of Corpus Christi, Texas. John McKellips, a Minneapolis investor who controls Texergy, notified the Arizona department in February that he was backing out of the $30 million deal (*BI*, Feb. 17, 1986; Sept. 30, 1985).

Union Mutual plan approved

PORTLAND, Maine—Maine Insurance Superintendent Theodore T. Briggs has approved Union Mutual Life Insurance Co.'s plan to convert to a publicly held stock company.

Under terms of the plan, policyholders between Jan. 1, 1982, and Dec. 31, 1984, will receive a combination of cash and stock totaling $652 million, said a company spokesman.

The plan must still be approved by two-thirds of the votes cast at a special meeting to be held in late October. The company hopes to complete the stock offering by year-end, said the spokesman. The new holding company to be created will be known as UNUM Corp.

According to the registration statement filed by Union Mutual with the Securities and Exchange Commission, the company will issue up to 60 million common shares, which it expects to price at $20 to $30 a share.

A group of policyholders who had originally opposed the conversion, consisting of former agents, dropped their opposition to the latest plan (*BI*, March 4, 1985).

Libel award reduced to $1

CHICAGO—A $3 million jury award for compensatory damages to Louisville, Ky.-based Brown & Williamson Tobacco Corp. was reduced to $1 by a U.S. District Court judge in Chicago who said that the company did not prove any actual damages, "let alone $3 million worth."

However, the judge let stand the jury's affirmative libel verdict and the $2 million in punitive damages against CBS Inc. and $50,000 in punitive damages against Chicago television anchorman Walter Jacobson.

A CBS attorney said an appeal probably will be filed by the end of August. If such an appeal if filed, a spokesman from B&W said his company would file a cross-appeal seeking restoration of the $3 million in compensatory damages (*BI*, Dec. 16, 1985).

Stadium finds more cover

CHICAGO—The Chicago Park District purchased additional liability insurance on its Soldier Field stadium late last week to complete the $100 million required by its contract with the Chicago Bears before the team's first home exhibition game last Saturday.

The team had threatened to play its games elsewhere if full coverage was not found (*BI*, July 28).

Lloyd's again taps fund to cover potential claims

By STACY SHAPIRO

LONDON—Lloyd's of London is setting aside another 13 million pounds ($19.5 million) from its Central Fund to pay potential claims owed by syndicates other than those managed by PCW Underwriting Agencies Ltd.

Altogether, Lloyd's is earmarking 92% of its Central Fund, or 238 million pounds ($357 million), to pay potential claims.

Previously, Lloyd's had set aside a record 225 million pounds ($337.5 million) from its 260 million pound ($390 million) Central Fund to pay the maximum potential claims expected by PCW syndicates. The funds were earmarked to allow about 320 PCW syndicate members, including Lloyd's Chairman Peter Miller, to meet last month's Lloyd's solvency test (*BI*, July 28).

Lloyd's Chief Executive Alan Lord said he believed this latest reserve would be the last time Lloyd's taps the Central Fund for potential losses before Lloyd's files its returns with the British Department of Trade and Industry later this month and announces its global results in early September.

Lloyd's last month amended its bylaws to replenish the fund.

The latest 13 million pounds earmarked from the fund will be used to:

- Pay 10 million pounds ($15 million) of potential claims against Syndicate 970.

The syndicate had been managed by Gardner Mountain & Capel Cure Agencies Ltd. until last week, when the Council of Lloyd's appointed Additional Underwriting Agencies (No. 3) Ltd. to manage it. AUA already manages the former PCW syndicates.

Lloyd's had learned in the past few months that there had been a "close relationship" between Syndicate 970 and the PCW syndicates, said Mr. Lord.

Lloyd's says that beginning in 1967 Gardner Mountain allowed former PCW Chairman Peter Cameron-Webb to underwrite for some of its syndicates.

- 3 million pounds ($4.5 million) for the combined losses owed by other Lloyd's syndicates that for various reasons may not be paid by Lloyd's members.

The Central Fund is designed to protect policyholders if Lloyd's members cannot pay a claim. Lloyd's calls tapping the fund a "last resort."

A Lloyd's spokesman said last month the 225 million pounds earmarked for the PCW syndicates represents the maximum amount of losses the PCW syndicates will face. AUA has not yet totaled the exact amount of claims the syndicates must pay.

PCW members so far have refused to pay these claims, charging underwriters were negligent and committed fraud. Lloyd's currently is trying to negotiate a settlement with PCW members and 37 other parties to pay for the losses.

Syndicate members have claimed that some of the losses stem from the mismanagement of the syndicates by Richard Beckett Underwriting Agencies Ltd. RBUA began managing the PCW syndicates in 1983, after it was learned that more than $58 million was misappropriated from the syndicates under PCW's management.

Both PCW and RBUA were subsidiaries of Lloyd's broker Minet Holdings P.L.C.

However, an independent committee that examined RBUA's management of PCW syndicates reported last week that "there is no evidence of fraud or gross negligence by the management of RBUA or by any party involved with RBUA during the period of time covered by the inquiry."

The committee—headed by John Davis, vice chairman of Lloyd's Bank, which is not associated with Lloyd's of London—also concluded that "the primary responsibility for the loss incurred by the names. . must rest on the former management."

That presumably includes Mr. Cameron-Webb and former PCW Chairman Peter Dixon, who was expelled

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Panels OK bills raising nuclear liability limits

By JERRY GEISEL

WASHINGTON—Congress is moving closer to increasing the maximum liability of the electric utility industry for nuclear accidents.

Four congressional committees have approved different bills to raise the nuclear power industry's maximum liability to between $2.4 billion and $7 billion per accident from the current $665 million cap.

Also, as Congress was expected to recess last week, the Senate Commerce Committee approved legislation to give general aviation manufacturers more protection from product liability suits by barring such suits in cases where an aircraft was more than 20 years old at the time of an accident.

However, members of a House Energy and Commerce subcommittee failed to vote on amendments to expand the federal Risk Retention Act, a proposal that would make it easier for businesses, trade associations and municipalities to form captive insurance companies or buy casualty insurance on a group basis. A vote had been expected.

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Settlement near in dispute over unpaid comp bills

By STEVE TARAVELLA

LOS ANGELES—California workers compensation insurers, self-insurers and third-party administrators are preparing to settle a 1981 suit charging them with untimely payment of medical and legal service bills.

As of last week, the settlement had drawn support from 20 leading California work comp insurers, about 80 other work comp insurers, about 70 self-insured employers and several TPAs. These parties—and others expected to join later—will collectively contribute $4.25 million to the settlement reached with California health care and legal services providers.

Each defendant is responsible only for claims asserted against it.

A final agreement is being drafted by attorney Pierce T. Selwood of Sheppard, Mullin, Richter & Hampton in Los Angeles. It must be approved by the California Workers Compensation Appeals Board, which has jurisdiction over the case.

But, the settlement is not expected to be presented to the WCAB until all plaintiffs and respondents have decided whether to settle.

The draft could be complete by year-end and the settlement consummated by mid-1987, speculates James M. Sevey, an attorney involved in the discussions who is vp and claims manager for California Casualty Group, a workers compensation insurer in San Mateo. "I think we're making significant progress," Mr. Sevey says.

A settlement would end several years of negotiations over *Sak Photocopy Service et al vs. Aetna Casualty & Surety Co.*

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inside

Noting that 34 states have enacted some type of tort reform this year, this week's editorial suggests that additional tort reform and a change in society's attitudes toward litigation and damage recoveries are needed to solve the problems of our civil justice system. **PAGE 8**

In the face of the tort reform activity across the country, some legal experts contend that state tort reforms do not address fundamental questions about the direction the U.S. civil justice system should be taking—questions that they say are more important than tinkering with the system on individual issues. **PAGE 30**

William J. Miner, an employee benefits actuary with The Wyatt Co. in Chicago, points out in the Perspective section that language in the pending tax reform bills would not make Voluntary Employee Beneficiary Assns., or 501(c)(9) trusts, any more feasible for funding retiree health care benefits. **PAGE 21**

departments

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Employees must learn options: Expert

By DONNA DiBLASE

NEW YORK—Employee benefits communication is becoming more challenging because employees must now learn about alternative health care delivery options, benefits communications experts say.


Mr. Stroud

"Benefits are more complicated today," sums up Thomas D. Stroud, director of market support for the Group Health Division of Louisville, Ky.-based Humana Inc. "Employees are most familiar with traditional indemnity insurance, but today there are many more alternatives."

"Some famous last words on benefits communication that I've heard are, 'communications are nice but not really necessary,' or, 'benefits haven't changed all that much,'" noted Eileen M. Nash, director of external communications for Equicor, a joint group health/life venture formed by New York-based Equitable Life Assurance Society of the United States and Hospital Corp. of America in Nashville, Tenn. (*BI*, Aug. 11).

"But, the fact is that employees relate to their benefits with the way they are communicated. Their perceptions have nothing to do with the quality of the benefits—they are only as good as employees think they are," she said.

Mr. Stroud and Ms. Nash advised benefit managers and communicators how to communicate alternative health care delivery systems at the *Business Insurance* Employee Benefits Communications Conference.

Although the traditional indemnity plan still is offered by almost all employers, these plans are more tailored to meet an employer's specific needs, noted Ms. Nash. Therefore, it is important to communicate variations clearly and comprehensively, she added.

To communicate the features of the indemnity plan, Ms. Nash advised benefit managers:

- "You've got to start applying marketing principles to benefit communication."

It is important to sell employees on the idea that benefits are part of their total compensation and that they need to take responsibility for their health care, she said.

For example, one employer that was increasing the deductibles employees paid under the health care plan positioned the increase as an advantage by communicating that certain options, like outpatient surgery or obtaining second surgical opinions, were reimbursed at a higher percentage, she said.


Ms. Nash

- "Mix the media used to communicate benefits. And, concentrate on communication as an ongoing process and not just the pieces of the process.

"Your competition is not the annual summary plan description. While the SPD is a necessary part of the communication process, 'highlights' brochures give employees bite-size portions when we want to spoon-feed certain points," she added.

- "Translate benefits into bucks."

For example, one employer that was introducing a flexible benefits plan that included copayments and deductibles decided it needed to raise employees' awareness of the company's cost of providing benefits, Ms. Nash explained.

So, each employee received an envelope designed to look like a paycheck, she said. Inside the envelope was a non-negotiable check made out to the employee for the amount the company spends annually on each individual's benefits, she said. Also included was an explanation of the company's rationale behind the changes.

- Use a graphic theme for the communication program to help make the point with employees.

A food processing company used a brown grocery bag with the slogan, "Food For Thought," to get its employees interested in attending meetings, Ms. Nash said.

Ensuring that employees fully understand the options available through preferred provider organizations also requires effective communication, Mr. Stroud said.

"We have to prepare employees to make an informed decision," he said.

Mr. Stroud suggests these communication methods to make sure employees understand the plan:

- Have nurses or other health care professionals present at enrollment meetings to answer health care questions.
- Make sure enrollment materials are clear and concise.
- Maintain a 24-hour telephone hot line for employees to ask questions and obtain medical referrals.
- Maintain a toll-free claims information hot line.
- Update provider listings.
- Make a patient-care coordinator available to employees and be sure a customer service representative is available to respond to employee concerns.

When communicating HMO options to employees, it is important to explain the differences between plans, the experts agreed.

"The most important thing we have learned is that HMOs must also be communicated heavily. You must discuss all of the options and the prices," said Ms. Nash.

All benefit options also should be communicated to employees' spouses, both speakers said.

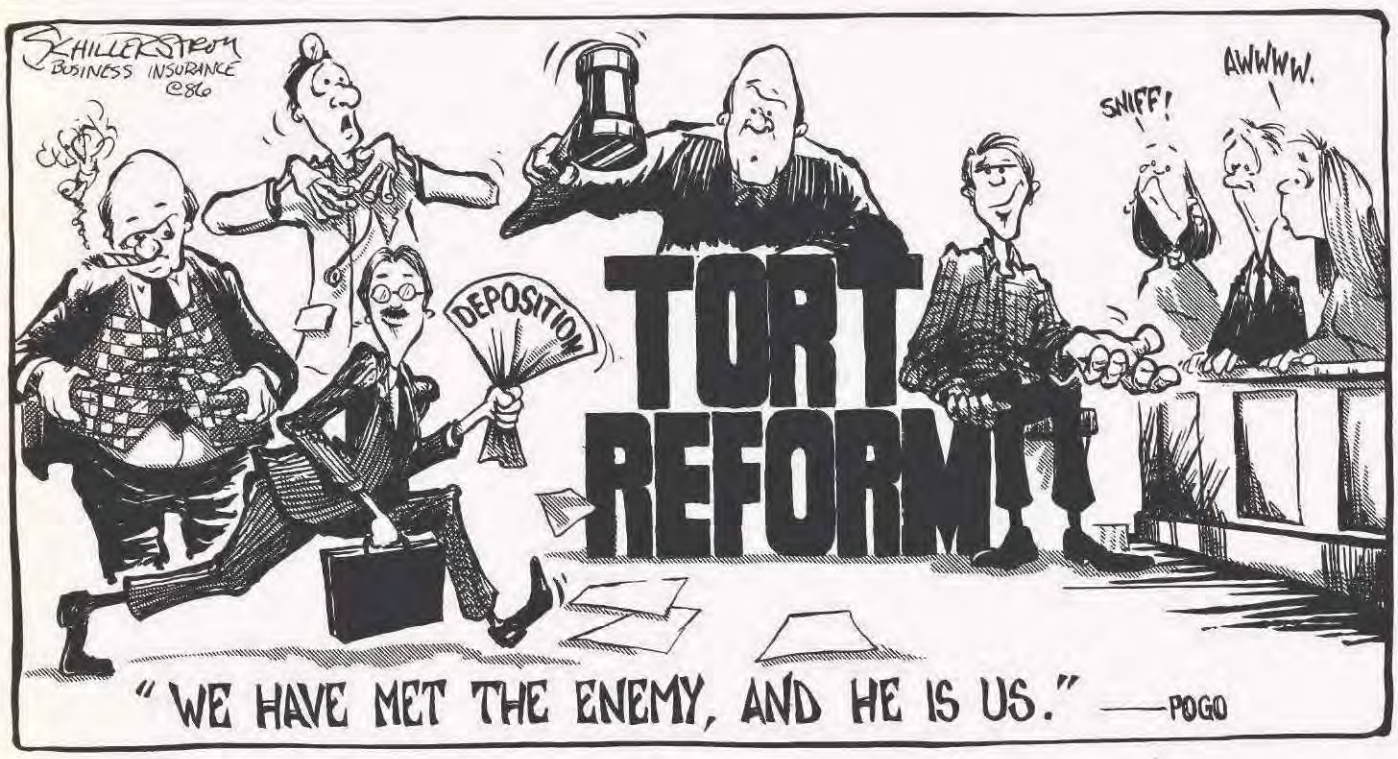
But, while the most effective way to include spouses is by having them attend meetings, most communication to spouses is done by mail, they said.

"I plan for all mail to be received on Fridays. Then, it's sure to get 'kitchen-table time'," Mr. Stroud said. The time the mail is received is as important as what it says, he maintained.

"Employees are cautious. They know that there is a trend toward cost containment," said Mr. Stroud. "So, if we don't do it right (communicate), employees will not say 'look what the company is doing *for* me,' but 'look what the company is doing *to* me.'"

Ms. Nash agreed, adding: "Today, benefit plans have to change. You have to start treating employees as consumers of health care. We're selling employees on taking charge, on being responsible for their own health care decisions. That's why communication has to be an ongoing process." ■

opinions



Only a beginning

TORT REFORM measures passed by state legislatures across the country can be hailed only as the beginning of civil justice reform.

Much more needs to be accomplished, in enactment of specific tort reforms in more states and in changing the public's attitude toward litigation and recoveries for injuries.

This week's report on state tort reform efforts, which was reported and written by Washington Editor Jerry Geisel and Los Angeles Associate Editor Steve Taravella, reveals how much has been accomplished—and how much has failed—in the nationwide effort to reform our civil justice system (see story on page 1 and chart on page 22).

We're not surprised that the most often adopted tort reform was designed to discourage frivolous lawsuits, usually the imposition of new penalties on plaintiffs and defendants who engage in frivolous lawsuits or stalling tactics. It's a reform no one can argue against. But, this reform will be effective in the 17 states that adopted it only if judges enforce the new standards.

There is hope in this regard. Federal judges are more frequently using their authority under Rule 11 of the Federal Rules of Civil Procedure to impose sanctions against parties and/or their lawyers for knowingly filing false or misleading proceedings.

We're also not surprised that the least popular tort reform was new controls on contingent fees, which were adopted in only six states. It's clear that plaintiffs' attorneys are fighting with the most zeal this reform that threatens their income, while giving in on other issues that would require less personal sacrifice.

Some progress was made in enacting the two reforms that would do the most to restore reason to liability awards and some predictability to judging liability exposures: caps on awards for non-economic damages and the repeal of joint and several liability. But, these reforms were too often rejected by state legislatures, or, when passed, too often weakly drafted.

Caps on non-economic damages were passed in 16 states, but these caps apply only to medical malpractice cases in eight of the states and sometimes are subject to important exceptions, such as cases of severe impairment or disfigurement.

The repeal or modification of joint and several liability in 14 states ranges from outright repeal of the legal doctrine as applied to all damages in a few states to modifications that only limit defendants' liability for damages owed by other defendants that cannot pay.

Only outright repeal of joint and several liability as applied to all damages will stop the search for deep pockets to compensate plaintiffs without regard to fault.

To provide compensation for those plaintiffs with injuries who cannot recover compensatory damages from the responsible party, we suggest that state legislatures reform punitive damage laws. All punitive damages awarded should be placed in a special state-managed fund available to pay compensatory damages to plaintiffs who can't recover from responsible defendants.

A few states have taken a small step in this direction by requiring that a portion of punitive damage awards be placed in state funds to be used for other purposes.

While advocating these specific reforms, we acknowledge that they alone may not adequately reform our civil justice system. We, as a society, have to change our attitude of entitlement to compensation for every injury. Or, at some point, we may have to decide that we need a no-fault system of compensation for injured persons.

But, changing societal attitudes is a long process. And, the public is not ready to elect no-fault compensation.

That leaves us here and now with these specific state tort reforms as the necessary starting point to reform our civil justice system. More states need to adopt these reforms, and there needs to be more uniformity among state laws.

We must redouble efforts for tort reform now, before the economic factors that control the cyclical property/casualty insurance business—namely new capital invested in the business and a return of higher interest rates—ease insurance prices and availability.

As soon as insurance becomes affordable and available again, the drive for tort reform will stall, just like the drive for product liability reform did in the late 1970s. Advocates of tort reform will become disinterested and state legislators will not act, although the problems and inequities in our civil justice system will not have been solved. They will just be masked again from view, only to reappear when the market again constricts.

These state tort reforms at least begin to solve the problems plaguing our civil justice system. And, in the process of enacting them, we make progress toward the long-term goal of changing society's attitude toward litigation and damage recoveries. We raise the public's level of awareness of who pays for damage awards: all of us.

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EPA will approve parent guarantees for waste firm units

By ROBERT A. FINLAYSON

WASHINGTON—Businesses that own or operate hazardous waste disposal facilities soon will be able to use a guarantee by a parent corporation to meet federal financial responsibility regulations.

Under the current regulations, businesses that own or operate hazardous waste disposal facilities must obtain commercial environmental impairment liability insurance with limits of $3 million per occurrence and $6 million annual aggregate, or must pass a strict financial test to self-insure their pollution exposures.

But the nearly non-existent EIL insurance market has made it difficult—if not impossible—for many businesses to find EIL coverage, while other companies do not have the financial resources to pass the stringent self-insurance test, even as subsidiaries of larger companies.

More than 100 businesses were forced to close their doors late last year because they could not meet a congressionally imposed deadline for obtaining EIL insurance or pass the self-insurance test (*BI*, Nov. 4, 1985; Nov. 25, 1985).

Three groups have announced plans to launch new EIL coverage facilities, but none are operating yet (*BI*, July 14).

As part of its effort to expand the number of options available for meeting the financial responsibility rules, new U.S. Environmental Protection Agency regulations that take effect Sept. 9 will allow subsidiaries of larger corporations to use a special corporate guarantee.

Under current regulations, subsidiaries of larger corporations can only self-insure their pollution liabilities if they meet the financial test on their own—independent of their parent. This requirement has virtually eliminated the self-insurance option for most corporate subsidiaries because they usually consolidate their financial statements with those of their parent.

The new rules allow a parent to "self-insure" a subsidiary's pollution liabilities through a corporate guarantee, in which a corporation promises to answer for the default of another.

Such guarantees typically require a parent company to respond to a specified third party for the default of a subsidiary.

The corporate guarantee devised by the EPA is unusual in that it eliminates the specified third party and obligates a parent to pay all claims submitted by "any and all third parties who have sustained or may sustain bodily injury or property damage caused by accidental occurrences arising from operations of the facilities covered by the guarantee."

Because of the unusual nature of this guarantee, the EPA is restricting its use to states where the attorney general or insurance commissioner has submitted written notice to the agency stating that the guarantee is legally valid and enforceable under existing statutes.

Carlos M. Lago, an EPA official who helped draft the new rule, says several attorneys general already have informally indicated that the guarantee would be legal.

Once the EPA has received responses from all states, it will publish the jurisdictions in which the guarantee has been approved, Mr. Lago says.

To qualify for the new corporate guarantee option, a subsidiary must be at least 50% owned by the company providing the guarantee.

The EPA still is reviewing other options for meeting the financial responsibility requirements, but does not have immediate plans to offer any other new alternatives, according to Mr. Lago. ■

Spreading the word

Benefit managers and communicators gathered at the futuristic Marriott Marquis Hotel in New York's Times Square.

Young workers need to plan for retirement: Consultant

By DONNA DiBLASE

NEW YORK—Retirement planning programs should be offered to employees—no matter what their age—as soon as they are hired by a company, one benefit communications consultant advises.

And, to increase employee participation in these programs, they must be effectively communicated to workers of all ages, he says.

"When it comes to retirement income, long-term planning and growth are critical," explains Julio Esteban Jr., vp and manager of Alexander & Alexander Inc.'s communications consulting services for the Central Atlantic states in Baltimore.

"A retired employee just won't have enough income to live on comfortably with Social Security and an employer's pension benefits alone," he says.

Mr. Esteban discussed how employers can develop and communicate retirement planning programs at the *Business Insurance* Employee Benefits Communications Conference held Aug. 4-5.

Most employers do not offer these planning programs to young employees, Mr. Esteban noted. Instead, most retirement planning programs are directed to employees close to retirement age, Mr. Esteban found when he

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Informed workers can help improve health care: Insurer

By DONNA DiBLASE

NEW YORK—Teaching employees to become wise health care consumers can actually improve the U.S. health care system, one expert says.

"Second-opinion programs, concurrent review and pre-certification are all things which put the knowledge of the health care purchaser in the hands of the employee and patient," explained John D. Moynahan, executive vp and member of the corporate management office of Metropolitan Life Insurance Co. in New York.

"If these programs are communicated well and are allowed to work, they can improve American medicine," he said.

Mr. Moynahan outlined trends in the health care marketplace and the importance of clearly communicating these trends at the *Business Insurance* Employee Benefits Communications Conference, held Aug. 4-5 in New York.

"In health care, products, plans and systems have changed faster than beneficiaries realize," Mr. Moynahan said.

"All of the changes made in the health care delivery and group insurance system have been driven by runaway cost inflation from which the patient has traditionally been sheltered. Patients have been sheltered from this because of the nature of the health insurance system.

"But now, the employee will need to function as the buyer instead of just the user of health care," he said.

Employers have introduced many changes in benefit plans in an effort to ensure cost-efficient, quality health care for their employees, Mr. Moynahan said. These include "changing benefit levels, reintroducing comprehensive benefit plans with cost sharing and utilization review for inpatient and ambulatory services."

But, many changes also have been made in the way health care in the United States is delivered, he said.

"There has been increasing vertical and horizontal integrating of delivery systems and a lot of joint-venturing. It's getting to the point where you have to ask whether the initials 'M.D.' mean medical doctor or marketing director," Mr. Moynahan said.

Health maintenance organizations and preferred provider organizations "will probably dominate the market by the 1990s, but they will probably be programmed somewhat differently than they are now," he predicted. "The two types of plans are getting closer and closer together and the majority of care will be delivered through managed care systems like these."

"HMOs have been living in a comfortable environment for many years," Mr. Moynahan said, noting that the HMO industry has a bright future. "But, they will have to become more

Continued on page 4

Brokers' surge to continue through '86

By LINDA J. COLLINS

Revenues and earnings continue to balloon for the publicly held insurance brokers, and the outlook for the rest of the year is more of the same.

However, analysts and brokers agree that revenue growth could slow in 1987, as commercial property/casualty insurance rate hikes moderate.

While the brokers' revenue growth should continue through 1986 and the first quarter of 1987, it will "lose some steam within the next 12 months" as rate hikes taper, said John E. Keefe, financial analyst with Drexel Burnham Lambert Inc. in New York.

"I expect to see a slight tapering off on revenue growth, but I still expect broker revenues to remain at a high level for the last half of 1986," said Leonard M. Wilson, special limited partner with L.F. Rothschild, Unterberg & Towbin in New York.

"I think, looking to 1987, we will see less and less increases in pricing," said Sidney A. Stewart Jr., chairman and chief executive officer of The Crump Cos. Inc. in Memphis, Tenn.

"We are beginning to see a strengthening in property insurance and a leveling off of rate escalation. Renewals are coming in at the higher levels, but not with the dramatic rate hikes of the last year and a half," said Michael J. Cloherty, vp of finance for Arthur J. Gallagher & Co. in Rolling Meadows, Ill.

Brokers' first-half results
(In thousands of dollars)

Broker	Gross revenues	% change	Net income	% change
Marsh & McLennan	$897,600	37.0%	$129,700	54.6%
Alexander & Alexander	519,000	18.6	41,700	94.0
Frank B. Hall	230,897	12.2	13,878	NM
Corroon & Black	159,057	27.4	18,637	69.7
The Crump Cos.	57,084	30.8	6,630	55.7
Arthur J. Gallagher	46,678	27.6	5,372	30.6
Poe & Associates	16,249	28.0	2,383	126.1

NM — Not meaningful

Chart: Anthony Ficke

Revenue growth at Marsh & McLennan Cos. Inc. showed no sign of slowing in both the second quarter and the first half, with all areas of M&M operations contributing to the advance, a company spokesman says.

Gross revenues for the world's largest insurance brokerage totaled $453.4 million in the second quarter, up 36.2% from $332.8 million in the second quarter of 1985. First-half revenues totaled $897.6 million, a 37% jump from $655 million in 1985.

M&M's net income for the second quarter rose 59.9% to $64.6 million from $40.4 million in the second quarter of 1985.

First-half net income rose 54.6% to $129.7 million from $83.9 million in 1985.

While M&M's revenue growth was strong in all areas, "Our most dramatic growth in the second quarter was in investment management," the spokesman said. Investment management revenues from M&M's Putnam Cos. subsidiary increased 108.7% to $48 million from $23 million in the second quarter of 1985 due to "the strength of the mutual fund business," he added.

"Putnam increased its revenues by two and its profits by three," Drexel Burnham's Mr. Keefe observed.

M&M's insurance and reinsurance brokerage business grew at about the same pace in the first and second quarters, the spokesman noted, adding that more than half of its revenue growth in the first half was attributable to new business.

Samuel J. Weinhoff, first vp at Shearson Lehman Bros. in New York, said that while it is likely that M&M's growth will

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Health care

Continued from previous page

efficient and financially accountable for their actions," he added.

"The ability of HMOs to skim the fat off fee-for-service plans will end—but not voluntarily. Competition will cause this as HMOs respond to employers' needs and demands," Mr. Moynahan said.

He said he believes that a "new animal" will emerge from today's managed care systems.

"I predict that there will be more 'triple-option' plans in which the indemnity plan, the HMO and the PPO are combined into a single plan," he added.

Along with changes in the health care delivery system itself, employers also have changed the way they provide benefits, including non-health care programs, to employees, Mr. Moynahan said.

"There is a growing trend toward defined contribution plans such as flexible benefits plans," he explained. "Employers offered defined benefit plans in the heyday of benefits, with the employer's cost of the plan being the variable and the employee's benefits remaining constant. However, employers realized that in order to control costs, the benefits must become the variable."

Mr. Moynahan

Clear and careful communication of these changes is necessary to change employees' behavior while maintaining their appreciation for their benefits, Mr. Moynahan said.

"Without a doubt, health care benefits can create the highest level of employee satisfaction with an employer. But, a bad perception of benefits changes can drag the whole program down," Mr. Moynahan warned.

"There is a lot more to communicating changes than writing a revised but little-changed summary plan description," he said.

"Employees need to learn the behavior of insisting on a second opinion for all care," he said. "But, not allowing the doctor to take over requires a fundamental shift in the psyche of Americans. We've always thought the doctor knows best."

One problem that has resulted from this philosophy is "instead of taking control of the health care we receive, we have reserved ourselves to vindictive behavior in the form of medical malpractice suits. We need more prospective means of receiving and taking responsibility for the health care services we receive," Mr. Moynahan said.

And, as employers work to change their employees' behavior as health care consumers, they also must work with health care providers in delivering efficient, quality care, he added.

"Doctors and hospitals need healthier attitudes about providing care. Employers and providers do, after all, have a common goal, and that is the efficient delivery of quality health care," he said.

But, as employers seek to contain their costs and make the health care delivery system more efficient, they also must be careful they don't push top-quality, efficient providers out of the system, Mr. Moynahan warns.

The changing health care environment is not the only factor challenging employee benefit communicators today, he added.

"We are getting older as a nation and we have to provide for our aged. The issue of post-retirement welfare benefits is a most serious one and many of our large industries are seeing the problem of funding these liabilities firsthand," he said.

These liabilities exist because, "historically, the government has placed more emphasis on pensions and not enough on health and welfare for retirees," Mr. Moynahan said.

To control these liabilities and ensure that retirees receive the health care they need, employees must prepare in advance for their retirement, he added.

"The public and private companies have to work together to take action now. Don't wait for the thundering crash of the rock and the hard place coming together," he warned.

"Benefits communicators are faced with a unique problem because they are right in the middle. They are faced with communicating both current employees' benefits and retirees' benefits," he said.

"In these areas—health care alternatives, benefit plan alternatives and post-retirement benefits—we have much communicating and educating to do. And, we have just begun," he said. ■

Benefits pros tackle thorny benefits issues

NEW YORK—Communicating benefits to employees on a one-on-one basis is a strategy that works well when a company makes major changes in its benefits program, employee benefit communications professionals agree.

"One-on-one personal delivery can prevent employees from becoming suspicious of a company's motivation for changing benefit plans," said one member of a special task force at the *Business Insurance* Employee Benefits Communications Conference.

Task forces—made up of benefit managers and benefit communicators—were formed during the *BI* conference, held earlier this month.

The objective of each group was to devise solutions to thorny benefit communications problems, including:

- Communicating the change to a health care plan with copayments and deductibles from a first-dollar plan.
- Improving participation in a 2-year-old 401(k) salary reduction plan.
- Introducing a flexible benefits program.
- Updating a long-standing, but ineffective, benefit communications program.
- Designing a communications program solely for top-level executives.

Following discussion of problems accompanying each of the scenarios, each task force developed strategies for solving the communication problem. These strategies were shared with all conference attendees.

The task force established to communicate the introduction of a flex plan proposed the use of interactive computer communications in special workshops with employees to introduce the new benefits.

Another task force concluded that some types of communications programs are not appropriate if the new plan is being introduced to cut benefit costs.

"If you're cutting costs by switching benefit programs, expensive audio-visuals are definitely out," a member of the task force examining medical plan changes explained. "But, an in-house produced slide show can be effective and inexpensive."

A member of the task force assigned with the task of updating the long-standing, but ineffective, communications program suggested that companies facing such a problem develop a communications theme to revitalize participation in already-established benefit options. ■

As employees grow more gray, so does the issue of who will pay for their future health care.

Slowly but surely, America is growing older. And as our workforce also grows older, the issue of who will pay for an employee's health care needs after retirement becomes more complex.

Individual savings are seldom enough. Government programs like Social Security, Medicare and Medicaid are already strained. And, according to some estimates, companies who have health care benefit plans for retirees are currently facing up to 2 trillion dollars in unfunded future liabilities.

Clearly, new ideas are needed for solving the complex issue of health care for retirees.

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Obviously for an idea of this magnitude to succeed, it will require the help of government legislation, the participation of health care providers and the support of business in making LifeScope℠ available to employees.

NWNL Group invites each of these institutions to join us in shaping our plan. Contact Ginny Patrick, NWNL Group, Box 20, Minneapolis, MN 55440 or call 612-372-5784 for a detailed report on the problem and how we can solve it together.

Quite obviously, our task is enormous. But so is the need.

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NWNL GROUP

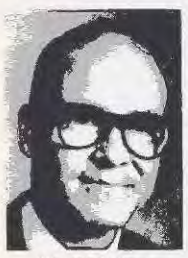
Life planning

Continued from page 3

surveyed 100 employers ranging in size from 600 to 10,000 employees.

To increase younger employees' participation, employers should communicate these programs as "life planning vehicles" instead of retirement planning programs, he suggested.

"Younger employees would be turned off by a retirement program. The 'life planning' program has the effect or benefit for retirement built in without the younger employee realizing it, since early planning strategies help meet intermediate goals and build a solid base for the future as well," he explained.



Mr. Esteban

These planning programs —no matter what they are called—usually cover such topics as the company's retirement benefits, Social Security, Medicare, housing and health care, Mr. Esteban said. However, most programs do not address retirees' psychological needs.

The majority of retirement planning programs are communicated through meetings with older employees and their spouses, individual interviews with older employees and printed materials distributed to older employees, he explained.

However, it is important for employers to begin communicating these life planning programs to younger employees because, "by the year 2000—less than 14 years away—over 14% of the American population will be age 65 or over," he said.

"We are faced with an inherent problem in the traditional approach to retirement planning education for young employees—the 'time-horizon' problem. That is, the further back we get in planning time, the less clearly we see the horizon of our goal."

However, younger employees may not realize the importance of planning for retirement when that is 25 or 30 years away, he stressed.

To help solve this problem, life planning programs can be structured so that they break the employee audience down into age groups, he said, suggesting that the groups could include workers from the late teens to early 20s; mid-20s to late 30s; 40 to 50; and 50 and older.

Mr. Esteban suggested that a life planning program targeted to a specific age group can be broken down into three critical retirement planning areas: finances; maintaining good health; and finding personal interests to replace lost work activity.

But these topics must be communicated differently to each age group, Mr. Esteban explained.

For example, capital accumulation and investment advice could be emphasized more to employees in older age brackets, he said. "Employees in the youngest age group—the 'starters'—have more short-term goals. But, employers could encourage them to save regularly by offering them an attractive employer-matched savings plan."

Maintaining a healthy lifestyle, though, should be emphasized to all age groups, he said.

"Your corporate wellness program will reap its greatest rewards" if the value of good health is emphasized to all employees, he added.

"All along in your health planning messages, you should stress health concerns and risks of different age groups. Your overriding message, of course, is one of prevention through positive action—a wellness program message," Mr. Esteban suggested.

It is always important to encourage employees to have interests outside of work, he said. "Not only are these interests absorbing, they also act as a good balance to work or personal stress. The skills learned may also be of great value to the individual in retirement," he said.

Some companies implement programs to ease employees into retirement, Mr. Esteban noted, such as gradually reducing the hours employees work as they approach retirement age.

Some even provide alternative career training programs in which employees can train for a post-retirement job such as teaching at a community center or working at a museum, he said.

Other ideas Mr. Esteban suggested that employers consider before implementing a life planning program include:

- Dividing a company's employees "possibly to address the special needs of your blue-collar, white-collar and executive staff—such as differing financial needs."
- Maintaining a modest non-contributory defined benefit pension plan, in addition to other defined contribution plans. The defined benefit plan provides a base for employees to build their retirement income, he said.
- Offering the life planning benefit to employees at all of a company's locations.
- Promoting the life planning program as "another important benefit in your overall employee benefits program."

"The typical one-dimensional retirement planning approach is really inadequate when we look at the employee's life needs and your own corporate goals for your benefits program," he emphasized.

A program that helps employees set goals in areas such as health, lifestyle and finances will produce the greatest returns for employers and employees, he said. ■

Changes complicate communication

NEW YORK—Rapid changes in the nation's health care system are making employee benefits communication increasingly difficult.

Benefit managers and communicators received advice on how to answer this challenge during a two-day conference, "Employee Benefit Communications: A Changing Environment Offers New Choices," sponsored by *Business Insurance*.

There were 165 registrants for this year's conference, which was held Aug. 4-5 at the new Marriott Marquis Hotel in New York's Times Square.

Along with reviewing case studies of employers that have produced successful communications programs, benefit managers and communicators attended workshops in which they received first-hand experience with interactive computer benefits communications. And, panel discussions about the changes in the health care system offered insight into communication strategies.

In addition, the 14th Annual *BI* Employee Benefits Communications Awards were presented at a special luncheon by Alfred Malecki, publisher of *Business Insurance*. These awards recognize successful employee benefits communications programs (*BI*, Aug. 4).

Information about next year's *BI* Employee Benefits Communications Conference can be obtained by writing Ann Vazquez, *Business Insurance* Communications Services Department, 220 E. 42nd St., New York, N.Y. 11017.

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IN ITALY
THIS ISN'T A FIRE.

Bell Atlantic works out enrollment bugs

By DONNA DiBLASE

NEW YORK—Even the most comprehensive benefits communications program can leave employees puzzled, one company has discovered.

After conducting a three-month, $120,000 multimedia communications campaign to introduce a new flexible benefits plan covering 8,000 employees, "we still had a 35% rate of errors on the enrollment forms for the plan," said Donald J. Olsen, manager of benefit plans for Princeton, N.J.-based Bell Atlantic Enterprises Corp., the holding company for Bell Atlantic Corp.

Mr. Olsen discussed the communications program, "A New Wave in Benefits," in a case study session at the *Business Insurance* Employee Benefits Communications Conference earlier this month.

Mr. Olsen

To help employees better understand enrollment procedures, the company has altered its communications program, which won third place in the total benefits communications program category of the 1985 *Business Insurance* Employee Benefits Communications Awards competition (*BI*, Aug. 5, 1985).

"We thought we covered all of the bases very well. But employees still made mistakes when enrolling. I think it's just something you have to expect when you communicate complicated benefits to employees," he said.

For example, employees were told to record the cost of benefit choices, which were printed on one section of the enrollment form, in a separate column. Employees often recorded the incorrect amount, he said.

To correct this problem, Bell Atlantic is now better explaining how to properly record benefit choices on the enrollment form, he said.

"We made some changes in the enrollment form," he added. "We changed some of the wording, but the basic content is the same."

After the program changes, "the error rate dropped to between 8% and 20% in the second year of the plan." Mr. Olsen said.

When developing its flexible plan and the ensuing communication program, Bell Atlantic Enterprises took into consideration the diversity of its workforce, Mr. Olsen said.

Specifically, since some of the company's employees had been employed by other Bell System units prior to the 1984 divestiture that formed the regional phone companies, "we wanted to create a benefits plan that was easily adaptable to all of the employees," Mr. Olsen explained.

Besides the problem of varying employee ages and lengths of service, the company had a geographical problem: Employees were spread out over 48 states, he added.

The company's benefits plan includes a choice of six medical plans; three dental plans; various group life insurance and accidental death and dismemberment insurance options; three long-term disability plans; and two flexible reimbursement accounts.

According to Mr. Olsen, the objectives of the communications program were to:

- Communicate management's philosophy for introducing the flexible benefits plan.
- Explain the concept and rationale of flexible benefits.
- Educate employees so that they could make informed choices under the plan.
- Encourage employees to think about cost containment and become good consumers of health care.
- Emphasize the value and cost of benefits.

'We thought we covered all of the bases very well. But employees still made mistakes when enrolling. I think it's just something you have to expect when you communicate complicated benefits to employees,' says Bell Atlantic's Mr. Olsen

The company also decided that the communications program would compare old and new benefit plans, while emphasizing the choices available, as well as stressing the tax-effectiveness of a flexible plan, he said.

The plan, which went into effect April 1, 1985, was announced to employees in a January 1985 letter from management, Mr. Olsen said.

The communications program that followed included articles in the company newsletter; payroll stuffers; posters; employee meetings; a slide presentation; enrollment kits that provided detailed descriptions of the options under the plan; and a personalized enrollment form.

As part of its ongoing communications, the company has started both a follow-up program to identify employees' misconceptions about the plan and a program that reminds employees of the importance of cost containment, Mr. Olsen said. ■

Experts critique benefits presentations

By DONNA DiBLASE

NEW YORK—Benefits communication presentations must be consistent and honest to be effective, communications experts agree.

Benefit managers and communicators used these guidelines to judge four audio-visual presentations during a session called "You Be The Judge" at the *Business Insurance* Employee Benefit Communications Conference, held Aug. 4 and 5 in New York.

The four presentations, all of which were entries to this year's *BI* Employee Benefits Communications Awards competition, were critiqued by conference attendees during the two-hour session led by Herbert Zeltner, president of the New York-based marketing and communications consulting firm of Herbert Zeltner Inc.

Mr. Zeltner gave the conferees four other guidelines he thinks are essential to producing effective communication presentations, including:

- Know exactly what you want to say in the presentation. "Develop a clear-cut strategy and stay with it," he advised.
- Don't let the execution of the presentation overpower the message.

"Too often, people in the advertising business fall in love with the wrapping," Mr. Zeltner pointed out.

- Put yourself in the prospects' shoes and work from their frame of reference and their concerns.
- Keep the message simple.

"Hit a single message hard. People can absorb very little at one time," he said.

The participants rated the audio-visual presentations in five areas: objectives, strategy, content, presentation and effectiveness.

After the presentations were viewed, benefit managers and communicators made several observations about the programs, including:

- The effectiveness of using a series of vignettes featuring different benefit areas and different employees whose ages and needs vary.

Some participants said it was important that a series like this support a main idea or thesis.

But, one participant said that one presentation that used this technique "was a series of disjointed vignettes that didn't build up to a final tagline."

- The lack of a central theme in one presentation.

One audio-visual program viewed by the group, which was the first benefits communications device used by a company after the merger of two corporations, did not present and support a theme, participants felt.

Mr. Zeltner

"There is no central theme," said one participant. "They should have hit the theme of the two companies merging first. The presentation was just a list of benefits."

- The use of real employees making candid comments about benefits.

One video that used this technique to introduce a new flexible benefits plan drew mixed comments from the audience.

"I reacted to the reality and believability of the people at the company and in the video," said one participant.

But, another said: "I felt a little uneasy about all of the personal information being given out here. I also don't think the employees in the video give a full representation of total employee population."

- The amount of detail given in the presentations.

Some participants felt that one video, which intended to be an overview of a new benefits plan, overwhelmed the audience with details.

"In some cases, there is too much information given without really saying anything. The main concept of the plan came across at the beginning and didn't need to be repeated over again," one participant commented.

- The use of a familiar song to build enthusiasm for a benefits plan.

The participants felt that this technique was very successful.

- Knowledge of the targeted employee audience.

One presentation used cartoon characters and puns to explain a new 401(k) savings plan to a group of blue-collar employees.

One participant felt that "given the employee group, this method worked well."

Another attendee said the presentation, "spoke at a good level to employees."

But, others said the presentation could have insulted employees. "The use of double entendre and cutesy sayings is almost talking down to employees. It wasn't honest; it's trying to trick employees into joining the plan," the participant said.

Mr. Zeltner ended the session by reminding participants of the objective of attending "You Be The Judge."

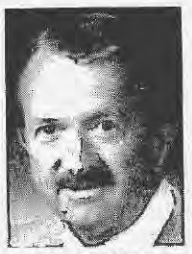
"These presentations should be used as study aids. We don't want to only show you presentations to beat up on, nor do we want to only show you the crown jewels. We're trying to learn from the strengths and weaknesses of them," Mr. Zeltner said.

"Keep in mind that the honesty in the content and style in which you talk to people is very important in communicating anything," he added. ■

Computers help workers make benefits decisions

By JENNIFER PELLET

NEW YORK—More employers are combining the use of interactive computer software with printed information to communicate employee benefits, experts say.



Mr. Bartlett

'It's the light at the end of the tunnel in benefit communication," says Doug Bartlett, director-employee benefits for NCR Corp. in Dayton, Ohio.

An employee using a computer terminal or personal computer programmed with information about a company's flexible benefits plan can access personal benefits data, project the effect the various benefit alternatives will have on his or her financial situation and decide on the benefit options that best suit individual needs, benefit experts point out.

"With benefits becoming more and more complex, the best way to communicate them is to provide specific information on each employee's benefits—that way there's a greater attention span," explains Gary Grom, executive director-human resources for Sara Lee Corp.

Mr. Bartlett and Mr. Grom were members of a panel at the *Business Insurance* Employee Benefits Communications Conference in New York earlier this month that discussed the advantages of using interactive computer communications.

Ms. Keeler

"The computer systems enable employees to control the timing of obtaining benefits information and can be used as an ongoing vehicle and not just for announcement programs," said Pamela Keeler, director-advanced benefit communications for Metropolitan Life Insurance Co. in New York, another panelist.

"The feature I think really sets the computer-based approach apart from 'traditional' communication tools is the forecasting and modeling capability," Ms. Keeler added, pointing to capabilities that allow employees to predict the value of their benefits under different scenarios.

"It gives employees the ability to see how different levels of participation affect them and their personal situation."

Peter O'Donnell, director-employee benefits at RCA Corp. in Princeton, N.J., says computer systems are necessary for accurate and efficient communication of employee benefits.

"There are considerable advantages to both employees and employers in using computer systems," he said. "It hasn't replaced print, but it's reduced it considerably and I've got quality control over the information provided."

Computer systems provide employees with hands-on interaction and completely confidential information, Mr. O'Donnell added. "An employee doesn't have to be afraid to ask a question—the computer doesn't acknowledge dumb questions."

Panelists also say computerized benefit communications may be a more cost-efficient way of communicating benefit information.

"It's relatively inexpensive," said Mr. O'Donnell. "If you look at the cost based upon what the offsets are—virtually no cost to update, considerably less print and the increased productivity of freeing staff from answering routine questions—it's definitely cost-efficient."

"We developed our system ourselves," he said. "That was more expensive, but still fairly low," when the cost is amortized.

Mr. Grom said cost was secondary in deciding to implement a computer system at Sara Lee Corp. "The issue was educating the employees in the most effective way possible," he said.

It's not hard to educate employees to use the terminals, Ms. Keeler noted.

"We use a simplified keyboard,

Continued on next page

Continued from previous page
just numbers and command keys, the approach is like a bank's automatic teller machine: Follow the simple instructions on the screen and get your information," she said.

Employees can use the system at Metropolitan Life, which the insurer markets to other employers, to obtain personalized benefit information such as savings plan account balances, accrued retirement benefits, and levels of life insurance benefits. They can also learn about general benefit information, she said.

The Metropolitan Life "Benefit Centers," which resemble video game machines, are computer terminals encased in special housings or "kiosks" that "appear less foreboding to the general employee population than computers standing alone and also serve to protect the equipment," she said.

The centers are placed in high traffic areas, such as a building's lobby, cafeteria and worksites, Ms. Keeler said. "We recommend one computer terminal for every 1,500 employees," she said.

The kiosks are designed to maximize user privacy. "We usually have them in a corner, so there is a wall to one side, and the information on the screen is only visible if the viewer stands directly in front the machine," Ms. Keeler said.

NCR's computerized benefits communications system, implemented in May 1985, is based on a software package designed by NCR and consultant Hewitt Associates to be compatible with NCR's personal computers, explained Mr. Bartlett.

"The employee enters data, such as a percent expected salary increase per year, age of retirement, personal savings and investments data and projected deferrals to the company's savings plan, and the computer can project his future benefits" under the company's pension and savings plans, he said.

The system has pre-programmed default values, such as 5% for an annual salary increase. Employees can calculate benefits for any percent increase by changing that value, but unless the value is changed, the 5% increase will be used in the computer's calculations.

"That's to protect the employees from not entering a value and getting a benefit calculation based on a zero increase in salary," he said.

The system also provides information on various benefit plans and can compute and compare the pension benefits amounts payable under the company's previous average-pay defined benefit pension plan with the company's new career average plan.

Because no personal information is stored in the computer system, no security is needed, a company spokeswoman said.

RCA's computerized communications system provides personalized information on all RCA benefits, including a company-sponsored loan program, Mr. O'Donnell said.

"We use IBM Personal Computers, with the keyboards covered except for the number keys, space bar and a few command keys," he explained. "If you want to use the system, you just go to the computer and push any key to get the main menu on the screen."

"The menu will show the benefits you have and you can choose whichever one you're interested in. You can specify the year you would like to retire and it will tell you what your monthly benefit will be if you retire that year with the benefits you have."


Mr. O'Donnell

Mr. O'Donnell said the system also can tell employees the balance in their savings plans, how much can be withdrawn and, "if you input the amount of money you're interested in borrowing and how long you need to repay it, it'll tell you how much you'll pay per month."

There are three types of security mechanisms built into the RCA system due to employee concern for confidentiality, according to Mr. O'Donnell.

"The employee has to enter his Social Security number and a security code before he gets access to personal information," he said. "And there's a safety mechanism in case the employee leaves the machine without signing off. If the employee stops responding or inputing information for a certain amount of time, the computer will return to the main screen."

Mr. O'Donnell says Johnson & Higgins is marketing the system, which is compatible with IBM AT or XT personal computers.


Mr. Grom

Like NCR's system, Sara Lee's system requires no security codes, Mr. Grom says.

"The system doesn't contain personal information about the employee so there's no need for security codes," Mr. Grom said. "Employees put in all the information needed as they use the terminal," he explained.

The system, which was developed by Sara Lee in conjunction with consultants from William M. Mercer-Meidinger Inc., consists of software programs that can be used on personal computers.

"We have a deferred compensation program which executives can use to calculate and project and evaluate potential investment options," Mr. Grom explained.

"We also have software which can be used by 401(k) participants," he added.

That software helps determine retirement income based on what portion of salary is deferred to the plan. ■

Colgate 'ads' communicate 401(k) plan

By JENNIFER PELLET

NEW YORK—A mock ad campaign is helping employees at Colgate-Palmolive Co. learn about the company's 401(k) savings plan.

Colgate's successful communications experience was presented as a case study from which other benefits communicators could learn during this year's *Business Insurance* Employee Benefits Communications Conference Aug. 4-5.

"Colgate had just introduced the 'Colgate Pump,' and the idea was to ride the coattails of the successful product campaign," explained Pamela Kekich, a principal of Fort Lee, N.J.-based benefits consultant Kwasha Lipton.

A team of Colgate managers worked with consultants to develop an eight-step communications program to introduce the new 401(k) savings plan that would achieve the company's objectives: explain the 401(k) plan; encourage employee participation; develop a corporate identity for the company's employee benefits; and market those benefits.

The program captured first-place in the special projects category of the 1985 *Business Insurance* Employee Benefits Communications Awards competition (*BI*, Aug. 5, 1985).

The Colgate program began with a poster showing painters working on a billboard. A partially completed illustration of the Colgate Pump covered the left side of the billboard, and the message, "Coming Soon. . .the New Savings and Investment Plan!" had been painted across the top.

Colgate wanted to market its 401(k) plan to employees as it would market a product to consumers.

The second step was a letter to employees from Colgate's chief executive officer.

"It introduced and gave an overview of the 401(k) option, but the chief purpose was to show his endorsement of the plan," Ms. Kekich explained. The next step was an advance announcement in the form of a package for employees to take home.

"It was a box of the new pump product packaged alongside a box resembling it in format but packaging the new plan." Ms. Kekich explained.

The copy "was sort of a takeoff of the copy on the Colgate Pump package.

"The markings and colorings were the same, but the copy had been replaced with copy about the new plan. For example, where the pump package read, 'Maximum Flouride Protection' the plan package read, 'More Financial Power.'

"The idea was to market the plan to employees as Colgate would market a new product to consumers," Ms. Kekich said. "So we took a successful new product and tried to do a kind of play on words with it."

Colgate's fourth step, was a 12-minute video, designed to resemble a commercial, that explained the benefits and changes that would accompany the introduction of the new 401(k) plan.

"It continued the theme of marketing a new product," Ms. Kekich said. "Colgate uses commercials to market new products, so we thought we'd have a commercial as the theme of the video.


Ms. Kekich

"Colgate also hoped that a continuous theme breaking up the flow of information would hold the attention of employees," she said.

The video begins with a businessman telling viewers that Colgate had wanted to explain the new benefits to employees with a 30-second commercial but problems arose. "This is what happened," he says, as the camera focuses on the filming of a commercial.

The viewer sees an actor, dressed in a blue suit and applying makeup, then a voice off-camera says, "Action!" and the actor begins to tell viewers about the new plan.

A voice interrupts the actor, saying he only has 10 seconds left and the actor responds, "but I didn't get to tell them about all of the benefits of the new plan—I need more time!" The camera shifts back to the original announcer who smiles and tells viewers, "So, we decided to make it a series of 30-second commercials."

The camera pans back to the actor, and viewers watch as a series of commercials are shot describing the major changes that will occur with the 401(k) plan's initiation and the advantages of saving on a pretax basis.

The film ends with a clip showing how all the information would have sounded crammed into a 30-second commercial, with the announcer sounding like Alvin the Chipmunk.

The video was shown during the fifth step of the program, a three-day meeting of 75 to 80 employee representatives from different company locations. "We wanted them to be, not experts, but enthusiastic, knowledgeable supporters of the plan," said Ms. Kekich.

A colorful plastic wheel-like "savings estimator" was distributed to all employees during the next step of the introduction program. The wheel can be used by workers to estimate possible savings under the 401(k) plan.

Employees match their salary level on the outer dial of the wheel with the percentage of income they invested in the 401(k) plan on the inner dial.

They can then see how much will accumulate in their 401(k) accounts over 10 years, 20 years and 30 years.

Next, a brochure containing a detailed description of the plan was distributed as a reference piece for employees.

And the final step, a second poster, this time showing the completed billboard, urges employees to 'Get More Financial Power. . . .Sign Up Now!"

The communications program paid off, according to Ms. Kekich. "In one location, where the employees had had no previous plan, participation went to 70%," she said. "And in the home office participation went from 89% (in an old savings plan) to 95%. So there was a clear indication that the campaign was successful." ■

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ASK A BENEFITS ACTUARY

VEBA often not practical for retiree health benefits

Q **Will my company be able to fund retiree medical benefits through a Voluntary Employees Beneficiary Assn. on a tax-preferred basis?**

A This question comes from the chief financial officer of a company providing retiree medical benefits. The company has reviewed the actuarially determined liability for these benefits and wants to begin funding for them, especially since the CFO believes the Financial Accounting Standards Board will soon require an actuarially determined charge to earnings for the benefits.

The company cannot fund retiree medical benefits on a tax-preferred basis under its defined benefit plan. Section 401(h) generally provides tax deductions within certain legal limits for employer contributions to a pension trust to accumulate in the trust tax-free. However, contributions for retiree medical benefits would not be tax-deductible for this company since the company is already contributing the maximum 25% of pay to its qualified pension and profit-sharing plans.

At this point, it appears that tax reform will not provide significantly improved tax preferences for funding retiree medical benefits through a VEBA, also known as a 501(c)(9) trust.

The Senate tax reform bill would make one change in the rules for funding retiree medical benefits through a VEBA: Section 1264 would allow the recognition of projected increases in medical costs under a specific index in determining the tax-deductible contribution to a VEBA.

Current tax law, as revised by the Deficit Reduction Act of 1984, does not permit recognition of these projected cost increases.

While this change is necessary to improve the tax-preferred funding of retiree medical benefits, an indexed medical cost inflation factor will not permit recognition of all elements that increase medical costs. Even though the price increase element of medical care cost inflation can be measured through an index like the medical care component of the Consumer Price Index, other elements of medical plan cost inflation are not so easily quantified.

Factors influencing the costs of medical plans include:

- Increased utilization of services.
- The propensity to use more expensive technology.
- Leveraging of deductibles.
- And, cost shifting from public to private payers.

All of these factors should be taken into account in determining a tax-deductible contribution for retiree medical benefits.

Two additional changes are also needed to the Internal Revenue Code in order to improve the tax-preferenced funding of retiree medical benefits.

The first change deals with the unrelated business income tax on VEBA investment earnings. Under current law, when assets accumulated in a VEBA for retiree medical benefits exceed the incurred-but-unpaid claim reserve, investment earnings on this excess accumulation are subject to unrelated business income tax. The incurred-but-unpaid claim reserves averages approximately three or four months of claim payments to current retirees and is generally dwarfed by the actuarially determined amount that should be held in a VEBA to finance retiree medical benefits.

If the employer in question were to begin today to use a VEBA to fund retiree medical benefits with maximum tax-deductible contributions, it would take only two or three years of contributions before at least 50% of the trust's investment revenue would be subject to tax, and probably no more than 10 years before virtually all of the trust's investment income would be taxable.

A second change deals with the separate account requirement for key employees under Section 419A(d) of the tax code. Under current law, all retiree medical benefit contributions made to a VEBA on behalf of key employees are paid to this separate account and all medical benefit payments to the key employee after retirement must be paid out of this account.

This requirement to pay retiree medical benefits from the separate account can easily leave a key employee without any medical benefits after retirement.

A key employee could retire and exhaust his/her account in the first year with a single accident or illness; however, if no funding of retiree medical benefits had proceeded the accident or illness, there is no limit on benefit payments to a key employee and no risk of exhausting his/her retiree medical benefits.

Since key employees generally decide whether the employer should fund these benefits through a VEBA and since such funding is contrary to their interest, the employer in question will probably not fund these benefits through a VEBA fund.

Without additional changes in the law, it is unlikely that any employer will use a VEBA to fund retiree medical benefits.

It's a shame that tax reform probably will not truly reform an area of the tax code that is in great need of revision.

Would you like advice from an experienced colleague on a risk management, benefit management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

Ask A Casualty Actuary, Ask A Benefits Actuary, Ask A Benefit Manager and Ask A Risk Manager answer written questions from readers on risk and benefit management issues and actuarial problems.

Mr. Miner

This month's column, on actuarial issues in the benefits field, is written by William J. Miner, an actuary with The Wyatt Co. in Chicago. Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field. Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco answers risk management questions. And, Joseph Duva, director of employee benefits and compensation at SCM Corp. in New York, answers benefit management questions.

Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Sherman's next column will appear in October.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Allegations dictate insurer's duty to defend

An insurer had no duty to defend a policyholder in a product liability suit where the allegations made against the policyholder, taken as true, would result in liability that was unambiguously not covered by the policy, a Louisiana court ruled.

Tommy Bourque filed a personal injury suit against Smith International Inc. and its insurer, Evanston Insurance Co. Smith sued Evanston seeking indemnification for and defense against Mr. Bourque's claim. Evanston denied coverage and asked that the suits against it be dismissed.

Mr. Bourque claimed that he was injured by a lathe manufactured by Lehmann Machinery Co. before the latter went bankrupt in 1969. Mr. Bourque alleged that Smith was the successor to Lehmann and, therefore, was liable for his injuries.

Evanston had issued a liability insurance policy to Smith that specifically covered only the "Caldwell Lehmann Hollow Spindle Lathe" manufactured by Smith after 1976.

The trial court ruled that the suits against Evanston be dismissed.

On appeal, both Mr. Bourque and Smith argued that Evanston should still provide coverage if Mr. Bourque's claim succeeded because that claim "arises" out of Smith's manufacture of "Lehmann" lathes.

The court rejected this argument pointing out that an insurance policy is a contract and that the plain meaning of the insurance policy here was to cover only injuries caused by lathes manufactured by Smith itself after 1976. The trial court decision was affirmed. *Bourque vs. Lehmann Lathe Inc.*, Court of Appeal of Louisiana, Oct. 10, 1985 (*BI*/02/Jy.-$5).

These abstracts were prepared by Cases Unlimited Inc. Copies of these decisons are temporarily unavailable.

legal briefs

Workers comp benefits

Did the New Hampshire workers compensation law include within its definition of compensable "dependants" a dependant who was neither the natural nor the adopted child of the deceased worker, but with respect to whom the deceased stood in a relationship in loco parentis?

The Supreme Court of New Hampshire ruled that it did.

Roger MacArthur died in a plane crash in 1973 while on a business trip.

Workers compensation benefits were paid to his wife and their natural children.

However, Liberty Mutual Insurance Co. refused to pay benefits for Nathan Wayne Burns, a child in the MacArthurs' custody since 1966. Nathan, who is mentally retarded, was placed in their guardianship as adoption was not feasible because of the natural mother's risk of trauma as a result of a prior adoption.

This suit was brought seeking benefits for Nathan.

The trial court ruled that Nathan could not recover.

The appellate court said that the existence of the parental question was a factual one. According to the court, a person "in loco parentis" is one who intentionally accepts the rights and duties of natural parenthood with respect to a child not his own.

The court said that state law contained no requirement of legal adoption that would expressly limit the child of a person in loco parentis from receiving benefits.

Furthermore, the court said that it could see no reason to impute a legislative intent to limit death benefits under the workers' compensation law to those having the relationship of either legally adopted children or of natural children, nor would payments to such persons as Nathan, the court observed, frustrate the purpose of the state adoption law.

Nathan was found to be entitled to benefits. *MacArthur vs. Nashua Corp.*, Supreme Court of New Hampshire, April 11, 1985 (*BI*/05/Jy.-$5).

Tort reforms enacted in 1986

State	Non-economic damages	Joint & several liability	Punitive damages	Periodic payments	Contingent fees	Frivolous suits	Collateral source rule	Government liability	Dram shop	Other reforms	Remarks
Alabama											Major battle expected next year
Alaska	$500,000	T	T	T			T		X	X	No damage cap for badly impaired or disfigured; non-profit D&O reform
Arizona[1]											Governor vetoed four-bill package
Arkansas											
California		T									Still in session; nothing expected
Colorado	$250,000[2]	T	T			T	T	X	X	X	Non-profit D&O reform; good Samaritan law
Connecticut		T		T	T	T	T	X	X	X	Far-reaching statute
Delaware										X	Corporate D&O reform
District of Columbia											Referendum sought
Florida	$450,000	T	T	T		T	T			X	Links reform to new rate controls
Georgia						T					
Hawaii	$375,000	T	T		T	T	T	X			Arbitration authorized for claims under $150,000
Idaho											
Illinois		P	P			P	P	P		P	Awaiting governor's signature
Indiana						T	T		X	X	Non-profit D&O reform
Iowa			T	T		T		X	X	X	Product liability reform
Kansas	$250,000(M)[3]			M		T				X	Product liability reform
Kentucky											
Louisiana								X	X		
Maine				M	M				X		
Maryland	$350,000			T							
Massachusetts	$500,000 (M)				M		M				No damage cap for badly impaired or disfigured
Michigan	$225,000 (M)	T		T		T	T	X	X	X	Exceptions to malpractice cap
Minnesota	$400,000[4]		T				T	X		X	Non-profit D&O reform
Mississippi											
Missouri	$350,000 (M)	M		M							
Montana[1]								X			
Nebraska											
Nevada											
New Hampshire	$875,000		T			T		X	X	X	Sets separate damage caps for municipalities
New Jersey											Bills pending; still in session
New Mexico									X		
New York		T		T		T		X			Non-profit D&O reform
North Carolina						T					
North Dakota											
Ohio											
Oklahoma			T			T					
Oregon											
Pennsylvania											Bills pending; still in session
Rhode Island				M		M	M				
South Carolina								X			Sets damage caps for public entities
South Dakota	$1 million(M)[5]		T	T							
Tennessee								X	X	X	Non-profit D&O reform
Texas											
Utah	$250,000 (M)	T							X		
Vermont											
Virginia								X			
Washington	T	T		T	T	T				X	Damage caps based on life expectancy and wages
West Virginia	$1 million (M)	M						X			Sets separate damage cap for public entities
Wisconsin	$1 million (M)				M						
Wyoming		T				T		X	X	X	Non-profit D&O reform

T — Applies to all torts
M — Applies to medical malpractice only
P — Passed, not yet enacted

[1] Constitutional amendments sought to facilitate reforms
[2] Damages up to $500,000 at court's discretion
[3] $250,000 on non-economic damages; $1 million includes economic damages
[4] Excludes pain and suffering
[5] Includes economic damages

Source: *BI* survey

Tort reform

Continued from page 1

land's $350,000 cap on non-economic damage awards in all tort actions.

Similarly, joint and several liability reforms vary considerably. A few states abolish joint and several liability for all awards—both economic and non-economic. Other states limit a defendant's liability for any damages unpaid by others to a percentage equal to the defendant's degree of fault. California voters repealed joint and several liability for all non-economic damages (see related story, page 1).

In two states—Minnesota and Illinois—the reforms contain so many loopholes, some experts charge, that some business groups urged that the proposals be vetoed. The Minnesota legislation was signed, while the Illinois measure is pending before Gov. James Thompson.

In other states, reforms were very narrow and thus unlikely to benefit many businesses. The most narrow reform: a Virginia reform that deals with one issue: ensuring that the liability of a certain transportation district in the state will not exceed the greater of $25,000 or the amount of insurance.

Businesses in states that have enacted weak tort reforms are unlikely to see much effect on insurance rates or availability. For example, the Alliance's Mr. Waligore says the Illinois tort reform statute is so weak that "at best, it will have only a minimal effect on insurance availability."

Generally, the effect of tort reform on insurance rates and availability remains to be seen in those states that have enacted significant tort reforms. But, there are some insurers who have said they will write more coverage and even reduce rates because tort reforms were enacted.

For example, Robert J. Clark, president of Aetna Life & Casualty Co.'s commercial insurance division, said that Aetna will expand its writings in Connecticut, New York, Michigan and California because of tort reform.

Meanwhile, The Hartford Insurance Group is cutting liability rates by up to 10% for many Connecticut municipalities. And, Fireman's Fund Insurance Cos. froze rates increases for commercial general liability insurance policies for one year.

Some observers believe that the drive to pass tort reform legislation has only just begun and that the issue will dominate state legislatures next year.

"The issue will be debated vigorously at the state level in 1987," predicted Victor Schwartz, a partner with the Washington law firm of Crowell & Moring.

By next year, tort reform coalitions are expected to be organized in nearly every state, said Mr. Coyne of the American Tort Reform Assn., a lobbying and informational organization that itself is only eight months old, but already has 380 trade association members.

It is the breadth of these coalitions that could help ensure that meaningful tort reform becomes a reality in more states next year.

"When you have manufacturers, insurers, professional groups and cities all on one side, you are talking about coalitions that will be pretty difficult to defeat," said Tom O'Day, assistant vp in the Washington office of the Alliance of American Insurers.

Following is a report, by region, on tort reform activity in each state.

New England

A **Connecticut** tort reform bill, signed into law by Gov. William A. O'Neill, is the most sweeping passed in New England and one of the most far-reaching enacted in any state, business lobbyists say.

For example, the Connecticut tort reform law modifies joint and several liability in all personal injury cases for both economic and non-economic damages. If an amount owed by one or more of the defendants is uncollectible, each other defendant pays only a percentage of the uncollectible amount equal to its degree of liability.

In addition, the law reduces awards by the amount a plaintiff receives from certain collateral sources; gives immunity to municipalities from damages in certain situations; mandates structured settlements for the portion of an award exceeding $200,000; establishes penalties for frivolous lawsuits and defenses; gives immunity from civil liability to unpaid directors, officers and trustees of nonprofit organizations; and limits the liability of liquor servers.

The Connecticut law also establishes a sliding scale for contingent fees. Under this scale, a contingent fee can not exceed 33.3% of the first $300,000 of an award, 25% of the next $300,000, 20% of the next $300,000, 15% of the next $300,000 and 10% of any amount exceeding $1.2 million.

The **Maine** Legislature put off comprehensive tort reform legislation until a special task force completes its study, but state legislators did approve measures to limit the liability of health care providers and liquor servers.

The medical malpractice law requires structured settlements for awards exceeding $250,000 and establishes a sliding scale for contingent fees. Under that scale, a contingent fee can not exceed 33⅓% of the first $100,000 of an award, 25% of the next $100,000 and 20% of amounts exceeding $200,000.

The malpractice law also limits the liability of health care providers in so-called wrongful birth suits, in which a suit is filed seeking damages for a failed sterilization procedure. Damages would not be allowed to cover the cost of raising a child that was born after a sterilization procedure failed.

Massachusetts enacted a medical malpractice reform measure, passed during a special legislative session, which creates a sliding scale for contingent fees and caps health care providers' liability at $500,000 for non-economic damages.

This $500,000 cap, though, would not apply to injuries in which there is a substantial or permanent loss or impairment of a bodily function or substantial disfigurement, which is not defined in the law.

While disappointed at the exceptions to the $500,000 cap on non-economic damages, Dr. Barbara Rockett, president of the Massachusetts Medical Society in Waltham, describes the medical malpractice reform law as an important first step.

Legislators recognized that it would be impossible to attract physicians to Massachusetts unless liability was limited, Dr. Rockett said.

The Massachusetts law also requires Blue Shield, Medicaid and workers compensation insurers to increase reimbursements to physicians to cover increases in medical malpractice insurance rates.

New Hampshire enacted comprehensive tort reforms that include capping liability for non-economic damages in personal injury suits, except those involving governmental entities, at $875,000. The liability of a governmental unit for all damages is limited to $150,000 per person and $500,000 per occurrence.

The New Hampshire's tort reform also reduces the statute of limitations to three years from six; makes a losing party responsible for the other side's attorneys' costs if a court finds that a suit or a

Continued on page 24

Tort reform

Continued from page 23

defense was frivolous; sets standards of care for liquor servers; and gives immunity from liability to directors and officers of charitable organizations for acts committed in good faith and without willful or wanton negligence.

The law also prohibits punitive damage awards, which codifies what had been the existing practice not to award punitive damages.

This sweeping legislation was achieved after dozens of business, governmental and professional groups—including school boards, general contractors, ski operators and hospitals—banded together under the auspices of the New Hampshire Coalition for Affordable and Available Insurance Protection to fight for reforms.

"A board-based coalition, without a doubt, was the major reason why the legislation was passed," said Brian Grip, public affairs manager with the Business & Industry Assn. of New Hampshire in Concord.

Rhode Island enacted a limited medical malpractice reform bill, while comprehensive tort reform was put on hold until a special 13-member commission, appointed by the Legislature, decides whether reforms are needed. The panel's report is due February, said Francis Holbrook, executive vp with the Rhode Island Chamber of Commerce Federation in Providence.

Rhode Island's medical malpractice reform allows a court to award attorneys' fees to the winning party if it finds that a suit or defense was frivolous.

The Rhode Island law also allows the introduction of evidence of a plaintiff's compensation for an injury from collateral sources and changes the time frame for awarding pre-judgment interest to the date a suit was filed, rather than the date of injury.

Tort reform legislation in **Vermont** that would have capped non-economic damages at $250,000 for all personal injury cases, among other provisions, died because legislators were confused by conflicting testimony from insurers and trial lawyers on whether the state has a liability insurance problem.

Business groups plan to begin a new effort next year to convince legislators to enact reforms like limits on pain and suffering awards and punitive damages, said Joseph Choquepete III, manager of research and communications with the Vermont State Chamber of Commerce in Montpelier.

Mid-Atlantic

Delaware failed to enact a series of broad tort reforms, including the elimination of joint and several liability, because of opposition from the state trial bar, said Ruth Mankin, vp with the Delaware State Chamber of Commerce in Wilmington.

However, the Legislature did approve a measure that shields directors and officers of companies incorporated in Delaware from liability in certain situations (*BI*, June 30).

This new law permits shareholders of Delaware corporations to approve provisions in certificates of incorporation that would limit or eliminate directors' liability for breaches of fiduciary duty. The new law, though does not limit directors' liability for acts or omissions not in good faith; for transactions in which directors derive an improper personal benefit; or for breaches of duty of loyalty to the corporation and shareholders.

A separate law exempts officers and directors of non-profit organizations from liability for official actions.

The newly formed **District of Columbia** Tort Reform Assn. will lobby next year for a comprehensive package that would modify joint and several liability; allow judges to reduce awards by collateral source income received by an accident victim; mandate structured settlements for awards exceeding $100,300; make it more difficult to collect punitive damages; and eliminate strict liability in actions involving professional and product liability.

If the City Council refuses to take up the reform package, the tort reform association may seek a referendum so voters could decide the issue said Lawrence Mirel, general counsel for the association and an attorney with the Washington law firm of Weissbrodt & Weissbrodt.

Jon Burrell, executive director of the **Maryland** Municipal League in Annapolis, describes the state's new $350,000 limit on non-economic damages in all personal injury cases as a "step in the right direction."

But other sought-after tort reforms, such as the elimination of punitive damages for governmental entities, failed to gain approval.

A package of tort reform bills in **New Jersey** will be considered when the Legislature reconvenes next month. Those measures would eliminate joint and several liability for non-economic damages and set sliding monetary caps on awards depending on the severity of an injury.

"A battle will go on in the fall. That is when things will heat up," said Don Scarry, a vp with the New Jersey Business & Industry Assn. in Trenton.

New York Gov. Mario Cuomo has signed sweeping legislation that modifies the application of joint and several liability in most personal injury cases so that only defendants who are at least 51% responsible for an accident would be jointly and severally liable. However, this provision would not apply in certain kinds of product liability and automobile lawsuits (*BI*, June 30).

New York's tort reform law also mandates structured settlements for future damages exceeding $250,000; allows the reduction of awards by the amount of certain collateral sources; provides for financial penalties—up to $10,000—for those who file frivolous lawsuits or engage in delaying tactics; and exempts unpaid directors and officers of non-profit corporations from liability except in cases of gross negligence or intentional harm.

A separate bill enacted by the legislature, covering only medical malpractice, reduces verdicts for loss of earnings by the amount of taxes the plaintiff would have paid had that amount been normal earnings. It also allows arbitration in cases in which the defendant physician concedes liability.

"This is a substantial tort reform," said Lawrence Justice, a partner with the Albany law firm of Rice & Justice, legislative counsel to the Business Council of New York.

"But there is much more to be done next year," such as limits on awards for non-economic damages, Mr. Justice added.

Proposals are pending in **Pennsylvania** to eliminate joint and several liability and place limits on contingent fees. Those proposals will be considered when the Legislature returns in September.

The **West Virginia** Legislature passed measures that modify the application of joint and several liability for both health care providers and public entities.

Under that modification, a health care provider or public entity can be held jointly and severally liable only if they are more than 25% responsible for an accident.

In addition, the measures limit non-economic damages for health care providers and public entities to $1 million and $500,000 respectively. Also, public entities no longer can be held liable for punitive damages.

The original version of the reform legislation led several malpractice insurers to withdraw from the state protesting restriction on policy non-renewals and rating controls. The legislation was amended to the insurers satisfaction.

Both governmental and medical officials say they wish the state had enacted more sweeping legislation, but they add the power of the trial bar prevented passage of additional reforms.

"The trial lawyers really are in command here," said Dee Crabtree, manager of government relations with the West Virginia State Medical Assn. in Charleston.

"The legislation was a good first step. . .about as much as could be obtained at the present time," added Gene Elkins, executive director of the West Virginia Assn. of Counties in Charleston.

Southeast

In **Alabama,** a variety of tort reform proposals that would have, among other things, capped non-economic damage awards at $250,000 and made it more difficult to collect punitive damages, died in the Legislature.

While the tort reforms contained in legislation passed this year in **Florida** are as extensive as in any state, insurers began blasting the proposal before it was even enacted and have filed suit to overturn certain provisions that would force them to roll back 1987 rates to 1984 levels (*BI*, June 16; July 7).

Insurers say the legislation infringes on their freedom to price coverage according to risk, and about a dozen insurers licensed in Florida say they will not write new commercial casualty business in Florida until the lawsuit is resolved.

The tort reform provisions of the Florida law are sweeping. The law sets a $450,000 cap on awards for non-economic damages and makes

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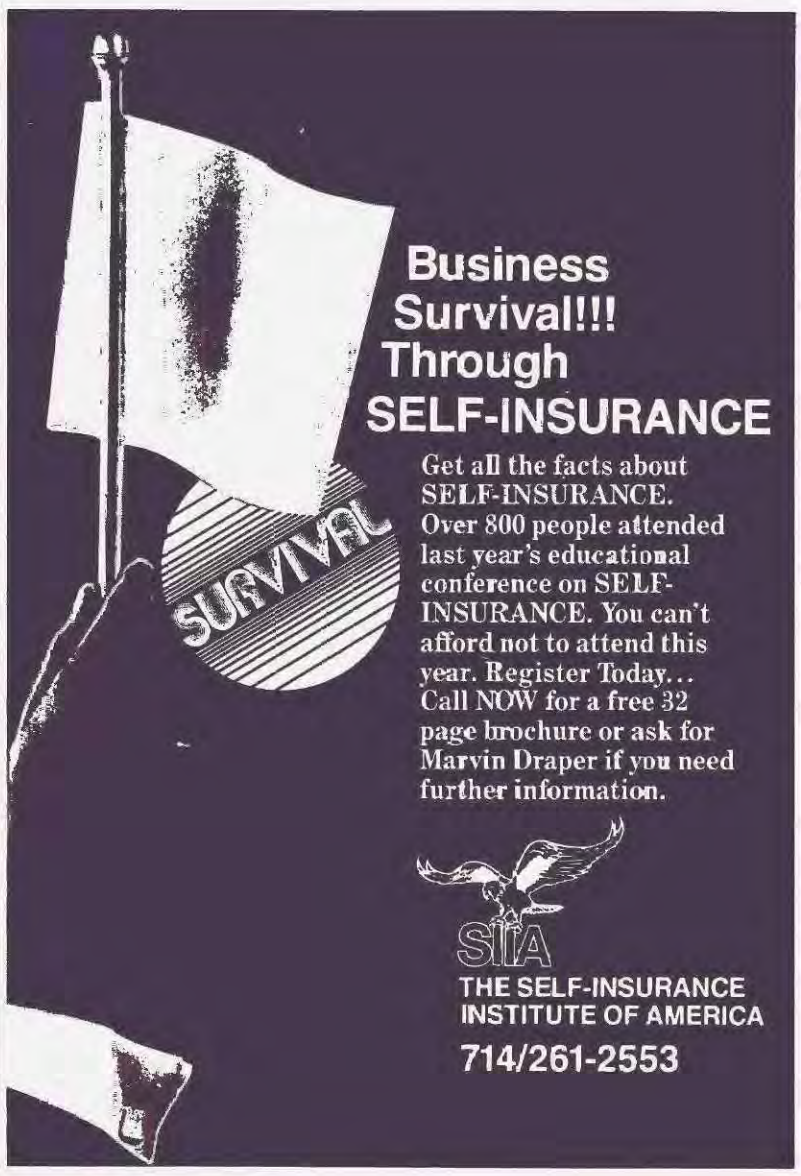

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changes in the application of joint and several liability.

In cases where a damage award exceeds $25,000, joint and several liability applies only to economic damages and only in cases where the fault of the defendant is equal to or greater than the fault of the plaintiff.

The provisions setting the $450,000 cap on non-economic damages and modifying joint and several liability will expire in 1990 unless the legislature extends them.

Florida's tort reform law also limits, in certain situations, punitive damage awards to no more than three times the amount of the compensatory damage award. Forty percent of a punitive damage award would go to the plaintiff and, in most situations, 60% of the award would be payable to the state's Public Medical Assistance Trust Fund.

Other provisions would reduce awards by collateral source income, require the losing party to pay the other side's attorneys' fees if a suit or a defense is deemed to be frivolous and, at the request of either party, require structured settlements for economic losses exceeding $250,000.

Comprehensive tort reform legislation in **Georgia** failed to make any headway, but legislators did approve a limited measure that gives courts the authority to order the losing party to pay the prevailing side's attorneys' fees if a suit or defense is found to be frivolous.

Legislators also approved a measure making clear that municipalities that purchase liability insurance do not, in most situations, give up sovereign immunity.

A **Kentucky** legislative commission will study tort reform and insurance issues, but no action is expected next year since the Legislature is not scheduled to meet until 1988, according to James Wiseman, executive vp with the Kentucky Chamber of Commerce in Frankfort.

The **Louisiana** Citizens for Legal Common Sense, under the auspices of the Louisiana Assn. of Business & Industry, pursued an ambitious proposal of more than a dozen tort reform bills, but with little success.

The defeated bills sought comprehensive product liability reforms; caps on both economic and non-economic damages; elimination of joint and several liability; repeal of the collateral source rule and the mandated reduction of judgments by the amount received by plaintiffs from outside sources; and caps on contingent fees.

The bills that were passed did not contain sweeping reforms and only affect particular interests: They limited the liability of liquor servers, owners of recreational land space and hazardous waste and asbestos removal firms.

The coalition will begin work again when the Legislature reconvenes in April, says Stewart E. Niles Jr., chairman of the group and a partner in the law firm Jones, Walker, Waechter, Poitevent, Carrere & Denegre in New Orleans.

In **Mississippi**, comprehensive tort reform bills that would have limited a defendant's liability for non-economic damages to $150,000 or three times actual damages, whichever was less, failed to clear legislative committees.

"Under the present system, the cards are stacked against us," said Hugh Ketchum, president of the Mississippi Manufacturers Assn. in Jackson.

"I'd say at the present time, the outlook for tort reform is bleak," Mr. Ketchum added, noting that judiciary committees, which have jurisdiction over tort reform legislation, are dominated by plaintiffs' attorney.

The Mississippi legislature did approve a measure that renews expiring sovereign immunity statutes for governmental entities.

In **North Carolina,** a $300,000 cap on non-economic damages failed to win approval after much bickering in the Legislature.

The only significant tort reform legislation to pass in North Carolina gives courts the authority to slap losing parties with the other side's attorneys' costs if a judge rules that a suit or defense was frivolous.

Public entities in **South Carolina** scored a limited victory with the passage of a measure that caps governmental liability in personal injury suits at $250,000 per person and $500,000 per occurrence.

The caps "seem a bit high, a little too rich for us," said Bob Lyon, general counsel for the Municipal Assn. of South Carolina in Columbia, which had favored capping liability for public entities at $100,000 per person and $300,000

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Tort reform

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per occurrence.

Other comprehensive tort reform measures in South Carolina that would have shortened the statute of limitations to three years from six years, eliminated joint and several liability, placed a $250,000 cap on non-economic damages and made it more difficult to collect punitive damages died in legislative committees.

Next year, though, lobbyists say reforms could be passed as more businesses band together to fight for reform under the banner of the newly formed South Carolina Civil Justice Coalition.

"Hopefully, the time is ripe for change," said T. Eugene Allen, president of the South Carolina Defense Trial Attorneys Assn. in Columbia.

Tennessee legislators approved measures that limit the liability of liquor servers. They also give immunity from liability—except for willful, wanton or gross negligence—to directors and officers of non-profit organizations and to all members of boards, commissions, agencies and other governmental bodies.

The only tort reform measure enacted this year in **Virginia** makes clear that the liability of a proposed transportation district to provide passenger rail service in northern Virginia will not exceed the greater of $25,000 or the limits of its insurance coverage.

Great Lakes

Illinois business lobbyists say a tort reform bill passed by the Legislature in late June is inadequate and are urging Gov. James Thompson to veto the measure (*BI*, July 7).

Gov. Thompson has until late next month to sign or veto the tort reform legislation.

"This isn't tort reform, it is tort deform," complains William Dart, vp-government affairs in the Springfield office of the Illinois Manufacturers Assn.

Mr. Dart says there are loopholes "that you could drive a truck through." For example, only defendants less than 25% at fault are exempt from joint and several liability for non-medical damages.

Defendants remain jointly and severally liable for plaintiffs' medical expenses, and joint and several liability would be retained in medical malpractice and environmental liability suits.

However, the Illinois legislation allows in certain situations for awards to be reduced by collateral source income, and it revises a comparative negligence standard so that a plaintiff cannot recover if he or she is more than 50% responsible for the accident.

Other provisions give courts the authority to impose financial penalties on those who file frivolous suits or motions, limit punitive damages to actions where defendants are guilty of willful and wanton conduct and require a separate hearing for punitive damages.

In addition, punitive damages against public officials acting in an official capacity would be barred and public entities would be immune from liability for damages in such cases as failing to detect or solve crimes, provide rescue or emergency services or improve streets and traffic controls to meet changing standards.

The Illinois legislation also makes clear that a public entity that purchases liability insurance does not waive any of its sovereign immunity.

But, the legislation does not contain reforms sought by business groups, like a cap on non-economic damages.

Business lobbyists, like the IMA's Mr. Dart, say they will go back to Springfield next year to seek true civil justice reform.

The newly formed **Indiana** Forum for Civil Justice, a broad coalition of business and professional groups, will spearhead the drive for comprehensive tort reform next year.

However, Indiana enacted a limited set of reforms that allow juries to be informed of plaintiffs' collateral source income, give liquor servers more protection from liability suits, generally exempt directors and officers of non-profit organization from liability and allow courts to slap penalties on parties that file frivolous lawsuits or motions.

Michigan public entities are cheering the enactment of tort reform legislation that modifies the application of joint and several liability for public entities.

Under the legislation, a public entity only is responsible for its proportionate share of economic and non-economic damages. If a court decides the amount owed by one or more of the defendants is not collectible, a public entity would pay only only a percentage of the uncollectible amount equal to its degree of liability.

For example, if a public entity defendant were 20% liable and another defendant who is 80% liable is insolvent, then the public entity would have to pay only 20% of the 80% of the award that is unpaid, in addition to its own share.

"This is a very important provision for cities and schools," noted Robert Kish, risk manager for the Michigan Municipal League in Ann Arbor.

For other defendants, the modification of joint and several liability applies only when the plaintiff's negligence is found to have contributed to the accident.

Michigan's tort reform package also places a $225,000 cap on non-economic damages in medical malpractice cases only. This cap, though, would not apply in cases where the victim died, a limb or organ was wrongfully removed, a foreign object was left in a victim or there was injury to the reproductive system.

"This does not give doctors a whole heck of a lot," said Mr. Kish.

The Michigan reform law also gives courts authority to reduce awards by collateral source income, mandates structured settlements for future economic losses that exceed $250,000, imposes penalties on those filing frivolous suits or making a frivolous defense and makes it more difficult to sue liquor servers.

More than a dozen tort reform proposals are pending in both houses of the **Ohio** legislature. Those measures would eliminate joint and several liability for all damages, allow structured settlements for large awards and allow evidence of plaintiffs' collateral source income to be introduced at a trial.

But new compromise legislation is expected to be introduced later this month. "We are a long way from coming up with a final bill," said Mark Davidson, staff director of the Ohio branch of the National Federation of Independent Business in Columbus.

Wisconsin legislators approved during a special session earlier this year a measure that caps liability for non-economic losses in medical malpractice suits at $1 million.

In addition, the new law limits contingent fees in malpractice cases to a maximum of 33.3% of the first $1 million of an award (25% if defendants admit to liability within six months after the case is filed) and 20% of any portion of an award exceeding $1 million.

The medical malpractice reforms were achieved because of a recognition among legislators that the high cost of medical malpractice insurance was curbing the availability of medical services, said

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Ruth Anne Riese, communications coordinator with the State Medical Society of Wisconsin in Madison.

While Wisconsin tort reform efforts were limited this year to medical malpractice, business lobbyists say comprehensive tort reform will be a major issue next year.

"There is a tremendous growth of awareness on the part of legislators and professional groups on the need for reform," said Eric Englund, a member of the Wisconsin Coalition for Civil Justice in Madison.

"There is no question that tort reform will be one of the premier, if not the premier, issues the legislature will be dealing with during the 1987-88 session," he said.

Midwest

Iowa has enacted tort reform legislation that limits punitive damages to cases in which the defendant shows willful and wanton disregard for the rights and safety of others.

The law also gives retailers, wholesalers and distributors immunity from strict liability in product liability cases and gives manufacturers the state-of-the-art defense in product liability cases.

Furthermore, a judge can stay proceedings until a plaintiff posts sufficient security to cover a defendant's anticipated legal costs if the plaintiff has initiated three unsuccessful suits in the past five years that the judge deems frivolous.

In addition, plaintiffs must now prove actual malice instead of negligence in certain claims against Iowa municipalities and their employees and officials.

The law also requires plaintiffs to prove willful, wanton and reckless misconduct before punitive damages can be awarded in personal liability cases against all municipal employees; that standard formerly only was applied to law enforcement and emergency personnel.

The Iowa law also permits periodic payments in any civil case.

The Iowa reforms are a step in the right direction, says Jack Soener, vp with the Iowa Assn. of Business & Industry in Des Moines, which may propose additional reforms next year.

Kansas has enacted reforms in three areas: medical malpractice, product liability and frivolous litigation.

In medical malpractice cases, Kansas plaintiffs are now limited to $250,000 in non-economic damages and to a total of $1 million in both non-economic and compensatory damages.

However, if plaintiffs can later show the court that the amount awarded for future medical expenses was insufficient, they can receive supplemental money from a state fund financed by health care providers. However, including the supplemental compensation, the total award cannot exceed $3 million.

Kansas also now permits awards for future economic losses in medical malpractice cases to be funded through structured settlements.

In product liability cases, Kansas plaintiffs can no longer submit evidence that a product was changed or improved after the article was sold.

The Kansas Citizens Committee on Legal Liability, whose 21 members were appointed by the state's insurance commissioner last April, is meeting monthly to discuss tort and insurance liability issues, and plans to issue a report to a legislative committee by Oct. 1. That committee, formed in response to lobbying by the Kansas Coalition for Tort Reform, is expected to propose further reforms, says Richard Harmon, a Topeka attorney representing the Kansas Assn. of Property & Casualty Insurance Companies, a coalition member.

Minnesota enacted several reforms this session, but observers label them as cosmetic.

For example, the state now caps at $400,000 all damages for intangible losses, but it defines these losses as embarrassment, emotional distress and loss of consortium. The law excludes damages for pain and suffering, disability or disfigurement from the cap.

In addition, joint and several liability was modified for Minnesota public entities.

If a public entity is judged to be less than 35% responsible for an accident, it can be held responsible for a proportion of all unpaid awards equal to no more than twice its percentage of fault.

Public entities are no longer responsible for paying punitive damages levied against their officials or employees, and are no longer held liable for recreational areas they own or lease.

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Tort reform

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Unpaid directors or trustees of non-profit organizations now cannot be held personally liable for damages incurred in the course of board activities.

Courts now must reduce damage awards by collateral source income, but only if the defendant so requests within 10 days of the verdict and only on those funds received before the court action. The size of the award after this income is subtracted would be the basis for determining attorneys' contingent fees.

Finally, punitive damages can no longer be initially sought in any suit filed in Minnesota. Plaintiffs must amend their complaints and submit affidavits to the court showing factual evidence for a punitive damage claim.

Missouri enacted a $350 000 cap on non-economic damage awards in medical malpractice cases, to be revised annually to match the change in the Consumer Price Index.

The state also modified joint and several liability in medical malpractice cases so that a defendant is only jointly and severally liable for any damages not paid by defendants with an equal or lesser degree of fault. And, Missouri now permits defendants in medical malpractice cases to use structured settlements to pay awards exceeding $100,000.

Missourians for Civil Justice Reform now is lobbying a blue-ribbon tort reform commission to support most of what was defeated in S.B. 742 last session.

That bill, which failed to clear a state Senate insurance committee, called for the repeal of joint and several liability; the automatic reduction of damages by collateral source income; limiting punitive damages to the amount of compensatory damages; limiting contingent fees; and establishing a state-of-the-art defense in product liability suits.

Members of **Nebraska's** young tort reform movement suffered defeat on the final day of the legislative session in their push for a bill that would have restricted the amount recoverable in professional liability actions to $1 million per person per incident.

Various business groups, including the Nebraska Assn of Commerce & Industry, recently gathered under the Project Justice Inc. banner to study the state's tort and insurance climate. Proposals likely will be drafted by Lincoln attorney David R. Parker, who was retained to spearhead the study.

Supporters of civil justice reform in **North Dakota** are drafting reforms to be proposed during next year's legislative session.

Legislation enacted in **South Dakota** caps both economic and non-economic medical malpractice awards at a total of $1 million. Previously, only non-economic awards were capped at $500,000.

Also, the state now permits periodic payments of all judgments of $100,000 or more.

Another South Dakota law requires plaintiffs seeking punitive damages to show clear and convincing evidence of willful, wanton or malicious conduct.

Southwest

Arizona Gov. Bruce Babbitt vetoed a four-bill tort reform package that, among other things, would have repealed joint and several liability for defendants found liable for less than 50% of a personal injury.

The package also would have enacted a sliding scale for attorneys' contingent fees, mandated the periodic payment of some awards and enabled juries to consider collateral sources of income. The latter is now possible only in medical malpractice cases in Arizona.

Citizens for Fair & Sensible Liability Laws now is pursuing an amendment to the Arizona constitution that would pave the way toward tort reform. Arizona is one of a handful of states whose constitutions prohibit statutes that would restrict a plaintiff's right to recovery in personal injury or death suits.

To avoid legal disputes, the group is seeking an amendment that would retain the essence of that constitutional protection for economic damages, but would permit statutes capping awards for non-economic damages, regulating contingent fees and allowing the periodic payments of certain awards.

The coalition secured more than 200,000 signatures to put the initiative on the state's November ballot, more than any other ballot proposal in the state's history, says Andra Schreier, chairwoman of the coalition.

If voters approve Proposition 103, the coalition will begin developing legislation on those three issues for the next session, explains Robert Robb, vp at Nelson/Padberg Communications in Phoenix, which is managing the campaign.

A lawsuit was filed last month to prevent the initiative from appearing on the ballot. The suit, filed against the Arizona secretary of state by two individuals, charges that the initiative raises too many issues for one constitutional amendment.

Little lobbying activity for tort reform has been reported in **Arkansas.**

New Mexico enacted a law that caps the liability of liquor servers to $50,000 per person and $100,000 per incident for death or injury claims and $20,000 per incident for property damage claims.

Oklahoma enacted a law that limits punitive damages to the amount of actual damages awarded unless the court finds—prior to consideration by a jury—"clear and convincing" evidence of fraud, malice, oppression or wanton or reckless disregard for the rights of others.

That exception is a victory for tort reform advocates, who fought trial attorneys who sought an exception only in cases of a "preponderance" of such evidence, reports Mike Sulzycki, associate director of the Oklahoma State Medical Assn. in Oklahoma City. The association is a member of Oklahomans Against Lawsuit Abuse, the 8-month-old coalition behind the state's "Return to Reason" tort reform campaign.

The law also permits prevailing parties to recover up to $10,000 in legal costs if the court finds that claims or defenses were asserted in bad faith, were unwarranted by law or were not grounded in fact.

The coalition will regroup this fall to decide whether to seek additional tort reforms. Until then, it is awaiting the recommendations of an 18-member committee established by the new law.

When the **Texas** Legislature reconvenes in January, tort reform proponents are expected to introduce "the whole laundry list" of reform proposals, says George Christian, secretary/treasurer of the Texas Civil Justice League in Austin, a group of 100 businesses and associations.

The basis for the bills will likely be a report due this fall by an interim legislative committee.

The Texas Legislature is now in a 30-day special session, but tort reform is not on the agenda.

Mountain/Desert States

Colorado enacted about 20 bills addressing tort or commercial insurance issues this year.

One of the bills establishes pro rata liability in the state, so that a defendant is not liable for a larger share of any award than his or her percentage of responsibility.

Non-economic damages were capped at $250,000 unless a court finds "clear and convincing" evidence to award up to $500,000.

In addition, punitive damages were capped at the amount of actual damages, but the court can award exemplary damages equal to three times actual damages if the defendant continues willful and wanton behavior during the trial. Two-thirds of an exemplary damage award will be given to the plaintiff; one-third is earmarked for the state's general fund.

Colorado also amended the collateral source rule. Awards are now automatically reduced by the amount of other income received in relation to an accident, unless that money comes from a contract—including an insurance policy—entered into and paid for by the plaintiff.

Colorado now applies one-, two- or three-year statutes of limitations to most civil actions, reducing the statute of limitations in most strict product liability cases to two years from three years.

To discourage frivolous negligence lawsuits against architects, engineers and land surveyors, Colorado now requires plaintiffs' attorneys to certify they have consulted at least one such professional who found grounds for the claim or contact at least five professionals, even if they do not agree the claim has merit.

Colorado enacted several municipal liability reforms, and established that directors of non-profit corporations cannot be liable for actions or omissions made in the course of carrying out their duties.

The Legislature also enacted a "good samaritan" law, which gives immunity to people acting in good faith when volunteering assistance or service without compensation.

Five tort reform bills failed in **Idaho** last year, although three did win House approval in an amended form.

The Idaho Liability Reform Coalition expects to use four of the bills as a framework for legislation it will introduce in January, says Jim Fields, vp and general counsel of the Idaho Assn. of Commerce & Industry in Boise.

The four bills sought to cap non-economic damages at $250,000; repeal joint and several liability and the collateral source rule; and permit periodic payment of awards greater than $100,000.

The fifth reform—capping attorneys' contingent fees—will not be sought next session, he says. Proponents of fee limitations "just got crucified" last session by those who claimed a fee schedule would be akin to restraint of trade, Mr. Fields says.

The **Montana** Liability Coalition, a federation of some 60 associations, businesses and insurers, expects to propose major tort reforms in January, says F.H. "Buck" Bowles, president of the state's Chamber of Commerce in Helena and a member of the coalition.

But the coalition first must secure an amendment to the state's constitution. The Montana constitution, like Arizona's, prohibits any restriction of a plaintiff's ability to recover damages for injuries sustained in tort actions. It is pursuing the amendment via an initiative on the November ballot.

If the initiative passes, it would pave the way for various tort reforms in Montana, where the Legislature was out of session this year.

In a special session, however, the Legislature limited the liability of public entities to $750,000 per claim and $1.5 million per incident.

Proponents of civil justice reform in **Nevada** are planning to push for legislation next year.

Three pieces of tort reform were enacted in **Utah** this year. One capped non-economic damages in medical malpractice cases at $250,000, one abolished joint and several liability for all damages and a third restricted the liability of liquor servers.

However, other comprehensive reforms—such as caps on punitive and non-economic damages in all cases—were defeated in the Legislature.

Civil justice reform advocates in **Wyoming**—spearheaded by Citizens on Uniform Responsible Torts—racked up an impressive roster of accomplishments last session.

These bills repeal joint and several liability for all damages; cap municipal liability at $250,000 per claim and $500,000 for all claims related to the same incident; limit the personal liability of directors of non-profit or municipal organizations; provide sanctions against the filing of ungrounded pleadings; permit judges to dismiss defendants who certify they were not involved in the alleged incident; remove municipalities from liability related to bridges, highways and other areas; apply a stricter "locality rule" burden of proof in medical malpractice cases, which would make it harder for plaintiffs to hold a rural defendant to medical standards used in more populated metropolitan areas; and limit the liability of liquor servers.

Far West

Alaska enacted major tort reform legislation in June.

The law caps non-economic damage awards at $500,000, except in cases of "disfigurement and severe physical impairment," and restricts punitive damages to cases with "clear and convincing evidence."

The new Alaska law also modifies joint and several liability so that any party responsible for less than 50% of the total fault cannot be held liable for any damages equal to more than twice its percentage of fault.

It also permits courts to order periodic payment of some future damages; prohibits recovery of damages from certain public officials, school board members and officers or directors of non-profit corporations and hospitals unless "gross negligence" is involved; reduces compensatory awards by the plaintiff's percentage of fault; and permits courts to reduce awards by the amount of collateral source income, less the amount of any attorneys fees not covered by the award and less the amount of plaintiffs' insurance premiums.

Al Tamagni Sr., chairman of the

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Comp settlement

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Teledyne Group; Travelers Corp.; Wausau Insurance Cos.; and Zenith Insurance Co.

Paying $10,000 each to the legal fees are: Cal Casualty; CNA Insurance Cos.; Continental Insurance Cos.; Employee Benefits Insurance Co.; Farmers Insurance Group; Kemper Group; Royal Insurance Group; and Western Employers Insurance Co.

The other parties that have so far agreed to the settlement—insurers, self-insurers, and TPAs—have collectively committed to contributing an additional $135,000 for attorneys' fees.

Among the other insurers, about 70, are: Allstate Insurance Co.; Beaver Insurance Co.; Central Mutual Insurance Co.; Chubb Group; Insurance Co. of the West; Ohio Casualty Group; The Atlantic Cos.; and Commercial Union Insurance Co.

Among the insurance groups that have so far declined to participate, the largest is SAFECO Insurance Cos. in Seattle, Mr. Holbrook pointed out.

Among the approximately 70 self-insurers committed so far are: Burbank Studios; Calgon Corp.; Chrysler Corp.; Coca-Cola Bottling Co. of Los Angeles; Denny's Inc.; Dresser Industries; Gillette Co.; Hilton Hotels Corp.; Kimberly-Clark Corp.; Marriott Corp.; Western Union Telegraph Co.; and the cities of Los Angeles and Carson, according to a list provided by one of the attorneys negotiating the settlement.

'If we made a mistake, we'll cover it. That's our business ethic,' says California Casualty's Mr. Sevey.

Others employers are expected to join as the settlement progresses.

Among the 24 "de minimus" participants, those with less than 50 litigated WCAB cases during the period at issue, are: Allied Mutual Insurance Co.; All West Insurance Co.; John Deere Insurance Co.; Luxfer USA Ltd.; and Witco Corp. These companies will each pay $700 toward settling claims against them and $250 toward attorneys' fees.

The only de minimus respondent who declined to take part is Peerless Insurance Co., a Keene, N.H., insurer that is approved to write workers compensation insurance in California but which has not yet done so. Plaintiffs named the company because it was an admitted insurer.

Plaintiffs could decide to pursue litigation against the self-insurers and insurers that do not participate in the settlement process, Mr. Sevey says. ■

Lloyd's Central Fund

Continued from page 2

from Lloyd's last year and fined 1 million pounds ($1.5 million) for his role in the misappropriation. Other former PCW officials have also been disciplined by Lloyd's, but Mr. Cameron-Webb was never formally charged with wrongdoing by Lloyd's because he had resigned as a Lloyd's member.

In its 300-page report, the Davis committee also commented on:

- Lloyd's role in the handling of the PCW affair.

Lloyd's suspended underwriting at the syndicates late in 1982, after allegations surfaced that PCW executives misappropriated syndicate funds.

Lloyd's allowed underwriting to resume on the PCW syndicates under RBUA's management in 1983 until Minet, the parent of RBUA and PCW, decided to cease underwriting and close RBUA in 1985.

Only then did Lloyd's appoint an independent underwriting agency, AUA, to manage the syndicates.

"Rather than being allowed to continue underwriting, the interests of the agency's names might have been better serviced by the immediate establishment of an additional underwriting agency," said the Davis committee.

- The role of two former PCW syndicate auditors—the British affiliates of Arthur Andersen & Co. and Arthur Young & Co.

The auditors should have done more to make sure that RBUA management was fully aware of the syndicates' problems and should have provided more information to RBUA's management so that it would be alerted to the syndicates' financial situation, the report says.

"However, some of the responsibility for the disappointing performance of the auditors as advisers rests on management for not seeking their advice," according to the report issued by the Davis committee.

An Andersen spokesman said the committee report was "seriously flawed."

Carl Liggio, Arthur Young's general counsel, said: "We are satisfied that the (auditing) work done was appropriate under the circumstances and with the information made available." ■

D&O coverage

Continued from page 1

an attorney for two of the directors who is with the Honolulu firm of Chuck, Jones, MacLaren & Chung.

Mr. Chuck declined to reveal the amount of the settlement, citing a provision in the settlement agreement that the terms not be revealed.

Each of the directors and officers in the litigation had hired defense counsel and sought payments from MGIC, which the insurer agreed to pay as they came due, according to court papers.

MGIC reserved its right to contest coverage and to demand reimbursement if the D&O policy did not cover the claims involved.

The eight directors received payments by MGIC for nearly two years totaling more than $1 million.

MGIC then stopped paying the defense costs of three directors, and they sued the insurer, seeking a ruling that MGIC had a duty to pay their defense costs as they were incurred.

The District Court granted the plaintiffs' motion for summary judgment.

In addition, the court found that the underlying lawsuits alleged separate acts, each of which was a potential "loss" under the policy, possibly triggering "multiple millions" in reimbursement to the policyholders.

The court also found that MGIC had acted in bad faith in refusing to affirm or deny coverage, to tender defense costs when due and to enter settlement negotiations on behalf of the three directors.

MGIC then appealed.

In its decision, the appellate court not only upheld the District Court ruling that MGIC owed the directors defense costs as they were incurred, but also went beyond the lower court in finding MGIC had an implied duty to defend.

The appeals court found the directors were entitled to coverage for defense costs as incurred because the applicable clause in the policy was ambiguous as to what claims it was intended to cover.

"When an insurance policy is ambiguous, it is read in favor of the the insured as a contract of adhesion," the court commented.

In finding an implied duty to defend, the appeals court, citing Hawaii law, found that where there is not a specific exclusion, an insurer has a duty to defend.

Because the applicable clause in the policy "does not unambiguously state that MGIC does not have a duty to pay defense costs for potentially covered claims, MGIC must pay the defense costs as they come due," the court said.

In finding certain clauses of the policy ambiguous, the court also ruled that MGIC would have to pay defense costs even for claims that eventually are determined not to be covered by the policy.

"The resulting ambiguity—whether the policy requires payment of defense costs for claims that are determined not to be covered by the policy—must be read against MGIC," the majority opinion said.

MGIC had argued that it was not obligated to pay defense costs until liability was established.

On the issue of how many "losses" there were, the appeals court also upheld the portion of the District Court decision that said there was more than one potentially covered "loss" and that MGIC could have to pay its $1 million limits more than once.

Also, the parties contemplated more than one loss because the directors chose a $1 million "per loss" policy rather than one with a $1 million aggregate limit.

"Thus, the district court finding was. . .correct," the appellate court said.

Finally, the court of appeals reversed the district court's grant of summary judgment on the issue of MGIC's bad faith because disputed material facts remained.

"None of the grounds on which the district court based its findings of bad faith—refusal to pay defense costs without reserving its rights, refusal to affirm or deny coverage, and failure to enter settlement negotiations—could have been resolved on summary judgment," the court said.

The court noted that it also is unclear whether Hawaii would recognize a duty of good faith and fair dealing for insurance contracts, or bad faith for a breach of such a duty.

In a vigorous dissent, Judge Hall disputed the court's view that a duty to defend was implied in the policy.

"The policy provides MGIC the option to advance litigation expenses as they come due, and the right to associate itself with the defense. The parties knew about these provisions when they signed the policy," Judge Hall said.

"Yet the majority takes statements regarding the scope of the insurer's duty to defend under Hawaii law out of context to conclude that Hawaii implies a duty to defend in all insurance contracts unless expressly negated, and ignores the plain, unambiguous language of the policy," she said.

"If the policy does not impose a duty to defend upon the insurer, then there is no duty to defend under Hawaii law," she added

"The majority's conclusion that Hawaii implies a duty to defend in all insurance policies unless expressly negated is the worst form of judicial activism by a federal court," she said.

Commenting on the opinion, the directors' attorney Ronald J. Verga, with the firm of John S. Edmunds in Honolulu, said: "I'm pleased it reinforces the insured's belief that when it pays premium for directors and officers coverage that it gets that coverage, including the defense of claims against them.

"They will not have to play Russian roulette where the outcome of the litigation will have to be determined before there can be a determination of whether there is coverage for defense costs," he said.

Mr. Verga said the alternative would prevent policyholders from putting up a strong defense in such cases if costs were not paid as they were incurred.

He added, however, that he was "a little unhappy" about the appellate court's reversal of the District Court's finding of bad faith on MGIC's part.

Wallace Christensen, representing MGIC, said: "We're of course greatly disappointed with the 9th Circuit decision. We think it contains a clearly unsupported interpretation of Hawaii law.

"We think the court in holding that Hawaii law implies a duty to defend substantially misconstrues Hawaii law and went far beyond that law."

However, Mr. Christensen, with the Washington, D.C., firm of Ross, Dixon & Masback, added, "We were pleased the court of appeals shared our view that there was no evidence to suggest MGIC acted in bad faith."

John Morrison, an attorney for insurers with the Chicago firm of Karon Morrison & Savikas, characterized the decision as "awful. I've never seen a case like it."

"It will be often cited but I doubt that it will be precedent that will be followed," he said. ■

Nuclear liability

Continued from page 2

The delay in the consideration of the risk retention legislation, H.R. 5225, until at least September could hurt the bill's chances of gaining House approval because only about four weeks will remain in the session, its supporters say.

The Senate already has approved its version of the risk Retention legislation, S. 2129.

The full House and Senate also may not complete action on the nuclear liability bills before the session expires.

However, the Price-Anderson Act, the federal law that establishes a formula for calculating the liability of the nuclear power industry, isn't due to expire until August 1987.

Judging by the current committee-approved bills, the nuclear industry eventually will face a much higher maximum liability limit.

"It is a fair statement. . .that the limit will be raised," said Tim Peckinpaugh, an associate in the Washington office of Preston, Thorgrimson, Ellis & Holman, which represents the American Nuclear Insurers pool. The pool provides liability insurance coverage to the nuclear power industry.

The Price-Anderson Act, which was enacted in 1957, sets up a two-step formula that places a cap on utilities' liability for nuclear accidents.

First, utilities are liable for an amount equal to the maximum nuclear liability insurance limits available. That liability limit now is $160 million.

In addition, the entire nuclear power industry can be assessed up to $5 million per reactor to pay any claims stemming from an accident.

With the $160 million in primary coverage and 101 reactors now operating, the nuclear power industry's liability is now capped at $665 million.

A measure, approved by the Senate Environmental and Public Works Committee last week, would boost the liability cap to just more than $7 billion by raising the assessment per reactor for an accident to $60 million from the current $5 million.

The committee assumes that there soon will be 115 reactors operating and that $160 million in coverage will continue to be available from nuclear insurers.

In April, the Senate Energy and Natural Resources Committee, also assuming the availability of $160 million of coverage and 115 operating reactors, voted to raise the assessment per reactor to $20 million, for a total industry liability of about $2.46 billion.

In addition, the House Energy and Commerce Committee last week approved legislation that would raise the assessment per reactor to $63 million.

That committee assumes the operation of 101 reactors and the availability of $160 million in coverage.

That would raise the nuclear power industry's total liability to about $6.5 billion.

However, a measure approved by the House Interior and Insular Affairs Committee would mandate that 101 power plants buy $200 million of coverage and would set the assessment per unit at $63 million for a total industry liability exposure of $6.56 billion.

Mr. Peckinpaugh, the attorney for ANI, criticizes legislation that requires utilities buy $200 million in coverage.

"You cannot just mandate capacity. We strongly support the current law," Mr. Peckinpaugh says.

The Edison Electric Institute, a utility industry association in Washington, worries that if the liability cap is set as high as $6.5 billion, utilities could have difficulty arranging financing. ■

Proposition 51

Continued from page 31

about joint and several liability and fight the campaign over that without having to get into what does retroactivity mean. So we just left it out," he adds.

Mr. Hiestand says ACTR will ask permission to file briefs in all the pending cases, arguing that Proposition 51 is merely a remedial or procedural change in the law and does not affect a substantive right of parties to third-party litigation.

"What you did with (Proposition) 51 was amend a remedy. Make a procedural change. That's what joint and several liability involves—not a substantive right," Mr. Hiestand says.

Under this reasoning, the issue of retroactivity is not relevant because the changes wrought by Proposition 51 affect only the allocation of damages, which have yet to be determined in cases that are pending before a court, Mr. Hiestand explains.

If the appeals courts were to disagree and find that Proposition 51 does constitute a substantive change in the law, "We would argue that the public interest in this obviates any constitutional concerns that may apply to retroactive legislation," he adds.

Attorneys for the plaintiffs' bar say they will argue that a statute cannot be retroactively applied unless the statute specifically states that it is to be retroactive.

"Historically in California, and in every jurisdiction that's based on British law, statutory enactments or initiatives are not applied retroactively unless it very clearly says they are to be, and even then the courts inspect them very carefully to be sure they're constitutional," argues Harry F. Wartnick, a plaintiffs' attorney with Cartwright, Sucherman & Slobodin in San Francisco.

Mr. Wartnick argues that it is "just basic fairness" not to change the rules governing acts that occurred before enactment of a statute or initiative.

Further, Mr. Wartnick maintains that to apply Proposition 51 retroactively would give a huge windfall to insurance companies.

"It would be giving a tremendous windfall profit to the insurance companies, which sold policies actuarially based on joint and several liability, because their indemnity payments would be based on only several liability," he says.

It is not yet known if the state Supreme Court will take up the issue before the lower appellate courts have a chance to rule, but both plaintiff and defense attorneys agree that the issue eventually will end up in the state's highest court.

"Neither party is going to be satisfied with a Court of Appeals ruling. At least for our firm, were we not to prevail in the Court of Appeals we would appeal it, and I'm sure that the defense bar, if they didn't prevail in the Court of Appeals, would also take it to the Supreme Court," Mr. Brayton says. ■

Comp settlement

Continued from page 2

et al, which was brought before the WCAB in 1981 by medical and legal service providers that claimed self-insurers, insurers and TPAs were not complying with a California regulation requiring timely payment of bills incurred during work comp hearings (*BI*, Feb. 4, 1985; April 1, 1985).

The plaintiffs charged they have not been paid for services in accordance with Labor Code 4601.5, which stipulates that bills be paid or objected to within 60 days of receipt. The bills were submitted by forensic physicians, photocopy businesses, interpreters and others whose services are used in hearings held to determine the degree of an employee's job-related disability.

Plaintiffs seek payment, plus penalty and interest provisions, for all bills outstanding or not paid promptly from July 1976, when the regulation took effect, to the present. The regulation requires employers to pay a penalty of 10% plus 7% annual interest on any medical or legal service bills that are not resolved in 60 days unless an objection has been filed.

The settlement, which would certify the proceeding as a class action, calls for a claims pool of $3.5 million, from which the delayed or unpaid claims would be paid, and a separate $750,000 fund that would compensate attorneys working on the settlement.

Advertisements are expected to be placed in medical and other industry journals soon, notifying potential claimants to submit outstanding claims within a certain time, perhaps 90 days. Plaintiffs' attorneys would pick up the tab for these notices, up to $50,000; if the cost goes higher, more negotiations on payment would be held.

To keep the anticipated claims within the $3.5 million cap, all claims will be immediately discounted to 60% of their face value; they could be discounted further to keep them within the cap.

No defendant would subsidize claims against other respondents, according to the plan. And, none would be required to pay more than 8% of the $3.5 million, a provision designed to protect defendants in metropolitan areas where the largest volume of claims are expected.

While each self-insurer is legally responsible for its own liabilities, several have asked the TPAs that administered claims for them during this period to pay all or part of the claims submitted against them, explains Bill Holbrook, an associate at Thelen, Marrin, Johnson & Bridges in Los Angeles, the law firm spearheading the settlement.

Such agreements are entirely between the self-insurer and the TPA, Mr. Holbrook notes; the settlement recognizes the self-insurer as the responsible party.

California Casualty Group is named in the suit in its capacity as work comp insurer, but is also taking part in the settlement as a claims administrator, Mr. Sevey said.

"If we made a mistake, we'll cover it," Mr. Sevey said. "That's our business ethic." Cal Casualty so far has assumed responsibility for the late claims of about 13 self-insured clients, all of them private-sector employers, he said.

Other TPAs' positions on contributing to the settlement on behalf of self-insured clients vary, he said.

Twenty of the 21 largest work comp insurers in the state have agreed to collectively contribute $290,000—or almost 40%—of the $750,000 pool for legal fees. Negotiated by about 50 attorneys, the insurers' contributions are based chiefly on premiums written in the state, but also take into consideration their claims volume and incidence of litigation, attorneys say.

The only major work comp insurer that has not agreed to take part is Mission Insurance Co., which is still in conservation and whose long-awaited financial restructuring is still pending, Mr. Holbrook reports.

The insurers contributing $20,000 each to the pool of legal fees are: Fireman's Fund Insurance Cos.; Fremont Indemnity Co.; Industrial Indemnity Co.; Insurance Co. of North America, a CIGNA Corp. unit; Liberty Mutual Insurance Co.; and the California State Compensation Insurance Fund.

Those kicking in $15,000 each toward the settlement's attorney fees are: Aetna Life & Casualty Co.; Hartford Insurance Group;

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Brokerage results

Continued from page 3

"slow down next year," due to smaller property/casualty insurance rate increases, "it still should be impressive."

Marsh & McLennan's involvement in the formation of new markets—like X.L. Insurance Co. Ltd, A.C.E. Insurance Co. Ltd. and American Excess Insurance Assn.—is helping both its image in the marketplace and its new business development, he said.

"It gives them great credibility with their clients and gives them the opportunity to place business no one else can place. It probably accounts for about a fourth to a third of their brokerage growth," Mr. Weinhoff said.

Revenues at Alexander & Alexander Services Inc. rose less dramatically. Second-quarter revenues advanced 18.5% to $269.2 million from $227.1 million in 1985. For the first half, revenues increased 18.6% to $519 million from $437.6 million in 1985.

The brokerage's 1985 figures have been restated to reflect its acquisition of Canadian-based Reed Stenhouse Cos. Ltd.

A&A's slightly lagging revenue growth is "due to the fact that its mix of foreign business is directed toward retail rather than wholesale brokerage," explained Rothschild's Mr. Wilson. "Foreign retail brokerage business has not been as pronounced as wholesale overseas or U.S. direct brokerage business.

"Their U.S. business has been very strong," he stressed, adding that A&A's "orientation outside the U.S. became heavily retail with the Reed Stenhouse acquisition, as opposed to M&M, which is heavily wholesale abroad."

Despite a $7.4 million writeoff in the second quarter to again bolster the reserves of discontinued underwriting operations, A&A reported significant profit gains for both the quarter and the first half of 1986.

A&A's second-quarter net income increased 136.1% to $19.6 million from $8.3 million in 1985. First-half profits jumped 94% to $41.7 million from $21.5 million.

The second-quarter writeoff was "primarily for reserve strengthening related to insurance companies previously owned by Alexander Howden," said John A. Bogardus Jr., A&A chairman and chief executive officer.

A&A's second-quarter 1985 results also included a $2.9 million writeoff for the discontinued underwriting operations.

"As far as we know, we will not have to (further) add to the reserves, although the uncertainty is still there. . .since a lot of the reserving is related to losses from long-tail exposures like asbestos," Mr. Bogardus said.

The second-quarter 1986 writeoff was partially offset by a $4.3 million extraordinary credit for tax benefits from prior year loss carryforwards.

"All of our operations are participating in our growth. Our retail property/casualty business is very strong and our reinsurance brokerage business is very strong," Mr. Bogardus said, adding that commercial rate increases and new business have contributed about equally to A&A's growth.

Frank B. Hall & Co. Inc.'s second-quarter revenue gains trailed the other public brokers', rising only 11.2% to $114.8 million from $103.2 million in 1985. First-half revenues increased 12.2% to $230.9 million from $205.8 million in 1985.

Hall's second-quarter 1986 net income totaled $4.8 million, compared with a $10.7 million loss in the second quarter of 1985. That loss stemmed from a $12 million after-tax charge for discontinued underwriting operations and a $4.9 million aftertax loss on the now-dissolved Jartran Inc. truck leasing unit.

Net income for the first six months of 1986 totaled $13.9 million, compared with an $8.7 million loss in the first half of 1985.

Hall's results are "way behind what its competitors are showing. It would seem they are losing market share," Mr. Keefe said. But, given the problems the brokerage has suffered during the past year, he noted "they have a difficult row to hoe."

Hall Senior Vp John A. Addeo stresses the brokerage has suffered "no significant loss of business." In fact, Hall saw a "20% increase in revenues in its domestic brokerage operations" in the quarter, he said.

"We're finally starting to see new orders coming in on a significant basis. Based on the influx of orders and new proposals. . .this new business should start to show in our third- and fourth-quarter results," Mr. Addeo added.

Eighty percent of Hall's second-quarter domestic brokerage growth can be linked to rate hikes, while about 20% stems from new business, he said.

Mr. Addeo attributed Hall's lackluster revenue performance to weak growth in Hall's other operations, including employee benefits, reinsurance brokerage and claims adjusting.

Shearson's Mr. Weinhoff agreed that Hall's "domestic brokerage business is performing in line with expectations and shows very positive growth," adding that growth from other operations is "not so positive."

Corroon & Black Corp.'s second-quarter gross revenues increased 24.2% to $78.4 million from $63.1 million in the second quarter of 1985. First-half revenues rose 27.4% to $159.1 million from $124.8 million in 1985.

Net income for the quarter increased 32% to $8.2 million from $6.2 million in the second quarter of 1985. For the first half, net income rose 69.7% to $18.6 million from $11 million in the first half of 1985.

Corroon & Blacks first-half 1985 earnings include a $2 million writeoff for discontinued underwriting operations of London broker Minet Holdings P.L.C., in which Corroon & Black holds a 25% equity interest.

"Our Benefits and Specialty Services Group is growing at a slightly higher rate than retail brokerage, although both showed strong growth," said Stephen A. Crane, C&B's senior vp and chief financial officer. "Our Reinsurance Group is lagging, but we have made some changes in management that we are hopeful will result in some significant strides in new business in the coming quarters" (*BI*, July 21).

Mr. Keefe said Corroon & Black "had a good quarter" despite any problems in the reinsurance brokerage operation. "Considering they are doing this well without the reinsurance gains, their results are quite good."

C&B's new business growth is "a slightly larger factor in our revenue growth than are renewal rates," Mr. Crane said.

"Although our net income was only up 32% for the quarter, our operating income before taxes was up 47%, a much more significant gain. A major cause of the apparent drop in the rate of increase in net income year-to-year was a significant increase in our federal, state and local tax rate in the second quarter."

The Crump Cos. Inc. reported a 24% growth in gross revenues in the second quarter to $29 million from $23.4 million in the second quarter of 1985. For the first half, revenues increased 30.8% to $57.1 million from $43.6 million.

Crump's second-quarter net income rose 50.6% to $3.4 million from $2.3 million in 1985. First-half net earnings jumped 55.7% to $6.6 million from $4.3 million in 1985.

Mr. Weinhoff said that while he was "surprised" that Crump's gross revenue growth for the second quarter was not as strong as the stellar increases in previous quarters, his firm will stand by its original earnings estimates for the year.

"I have a lot of respect for Crump's management," he added.

"Our first quarter was great. Our second quarter was good," explained Crump's Mr. Stewart. Although Crump reported significant new business growth in the quarter and continued to benefit from rate increases for liability coverages, "we've lost some renewals as people turn more toward self-insurance for portions of their accounts," Mr. Stewart said.

Crump's newest division, Crump Risk Management Services, designed to help clients establish and monitor self-insurance programs, will not have a major effect on revenues unitl 1977, Mr. Stewart said. CRMS began operating on the West Coast in July and on the East Coast earlier this month.

"Our reinsurance operations have been particularly strong, as have excess abd surplus lines underwriting and brokerage activities, across the board," Mr. Stewart added.

Second-quarter gross revenues at Arthur J. Gallagher & Co. rose 28.3% to $22.1 million from $17.3 million in 1985. First-half revenues increased 27.6% to $46.7 million from $36.6 million in 1985.

Gallagher's net income for the quarter jumped 68.6% to $1.7 million from $1 million in the second quarter of 1985. For the first six months of 1986, net income increased 30.6% to $5.4 million from $4.1 million in 1985.

Gallagher's Mr. Cloherty attributes the broker's growth to a significant increase in new business in addition to the self-insurance services and claims management expertise of its Gallagher Bassett Insurance Services subsidiary.

"People are clamoring for an alternative source to insurance—alternative funding mechanisms," Mr. Cloherty explained.

Gallagher announced in May that it will acquire Lloyd's of London broker John Plumer & Co. Ltd. (*BI*, May 12). The transaction should be finalized this month.

Mr. Cloherty said the acquisition will "strengthen us in our overall international operations and bring us an even more diversified range of expertise in marine, aviation, construction and reinsurance business." The acquisition also will add about 100 employees to Gallagher's London operations.

Poe & Associates Inc. reported gross revenues of $8 million for the second quarter, a 21.7% increase from $6.6 million in 1985. First-half revenues rose 28% to $16.2 million from $12.7 million in 1985.

Poe's net income for the quarter rose 121.7% to $1.2 million from $535,000 in the second quarter of 1985. First-half net income jumped 126.1% to $2.4 million from $1.1 million in 1985.

In July, Poe & Associates purchased 11.9% of its outstanding common stock from former board members. The brokerage also acquired options to purchase an additional 4.8% of its outstanding shares by December.

"We felt it was the best investment we could buy," said Chairman William F. Poe.

"We made a comment in the first quarter that we were looking for something like $1.05 to $1.25 in earnings per share in 1986. Looking at our first-half resuits, we think that prediction is still valid," Mr. Poe said.

The recent decision of several insurers to stop writing new business in Florida, following passage of legislation that would freeze commercial insurance rates in 1986, and roll them back to 1984 levels next year, has had some effect on the Tampa-based broker's business, Mr. Poe acknowledged (*BI*, June 16). About 75% of Poe's retail brokerage business is Florida-based.

However, Mr. Poe said any loss of business in Florida is factored into his earnings predictions.

"It has taken a lot of time to plan, react and create strategies to deal with the situation. Right now on new business we are almost closed. We're concentrating on renewals at this time," Mr. Poe said. ■

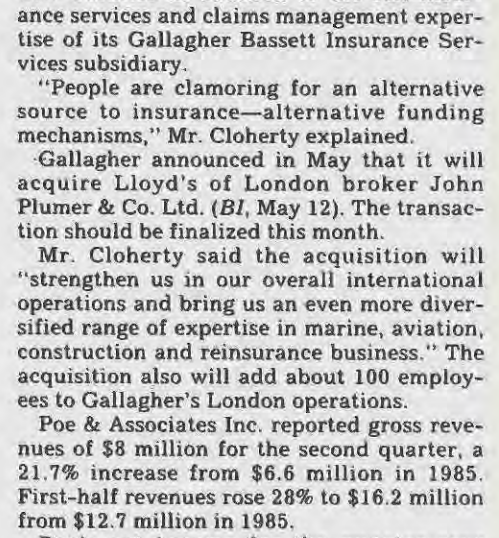
BI Industry Stock Report

August 13, 1986 **8/7/86 thru 8/13/86**

Brokers		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE	38.88	8.7	259.2	1.00	2.6	38.88	36.63	634.2
Baldwin & Lyons Inc	OTC	24.00	-17.2	30.8	0.16	0.7	24.50	24.00	1.0
Corroon & Black Corp	NYSE	37.63	13.2	18.9	0.65	1.7	37.63	34.25	463.2
Crump E H Cos Inc	OTC	30.00	2.6	23.3	0.25	0.8	30.00*	29.00	153.2
Gallagher Arthur J & Co	OTC	30.00	7.1	24.2	0.20	0.7	30.00*	28.00	47.2
Hall Frank B & Co Inc	NYSE	23.50	-5.5	0.0	0.00	0.0	24.88	22.00	268.5
Marsh & Mclennan Cos Inc	NYSE	67.75	7.3	23.9	1.50	2.2	68.00*	65.13	614.6
Poe & Assoc Inc	OTC	12.25	0.0	0.0	0.32	2.6	12.25	12.25	3.7
AGENTS/BROKERS	AVERAGE			-53.2		1.5			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	62.75	6.6	11.9	1.36	2.2	63.00	59.50	3,665.0
Anderson Clayton(Ranger/PanAm)	NYSE	55.88	0.0	31.9	0.00	0.0	0.00	0.0	0.0
Armco Inc	NYSE	7.25	0.0	0.0	0.00	0.0	7.38	7.25	638.4
Berkley W R Corp	OTC	34.25	7.9	25.9	0.24	0.7	34.25	32.00	301.0
Berkshire Hathaway Inc Del	OTC	2980.00	7.2	725.1	0.00	0.0	2980.00*	2785.00	1.5
CIGNA Corp	NYSE	59.63	-1.9	0.0	2.60	4.4	59.63	58.25*	2,572.7
CNA Finl Corp (CNA)	NYSE	64.00	7.6	17.7	0.00	0.0	64.25	60.50	265.3
General Re Corp	NYSE	67.63	9.7	29.4	0.88	1.3	67.63*	61.00	1,074.2
ITT (Hartford Group)	NYSE	53.50	6.2	29.1	1.00	1.9	53.50	51.13	3,862.3
Sears Roebuck & Co. (Allstate)	NYSE	44.25	6.3	12.6	1.76	4.0	44.50	42.38	3,381.2
Teledyne Inc (Argonaut)	NYSE	326.00	6.2	11.9	0.00	0.0	326.00	308.13	202.1
Transamerica Corp (Occidental)	NYSE	35.63	2.5	15.6	1.68	4.7	35.63	34.50	782.2
CONGLOMERATES/HOLDING COS.	AVERAGE			102.3		0.3			
Insurers									
Aetna Life & Cas Co	NYSE	63.50	7.4	12.7	2.64	4.2	63.50	59.50	1,911.2
American General Corp	NYSE	41.00	3.1	12.2	1.12	2.7	41.13	39.75	1,262.7
Amern Heritage Life Invt Co	NYSE	42.63	0.3	15.4	1.32	3.1	42.88	42.13	0.7
American Indty Finl Corp	OTC	17.00	0.0	0.0	1.12	6.6	17.25	16.75	9.4
American Intl Group Inc	NYSE	139.00	7.8	22.7	0.44	0.3	139.38*	130.00	675.7
Aneco Reins Ltd	OTC	2.25	28.6	0.0	0.00	0.0	2.25	1.75	11.0
Avemco Corp	NYSE	30.88	8.3	16.2	0.50	1.6	30.88*	28.50	16.8
Business Mens Assurn Co Amer	OTC	27.00	0.9	22.1	1.10	4.1	27.25	25.50	28.8
Chubb Corp	NYSE	75.25	8.7	56.2	1.56	2.1	75.25	69.63	552.8
Combined Intl Corp	NYSE	59.25	5.8	11.5	2.24	3.8	59.25	56.75	144.9
Continental Corp	NYSE	48.63	9.3	0.0	2.60	5.3	48.63	45.13	521.4
Crown Life Ins Co	OTC	339.75	-2.9	3.4	6.40	1.9	350.00	339.75	0.1
Durham Corp	OTC	44.00	0.0	11.8	1.36	3.1	44.50	44.00	3.5
Farmers Group Inc	OTC	43.50	12.3	15.1	1.00	2.3	43.50	38.50	1,094.3
Fairmont Finl Inc	AMEX	19.38	7.6	20.0	0.00	0.0	19.50	18.38	191.8
Fireman Fd Corp	NYSE	39.63	2.9	0.4	0.30	0.8	39.63	37.13	599.1
Fremont Gen Corp	OTC	24.13	2.7	0.0	0.48	2.0	24.13	23.38	75.0
Great West Life Assurn Co	OTC	850.00	0.0	8.5	18.00	2.1	850.00	850.00	1.5
Home Group Inc	AMEX	23.75	4.4	113.1	0.00	0.0	23.75	22.00	793.5
Hanover Ins Co	OTC	64.75	14.1	18.7	0.56	0.9	64.75	59.00	221.6
Hartford Steam Boiler Inspctn	OTC	48.25	0.5	15.3	0.84	1.7	48.25	47.50	60.6
Kans City Life Ins	OTC	33.00	-0.8	13.0	0.87	2.6	33.25	33.00	8.0
Kemper Corp	OTC	32.50	9.2	14.8	0.60	1.8	32.50	29.75	1,134.0
Liberty Corp S C	NYSE	40.75	4.5	15.0	0.72	1.8	40.75	39.50	20.9
Lincoln Natl Corp Ind	NYSE	53.63	6.5	12.4	2.00	3.7	53.63	51.25	277.8
Mission Ins Group Inc	PAC	4.00	0.0	0.0	0.00	0.0	4.38	2.88	100.0
Monumental Corp	OTC	55.50	0.9	18.7	0.00	0.0	55.50*	55.00	54.6
Nac Re Corp	OTC	33.75	3.1	0.0	0.00	0.0	33.75	32.00*	251.1
Nobel Ins Ltd	OTC	16.25	12.1	21.4	0.37	2.3	16.25	14.75	78.6
Northwestern Natl Life Ins	OTC	29.50	5.4	12.9	0.86	2.9	29.50	28.38	272.8
Ohio Cas Corp	OTC	78.00	3.7	16.6	3.00	3.8	78.00	74.00	120.0
Old Rep Intl Corp	OTC	38.63	7.3	12.9	0.78	2.0	38.63	35.50	279.3
Orion Cap Corp	NYSE	34.13	10.1	0.0	0.76	2.2	34.13	32.00	110.8
Protective Corp	OTC	21.50	1.2	11.6	0.70	3.3	21.50	20.75	227.2
Provident Life & Acc Ins Co	OTC	25.63	-5.5	9.4	0.84	3.3	26.88	25.13*	556.5
St Paul Cos Inc	OTC	39.50	0.0	23.1	1.50	3.8	39.50	38.25*	3,299.0
SAFECO Corp	OTC	61.50	6.5	14.6	1.68	2.7	61.50*	58.38	391.1
Seibels Bruce Group Inc	OTC	16.13	-2.3	0.0	0.80	5.0	16.13	15.50*	175.6
Selective Ins Group Inc	OTC	21.00	1.8	0.0	0.92	4.4	21.00	20.50	164.9
Statesman Group Inc	OTC	5.50	-4.3	45.8	0.05	0.9	5.75	5.38	68.6
Tokio Marine & Fire Ins Co	OTC	523.50	15.3	98.6	1.66	0.3	523.50*	454.25	11.8
Torchmark Corp	NYSE	31.25	5.0	12.6	0.60	1.9	31.25	29.75	640.5
Travelers Corp	NYSE	46.00	2.8	11.5	2.16	4.7	46.00	44.13	1,790.6
Trenwick Group Inc	OTC	21.25	4.9	0.0	0.00	0.0	21.25	20.25	125.6
United Fire & Cas Co	OTC	29.25	13.6	15.2	0.80	2.7	29.25	26.00	37.7
United States Fid & Gty Co	NYSE	39.75	0.6	0.0	2.32	5.8	40.00	39.25	1,090.8
Uslife Corp	NYSE	43.88	5.4	11.5	1.12	2.6	43.88	42.00	143.9
Washington Natl Corp	NYSE	31.25	1.2	14.1	1.08	3.5	31.25	30.63	19.6
Zenith Natl Ins Corp	OTC	28.25	6.6	48.7	0.80	2.8	28.25	26.00	206.4
INSURANCE COMPANIES	AVERAGE			9.1		2.0			

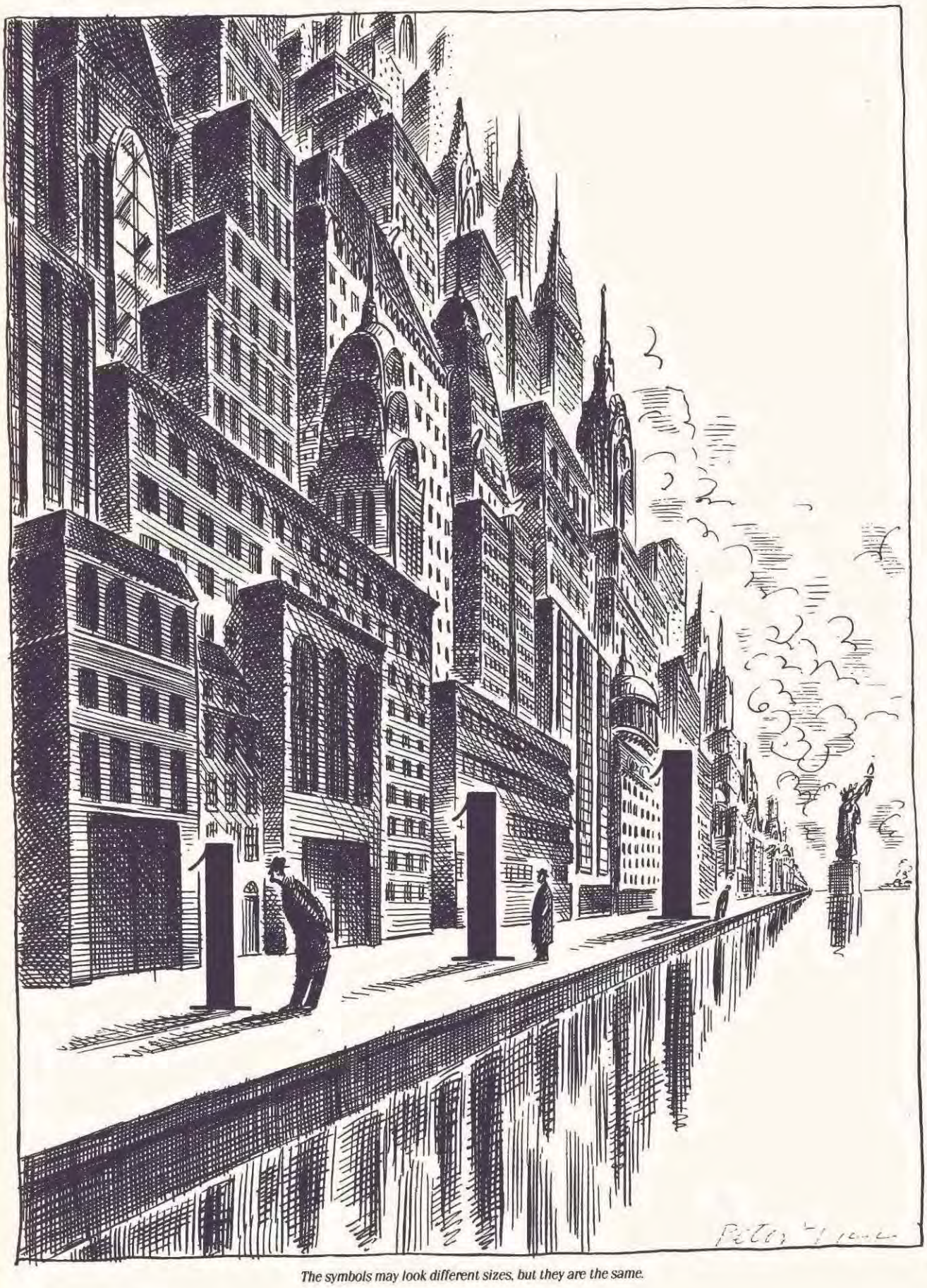
System design: Altman Information Systems

BI Insurance Index



The *Business Insurance* index of insurance industry stocks soared 24.7 points to close Aug. 13 at 523.4, up from 498.6 on Aug. 6. Forty-eight stocks advanced, six declined and four remained unchanged during the period. Stocks posting the biggest gains were: Aneco Reinsurance Co. Ltd., up 28.6%; Tokio Marine & Fire Insurance Ltd., up 15.3%; Hanover Insurance Co., up 14.1%; United Fire & Casualty Co., up 13.6%; and Corroon & Black Corp., up 13.2%. Stocks posting the largest losses were: Provident Life & Accident Insurance Co. and Frank B. Hall & Co. Inc., both down 5.5%; Statesman Group Inc., down 4.3%; Crown Life Insurance Co., down 2.9%; and CIGNA Corp., down 1.9%. The *BI* index rose 5% during the period, outperforming broader market indexes.

If you need reinsurance, what do you see as your biggest priority?



The symbols may look different sizes, but they are the same.

Financial security?

Having the most experienced underwriters?

Or knowing that the company you're dealing with will always be there?

At Clarendon, we don't make any distinction between the three.

To us, they're equally important.

That's why we have:

Surplus of $225m.

Creative, flexible underwriting dedicated to traditional licensed treaty reinsurance.

A long term commitment to the brokerage market.

CLARENDON NATIONAL INSURANCE Co.