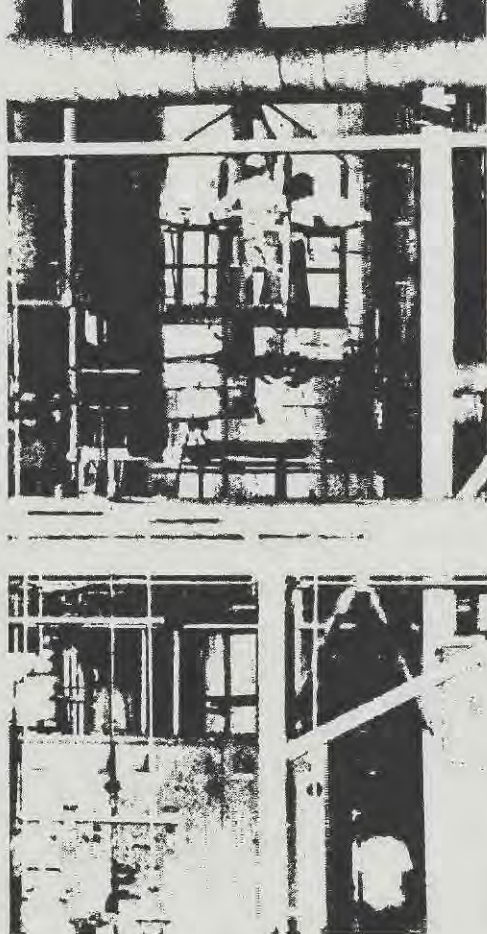


Investigate explosion at oil refinery

Workers remove a body from the 207-foot tower at the Tenneco Oil Co. refinery in Chalmette, La. An explosion killed 12 men and injured several others. Ten of those killed were employees of Delta Field Erection Co., a refinery maintenance subcontractor; two were Tenneco employees. Delta insures its workers' compensation and liability with Liberty Mutual Insurance Co. No property damage estimates had been made at press time. A Tenneco spokesman said all damage occurred inside the tower. "The silo itself is intact," he said. The tower, an ethyl benzene unit, had been shut down for routine maintenance work and repairs prior to the explosion.



Underwriters lose points with costly vaccine coverage

By PAUL R. MERRION & MARGARET LeROUX

WASHINGTON—As an eleventh-hour compromise solution to the swine flu program's insurance problems was rushed into law earlier this month, the weeks of hearings and negotiations had left a great many legislators sour about the behavior of the insurance industry.

As it turned out, the federal government paid a heavy price for the continuation of the \$135 million venture. Not only will it be the sole target for all liability suits, but the cost of insuring the vaccine makers against their single liability—negligence in manufacturing—will be passed on in the cost of the vaccine.

Reliable sources told *Business Insurance* that the first \$5 million layer of insurance, after a \$2.5 million deductible, will cost a total of \$2.4 million, with each of the four companies paying a share based on the amount of vaccine they produce.

The next \$50 million layer for each of the four manufacturers will cost a total of \$6.25 million, resulting in a total cost \$8.65 million for \$220 million in coverage.

At least one drug company source was unhappy with the arrangement: "The drug companies are paying for coverage that there's a good chance will never be used." Although the swine flu bill allows the manufacturers to

include the cost of the insurance in the cost of making the vaccine, the bill also says the companies cannot make a profit on the swine flu vaccine and that any insurance rebates must be passed on to the government.

The four drug manufacturers are Merck & Co., Richardson-Merrell, Warner-Lambert and American Home Products.

At press time, a source at Aetna Life & Casualty Insurance Co., one of the major insurers involved in the program, told this magazine that the \$220 million pool was still not fully subscribed, but that the London markets were not yet in the pool.

One of the brokers involved in setting up the program said that London considers the coverage "grossly inadequate."

The vaccine program involves a broader risk than other product liability situations, according to the Aetna spokesman, "in that the program is massive and the time element is telescoped."

But the bill is a vast improvement over previous attempts at making insurance available for the program because in one swoop it also eliminates "next week's problems" that were nagging public health officials: coverage for those who administer the vaccine.

The bill makes the government initially liable for all suits, including those brought against doctors and health care facilities. Many had feared that the product

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business insurance

the national newsmagazine for buyers of employee, property and liability protection and financial services

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Hospital chains use own insurer for excess covers

By SUSAN ALT

CHICAGO—Four corporations operating more than 100 proprietary hospitals nationwide established their own insurance company in Bermuda to underwrite hospital malpractice insurance on an excess basis.

This is one of the few captives—if not the only one—established to write excess liability insurance for its owners, who are American Medicorp, Philadelphia; Medenco Inc., Houston; Charter Medical Corp., Macon, Ga.; and Hospital Affiliates Inc., Nashville.

Policies written by Hospital Underwriting Group, affectionately known as HUG, are provided on an occurrence basis covering losses above a minimum retention level of \$500,000 up to \$7.5 million per occurrence for malpractice. The accompanying umbrella general liability covers up to \$30 million. Both the malpractice and the CGL policies are subject to \$30 million annual aggregate limits.

The industry-owned stock insurance company began operations May 15 after being capitalized with about \$2.5 million, far above the minimum capital of only \$250,000 required in Bermuda. The four companies participating are paying

about \$10 million a year in premiums into the captive, which provides insurance for about 100 hospitals.

Marsh & McLennan is managing the Bermuda insurance company, while Baker & McKenzie, a New York law firm, is acting as chief counsel. (This is the same team which established and manages Nuclear Mutual Ltd., set up electrical utilities to underwrite some insurance of nuclear exposures.)

Tillinghast & Co. of Atlanta did the actual work on HUG.

HUG is reinsuring the general liability portion of its book of business in the domestic reinsurance markets, said Peter Lederer and James Cameron, attorneys with Baker & McKenzie who are acting as official spokesmen for the industry-owned insurer. HUG is now "exploring the reinsurance for the malpractice risks," they added.

In the event of large losses, the four HUG participants are subject to an assessment equal to two times the annual premium charge for each company.

Work began on HUG in the autumn of 1975 when malpractice markets began tightening. Other brokers and consultants also were

involved in the planning stages of HUG since each of the four companies worked with its own broker. American Medicorp, Charter Medical, Hospital Affiliates and Medenco began discussing the idea of an industry insurer seriously last November after Gerald P. Breslin of American Medicorp proposed it. The theory behind HUG was that the companies which own and operate for-profit proprietary hospitals, and manage some others under contract, constitute a preferred-risk group because of the centralized management control exercised over the health care facilities. As participants in HUG, each of the four agrees to maintain a superior malpractice and third party injury loss prevention program.

Until recently, there were two other companies owning and operating hospitals which also considered joining the group. One dropped out because it reportedly did not see enough of a cost advantage over insurance purchased in the traditional markets; the other apparently wanted to maintain its relationship with its present malpractice insurer.

Participation in HUG isn't limited.
Continued on page 2

Lloyd's insurer tells Bar Assn.

Big boost for bank bond rates

By ELISABETH M. WECHSLER

ATLANTA—Lloyd's of London is raising its rates on bankers blanket bond "20% to 30% on the expiring premiums of a clean risk," according to John Twitchett, senior bank underwriter for the Dew Syndicate of Lloyd's.

And, as Mr. Twitchett explained it, that's the rate on a policy "with no losses on that risk." He said he doesn't think there has been an increase in fidelity claims in the last year.

The problem of fidelity is a greater problem for banks than the problem of bank robberies, he believes, though he commented that there "can be an element of fidelity in a break-in" if an employee is indirectly involved.

At Lloyd's about 60% of the bankers blanket bond claims involve fidelity matters, as compared with robberies and other external crime.

Mr. Twitchett commented to participants at the American Bar Assn. Conference here that he doesn't think self-insurance is the answer to rising costs of the cov-

erage "because you can't levy enough premiums to pay the risk."

The American Bankers Assn. has considered offering a self-insurance plan among its member banks Mr. Twitchett said. He doesn't think this would provide a large enough premium base to adequately spread the risk.

Limits on Lloyd's policies vary according to the size of the institution, but the maximum limit for

blanket bond risk, according to Mr. Twitchett. He called the pricing of fidelity risks "an imperfect art: All the rates in the world cannot quantify fidelity losses."

"We're getting more and more submissions from small and medium size U.S. banks as well as from large money center banks," he noted.

To avoid fidelity claims and problems, Mr. Twitchett advised banks and commercial institutions to use "manual procedures, mandatory two week holidays for every employee, rotation of duties, and dual control of the vault."

"The courts have not settled on a single definition of dishonest and fraudulent acts," he said. Deciding whether a claim is covered boils down to "an insurance interpretation of what an employee has done when a loss has been sustained—usually when an employee has exceeded his or her authority."

Acts involving "mere carelessness" are not considered dishonest and fraudulent acts, Mr. Twitchett said. "While dishonesty is always fidelity, fidelity is not always dishonesty," he added.

ABA COVERAGE

Complete coverage of the American Bar Assn. insurance section proceedings are on pages 12, 13 and 14.

a "large international bank" would currently be five million British Pounds Sterling (about \$9 million), Mr. Twitchett told *Business Insurance* following his speech to the ABA's section on insurance, negligence and compensation law.

The Dew Syndicate, one of two large underwriters of bank risks at Lloyd's, usually participates about 12.5% to 15% in a bankers

Hospital captive . . .

Continued from page 1

ited to the four founding companies even now, however. Other companies "which would bring similar risks" into HUG are welcome, said the spokesmen. Baker & McKenzie is currently in the process of "exploring the universe" of potentially acceptable organizations which might want to participate in HUG's underwriting facilities. The spokesmen estimated there are probably "several dozen companies" with operations similar to those of the four HUG founders. The 100 hospitals represented in HUG range from small size (about 50 beds) up to large units of about 600 beds.

Colorado also was considered as a domicile for HUG, but was ruled out because that state's insurance laws require an association of companies to exist for at least a year before the group can legally establish a subsidiary insurer.

Charter Medical Corp., based in Macon, Ga., owns and operates 14 hospitals with 60 to 200 beds each. Although the corporation also manages eight hospitals under contract, none of the eight are insured through HUG; only the proprietary hospitals are covered, said Charles Chapin, an official of the firm.

Charter Medical estimates its malpractice and CGL insurance costs were slashed a whopping 45% to 50% by using HUG, said Mr. Chapin. The firm purchased primary insurance policies to cover its minimum retention, he added. Charter Medical continues to

use Marsh & McLennan in Richmond, Va. as broker for the primary coverage, although the company dropped its former malpractice and CGL insurer when it went into HUG.

American Medicorp in Philadelphia formerly used Argonaut Insurance Co. for its liability insurance. The firm continues to use Alexander & Alexander as brokers, but now purchases primary liability coverage from American Home Assurance Co., a division of American International Group. American Medicorp expects long term savings by using HUG, but reportedly did not experience the large short term savings on liability premiums. American Medicorp buys coverage through HUG for 36 hospitals owned and operated in 13 states, ranging in size from 100 to 600 beds each, as well as for 11 others managed under contract.

Medenco, which buys coverage for 14 hospitals through HUG (only one of those is managed under contract; the others are owned), is using its recently-established Colorado captive insurance company to underwrite primary coverage. "We're continuing to make use of Greenway Insurance Co. as a reinsurer" of Medenco's deductibles, although the amounts of risk being put into Greenway have changed, said John Hobbs, treasurer.

Greenway was established in January 1976 to underwrite \$750,000 per occurrence and \$1.5 mil-

lion aggregate malpractice coverage for Medenco's hospitals. The captive now writes coverage for amounts "quite a bit lower," said Mr. Hobbs.

"This has had an effect on our excess carriers, because we cancelled those policies to go with HUG," he told *Business Insurance*. The excess policies had been brokered through Alexander & Alexander. (A&A continues to manage Medenco's captive in Colorado.)

Medenco also recorded substantial savings on premium costs for liability insurance when it went into HUG, said Mr. Hobbs.

The treasurer of Hospital Affiliates in Nashville, which owns and manages about 70 hospitals internationally, was not available for comment.

Vaccine . . .

Continued from page 1

liability problems of the manufacturers would seem puny compared to the malpractice problems. There is a stipulation, however. Just as the drug manufacturers will not be allowed to make a profit on the swine flu vaccine, those who pass it out must provide their services free of charge in order for the government to assume their liability.

Although the backers of the emergency measure, which passed both houses on August 10, vowed that it does not create a precedent for handling the insurance of other mass immunization programs, Sen. Edward Kennedy (D-Ma.) is planning to hold hearings on the matter sometime before the October recess.

At hearings on the swine flu bill earlier this month before his Health Subcommittee, Sen. Kennedy learned from Secretary David Mathews of the Department of Health, Education and Welfare that insurers are now balking at providing coverage for standard inoculation programs for diseases such as polio, mumps and measles.

"This is an intolerable situation and warrants a full investigation by the Senate Health Subcommittee, which it will receive," Sen. Kennedy said.

And the chairman of the Senate Labor Committee, Sen. Harrison A. Williams Jr. (D-N.J.), said "An entirely new approach may be required to insure the implementation of future federal mass immunization programs," although he cautioned that the swine flu bill passed this month should not be viewed as a precedent.

The stubbornness of the insurance companies' refusal to insure the drug manufacturers also prompted Sen. Kennedy to call for an amendment to the McCarran-Ferguson Act, which exempts the insurance industry from federal antitrust laws. "I believe the time has come to fundamentally reexamine the special privilege that the swine flu situation demonstrates the industry has abused."

And at the House Health Subcommittee, which also has jurisdiction over national health insurance, a high-ranking staff aide, Lee Hyde, said that consideration of future insurance problems for mass immunization programs is "clearly on its way."

He said the subcommittee probably wouldn't take up the matter until a study mandated by the swine flu law is completed. That provision directs the Department of Health, Education and Welfare to investigate the scope of liability under such programs and to study alternative approaches to providing protection against that liability, with a report and recommendations due back at Congress within one year.

Guernsey captive will cover Gould's products

CHICAGO—Gould Inc. established a captive insurance company on the Isle of Guernsey off the coast of Great Britain, and plans within the next few months to begin placing product liability risks in the insurer, *Business Insurance* learned.

Corroon & Black's Armistead Miller Wallace division did the feasibility study, which was directed by Tom Allen. The Guernsey captive, Meadows Indemnity Co. Ltd., will be managed by Island Risk Management Ltd., a joint venture of U.K. insurance broker Hogg-Robinson and Canada's MacMillan-Bloedel Inc. Corroon & Black will also broker the captive's reinsurance.

The captive's charter is understood to be very broad, so that eventually employee benefits may also be insured with the subsidiary, in addition to property and casualty programs.

At the present time there is no insurance being underwritten by Meadows, although within three months the domestic product liability risks of ITE-Imperial Corp., recently taken over by Gould, will be the first exposures put into the captive. ITE has had a large retention of about \$1.5 million under its product liability largely attributed to a product loss exceeding \$1.5 million.

ITE's casualty insurance is presently handled by Fred S. James. The insurer isn't known.

After the ITE product liability covers are put into the captive, the Gould product liability exposures will follow. After that, all other Gould domestic casualty programs will be shifted into the captive, along with domestic property programs and, last, international property programs.

Alexander & Alexander is Gould's broker for casualty and international property insurance. A&A will continue to be involved in the firm's insurance when the captive is used, but will provide services on a fee basis. Gould's domestic casualty coverage is now with CNA on a cash flow program,

while Gould's property coverage is with the Factory Mutual System.

Annual casualty insurance premiums for Gould are estimated to amount to \$3 million to \$5 million, including ITE, with the bulk of those for domestic casualty and product liability coverage. International property, casualty and marine insurance generates an estimated \$500,000 a year in premiums.

Gould's risk manager, James Mascarella, declined to comment on the establishment of the captive or any planned changes in programs.

Although not many captives have been domiciled in Guernsey, Gold is thought to have chosen the island because it afforded the best access to London markets, and because as an affiliate of the European Economic Community, Guernsey affords insurance companies the status of admitted reinsurers in other EEC countries, where Gould has the bulk of its overseas operations.

Gould manufactures electric and electronic products, battery products and other industrial goods. ITE Imperial produces electric products and hydraulic systems.

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The position taken by some underwriters of Directors and Officers Liability Insurance has been that certain professionals who are also officers of the corporation are not insured under the Directors and Officers Liability Insurance because they possess professional skills. This is of major concern to insurance brokers. The corporation frequently requires people with professional skills to carry out their duties as officers of the corporation. As an insurance broker, it would be proper for you to question your Directors and Officers Insurance Underwriter as to his position on this matter before loss!

Similar disputes can take place where one person, acts in more than one capacity. It is not uncommon for one person to be a director, officer, fiduciary, employee, an employee benefit plan participant and a stockholder. The Department of Labor has issued several helpful ERISA bulletins on this matter.

The standards to apply to measure the adequacy of coverage are:

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2. The corporation as Sponsor Employer and Named Fiduciary must be covered for its obligations to plan participants and plan beneficiaries plus for its obligation to indemnify Directors, Officers, Trustees or Fiduciaries.
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Resort owner sues Lloyd's and Unigard over interruption claim

By HARRIET KING

PORTLAND—After nearly 1,500 persons became ill from drinking polluted water at Crater Lake Lodge last summer, the owner closed the resort from July 10 to Labor Day.

Now, the owner has taken Lloyd's of London and Unigard Mutual Insurance Co. to court, charging that the carriers refused to honor \$748,000 in claims filed under business interruption and property damage coverage.

The pollution incident occurred when a rock in the sewer line caused the line to overflow. Some of the overflow ran into the water supply, which was uncovered.

The sewer line had been installed, operated and maintained by the federal government because the lodge is located in Crater Lake National Park. But when people became ill at the mountain resort in 1975, it took until July 10 to discover the cause because much of the sewer and water system was still covered with snow.

Crater Lake Lodge was insured under a \$500,000 business interruption policy and it also had \$1 million in property damage coverage. Lloyd's carried the first \$100,000 for each policy and Unigard carried the balance.

The Lodge's owner filed a claim for business interruption and property damage caused by contaminated pipes. But the insurance com-

panies denied the claim. Velma King, secretary-treasurer of Griffin & Co. of Seattle, the broker who arranged the coverage, says her lawyer has advised her not to comment since the matter is in court.

A Crater Lake spokesman for Ralph Peyton, who owned the Lodge last summer and has since sold to Richard Esty, president of Canteen Co. of Oregon, says the insurance companies denied the claim because they're disputing whether the entire complex needed to be closed from July 10 to August 1.

The carriers have also denied the claims, continued the spokesman, "saying that our contracts contained an exclusion for losses caused by sewers backing up. We say that this exclusion does not apply. We say the losses were not caused by a sewer backup, such as those that would occur if toilets backed up and into a building, but by contaminated water caused by sewage overflow into our water system. We are emphasizing the term overflow. We say the exclusion is irrelevant.

"The carriers still haven't answered our suit (in Multnomah County Circuit Court in Portland), but we're not being pushy as we're still exploring informal settlement procedures," says the spokesman.

He notes that the former Crater Lake Lodge owner also has pressed

a \$4 million suit against the National Park Service. "We're saying that the park service is responsible for the loss since the sewage and water system was installed, maintained and operated by the government."

Under the Federal Tort Claims Act, the suit has been filed with the Department of Interior; among other things, the former owner is charging a loss of name and credit since the business interruption occurred during the park's peak operating period.

The Interior Department has until December to make a decision whether to pay the claim. If its decision is negative, the suit can then go into the normal court system. "We're pushing on both fronts," says the spokesman. "We don't care who pays, the insurance company or the government."

The spokesman says that Mr. Peyton sold the lodge because he had borrowed money to make improvements to his property, to be paid for through cash flow. "When the cash flow was disturbed by the lodge's closure, the debts continued to accrue. The only way he could get out from under them was to sell," says the spokesman.

Perhaps as many as 100,000 persons were exposed to the polluted water during the time the park was open last summer from June 15 to July 10. Through July 1976, 1,543 claims were processed—and

there could have been more than one person per claim, says Ben Brooks, attorney for the Interior Department in Portland.

Suits filed by those who claim to be ill have gone directly through the National Park Service—which last summer even put out press releases notifying people where to file. The claims are also being handled under the Federal Tort Claims Act.

"The claims have ranged from \$2.50 for a student who had to pay a fee at his university student health center, to \$17,000 for a vacationing husband and wife who were both engineers. They became very ill and lost several months' time from work," Mr. Brooks explained.

Generally, he will authorize out-of-pocket expenses, time lost from work, motel bills for those who were too sick to travel, doctor and hospital bills, medication, etc., he says. "We even paid the difference in plane fare when one couple became sick and couldn't get the special Bicentennial return airfare," says Mr. Brooks.

Total outlay through July 1976 has been \$293,120. "Initially, claims flooded in, now they're down to a trickle, maybe five or six a month," says Mr. Brooks. "We decided to pay because the government is a self-insurer and mainly because the government had control of the park and the sewer system."

He denied only one claim to date, from someone who said he was in the park after it was closed. "And we're still negotiating the big one—a claim for \$300,000 filed by a fellow who was pretty sick. He wound up in the hospital and caught pneumonia and had to change jobs because of it. We're in

court with this one, and trying to negotiate with his lawyer," says Mr. Brooks.

Richard Estey, the lodge's new owner, says "it would be a very remote possibility that the pollution could reoccur. We now have a totally new covered system; the government has gone miles into the hills and found a new watershed." He notes that the lodge "shouldn't be held responsible because buying water from the government was like the city of Portland supplying water to your home."

Mr. Estey also says that acquiring insurance coverage when he bought the lodge "was not a problem. I have my own Canteen Co. I buy insurance for it, and this is an extension of my policy."

And, says Lawyer Brooks, "today, Crater Lake Lodge is the cleanest place in the U.S. to get a drink of water. We had two doctors and three sanitary engineers checking the water quality this year when the lodge reopened."

Howden reorganizes

Howden Reinsurance Corp., New York, was assumed by the Drake Insurance Co. of New York effective July 1. The assumption created a policyholder surplus of approximately \$6.8 million, said a Drake senior executive.

Drake, formerly the Seaboard Fire & Marine Insurance Co., is part of Howden Swann Ltd., an international insurer. Its new reinsurance operation resulting from the acquisition of Howden Re's assets will be structured as a separate division of the company, and will use reinsurance intermediaries to market property and casualty, pro-rated and excess of loss coverages.

the benefit beat

Exxon taps Pru to insure thrift plan til 1986

AFTER SCREENING "most of the major insurance companies," Exxon Corp. picked Prudential Insurance Co. to provide a 10-year guaranteed return contract for the oil company's thrift plan participants. About 40,000 such employees can opt to invest in the plan, which guarantees a rate of return of 8.85%. George Bradford of Exxon's treasury department said the guaranteed contract did not replace another form of benefit for thrift plan participants, but is an additional option voted by the \$800 million fund's five-member board of trustees. The contract offers employees two options for investing their contributions, and so far, response has been "pretty good," Mr. Bradford said. Employees can make their contributions in a single arrangement in which 25% of their thrift plan account as of April 30 is paid into the plan in six installments. The first of these was made at the end of July. Employees can also invest up to 6% of their salary in the guaranteed plan, and that percentage will be matched by the corporation. Contributions made under this second option were scheduled to begin in mid-August. The contract is distinctive in that it was one of the last plans of this type to be negotiated with Prudential, which will now only write guaranteed return contracts for plans in which the total amount is invested initially.

BUFFUMS, A 13-UNIT department store group headquartered in Long Beach, Ca., began self-insuring its group health benefit program including major medical coverage for employees. The benefit plan was formerly insured with Aetna Life & Casualty Co. R. L. Kautz was selected to administer the program, which covers some 4,000 employees, both hourly and salaried.

THE LABOR DEPARTMENT extended the deadline for filing Form 5500, the annual pension plan report, to December 15, because of additional information being required. The Internal Revenue Service, which also uses sections of Form 5500, is still asking for its information by October 15. The changes in the proposed regulations issued earlier this month also eliminated the requirement for an accountant's opinion for plans with less than 100 participants. Small plans were also relieved of having to report names and addresses of agents, commissions paid and the purpose of the payment, although this requirement will go into effect next year. Other changes in the revised regulations are a waiver of an accountant's opinion and actuarial in-

formation on the summary annual report for participants, elimination of the need for accountants to examine the financial statements of the plan's bank or insurance company, and a simplification of procedures for calculating reportable transactions.

NATIONAL ACCOMMODATIONS Co., of Studio City, Ca. named R. L. Kautz & Co. to replace Health Plan Administrators (HPA) as administrator of its year-old self-insured group health benefit program. National Accommodations, owner and operator of hospitals, moved into self-insurance for its group health plan a year ago to shave costs. The insurer had previously been Prudential Life Insurance Co. After six to eight months of self-insurance on the benefit plan, "We are about at a break-even point," said a spokesman for National Accommodations. About 300 employees out of a total workforce of about 500 are now covered by the self-insured plan. Kautz was selected as the new administrator because of the breadth of services it offers, the spokesman said.

NATIONAL BASKETBALL ASSN. players' pension benefits were increased to \$75 a month per year of service, up from \$60 a month per year of service. An unreduced benefit is available at age 50, according to Kenneth Bailey, NBA controller. The plan centers around a three-year eligibility requirement, and players can look forward to a cost-of-living adjustment with no "cap." The increased benefits include improvements in the life, major medical and dental plan, underwritten by Guardian Life. A 100% reimbursement for major medical represents a 20% improvement. The dental deductible was reduced to \$25 from \$50. Life insurance coverage was increased to \$50,000 from \$35,000. The three-year agreement affects 264 players with the addition of four teams this fall, Mr. Bailey noted. These benefits, plus per diem and All-Star Game shares, is estimated to cost each club an average of \$28,000 per year more than the previous package.

MONOGRAM INDUSTRIES INC., Santa Monica, moved its largest group health program, generating annual premiums in the neighborhood of \$2.5 million, from John Hancock to Travelers Insurance Co., according to Leonard R. Hutchinson, vp of finance and treasurer. The group health program includes both contributory and non-contributory plans, and covers between

1,500 to 2,000 participants. The program is the largest of several group programs sponsored by the company. Blue Cross and Aetna are the carriers for some of the other smaller programs. Johnson & Higgins directed the marketing effort on the carrier change. Mr. Hutchinson said economic considerations prompted the change. Monogram Industries is a \$200 million company in the electrical insulating, industrial fastening products and sanitation products markets.

CALIFORNIA PORTLAND CEMENT, Los Angeles, inaugurated a long term disability (LTD) program for its salaried employees. The underwriter for the non-contributory program is Crown Life and the broker is Booth & Simpson, Los Angeles. In the past, the company had included disability benefits in its pension plan, according to David Mayhew, employee benefit manager. He said the decision to set up a separate LTD program was made in order to offer salaried workers disability benefits commensurate with those granted union employees. A premium volume of about \$25,000 a year is anticipated from the program.

CALCULATING PREMIUMS PAYABLE to the Pension Benefit Guaranty Corp. was made much simpler under new regulations issued earlier this month. The new method, sometimes called the "snapshot" approach, counts the number of participants in the pension plan on one day, the last day of the plan year. Previously, PBGC required premiums based on the number of participants in the plan at any time during the year, which amounted to an enormous record-keeping problem for firms with fluctuating workforces. Annual premiums for PBGC's termination coverage are figured at \$1 per participant; 50 cents per participant for multiemployer plans.

NORTHROP CORP. SELECTED Travelers Insurance Co. as carrier for its employer-pay-all dental program, formerly underwritten by Crown Life of Canada. Premiums of about \$2 million a year are generated by the program, according to a spokesman for the Los Angeles-based corporation. Travelers was chosen to replace Crown Life "because as a defense contractor we are subject to audits and we wanted to be assured that we are paying what we should be paying for the program" said Northrop's spokesman. Bidding began in June. (Business Insurance, July 26).

benefit tax slants

Ceiling on benefits paid out to top execs applies to combined plans

By JOSEPH S. ROBINSON
Attorney-at-Law

WHILE THE PENSION Reform Act does not affect retirement payouts of most employees, it does curtail benefits to top executives. That's because the new pension law places a ceiling on the amount of benefits and contributions in qualified retirement plans. (I.R.C. Sec. 415).

Under a defined benefit setup, the maximum annual benefit is the lesser of \$75,000 or 100% of the participant's average aggregate compensation for the three con-

secutive calendar years during which he was an active participant in the plan. An escalator provision allows IRS to revise the law's dollar limitation because of increases in the cost of living. IRS has recently announced a 7.3% boost for the first adjustment. Thus, the maximum annual benefit which is non-taxable has been raised from \$75,000 to \$80,475, retroactive to January 1, 1976.

In a defined contribution plan, there is no dollar limitation on the amount of benefit payable. However, the amount of annual additions to a participant's account

cannot be greater than the lesser of \$25,000 or 25% of the participant's compensation. This limitation is subject to the same cost-of-living escalation that applies to defined benefit plans. Thus, IRS has also adjusted upward to \$26,825 the maximum annual addition, retroactive to January 1, 1976.

The basic rule for a combined defined benefit/defined contribution plan involves a calculation of the "fraction of utilization" for each part of the plan. For instance, if the fixed-contribution portion of the plan was funded in a given

year with a \$17,500 contribution, the fraction would be \$15,500 divided by \$26,825, or .578. If the fixed-benefit portion of the plan were funded to provide a retirement benefit of \$50,000, the pertinent fraction for this portion of the plan would be \$50,000 divided by \$80,475, or .621. Thus, the total of both fractions is 1.273. The limitation for combined plans is satisfied if the total of both fractions does not exceed 1.4. Expressed as a percentage, the total cannot exceed 140%.

Keep in mind that all defined benefit plans of an employer (whether or not terminated) are treated as one defined benefit plan. The same rule applies to defined contribution plans. In addition, all employees of corporations under common control are treated as employed by a single employer. The test used is that of the "common parent" or "brother-sister" relation, as spelled out in the tax rules.

(I.R.C. Sec. 1563 (a)).

Trustees no longer have unlimited discretion to invest trust funds as they see fit, under current pension rules. The investments must meet the requirements of safety and diversity that a prudent investor adheres to; in other words, they must be for the exclusive benefit of employees.

Now, for the first time, the Department of Labor has commenced a legal action against alleged wrongdoers in an effort to make them comply with their fiduciary responsibility under the federal pension reform law. Here's the story:

A benefit plan bought 70% of the stock of a company after the new owner became trustee. The prior owners had been trustees when they agreed to sell their stock. The government contends that the funds were not used solely for the benefit of the plan participants . . . and this violated the fiduciary responsibility rules. The law suit seeks restitution of plan funds and lost income resulting from the stock purchase; also, removal of the present owner as Trustee.

Normally, contributions to a qualified plan have to be made for covered employees with one year of service. Under present rules, a year is considered 1000 hours of employment. Suppose an employee with 1000 hours severs his employment before annual contributions are made to the plan. Does the company have to make the allocation? IRS says that no pay-in need be made for him (Rev. Rul. 76-250).

There is one exception to this rule. IRS will weigh the zero allocation of any pay-ins for ex-employees to determine whether the plan improperly discriminates in favor of highly compensated employees, officers, etc.

Treasury rules provide that if an employee, covered under a qualified pension plan, hangs up his work clothes after working the required number of years—but could have retired for disability—would be entitled to a sick pay exclusion of \$5,200 a year until he reaches mandatory retirement age.

Suppose a non contributory retirement plan provides few lump-sum distribution to a participant who becomes permanently disabled. Query: Is such payout entirely exempt from tax? The answer is "Yes" according to a district court in California. Here's the situation:

A profit sharing plan stipulated that permanently disabled employees would be entitled to receive 100% of their account without regard to eligibility for retirement or reduction of benefits because of age. James Wood retired when he became disabled and elected to receive a lump sum of \$100,000 (his 100% interest). Had Wood been paid only his vested account at the time, it would have been \$85,000.

Here's the tax clash: Wood claimed the \$100,000 was tax exempt because it was paid for disability under an employer's accident and health plan. IRS called it a retirement plan payout and thus taxable.

The court held that an accident and health plan can be encompassed within a broader profit sharing plan. One of the express purposes stated in the profit sharing plan was to provide a measure of security for the employees in addition to sharing profits. Also, the disability clause allowed an employee to collect 100% of his account upon permanent disability even though less was vested. The plan thus qualified as an accident and health plan and the entire \$100,000 was exempt. (Wood, Dist. Ct. Calif., 4/7/76). The case is on appeal.

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Benefit manager finds dental plans widespread at major corporations

CHICAGO—Well over half of the 46 major corporations surveyed by an interested employee benefit manager indicated that they offer dental benefits to at least one of the three types of employee groups: salaried employees, non-union hourly workers and union hourly employees.

Some 20 other companies—43%—said they offer no dental plan at all. But five companies reported that they are seriously considering

a dental plan.

According to a copy of the survey provided to *Business Insurance*, with the request for anonymity from the person conducting the survey, 22 of the companies provide a dental plan for salaried employees. Well over half of those are fully paid by the employer, the survey found.

Only one-third of the firms answering provide dental benefits for non-union hourly employees, with

half of those plans contributory, and half being non-contributory.

Union hourly employees most frequently are the beneficiaries of dental benefit plans, with 57% of the survey respondents noting they provide dental benefits to these employees. Of those plans, nearly two-thirds are fully employer-paid (non-contributory).

Six of the 22 companies providing plans buy dental insurance

from Prudential Insurance Co. Four others buy coverage from Travelers, three from Metropolitan Life, three from Connecticut General, two from Aetna Life & Casualty and one from Equitable. Two firms said they self-insure dental benefits or use 501(c)(9) trusts to fund the plan.

The survey showed a wide range of costs for various plans already in effect. Highest cost was for the Steelworkers dental plan, at \$21.14 monthly cost for employees. This program's cost reflects 50% coverage of major services, and annual maximum coverage of \$750 per employee.

The Steelworkers plan also covers 50% of orthodontia with no

deductible up to \$500 maximum. The estimated total company cost per year for this union plan is \$5,158,296.

Two major corporation plans were shown, as the middle priced programs. One has a monthly cost for employees of \$17.25, applying a \$25 lifetime deductible for basic services, benefit coverage of 80%, 90% and 100%. Major services have no deductible, with 50% coverage to an unlimited amount. Orthodontia is not covered. This was the only plan not providing for extension of benefits. Total company cost per year was shown as \$4,210,848.

The third plan was for a large national cosmetics firm. Estimated monthly cost for employees was \$13.77, applying a \$25 annual deductible for basic services and 80% coverage in that category. Under major services, a \$25 annual deductible appears again, with 50% coverage up to \$500 for basic services and \$500 for major services. This plan doesn't cover orthodontia. Total annual cost to the company is \$3,361,824.

The dental plan used by a major insurance company costs employees \$12.80 a month, has a \$50 lifetime deductible for basic services, and provides coverage of basic services on a sliding scale of 70% for the first year up to 100% in the fourth year and beyond.

This insurer's own plan has a \$50 annual deductible under the major services category, which are listed, as qualifying for 50% coverage, up to \$1,000 annual maximum for combined basic and major services. The plans covers orthodontia at 50% beyond a \$50 deductible up to \$1,500 lifetime maximum. Total company cost per year is \$3,124,282.

The least expensive plan shown on the chart belongs to one of the nation's largest employers in the communications field. Employees pay \$12.01 per month, and the total annual cost to the company for this dental plan is \$2,957,184. Provisions include: non deductible and 100% coverage for basic services, on a schedule; \$50 lifetime deductible and a schedule of covered benefits for major services; a \$550 combined maximum benefit for basic and major services; orthodontia is not covered.

Statistical results of the survey showed that the 22 companies offering dental benefits to salaried workers most frequently cover reasonable and customary charges (14), while four firms cover dental charges as part of major medical plans, three use scheduled benefit programs, and one uses some other plan. In the non-union hourly employee plans and the union hourly plans, employers also indicated that the usual coverage is for reasonable and customary charges, with a few firms using a schedule of benefits or including dental charges in major medical plans.

Arco settles seven suits

LOS ANGELES—Out of court settlements totaling "close to half a million dollars" terminated seven of nine lawsuits filed against Atlantic Richfield Co. in the deaths of nine persons killed by hydrogen sulfide seepage from one of the company's oil wells.

Edward Kettel, manager of Atlantic Richfield's insurance division, confirmed the settlement amount, covered by insurance with Continental Insurance Co.

The nine died when the lethal gas escaped from an oil well in Denver City, Tx. Feb. 2, 1975. Claims totaled more than \$20 million as a result of the incident.

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Eye cancer screening as new prepaid benefit

WASHINGTON—The feasibility of offering cancer screening as a new prepaid health benefit is under study by the National Cancer Institute (NCI), under a \$245,726 grant from the Blue Cross Assn. (BCA), the national coordinating agency for the 69 Blue Cross plans in the United States.

Theoretically, early detection and treatment of cancer would lead to lower treatment costs in the long run, as well as better survival rates, according to BCA's president, Walter J. McNerney.

Figures from the National Center for Health Statistics show that cancer, the second leading cause of death in the U. S., has a nationwide cost of nearly \$19 billion annually in lost earnings, productivity, medical treatment and other care. Last year, there were 665,000 new cases of cancer and 365,000 patients died from some form of the disease.

The cancer screening project will seek to determine if the latest medical techniques for detecting the disease can be developed in a program that will lower screening costs to a marketable level, said Mary Jo Gibson, NCI's project officer for the study.

"To date, however," she said, "the traditional modes of screening have generated costs that are considered too high for coverage by health insurers and other third-party payers."

During the year beginning August 1, BCA and NCI, the government agency for cancer research, will seek to determine the following:

- How will the cost of treatment and the decrease in deaths for patients being screened compare with the costs of cancer treatment without early screening?
- If savings occur, will they at least balance the cost of administering the program and providing the benefit?
- What sort of screening facilities should be used—hospital outpatient clinics, health maintenance organizations, industrial clinics, mobile or outreach clinics, or others?

BCA's president, Mr. McNerney, explained Blue Cross's inter-

est in the project as an outgrowth of its desire to affect the allocation of health care resources.

"If the project proposed here demonstrates a cancer screening benefit is desirable and feasible, the coverage will increase both resource expenditures and emphasis on prevention, early detection and early treatment of the disease."

"The broader distribution of limited resources should have a beneficial impact on the health of the population in terms of fewer cancer deaths and increases in productive man years to society."

"Thus our Blue Cross plans could help bring about a more rational and complete distribution of the nation's limited health care resources."

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NML carrier pays dividend

HAMILTON, BERMUDA—According to a report released on the June 16 annual meeting here of Nuclear Mutual Limited (NML), the 3-year old captive of the nuclear utility industry distributed nearly \$10 million to its insureds in 1975.

The exact amount, \$9,981,254, exceeds the amount of earned premiums the captive took in the previous year, \$9,122,965, the report stated.

NML provides property insurance coverages for 21 nuclear power plants and coverage under nuclear transit policies for its eleven utility members.

Its insurance committee, according to the report, recommended against NML's making sublimity available to insureds for earthquake coverages.

The committee reviewed utility practices for establishing the insurable value of nuclear fuel, and found "significant inconsistencies." It therefore developed a uniform procedure to be used by all NML members, which should be adopted as of April, 1, 1977, the report stated.

editorial opinions

A license to steal

BENEFIT COST control is in the news a lot these days—ours and the nation's. We commend employers' efforts to become involved in holding down the cost of health care, and in holding down the number of claims to be paid for employees under medical benefit plans.

But we have cause to wonder if employers are establishing controls in all the right areas. To wit: *A Business Insurance* editor recently spent a few days in a large urban hospital which said it has an automatic billing program, so that the hospital would bill the editor's health insurance carrier directly for the portion of the hospital bills to be covered under a group insurance plan.

Five months later, the editor received a phone call from the hospital's billing department. The hospital had, on its own, billed both the editor's group insurer as well as the editor's spouse's carrier, Blue Cross of Greater New York, which wasn't the primary carrier at all, and in the editor's opinion shouldn't ever have been billed.

But the hospital explained that N.Y. Blue Cross would, indeed, be the carrier to end up paying the sizeable claim, and not the editor's own group carrier. The reason: New York Blues are prohibited by the state insurance commissioner from having a provision in its group programs called "coordination of benefits," which means that a primary carrier (the editor's own group plan) would have to pay first, and a secondary carrier might be billed for the residual claim not covered by the primary plan.

Thus, another employer (not the editor's own) and the Blues were stuck with a claim not rightfully theirs, while the full payment received under the editor's group plan was returned intact to the insurer involved.

Another interesting point: The hospital employee who called the editor to discuss this said she handles *nothing* but this kind of duplicate-payment situation. The hospital routinely bills every carrier it can find for the full amount of the claim involved, said this billing person. The carriers themselves seldom, if ever, check to see if they should be paying these claims, she added. We assume the employers don't check, either, since we believe they'd be up in arms over this situation if they did catch it.

The hospital has a regular full-time staff of people, this lady informed the editor, to handle hundreds of these so-called duplicate payments. And it quite often happens that an insurer other than the one underwriting a patient's own group plan, is the one paying the final tab.

The editor asked the hospital if it always returns the duplicate payment checks to the insurers, keeping just one payment for itself. "We try," said the hospital billing person. Who's to know if you bill two or three carriers for the same hospital claim and keep all of the duplicate payments?, the editor probed. "Probably no one," said the billing manager at this hospital.

Seems to us to be putting a terrible temptation in front of the nation's hospitals, which might just be encouraged not to run their billing operations too efficiently. A hospital's cash flow could certainly improve as a result of failure by employers or insurers to check on coordination of benefits with other third party payers.

Only a few days after this incident, *Business Insurance* received an annual report from Blue Cross of Greater New York, which noted it had chalked up benefit savings of more than \$22 million in 1975 through third party recovery programs.

The N. Y. Blues went on: "We developed a coordination-of-benefits program to assure that the costs of benefits for subscribers with coverage by two or more group health plans (primarily in families where more than one person is employed) are allocated against the appropriate group coverage on a uniformly equitable basis. Another objective of the program was to prevent illness from becoming a profit-making situation that can adversely affect both the cost and quality of health care.

"Though coordination-of-benefits can plan an important role in controlling the cost of benefits—and ultimately the cost of health care coverage—the New York State Insurance Department has withdrawn permission for us to include it in our community-rated group contracts. It is our hope that this decision will eventually be reversed."

As indeed it should: The New York commissioner has no reason to be proud of this action. Coordination of benefits appears to be an important benefit management tool. We urge employers and health insurers alike to get busy on a program of claims control to prevent the automatic, unsupervised payment of claims.

Prominent role

EXCESS AND SURPLUS lines markets were, a few years ago, used for specialty risks (Evel Kneivel's motorcycle leap over a canyon) and for some routine large risks of a few major companies in the country, such as, to obtain enough product liability insurance to cover the manufacturer of a tricky product like birth control pills.

Those were the days. "Primary" insurers competed aggressively for commercial accounts, undercutting each other's rates and pirating business with competitive bids so low that even tough competitors couldn't meet them.

Medium and small sized agents and brokers across the land are now using excess and surplus lines markets to obtain insurance for even relatively small commercial risks. Corporate financial managers and insurance buyers are themselves surveying excess markets for coverage they'd never had any trouble purchasing, until the onset of 1976.

What's emerging is a class of buyers, brokers and underwriters very knowledgeable at using a segment of the world insurance market which has come to assume a prominent role in the realm of corporate risk management.

Business Insurance's issue of November 15 will zero in on the excess and surplus lines, and specialty risks, markets. With this first-time spotlight report, we'll look at who's using the excess markets, at how the markets themselves are changing and adapting to insurance buyers' altered needs, at the ability of excess lines brokers and underwriters to fill the capacity gap created by problems in the primary markets.

Do you have suggestions for stories or material you'd like to see in this spotlight report? If so, contact Susan Alt, Editor, *Business Insurance* 740 No. Rush St., Chicago, Il. 60614, (312) 649-5278.

letters

Letters are welcome. Address letters to the Editor of *Business Insurance*, 740 N. Rush St., Chicago, Il. 60611.

Superior effort

To the Editor: Having thanked our broker for putting me in touch with your publication, *Business Insurance*, I would be remiss if I failed to thank your entire staff for what I consider to be a superior publication.

The selection of articles, their content and, yes, even your format, all lend themselves to a vivid understanding and appreciation of what is taking place in the market.

Although, admittedly, the import of an expression of appreciation would be greater if it came from the risk manager of a large multinational corporation please know that our gratitude is of equal magnitude relatively speaking.

Once again, thanks to one and all.

John T. Evans, Jr.

Treasurer, Rubatex Corp., Bedford, Ma.

Just the reverse

To the Editor: In an April 19, 1976 article you quote an underwriter as saying: "The cost of product liability insurance to a punch press manufacturer will be the same whether it is a \$100 million sales company or a \$1 million sales company." All the information which we have available today indicates just the reverse. The developing statistics indicate that the premiums charged are in an inverse proportion to sales.

E. H. Rosenberg

President, RETORT INC., Franklin, Ma.

Favors "equality"

To the Editor: It is strange indeed that an insurance publication should take a position in favor of the plaintiff on the issue of benefit discrimination charges against the General Electric Co. ("stalling tactics", July 12). The propriety of taking an editorial position on a case in litigation is questionable enough. That the editorial should favor granting disability benefits to a female employee while she is essentially on "maternity leave" in the same manner as an illness or accident is incongruous.

It continues to bewilder me that some people believe that female employees are being discriminated against versus male employees when in fact they are indeed receiving "equal" treatment; i.e., there is no disability benefit for either sex due to pregnancy. Should disability maternity benefits be granted to female employees, such employees

Continued on page 10

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letters

Continued from page 8

would be obtaining a greater benefit than their male counterparts, simply because of the obvious fact that male employees are incapable of "disability" due to pregnancy. We would then indeed discriminate against male employees (or should we have "paternity leave" with disability income benefits allowed?).

If the court rules for GE (as I think they should), civil rights and equal opportunity for the sexes will not be "dealt a setback" as you put it—the court would simply affirm that logic and common sense will again prevail.

Duane E. Hitz, CPCU

Northwestern Financial Center,
Minneapolis, Mn.

Don't blame us.

To the Editor: We have read with dismay the news article entitled "Contractors Fear Shut-down Over Insurance" published in your July 26, 1976 edition.

You have quoted Mr. Cecil Nickel, a Detroit area insurance agent, in blaming the Greenfield Construction Co. Inc., for being responsible for the present climate in the tunnel insurance field.

Mr. Nickel's remarks are unfortunate, inaccurate and damaging. He is in a position to know that the Port Huron tunnel was not built by Greenfield Construction Co. Inc., but was constructed by a joint venture of four well-known contractors d.b.a. Greenfield & Associates.

All the suits resulting from the Port Huron tragedy involving death or injury to the joint venture employees have been completed. All the judgments and settlements have been satisfied by the

City of Detroit and other contractors not connected with the joint venture. Neither Greenfield Construction Co. Inc., nor the joint venture have been held culpable in any of these actions.

Why Mr. Nickel has chosen to distort these facts we do not know.

In the Mt. Clemens case, Greenfield Construction Co. Inc., was directly involved. However, only nominal workers' compensation payments have been made and litigation is unlikely in view of the evidence which indicates the tragedy was occasioned by acts of certain employees in direct violation of company rules and procedures. The insurance industry has not been hurt by this accident.

Local political forces did try to blow the Mt. Clemens accident out of proportion, but the Macomb County prosecuting attorney and the state attorney general held that no criminal action was appropriate.

The Michigan officials which

Mr. Nickel refers to are local elected officials (currently running for office) who are rehashing a five year old incident in an attempt to publicize their candidacy.

Your publication must have a wide circulation in the insurance industry because we have heard from several sources around the country regarding your article. In each case, we were informed that such publicity even though unfounded would hurt us with potential carriers.

Mr. Nickel's remarks apparently were prompted by his frustration in not being able to place coverage for his client easily. However, his distortions and half truths have seriously diminished our opportunities in the same market.

Warren V. Nielsen

Vice President, Greenfield Construction Co. Inc., Livonia, Mi.

Editor's Note: A Wayne County circuit court judge on August 9 found Greenfield Construction Co.

innocent of criminal charges resulting from the death of an employee in the collapse of an excavation in Dearborn, Mi. last November 12. Greenfield had been charged with willful violations of state safety regulations. The court ruling capped off five years of legal actions involving three unrelated underground construction accidents in Michigan. Greenfield wasn't held responsible in any of the cases arising from the accidents.

Motorola cut RBH and FIA after 30 yrs; FM is winner

CHICAGO—Motorola Inc. moved its entire property insurance program to direct writer Arkwright-Boston Manufacturers Mutual Insurance Co., part of the Factory Mutual System, dropping its property underwriter and broker of 30 years in the process, *Business Insurance* learned.

Motorola chose Arkwright-Boston for the cost savings generated in the program, which covers corporate assets of over \$1.5 billion. Further, FM was chosen because it undertook extensive flammability testing, resulting in reduced requirements for fire protection and sprinkler systems in several Motorola manufacturing plants, said Don Schieck, director of insurance and risk management.

Factory Insurance Assn., now part of Industrial Risk Insurers, had underwritten the Motorola account through Rollins Burdick Hunter for 30 years, Mr. Schieck confirmed. The property direct damage and business interruption insurance purchased by the corporation cost \$471,000 last year, although Mr. Schieck is confident that the new plan with Arkwright-Boston will save about \$150,000 to \$180,000 a year premiums.

Deductibles on direct damage coverage were increased in the process, however, to \$50,000 per occurrence from a much lower \$5,000 per occurrence, said Mr. Schieck. Motorola for a number of years has had a \$50,000 deductible on its business interruption coverage. "I moved from the \$5,000 to the \$50,000 because our past loss history showed we were trading dollars with the insurer in that area," he added.

"There are also some significant changes in engineering recommendations which will save Motorola additional dollars which are not included in that other figure," said Mr. Schieck. For example, Arkwright-Boston performed flammability tests on the plastic ductwork and made recommendations for Motorola's Phoenix and Mesa, Az. plants, coming up with "lesser requirements for sprinklers within the ducts," he noted.

"Right now they're getting into reduced protective systems requirements at other facilities."

Motorola has insured values for business interruption and direct damage to property exceeding \$120 million, said Mr. Schieck.

No annual aggregate limit has been applied to the new property insurance program at this point, Mr. Schieck added. "Arkwright-Boston also underwrites our boiler and machinery coverage, and we're talking to them about getting an annual aggregate loss limit which applies to all three policies"—the business interruption, direct damage and boiler & machinery. "We're evaluating what annual aggregate we want based on our past loss history."

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Tell of Swedish system for malpractice problem

WASHINGTON—Sweden's system for compensating victims of medical malpractice—a low-cost, no-fault approach—has caught the attention of a top federal health official and may one day serve as a model for the overhaul of this country's system.

Dr. James K. Cooper, director of health care systems for the Department of Health, Education and Welfare (HEW), recently returned from Sweden where he got a firsthand look at the country's national health care program and its malpractice compensation system.

The Swedish system costs about 50 cents per person to operate, compared to about \$5 per person in the United States, Dr. Cooper told officials at a briefing.

Dr. Cooper later told this magazine that the Swedish malpractice system goes hand in hand with national health insurance. "If we have national health insurance, there's no reason why we can't have the same thing (as Sweden)," Dr. Cooper said. "And there's no doubt we'll have national health insurance."

As Dr. Cooper explained it, only hospitals, not doctors, are liable for malpractice claims in Sweden. The system works much like workers' compensation does here, he said, with a schedule of benefits for each type of injury, based on awards made in recent mal-

practice cases before the system was instituted about 18 months ago.

The Swedish system is similar to a form of universal health care accident insurance, Dr. Cooper said, operated by a group of private insurance companies that pool the risk.

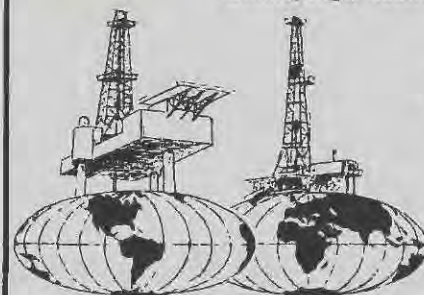
The compensation process cuts costs by eliminating almost all legal dickering. A malpractice victim files a claim with a local in-

surance office, which verifies the incident with the hospital and then initiates payment according to the benefit schedule.

If the insurance office and the patient do not agree on the compensation, the case goes to a local arbitration board. If that is not satisfactory, the case can be heard before a national arbitration board.

Besides eliminating the cost of going to trial the Swedish system is also attractive because it has built-in safeguards to control the quality of medical care Dr. Cooper said. All claims are reviewed by committees with the authority to impose sanctions on health care providers whose performance is not acceptable. ■

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Study captive possibility for B. F. Goodrich

AKRON—B. F. Goodrich Corp. has contracted with Armrisk for a feasibility study prior to establishing a captive insurance company, but says it hasn't made a final decision on whether to set up the subsidiary insurer to underwrite some of its insurance.

Goodrich confirmed that Armrisk, a division of American Risk Management Inc.-based in Englewood Cliffs, N. J., is in the process of doing the feasibility study for the captive.

That Armrisk is going ahead with the study apparently puts to rest reports which surfaced several months ago that some friction had occurred because Armrisk was set to do the study but then was held back by a Firestone objection to the project. American Risk Management's affiliate company, International Risk Management Ltd. in Bermuda, manages a Bermuda captive insurance company belonging to Firestone.

A Goodrich spokesman acknowledged that this "possible conflict" had been discussed with Armrisk. "But as far as we know, there is no objection on the part of Firestone," the corporate spokesman told *Business Insurance*. He further acknowledged, however, that such a conflict could arise because such feasibility studies involve gathering information considered to be proprietary, such as details of technologies involved in manufacturing operations.

The feasibility study now underway involves primarily Goodrich's property exposures worldwide, but it also includes some casualty and product liability programs. Johnson & Higgins, Rollins Burdick Hunter and Marsh & McLennan also made proposals to Goodrich on the international captive program. ■

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Flexible no-fault could cure product liability

By ELISABETH M. WECHSLER

ATLANTA—A "flexible" no-fault system for compensating product liability injuries, including a provision for binding arbitration, was proposed by a corporate attorney at the American Bar Assn. conference on insurance, negligence and compensation law here.

The proposal provides for "immediate compensation up to a threshold of, for example, \$5,000" to cover medical expenses and other provable out-of-pocket expenditures, including property damage, wage loss or loss of profits up to a predetermined maximum, rehabilitation expenses and attorney's fees.

"Pain and suffering, inconvenience, mental anguish and other intangibles would not ordinarily be reimbursable, unless the victim's provable claim . . . exceeded \$5,000, or unless the product injury resulted in death, dismemberment, permanent disability or serious disfigurement," explained Joyce S. Kornbluh, staff attorney

for Bristol-Myers Co., New York.

"In either of these events, pain and suffering would be awarded according to a predetermined schedule," she continued.

The plan's built-in flexibility makes it a realistic one to implement, Ms. Kornbluh believes: "The product manufacturer could elect to make the no-fault option available for a few specified products or for its entire line. Threshold levels . . . could be varied for different products."

Ms. Kornbluh suggested that "legislative approval of the plans would not be required, again so that maximum flexibility could be maintained."

If the injured consumer accepts the no-fault approach, he or she would "have to resort to final binding arbitration for recovery of loss or damage in excess of the immediate \$5,000 payment," she explained.

The American Arbitration Assn. or a "similar group" was named as a possible provider of the forum.

Ms. Kornbluh allowed for a con-

sumer's rejection of the no-fault approach in her plan. "If the injured consumer does not subscribe to the no-fault or products compensation system, he or she could resort . . . to the court system for relief."

"It is anticipated, however, that most consumers will prefer the no-fault system of ready cash to the uncertain reward, many years later, of possibly greater compensation in a court of law."

The advantages of the system to the product manufacturer center around the fact that it would afford protection from lawsuits for negligence or fault, Ms. Kornbluh noted.

"In order to deter the product

manufacturer from unreasonably resisting payment, a penalty of an added fixed fraction of the court award would be allowed to the successful litigation claimant where a no-fault claim was initially denied," she continued.

The adoption of a no-fault approach "should provide safety incentives for the product manufacturer to change the design of its products to reduce dangers." It should also spread the loss more equitably and reduce administrative costs.

Ms. Kornbluh emphasized that the plan is voluntary and must involve an injury that is "foreseeable by the product manufacturer and

within its control."

To prevent a "windfall" to the injured consumer and to restore to collateral sources at least some of the money paid out for the injury, the plan provides for the product manufacturer to compensate those collateral sources directly.

"Another reason for allowing compensation to the collateral sources is the expectation that, in return, they will give full cooperation to the product manufacturer in its handling of no-fault claims."

"The insured risk would be calculable, the limits of liability relatively ascertainable, the insured event definable, and the resulting lower premium attractive to the products manufacturer." ■

Health suppliers may lose revenues

ATLANTA—A physician connected with the Kaiser health maintenance organization system in California warned that workers' compensation benefits as reimbursement for medical treatment may be lost to the provider if there is no permanent disability.

"The patient usually does not apply for workers' compensation benefits since he has little or nothing to gain," said Walter E. Hook, M.D., of the Permanente Medical Group and Kaiser Foundation Hospitals of Northern California.

"We must pursue these cases aggressively and file our own applications for medical benefits to offset the real costs we incurred even if the patient did not," he continued.

Currently, the Kaiser plan provides complete medical care for

\$24 a month to an individual. "There are no surgical or hospital bills for the patient" he said.

Dr. Hook warned that this loss of medical reimbursement could dramatically affect an HMO's revenues. For Kaiser, gross revenue from workers' compensation increased from \$1.2 million in 1968 to \$7 million in 1975, he explained in his speech.

"Our experience has shown that we must be actively and aggressively represented in the litigation process by attorneys," Dr. Hook told participants at the insurance, negligence and compensation section of the American Bar Assn. Conference here.

"A provider of medical care in California is permitted to file a lien and pursue it even in the

absence of action by the injured employee," he continued.

Among other suggestions, Dr. Hook said that "employers must make available to physicians more meaningful information about the chemicals to which their employees are exposed."

"Better criteria for determining occupational illness must be developed, including expansion of standards for maximum allowable concentrations or threshold values," he advised. The impact of the occupational environment is often difficult to pinpoint, he noted.

In California, cases can be settled either by a findings-and-award or by a lump sum settlement. In 1974, approximately 52% of the some 80,000 cases were resolved by the lump sum approach, he continued. ■

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agent/broker topics

Brokers see claims handling service as yardstick of quality

By MARGARET LeROUX

NEW YORK—Claims adjusting may not make any money for brokers, but it rates among the most important functions they perform for their clients, representatives of a number of brokerage firms told *Business Insurance*.

"People want service," one broker said, "and the more service you give them, the more business you'll get."

Claims administration is "the single most important factor," in dealing with clients, says Gary Raeckers, president of Plan Services Inc., the administrative subsidiary company of Guy, Murray & Smith Inc., a Tampa brokerage firm.

"When people buy insurance they're buying something intangible," Mr. Raeckers explained. "How we handle claims is the means by which they measure us," he said.

Plan Services Inc. has a staff of six claims examiners and pays claims for 12 different insurance

companies. The company's clients include large group health plans, multiple employer trusts and self-funded plans for group health benefits.

Brokerage firms with subsidiaries in a number of cities usually have claims personnel in each office. At Schiff Terhune International Inc., a spokesman said "most of the claims activity is handled out of the New York and Philadelphia offices."

Though Schiff Terhune has in-house claims adjusters, the firm uses independent adjusters also—"GAB (General Adjustment Bureau) as much as any of them"—the spokesman said.

When there is a dispute over a claims settlement between the insurance company's adjuster and the broker, "it's our responsibility to represent the insured in any negotiations," the spokesman continued.

Here size is an advantage to the broker. "We can bring our weight to bear, on behalf of the insured," the Schiff Terhune spokesman said.

This point of view was echoed by spokesmen for Alexander & Alexander Inc., Johnson & Higgins, and R. B. Jones.

Each of A&A's eight regions has a claims office headed by a vp, explained Gerard Curtis, vp in the firm's New York office.

Each regional office is responsible for its own clients, although there is some interplay between offices. "If a client in San Fran-



Claims adjusting is critical service

When the infrequent disaster occurs, the claims adjuster becomes the key element in recovery efforts. A 1970 tank car explosion (right) brought dozens of

claims experts to survey the scene of the holocaust. After a factory fire (left), an adjuster examines records to decide what's salvageable and what's lost.

cisco has a claim in New York, the New York office may get involved," Mr. Curtis said.

"If it's a case where we have the only experienced adjusters in the area, we might assist another broker with a claim," Mr. Curtis said.

One of the biggest problems in claims administration is interpreting questions about coverage, said an official of Kansas City-based R. B. Jones.

"A single word injected into a policy can mean the difference when a question of coverage comes up."

Spokesmen for the larger brokerage firms said they don't pro-

vide claims adjustment services on a fee for service basis for non-clients, although there are exceptions to the rule.

"If it's a case where we think we can get the account we'll handle the claim on a service basis," one of the brokers said.

At Cook-Treadwell & Harry Inc. agents have draft authority for some of their clients which results in faster payment of claims, noted, John Litton, head of claims administration in the firm's Memphis office.

"We have limited draft authority, the right to pay claims up to certain amount, (usually \$1,000) for some of our clients," Mr. Litton said.

One client allows the firm unlimited draft authority, he added, "although I would never issue a draft in excess of \$5,000 without calling the client first."

"To me, claims administration is the public relations function of the brokerage business," one broker noted.

"It's a sales tool," A&A's Mr. Curtis said. "If we have better claims facilities than our competitors, it gives us an edge."

"Claims administration has always been a major part of the service we offer our clients," a spokesman for J&H said. "It was one of the things that made a broker years ago; it still is."

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Poe of Florida cashes in on groups, regional boom

By JANET MROCZEK CORRADO

TAMPA—Poe & Associates started operations in 1956 with one account. Today it is the largest independent insurance agency in Florida with offices in six cities.

Its gross revenue nearly tripled in the past five years, from \$1.36 million in 1971 to \$3.87 million in 1975. And for the first six months of this year the agency had pulled in commissions and fees totalling over \$2.7 million, a 51% increase over the same period last year.

The Poe & Associates success formula incorporates association business and continuing expansion, primarily through mergers and acquisitions.

Real growth started when the agency got involved in marketing property and casualty coverage for associations, said Joseph E. Brown, president. In 1970 it landed a big fish in the American Dental Assn., and now handles ADA business in every state except New York and California.

"We really did a risk management job for the dentists," Mr. Brown said. "We designed a homeowners' policy for the office, called the 'Professional Protector Plan,' a trademarked name since 1970.

The insurance package is com-

plete for the dentist. Besides the usual coverages, it includes fidelity bond as well as professional liability. Experience in professional liability "is marginal at best," he said, "but we always look at the whole package."

Poe & Associates really acts as a branch office of Chubb, which underwrites the ADA plan. Local selling and servicing is handled by state administrators, who "almost get standard local commission rates," Mr. Brown said.

The agency has about a dozen associations as clients, some national trade groups like the National Assn. of Dental Laboratories, and some local, like the Florida Air Conditioning Construction Assn. and the Florida Concrete Products Assn., which it has had since 1957.

In 1973, it was appointed agent for The Florida Bar Assn., and handles the property/casualty, life and accident and health coverage as well as professional liability, for the bar's 17,000 lawyers. Gulf Insurance Co., Dallas, is the carrier.

The professional liability experience for the attorneys has been moderate, Mr. Brown said. There have been rate increases, but the market "hasn't fallen apart," he added.

"We like association business,"

Mr. Brown said. "We can take a good producer and make him a super producer by giving him a market and getting him enthused about it."

Poe & Associates also likes expansion. Based in Tampa with offices in Miami, Ft. Lauderdale, Orlando, Venice and North Port, Poe plans to start or acquire an office in Jacksonville and hopes to be "through" growing in Florida within the next three years, which means an office in the panhandle area of the state, like Tallahassee, and perhaps one in Ft. Meyers.

Then, the agency will branch out around the Southeast. In the next year or two, "we will start looking outside the state," Mr. Brown said.

The company started acquiring local agencies in 1964 when Mr. Brown joined the firm. William F. Poe, founder, is not active in the business now. He is now serving as mayor of Tampa.

Since 1973, Poe & Associates has purchased two agencies, merged with one, and started two scratch operations, which you can do "if you have the right people," Mr. Brown said. This year it is looking for only one new firm to acquire.

In 1973 Poe & Associates became the first Florida domiciled

publicly-owned insurance agency.

The idea was to finance expansion, Mr. Brown said. It costs \$50,000 a year to meet government requirements, "to maintain a public posture, but it means something to our employees to see our stock quoted in the papers."

William Poe is the largest single shareholder, of course, although over 40 employees have acquired stock, traded over-the-counter.

Earnings per share for the six months ended June 30 were 30 cents, compared with 21 cents in the same period last year. Its operating profits for the first half of the year were \$340,312, 50% higher than results for the first six months of the previous year.

"We have exceeded our goal of 20% growth each year," Mr. Brown said. Last year the agency had a 23% or 24% increase, and so far this year it is up 50%, which is "unreal," he said. "It won't hold up that high by the end of the year."

After-tax profits were \$533,000 in 1975, up 20.5% from \$442,000 the year before. Profits are more than two-and-a-half times greater than the \$199,000 earned in 1971.

Commercial accounts represent 93% or a bit more of Poe's business. The agency's largest account

brings in \$2 million to \$2.5 million in premiums. Poe has about 10 accounts that exceed \$100,000, and approximately 100 in the \$10,000 to \$100,000 area. Total commercial accounts, spread throughout the state, number about 10,000 to 15,000.

Unlike many agencies in the country, Poe & Associates has very few fee arrangements, Mr. Brown said. A commission-only situation is normal in Florida, he explained, since you cannot get both a fee and a commission in the state.

"But, we negotiate the commission down to a fee anyway," he said, "We figure how much it will cost to handle the business, and structure up from there. And this is openly discussed with the client."

The agency budgets for \$25,000 a year in contingent commissions, "but we don't depend on it," Mr. Brown said. "Sometimes they are significant and sometimes nothing."

Last year Poe & Associates got \$160,000 in contingent commissions, but this year \$35,000 is it. The reason—"there has been an inadequate rate structure in Florida so companies can't make money," he said.

Continued on page 12D

Commercial clients' slow pay habits cut into 'float'

By JOANNE GAMLIN

LOS ANGELES—Investment income from 'float' funds is not an impressive contributor to earnings for brokerage firms outside the ranks of the largest national firms, say brokers located on the West Coast. And, given the adverse economic winds of the past two years, provoking the slow-pay habits of insureds and the fast pay orders of insurance companies, the float can sometimes appear to be more of a detriment than an earnings enhancement, contends the Pacific Coast insurance brokerage community.

As the negative case was expressed by an executive for a major firm here, brokers unfortunate enough to have commercial insurance clients who cannot pay the premium when it is due "must put

the money up front themselves."

One consequence, he said, has been a "massive" campaign to tighten up premium collections at his firm. Stung first by inflation and then by a brutal recession, many of the firm's clients have been visited by the slow-pay syndrome, he told *Agent/Broker Topics*.

Beyond this, the need to 'educate' employees, particularly middle-aged account executives, in the art of extracting late payments from recalcitrant clients has been a big headache, he continued. He said their habit of identifying 'good' customers and then relaxing credit standards is strictly a thing of the past, an era long gone when clients paid speedily and underwriters didn't demand premium payment guarantees.

This spokesman contended that brokerage firms must be larger than his, must be in the ranks of the top five or six concerns, before the investment income from floats graduates to a significant ingredient in the bottom line.

Another dissenter to the idea of the float as a positive force was Gordon Beamer, head of The Risk Management Group, San Francisco. He said his organization, which nabbed the University of California as a client to launch its existence, is disenchanted enough with the float concept to be debating the idea of having the university pay its premiums directly to its underwriters.

"We at Risk Management Group believe the cash flow advantage should go to the underwriters," he explained.

There is another negative for

brokers and agents situated in California. It is, according to Angele Khachadour, chief counsel of the California Department of Insurance, that brokers must obtain permission from their clients as to how they may invest float funds. Agents, by the same token, must win agreement from their carriers on the matter of investment practices. For brokers, to be sure, it is impractical to go to each client to dicker for approval on investment practices.

The state of California furthermore limits the vehicles which agents and brokers can use to draw investment income from their float funds. The regulations dictate that the vehicles must, first of all, be liquid, in effect restricting brokers and agents to short-term money market instruments such as certifi-

cates of deposit, commercial paper and bank savings accounts. California also requires brokers and agents to segregate their float funds from other cash or equivalent accounts in order to protect these funds, should the agent or broker topple into bankruptcy.

Given all this, it is no wonder that a number of California-based brokerage firms come down hard on the negative side of the float picture. Bernard Mizel, head of Albert M. Bender Co. Inc. of San Francisco, noting that float income is insignificant for his firm, pointed out that he favors letting the carriers have any earnings advantage to flow from floats.

"Insurance companies should get together to prohibit brokers from milking the floats," he declared. "In reality, it is to the brokers' advantage that the carriers' financial position is upgraded, because the underwriter will then be able to accept more business."

Mr. Mizel went on to state that the float concept is useable mostly for brokerage firms that have a small number of large accounts. Since larger clients tend to pay more promptly, he said a broker is better able to earn an investment income on float funds.

Offering another side of the story was a competing San Francisco brokerage firm where a spokesman said that investment income derived from floats rose between 1974 and 1975.

While forecasting that investment income will not climb this year, primarily because of slow-paying clients and a shorter period for brokerage firms to hold premium dollars, this spokesman asserted that float income is a pleasant addition to his firm's financial picture.

"We regularly have a six figure amount of money in the banks or wherever, earning between 6% and 8%," he elaborated, suggesting that no matter how you slice it, this kind of income has got to be good.

Certificates of deposit (CDs) and high grade corporate paper, sporting yields from 6% to 8%, are what this brokerage firm uses to convert a float into a positive earnings contributor.

Investment patterns have turned a trifle more conservative this year, he added, due mostly to the general uncertainty about the direction of short-term interest rates this year.

Erich Dahlberg, vp finance for Bayly, Martin & Fay Inc., Los Angeles, struck the more common note by disclosing that investment income is of "limited value" to his firm. He said that 30 to 90 day CDs and bank savings accounts are where he places BMF's float funds. Mr. Dahlberg estimated that investment income for his firm declined from 1974 to 1975 in line with the shattering of short term rates. However, the rise in these rates this year should drive up investment income, he figures.

"Of course, we must regard the money as a fiduciary and invest only with the approval of the client," he said, noting that he has been impressed with the extent to which the major brokerage firms in Los Angeles accept their fiduciary responsibilities.

Penn General Agencies Inc. in Santa Monica, Ca., anticipates that investment income will be a growing factor in its future earnings picture, said G. R. Ginsberg, treasurer.

Although investment income declined from 1974 to 1975, he expects it to rise this year, what with the big strides in the economy and

Continued on page 12D

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Poe . . .

Continued from page 12A

The agency has 35 producers out of 164 employees, up from 105 in 1974, primarily because of an acquisition in Miami. Producers are responsible for selling, servicing, "and collecting," Mr. Brown emphasized. An inside staff markets and puts the package together.

A producer, technician and secretary work together in a unit system, though one technician may have two or three producers depending on the producer's book of business.

Most producers get a salary plus incentive, Mr. Brown said, though some primarily employees of proprietors which Poe acquired, are on straight commissions. Producers in the surety department are also on straight commissions.

"We like specialization," Mr. Brown said. The agency set up a surety department six years ago,

has an employee benefits department, and not only a separate department but a separate location in Tampa for personal lines.

Personal lines business is actively sought, "though we acquired a good amount of personal lines with the mergers and acquisitions," Mr. Brown said. It represents 5% to 7% of the agency's business overall, and "it is not a high profit item for us."

Though not over \$200,000 comes from life and group accident and health, (40% life, 60% group medical) "we want to do more and are trying to expand those sales," Mr. Brown said. The absence of service makes life and accident and health profitable," he said.

A year ago Poe & Associates put in its own computer which now handles financial and statistical information. Next it will look to the computer for renewal invoicing, then perhaps as a selling aid.

Could Poe & Associates be do-

ing anything wrong?

Mr. Brown admits to being weakest in the area of personnel. "We don't have a plan to go out and get the right kind of people," he said. "We mostly rely on word of mouth now."

"We try to work with the high schools and colleges, and we have friends. Our market for college graduates has been good, since our main competitors, like the banks, haven't been hiring lately."

"We've found that it is not always the answer to look for insurance company employees." The demands are much more immediate in an agency, Mr. Brown said. Clients have to be taken care of right now.

While the agency emphasizes continuing education and pays for all college or CPCU courses, "we could do a better job there too."

"The whole business is people," Mr. Brown said. "If we can get the right people, we can continue to grow."

Earnings on 'float' . . .

Continued from page 12B

the leap forward of short term interest rates. Triple A-rated paper, CD's and savings accounts are the favored investment modes.

The organization is currently in the process of instituting a national cash management program, noted Mr. Ginsberg, which should give a boost to investment income.

On the problem of dealing with clients who refuse to meet their premium deadlines, Mr. Ginsberg said that 'premium financing' is a worthwhile tool. Under such an arrangement, the brokerage firm arranges for a finance company to advance the premium payment to the delinquent client.

"In this way, we get our money in 10 days," he said, noting the rule that the brokerage firm must remit the money to the carrier within 45 days.

Seasonal businesses with premiums due in June but having sales patterns of takeoffs in January can be handled by having the policies re-dated, he said.

Float-related woes that loom so large for California brokerage firms are not absent in the Pacific Northwest. In Seattle and Portland, brokerage spokesmen stressed the difficulties in extracting a solid investment income from float funds.

"We are on the bottom rung of the top 8% of all agencies, doing over \$2 million a year in gross premiums, and still the float is not a big factor for us," lamented a Portland, Or., broker. For one thing, he said that a firm like his must compete with direct writers who can attract clients by offering them time payments on premiums. For another, he said that clients normally pay so late that he does not have sufficient time to invest premium dollars before they must be turned over to the carrier.

Farther north, a Seattle broker echoed the sentiments that floats are moneymakers only for the largest brokerage firms. He noted he copes with delinquent clients by means of a stringent collection procedure. Customers who fail to meet a premium deadline are swiftly cancelled, he pointed out.

The West Coast broker who spoke so forcefully on negative aspects of float income said that his firm has had to spend a lot of time re-educating older account executives who are reluctant to crack down on slow paying clients.

"We have just about run out of fresh ways to hit them over the head," he said, noting that in recent months bonuses have been restored to as a means of rewarding executives who persuade clients to pay up on time.

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Directory

To the Editor: A directory listing the members of the Assn. of Managing General Agents was mentioned in the April 19 issue of *Agent/Broker Topics*. Is there any way that we might get a copy of this directory?

Lida Kane

George V. Kane & Co., Houston, Tx.

Editor's note: You can obtain a copy of the directory of managing general agents by writing to William Stringfellow, executive director of the American Assn. of Managing General Agents at #942 Washington Building, 1435 G Street N.W., Washington, D.C. 20005.

Non-piracy agreement

To the Editor: We read with interest your article of May 31, 1976, "The Well-Managed Agency: Only 1 in 10 Qualifies," by Susan Alt.

In the article Ms. Alt quotes Mr. Dave Hales, president of Hales and Associates, concerning the need for non-piracy agreements. If possible, we would be most grateful for the opportunity to see an outline of or a copy of such an agreement.

J. P. Garlington Jr.

Garlington-Hardwick Co. Inc., Atlanta, Ga.

Editor's Note: We plan to do some stories in the very near future on the style and content of these so-called non-piracy agreements. In the meantime, we've relayed your request to Mr. Hales in the hope that he can supply you with one of these. Mr. Hales' discussion of non-piracy agreements piqued our interest, too, so we'll look into these.

Pro-agent group pushes views on federal regs

By MARIE KRAKOWIECKI

WASHINGTON—The National Agents Political Action Committee persuaded some 500 private insurance agencies to donate at least \$100 apiece to fight what it perceives as "anti-agent" legislation at the federal level.

Within a year it hopes to get 1,000 agencies to do the same. NAPAC tells them they are then members of its "Century Club."

The money that pours into NAPAC from private agencies goes to Congressmen who have been sympathetic to some of the pet causes of agents—preventing banks from getting into the insurance business and keeping no-fault at the state rather than the federal level are just two examples.

In some cases, the money has been poured into campaign funds for the politicians, although Hill Rylander, paid lobbyist and secretary-treasurer of NAPAC, says campaign contributions account for only a small part of the \$100,000 a year the committee raises.

Much of the money donated by agencies to the lobbying efforts of NAPAC is the result of a direct mail solicitation letter the committee theoretically sends out to all 33,000 agent-members of the Independent Insurance Agents of America, NAPAC's parent organization. (Several states prohibit direct-mail solicitations to agents, so those members are not reached, Mr. Rylander explained.)

The direct mail campaign does not promise the individual agent any particular immediate benefits he can expect from a monetary contribution. Why then are the agencies sending in the cash?

Bernard J. Burns Sr., this year's chairman of NAPAC, explained that the agents who contribute money to its political lobbying efforts hope to achieve a philosophical victory rather than any tangible change in management practices or profits.

"Preserving the (agency) system is what we're all about. If the government takes over, we could be through," Mr. Burns of the Milford, Connecticut agency Burns & Howlett Inc. said.

As agents realize their stakes in government decisions affecting such areas as malpractice, no-fault and workers' compensation, their acceptance and support of the political action committee concept of the IIAA is increasing rapidly, Mr. Burns added.

Mr. Rylander, who also serves as director of government affairs for the IIAA, said money is solicited for political action not only through the direct-mail campaign, but also by requests made at agents' conventions.

So far, none of the money raised by NAPAC has been channelled into the campaigns of any Presidential candidates: this is specifically prohibited by NAPAC's constitution.

However, at NAPAC's annual meeting coming up September 18, the whole question of contributing to this year's Presidential campaign will be debated and discussed "and hopefully revised," said Mr. Rylander.

Does this mean that NAPAC would come out in favor of a certain Presidential contender as being "pro-agent"?

"Welllll, I have my own opinions on the subject," Mr. Rylander said, obviously favoring one candidate, "but I can't give you NAPAC's official position yet."

Mr. Rylander said that the September 18 meeting will also be a key forum for deciding the agents' position with regard to tort reform in the areas of malpractice, no-fault and production liability.

Some of the politicians to whom NAPAC has contributed money donated by insurance agencies across the country include Senator William Proxmire (D., Wisconsin) and Congressmen Henry S. Reuss and Fernand J. St. Germain for their work in limiting the expansion of banking business into the insurance area; Congressman John McCollister, for his position favoring a state-by-state approach to no-fault; Butler Derrick, of South Carolina, and to Sen. J. Glen Beall, of Maryland.

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Non-compete contracts are common for brokers wanting to retain clients

By JANE WINEBRENNER

CHICAGO — Non-competitive contracts between producers and their brokerage employers remain on the underside of the brokerage business, not often discussed publicly but always present. And just as Macy's doesn't tell Gimbels, one broker doesn't want to lose his clients to another.

To forbid a former employee from soliciting, diverting, or accepting accounts from an agency or brokerage firm for two years after his departure, "non-compete" contracts, also called non-piracy contracts or protective covenants, are signed. In the case of mergers or acquisitions, they forbid former employees of the acquired firm

from accepting their old accounts for anywhere from three to five years after the merger.

In the case of new or existing employees, a contract is signed as a tacit agreement that the business produced by the employee during his employment belongs to the company. In the case of mergers and acquisitions, it is signed to insure that a person who was bought out will not leave the new company and walk away with his previous accounts.

At Alexander & Alexander, the practice of non-competitive agreements was recently centralized and standardized. Where before the practice was to let each regional director decide if an employee should sign the contract, now the

national policy requires all new employees to sign.

"In a society like the U.S. has, it flies in the face of free competition, but in a service business like ours it is the only way a corporate entity can protect itself," Alexander & Alexander's legal counsel Ronald Roessler said.

At Frank B. Hall, employees are sometimes required to sign such agreements but not "100% across the board," according to a Hall legal counsel, Marv Cashion.

"There is not a set policy. As in all aspects of the business, it's left up to (the profit-center manager's) discretion.

"If we continue to get increased demands, or employees who leave

the company, we may change the policy," Mr. Cashion said.

At Corroon & Black, one official said, "We don't care to release that information; we feel it's confidential."

Non-competitive contracts are not uniform in all agencies and are not used by all firms.

Mr. Roessler refers to the relationships between brokers and their clients as similar to those of "an old family doctor." Thus, it is realistic to assume that when an employee leaves he could easily take his account with him. Even if a client wants to keep his old broker, that broker is forbidden by the contract from accepting his business. Mr. Roessler, who has researched non-competitive agreements, said the courts have ruled that the client is free to choose any broker but the broker cannot accept or receive his business.

Though such contracts are a potential legal thicket, Alexander & Alexander until now has never

had to test their employee non-competitive agreements according to Mr. Roessler. He did admit, however, that now more employees are required to sign them, there may be more cases in the future.

"If we have to go to court to enforce it, we can generally work it out. The new employer may not want the problem of a court case," Mr. Roessler pointed out.

It is one thing to draw up such contracts, but to make them legally binding involves civil court cases and as Mr. Roessler notes, the burden is on the party seeking to invoke the covenant.

According to one broker consultant, the problem with some contracts is that they are written too broadly by the broker and cannot be enforced in court: "A contract is made less stringent but it can be enforced to get relief."

Whether a particular contract can be upheld depends on the state law, the court and the circumstances of the case. In Oklahoma and California, according to Mr. Roessler, non-competitive contracts with employees are not legal but those involving merger and acquisition are.

In some states, courts will "blue-line" covenants which means the judge will uphold the contract but will reduce the restrictions set forth in the agreement to a time period "reasonably necessary."

Mr. Roessler has found that in acquisition contracts, the time period forbidding competition is from three to five years but never longer. In employee contracts, "two years is as much as I feel I can write." He has also found that courts are always more willing to enforce the contracts when acquisitions are involved but not as willing when employees are.

At Alexander & Alexander an ex-employee is forbidden to solicit or receive only those accounts which he personally serviced. While an employee would not be fired or passed over if he refused to sign a contract, Mr. Roessler said, it could place him in a difficult situation with superiors.

"It places the managing vp or regional director in an awkward position. It tells them that this person could leave tomorrow and walk away with the accounts. It might affect his (the vp's) judgment when assigning new accounts," Mr. Roessler said.

According to Dave Hales, president of the insurance brokerage consulting firm of Hales & Associates, provisions that should be included in a non-piracy agreement are injunctive relief and damage awards if the employee violates the agreement.

This means if the employee does solicit or accept business, the former employer can bring an injunction against him prohibiting him from doing business; or damages can be awarded, such as returning twice the commission fee.

Usually, geographic limitations written into non-piracy agreements do not hold up in court if they involve an employee but they will if the principal of a merged or acquired firm has signed it.

Mr. Hales strongly believes any employer in the insurance brokerage business should protect itself. "Ownership of renewals is a very valuable thing."

He also feels size is not an issue in determining whether to draw up non-compete agreements. While such agreements are a "growing practice" among firms in the \$750,000 to \$1 million commissions range, it is not, below that size. The large national firms sometimes feel they do not need such agreements, according to Mr. Hales.

At the medium-sized brokerage firm, Insurance & Risk Management
Continued on page 12G

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Agent defines the 'ideal' small group prospect

By ELISABETH M. WECHSLER

BOSTON—"I prefer a corporation with between one and 25 employees eligible for a pension or profit sharing plan," said Edwin W. Arsham, a CLU member of the Million Dollar Round Table and a producer with New York Life Insurance Co., Cleveland, Oh.

"With a workforce exceeding that number, another approach such as a group pension may be advisable," he noted.

"Generally, anyone who owns his or her own business is a prospect," Mr. Arsham stated in remarks prepared for the annual Million Dollar Round Table conference here.

"Sales figures are interesting but the key word is profit. If the corporation is making money and paying income taxes, that is what you are looking for," he emphasized.

Another important criterion is a good prospect, which he defined as "one with whom you have some measure of control: An existing client, a friend or relative who owns the company. The closer your contact is, the easier your sale will be," Mr. Arsham said.

"When you get an appointment for an interview, it might be advisable to take an experienced associate with you on your first case," he said.

The next step is determining why the prospect agreed to see you. "Why is he letting you sit in the chair across from him taking up his valuable time? Is there something about his business which is disturbing him? Ask him about it . . . Do some probing. Disturb your prospect," he advised.

Mr. Arsham pointed out that accountants are "partial to profit sharing plans because the employer's contribution may be determined each year by the board of

directors . . . (and) there is no fixed contribution."

In contrast, a defined benefit pension plan is more attractive "when the owner is considerably older than his employees. In some small corporations it is not uncommon for 75% or more of the total contribution to be used for the owner . . . because there is a shorter period in which to fund a larger benefit," he said.

Though he advised the life insurance agent not to become involved in processing the various legal documents and in carrying out the plan's administration connected with the Employee Retirement Income Security Act (ERISA), he does advise meeting with each participating employee.

"This gives me an opportunity to do some public relations work

for the prospect who is now my pension client," Mr. Arsham said.

He explained that until ERISA was passed, he had assumed a greater fiduciary role in helping his clients with the necessary paperwork and administration.

"Simply stated, ERISA tells us that you can't be all things to a qualified plan and still earn commission by selling life insurance to the participants," he said.

"Agents may continue to sell life insurance to qualified plans until June 1977 without running afoul of government regulations. What will happen then is anybody's guess but it is entirely possible that agents acting as pension consultants and offering a complete line of services may be prohibited from selling life insurance to pension and profit sharing plans."

If your own companies do not offer ERISA-related services to help clients with these other matters, investigate companies in your area that do provide them, Mr. Arsham suggested. "Check it out before you refer your client to it."

"ERISA has caused some other special problems for life insurance agents," he continued, referring to the complicated legislation and changing interpretations.

"Consequently, you have to make certain that you are completely familiar with ERISA and that you are kept abreast of the constant changes in its interpretation," Mr. Arsham noted.

"The burden on you as agents is to be able to answer any questions or objections raised by your prospect. Knowledge of your subject matter is the key. You will have

to study," Mr. Arsham continued, referring to a manual developed by the Million Dollar Round Table.

But Mr. Arsham indicated he is anything but discouraged about the potential sales advantages of the ERISA market.

"It's true that all qualified retirement plans are a bit more cumbersome to administer than they used to be, and defined benefit plans are not quite so popular as they used to be, but let's pull up the shades and let some sunshine in. The tax advantages to the employer and the participants are still outstanding, and the rewards to the agent are still as sweet as they always were," he believes.

"When the dust settles and the regulations are simplified and clear, the use of pensions and profit sharing plans as a matchless benefit will continue to expand." ■

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Non-compete

Continued from page 12F

ment new employees have been required to sign non-competitive agreements for the last 10 years according to managing partner Julian Bowers. Though he has not had any court cases, he said he would first try to reach some kind of compromise with the former employee, such as making the ex-employee pay for his former accounts.

Insurance & Risk Management is a Fort Wayne, In. firm with 71 employees and gross revenues of over \$1.6 million. No matter what size the agency, Mr. Bowers said he thought any "aggressive agency would be interested in closing this exposure.

"A long-time employee working for 10 to 15 years could take 80% of his business with him when he leaves," Mr. Bowers said. "I would be disappointed in him if he couldn't take that much with him."

For those brokerage firms or agencies paying straight commissions to their employees an additional problem is raised. According to the brokerage consultant, the decision has to be made who owns the business. Usually in privately-held agencies where straight commission with no salary is paid, the employee owns his own business and the renewals.

This consultant also points out that a recent court case, established the legal point that something must be given to the employee in return for signing a non-competitive contract, such as job security or compensation. "The courts are very reluctant to take a man's livelihood away from him." ■

Insurance market forces translating into new demands on brokers' time

By PAUL R. MERRION

WASHINGTON—As the traditional role of the broker evolves along with changes in the rest of the insurance industry, there are also some subtle shifts underway in the broker/risk manager relationship.

Many offsetting factors are at work determining how much time a typical client can and will demand from a broker.

Tight insurance markets, rapid changes in market conditions and the need for newly developed services outside of marketing policies are putting new demands on the number of hours in a broker's day.

At the same time, the increasing sophistication of risk managers,

especially the tendency to be less dependent on insurance and the growing use of fees rather than commissions, are limiting what a broker is expected to do for a client.

Yet there is no "typical" client and no "typical" broker/client relationship. The job of a broker is determined by many factors, and it varies from industry to industry, from company to company, and even from risk manager to risk manager.

"There are no hard and fast rules," said Russell Drake, director of corporate risk management at Borden Inc. "It depends on what your needs are and the size of the commission.

"You can't expect a broker with a \$5,000 premium client to provide the same service as he does to someone with a \$250,000 premium," said Mr. Drake.

With the increasing importance of the insurance program in the total corporate financial picture, "small and medium-sized companies are leaning more on insurance brokers than ever before," he added.

But larger corporations who beef up their insurance staffs rely on the inhouse staff more and use a broker only for insurance marketing, Mr. Drake said.

Two things that can be expected of any broker is that he keep the insured advised of any changes in market conditions and that he

be available as a sounding board if a risk manager is trying to develop a special insurance project, such as consolidating all property damage policies into one super-policy, Mr. Drake said.

In the same way, there are some things that a broker should be able to expect from his client, Mr. Drake continued.

"Too often brokers are treated as adversaries," he said. "Some risk managers tend to withhold information, which places the broker in a disadvantageous position."

Full communication on the part of a risk manager is an advantage, he said. "If a broker knows all the facts then he's better able to approach markets."

Harry R. House, risk manager for the National Paint and Coatings Assn. here, said there has been a 50% to 100% increase in the amount of time he has spent working on problems with product liability coverages, including the

time he has to spend with brokers.

Yet at the same time, Mr. House said the most significant change he has seen in the last few years is that "we are using brokers less and less for placing coverage."

As Mr. House said, "The time depends on the type of program involved."

Because the need for a broker's time goes up as problems increase, and because premiums may or may not go up correspondingly, Mr. House said he recommends to the members of the association that they "pay with fees in almost all situations."

Because brokers have to spend more time on troublesome coverages, a small broker with a limited number of personnel can get stretched thin trying to meet all the demands of clients.

"We'd rather see the small broker continue to exist," Mr. House said. "The small guy can give personal service."

"Fees are the best basis of payment whenever possible," he added.

"Forget about commissions," Mr. House said. "Talk about the utilization of time and the fee."

"And we tell our members, 'Your brokers won't get enough money on a commission basis. Your costs in the long run will be lower' if payment is based on fees," Mr. House said.

John Woods, risk manager for Marriott Corp., also said that the amount of time that can be expected from a broker depends on whether he is paid with fees or commissions.

"The broker who figures the fee bases it on how often he'll have to talk to the client," Mr. Woods said. "In some cases, the company actually lists specification on what is expected from broker." For instance, a risk manager might want to drop the broker's claims service or loss prevention service, he said, if he feels his inhouse staff or the insurance company can adequately handle the job.

Another important factor is the type of firm a risk manager works for, and the type of business it does.

Charles H. Harry, newly hired corporate risk manager at Dynallectron Corp. near here, said he has been spending about 20% to 25% of his time in communication with brokers, plus another 15% to 20% of his time with representatives of the direct writers that Dynallectron uses.

"That may taper off—we were in the middle of renewals when I walked in here," Mr. Harry said. But because his new employer is a manufacturer and international contractor of electrical systems, Mr. Harry figures the time he spends with brokers and company representatives won't get "much below one-third of my time."

That compares to less than 5% of his time when he was at RFS Products Inc., which is a retailer with a simpler insurance program.

The expertise of the individual risk manager is still another important factor in how much time he will need from his broker. Obviously, a neophyte in the insurance field will be very dependent on—and at the mercy of—his brokers, but as he and risk management in general become more sophisticated, he will grow less dependent on insurance and therefore less dependent on brokers.

"There's no question that everybody is demanding more and getting less—because of the state of the underwriting market," Mr. Harry said. "Brokers have to get involved more and that takes more time."

"But in general, risk managers are becoming less dependent on brokers because they're becoming less dependent on insurance," Mr. Harry said.

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Accountants' risks are becoming uninsurable

ATLANTA—The professional indemnity insurance situation for accountants has "deteriorated dramatically," commented Eldon Olson, general counsel for Price Waterhouse & Co.

"The cost of primary coverage became prohibitive," he told participants at the American Bar Assn. Conference on insurance, negligence and compensation law here. "One major firm with a very good record concluded that it could not economically afford to have any insurance for the first \$3 million of any claim and has recently dropped its primary coverage."

"Equally disturbing, it also found that it was simply unable to renew over 25% of its catastrophe (excess) coverage," Mr. Olson said.

These two trends underlie "adverse developments of the last few years" pertaining to accountants' liability, he continued.

Still, he praised the U.S. Supreme Court's action in March to reject an interpretation of SEC Rule 10B-5 as "a national negligence statute" in Ernst & Ernst versus Hochfelder.

"A contrary interpretation would have provided a basis for recovery by investors and speculators of their market losses from companies, directors and . . . accountants . . . who were found by a jury to have acted in good faith but to have been negligent," Mr. Olson pointed out.

He emphasized that if the Court had decided the Hochfelder case differently, "such liability could result because a jury of laymen concluded that professionals were negligent because they failed to prevent the particular . . . issue from being misstated or omitted by the company."

The Hochfelder case was "tremendously important" in determining the degree of culpability

required for accountants and others to be liable under Rule 10B-5, he said.

"It is not possible at this time to predict the final form of any new legislation," Mr. Olson said. "But if it does become a crime to lie to an independent public accountant . . . it may tend to shift the emphasis away from the facts concerning the company's transactions and whether they were fairly reported, to exactly what was said to the auditor."

Mr. Olson believes that "if this tends to make honest company officials more guarded in their discussions with auditors, the proposed provision (to make lying to an accountant a felony) would be most unfortunate." ■

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WASHINGTON—The Internal Revenue Service ruled late last month that a business executive who pays for his own liability insurance against corporate "wrongful acts" can claim that cost as a deductible business expense.

The IRS issued the ruling upon a request for advice from an unidentified company that arranged liability insurance for its principal executives who were not directors or officers and then charged each executive a pro rata share of the premium.

The ruling was parallel to a 1960 revenue ruling that allows physicians to deduct the cost of malpractice insurance as a necessary business expense.

The liability insurance that was arranged for the executives covered "wrongful acts," which were defined as "any alleged error or misstatement or misleading statement or wrongful act or omission or neglect or breach of duty while acting in their respective capacities as principal executives."

Previously, the IRS had specifically said that business expense deductions would be allowed for insurance premiums against fire, storm, theft, accident or other similar losses.

The deduction for liability insurance is to come out of adjusted gross income when computing taxable income, the IRS said. ■

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ABA shouldn't defend poor state comp systems

By ELISABETH M. WECHSLER

ATLANTA—A workers' compensation expert criticized the American Bar Assn. for its implicit defense of continued state control "no matter how poorly the states are running their programs."

He also urged lawyers to put aside self-interest and participate in a "constructive" reform of workers' compensation in those states which still lag behind the national average.

"I don't think firms move out of states because of workers' compensation reform," said John F. Burton Jr., associate professor at the University of Chicago's Graduate School of Business. He delivered his remarks to the ABA Conference here on insurance, negligence and compensation law.

Prof. Burton pointed out that abrupt action would not be war-

ranted "for the magnitude of expense involved" which he estimates to be about 2% of payroll for states with the highest workers' compensation standards and about 1% of payroll for states at the low end of the scale.

"What's disturbing to businessmen in Illinois (and in other states where changes have been made) is that it's been a sharp increase," he said. "They got pulled up to other states' levels."

He observed that there is "a kind of paranoia going on" as a result of these relative changes and he clearly blames lawyers for part of the problem. "In several states it now appears that one of the obstacles of reform is the resistance of lawyers."

"There is no questioning of the need for lawyers to represent insured workers and employers or

their carriers in complicated or novel cases," Prof. Burton said. "But in some states lawyers are involved in routine cases where their services and fees are hard to justify."

He went on to say that in Illinois, for example, it is "almost impossible to get benefits paid unless you have a lawyer." But he was pessimistic about whether anything could be done to change that practice.

"The best we can hope for is that a Wisconsin doesn't become an Illinois," Prof. Burton said.

"The American Bar Assn. can serve as a counterpoise to these resistance activities by local lawyers if the ABA will unequivocally endorse the view that workers' compensation is not just a full-employment act for lawyers," he said.

Prof. Burton thinks such a stand

"may be the most important contribution this Association could make to the improvement and preservation of the state workers' compensation system."

The National Commission's 1972 conclusion that state workers' compensation laws are neither adequate nor equitable "is still valid" in Prof. Burton's opinion.

"While the record of the states virtually invites constructive federal action, the response of Congress has exceeded the wildest hopes of the defenders of states' wrongs," he continued, calling recent legislative proposals "unrealistic and unworkable."

"The struggle between the federal government and the states for the control of workers' compensation reform suggests that victory will belong not to the swift but to the least lame," Prof. Burton said.

"Even if the American Bar Assn. decides that federal standards for workers' compensation are inappropriate, there is a constructive role that (it) can assume," he believes.

"There is a good chance that within the next few years Congress will enact legislation mandating federal standards for state workers' compensation programs. The ABA can draw on the expertise of its members to assist Congress in drafting legislation that has realistic standards and a workable enforcement mechanism."

Prof. Burton emphasized that

this action could be taken "even if the ABA opposes enactment of the legislation: The tradition of providing representation to clients who hold repugnant views is a cornerstone of our profession," he reminded his audience.

"If we fail to provide this assistance, the country is likely to be burdened with legislation as unrealistic and unworkable as the bills introduced in the last two sessions of Congress," he warned.

The basis for Prof. Burton's criticism of the ABA concerns a March 1976 statement of the Senate Subcommittee on Labor which argued that states should make the ultimate decisions about reforms and which opposed federal legislation because of "philosophical and practical concerns."

According to Prof. Burton, the ABA statement went on to say "the Association believes workers' compensation, like other personal injury matters, falls clearly within the scope of those matters which are reserved to the states under the Constitution."

"If this is meant to be a summary of current law, it seems both false and superficial," he said, noting that "not a single citation is provided to support this radical view of Constitutional law."

"If the passage is meant to be an ABA statement of what it wishes Constitutional law were, it should be so labeled," Prof. Burton said.

Slow acceptance blamed on recession

No real demand for prepaid legal

ATLANTA—"In 10 years perhaps 25% of the public will obtain lawyers via (prepaid legal plans)," predicted William T. Kirby, president of the American Prepaid Legal Services Institute. "At that time (many) will be underwritten by insurance companies."

He blamed the slow growth rate on the lack of information among union leaders and members concerning the various non-litigative services available and their emphasis on more take-home pay during the recent inflation-reces-

sion economy.

"Most of us were optimistic that prepaid plans would spread like wildfire after the Taft-Hartley Act was amended in 1973," Mr. Kirby told participants at the American Bar Assn. Conference here. "No explosive growth happened."

Problems still unresolved include the Internal Revenue Code, which considers these services taxable to the beneficiary. Also, the antitrust division of the Justice Department is concerned that plans sponsored by bar associations might have the effect of setting fees for participating lawyers; it does not want open panel plans to have a competitive advantage over close panel systems, he said. He addressed the section on insurance, negligence and compensation law.

Another problem is insurance regulation, Mr. Kirby noted. "The picture of state regulation is still fairly chaotic. Many (insurance) commissioners will not allow prepaid legal offerings until the legislature specifically authorizes them. Others do not want it sold as a group offering. Still others do not want it sold at all by insurance companies."

A model bill approved by the National Assn. of Insurance Commissioners is being considered in several states, he said.

Prepaid legal plans currently fall into three categories, Mr. Kirby explained: Through collective bargaining agreements or from union dues; bar associations; and insurance companies.

Some 60 plans funded by collective bargaining or by union dues

were in operation in January of this year. This represents a 300% increase over 1974, he said. These plans include dependents, and approximately 750,000 persons had access to lawyers through them.

Ten bar association-sponsored plans covering about 25,000 people were in operation in early 1976. In contrast to the collective bargaining agreements, these plans do not include group consultation and referral programs, he pointed out.

Only two insurance companies had actually issued policies for prepaid legal insurance at the beginning of this year, although a number of companies had invested time and funds developing programs, he said.

"The insurance industry is watching and waiting for the lessons from loss leaders," Mr. Kirby said.

He is a principal in the Chicago-based law firm of Hubachek, Kelly, Rauch & Kirby and is an active member of the ABA's committee on pre-paid legal services.

Limit use of experts to cut court costs

ATLANTA—A plaintiff's attorney pointed to an "excessive use of expert witnesses" in aviation accident cases and urged fellow attorneys to "take the initiative in limiting the number" so that litigation costs do not become unrealistic.

"The trend appears to be grounded in a desire by all parties to use the best possible expert witness on every subject rather than a single expert who has general knowledge of aviation related subjects," said Marshall L. Foreman Jr., a San Diego attorney, who participated on a panel at the American Bar Assn. conference's section on insurance, negligence and compensation law here.

Another panelist advised defense witness who knows a little about a attorneys to avoid the "all-purpose lot of things. Impeachment of his testimony in one area will have an effect on the other areas in which he has testified," said Edwin R. Green, a San Francisco-based attorney.

"One should not be afraid of using several experts if there are several points to cover, or of having different styles of presentation," Mr. Green added.

Price-Anderson Act is seen as barrier to safety

ATLANTA—A physics professor charged that the Price-Anderson Act, which provides the bulk of coverage for nuclear incidents in the private sector, not only fails to promote safety in the nuclear industry but "perhaps even decreases the public safety."

"All the economic incentives are toward reducing the cost of safety research, of extra checks and procedures, and of retrofitting reactors with improved safety devices," said Gordon L. Kane, a professor at the University of Michigan.

He was particularly critical of the Act's total liability limit of \$560 million, which represents a federal indemnity of \$500 million against a nuclear incident and \$60 million from private insurance pools.

"This limit was chosen arbitrarily and is not related to actual or expected damages," he told participants at the American Bar Assn. Conference here on insurance, negligence and compensation law.

Prof. Kane said he is concerned that vendors and suppliers of parts "are explicitly excluded from any liability even though it is not too unlikely that negligence on their part could cause or exacerbate an accident."

"Under certain well-defined conditions the regulatory agency can declare that a nuclear incident is an extraordinary nuclear occurrence," he continued. "In that event, any defense against fault is waived and liability is absolute—up to the aggregate limit of \$560 million," Prof. Kane said.

According to conservative "worst case" estimates made in a study for the Atomic Energy Commission, \$14 billion in property damage would result from radioactivity contamination, while injury and death damages would reach at least \$10 billion, he noted.

Another panelist, Richard Wil-

son, a physics professor at Harvard University, strongly disagreed with Prof. Kane's allegations. "Once in a hundred thousand years the damage might exceed \$560 million," asserted Prof. Wilson.

"Any legislative removal of the limitation of liability must either be accompanied by a corresponding availability of insurance or a clear modification of the requirement of financial responsibility," Prof. Wilson continued.

The total of all paid loss and loss expense has been \$600,000, of which approximately \$400,000 was paid in two incidents involving workers in 1963 and 1964, according to Joseph Marrone, general counsel of the Nuclear Energy Liability-Property Insurance Assn. (NEL-PIA).

The other \$200,000 covered investigation and litigation expenses and payments for minor claims, Mr. Marrone said.

The insurance pools have never received a liability claim for bodily injury or property damage to off-site persons or property arising from the operation of a licensed nuclear reactor, he said.

Future may be ripe for indexed premiums

Indexed insurance premiums were advocated by Thomas F. Sheehan, president of GATX Insurance Co., Chicago, who addressed the insurance, negligence and compensation law section of the American Bar Assn. Conference, Atlanta. He sees the idea as a solution to "the problem of inflation and its effect on insurance policies." He believes the problem is further compounded in the U.S. where state-granted increases "are often delayed and inadequate. An indexed insurance policy... would either increase or decrease in keeping with a predetermined price index," Mr. Sheehan said.

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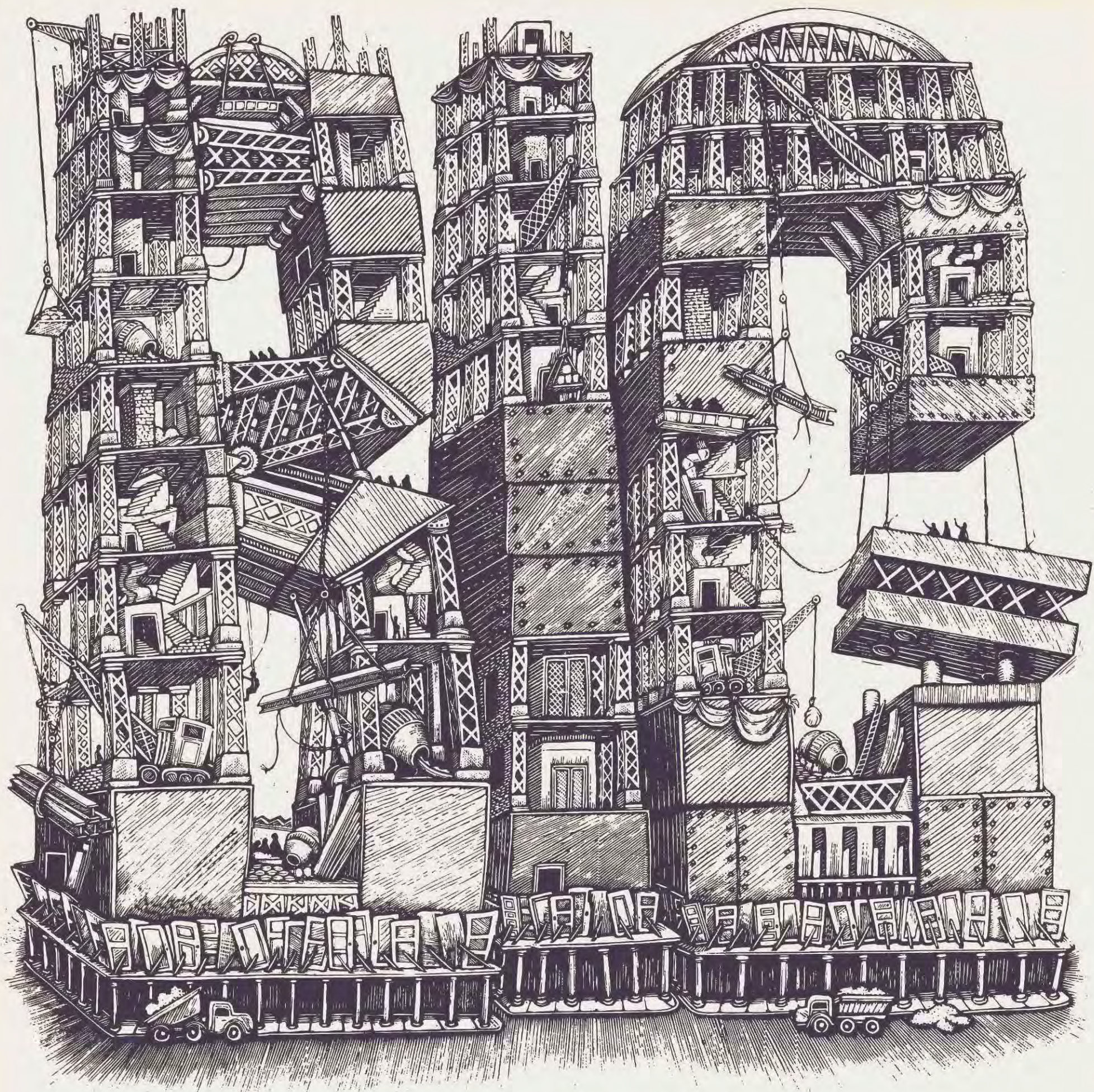
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PERSPECTIVE

REPLACEMENT COSTS:

Complying with SEC rule on asset values may involve insurance

By DAVIS R. BLAINE

Vice President

and

ROGER J. GRABOWSKI

Director of Research

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ON MARCH 23, 1976, the Securities and Exchange Commission (SEC) adopted amendments to Regulation S-X requiring disclosure of certain replacement cost information. The rule initially applies to registrants with inventories and gross cost of property, plant, and equipment totalling more than \$100 million and amounting to 10% or more of total assets. The disclosure is required for fiscal years beginning after Dec. 25, 1975.

The SEC is not requiring a change in the basic financial statements, but a supplementary reporting designed to aid in assessing the effects of current cost changes on a firm's business. What must be disclosed is the lowest current cost to replace inventories and "equivalent productive capacity," and the cost of sales and depreciation if computed on the basis of these replacement costs.

This rule is the most authoritative of many recent proposals to change financial reporting to reflect inflationary conditions. It is a definitive step beyond the general price level adjustment proposed by the Financial Accounting Standards Board (FASB).

That proposal would require broad "indexing" of historical financial statements. It is designed to show only "overall" inflationary effects, not specific changes in prices peculiar to one firm or industry. The advent of the replacement cost reporting will likely spur additional changes to financial statements. Currently, the FASB is considering the entire framework of finan-

cial reporting, including the use of current or market value measurements for all assets.

Numerous objections have been raised since the SEC first proposed the disclosure rules back in August of 1975. This reaction was expected given the fact that the required change in asset reporting is such a drastic break from tradition.

It is not the change, per se, which is the biggest obstacle; rather, it is the lack of current standards for computing replacement costs that has caused the most distress. Registrants must now work with numbers which they feel lack the objectivity of the historical cost information. What many fail to remember is that current historical cost data is the result of relatively arbitrary rules which developed over time in the form of generally accepted account-

Asset values to undergo revisions

In the near future, many large publicly-held firms will change their methods of reporting asset values to shareholders. Large industrial operations like this one will be reassessed to determine what it would cost to replace buildings and productive capacity. BI asked the authors on this page to examine what impact this process would have on insurance and risk management.

ing principles. For example, FIFO and LIFO are two accepted methods of assigning inventory cost. Neither method necessarily results in the cost of the inventory actually on hand (or the actual cost of the goods sold). Likewise, replacement cost depreciation need not be considered any less objective than historical cost depreciation.

As currently computed, historical cost depreciation is based on the estimated useful life of an asset; there is nothing precise about making such an estimate. Life assignments are most often made out of convenience, and are seldom based on in-depth analyses.

What is a registrant's exposure to legal liability for the information disclosed? The SEC has provided a "safe harbor" rule which does afford some protection from liabilities where the data is prepared in good faith and an explanation of the methods of calculation is provided. Further, accountants are somewhat protected by the fact that the information will be labeled "un-audited." At the same time, auditors will remain "associated" with the information. Thus, they will likely want to pass on the reasonableness of preparing and the replacement cost results.

Given the flexible guidelines provided by the SEC, there is no one simple solution to implementing a replacement cost data base. However, while the approach to be used for each industry may vary, the standards should be consistently applied.

Many companies today purchase their property insurance coverage on the basis of full replacement cost. This trend is a distinct movement away from the traditional coverage based on actual cash value (reproduction cost less physical depreciation). Replacement cost is a more objective criterion than actual cash value, since the inherent subjectivity of estimating physical depreciation is eliminated. One major question is: "Can the SEC replacement cost

disclosure be used for reporting values to the insurance carrier?" Perhaps.

What does the SEC mean by replacement cost? The SEC is requiring disclosure of the lowest cost to acquire equivalent productive capacity (assumed replacement cost). Some engineering analysis is most likely needed to determine the best alternative for replacing current productive capacity; the replacement may be an exact duplicate or a completely different process or layout, so long as it provides "like utility".

Replacement cost may differ substantially from reproduction cost. The SEC distinguished between reproduction and replacement cost as follows:

- **Reproduction Cost:** The cost to replace property as nearly as possible in like kind (exact replica) using current costs.

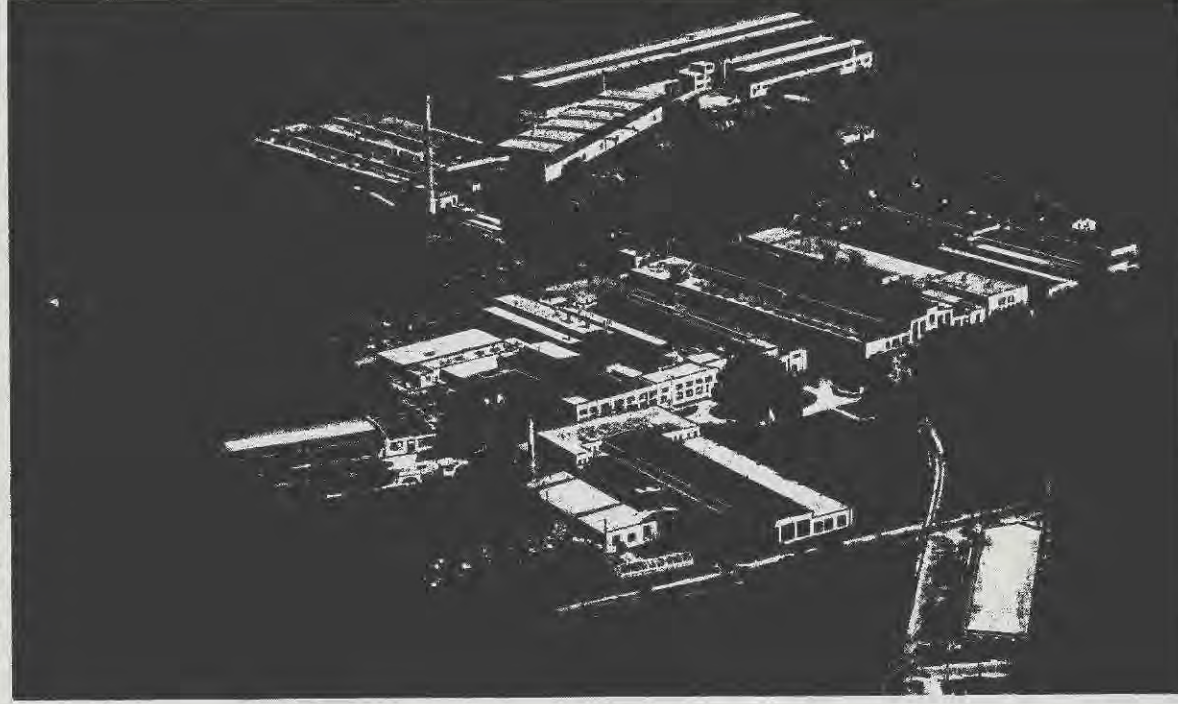
- **Replacement Cost:** The cost to replace property with like utility using current costs.

Older plants or buildings may now have excess construction costs in walls, framing, etc. that provide no utility to the current operation. Furthermore, there may be wasted space because of poor initial design or conversion from some prior use. The reproduction cost in these cases is probably higher than replacement.

Although a property insurance contract states that replacement cost is the coverage amount, the use of either reproduction or replacement cost for existing assets is acceptable. For an asset that represents the latest technology, its replacement and reproduction costs are the same. For machines which are no longer made or which are technologically obsolete, replacement cost for similar machines providing like utility should be developed.

If replacement cost for SEC reporting purposes is generated on an asset by asset

Continued on following page



Asset reports: Does risk mgr. have a role?

By STEFAN J. VALOVIC

Director of Insurance

and

RICHARD J. KOSTYRKA

Senior Insurance Representative

Kaiser Aluminum & Chemical Corp.
Oakland, Ca.

AS RISK MANAGERS, we want to be involved in our firm's evaluation and preparation of asset value reporting to comply with the SEC rule. With the help of our accounting, financial and tax groups, we need to better understand what this SEC rule can mean. We need to hear what other risk managers think about replacement cost accounting, and the implications of the SEC rule.

Present methods of determining insurable values should not be too quickly jettisoned for the new SEC reporting, which is still evolving. Let's proceed with due haste, but very cautiously.

Replacement cost accounting is a subject that will immediately begin to affect the financial side of business on a worldwide basis. Our intent is not to comment on the areas where we may agree or differ with the Blaine/Grabowski paper. Rather, our purpose is to use this opportunity to consider what the SEC ruling might mean to risk management. Risk managers now have an excellent starting point to become more aware of, and be involved in, evaluation of the replacement cost accounting rule, which is being studied and will be implemented by accounting and tax departments of major corporations.

We agree with business' and government's concern to improve balance sheet and income statement reporting. The continued use of unadjusted historic asset values and costs distort resultant balance sheet and income reports. Our concern is not about changes to corporate accounting practices, but rather that risk management will continue to be responsible for developing and reporting asset values for risk management purposes.

We see a real need to walk carefully in this forest of definitions, rulings, redefinitions, and interpretations of the SEC rule. Because it is so easy to become involved in what appears to be a real issue, but actually is tangential to risk management concerns, we would like to be presumptuous and state a primary risk management objective.

"A primary risk management objective is to contribute to profits or services by reducing and stabilizing the total cost of risk. This includes protecting human resources, property, and productive capability of the firm so that business can function at a level desired by its management."

Unless this objective is kept in focus, risk management can end up being the proverbial lad picking flowers on a sunny morning when he should be tending the store.

It is not a perfect definition, but we see it as focusing on the main risk management responsibility of protecting company assets (human, property, and productive capability) while at the same time contributing to maximizing profits and services. This is the "why" of risk management; the "how" in-

cludes all the things done to implement that objective. The "how" will include, among other things, replacement value accounting practices, whatever the final decision promulgated by the FASB or the SEC.

From a risk management standpoint, good replacement costs or actual cash values represent the assets at risk in an ongoing business. That is, replacement cost or actual cash values should reflect the magnitude of property asset exposure to loss. SEC's "value of equivalent productive capacity", to the extent that it requires computation of assets different than those that exist and are at risk, is beyond the traditional risk financing technique of commercial insurance.

The probability of a loss destroying a total facility is relatively low; in the case of multi-buildings at a facility, the likelihood is further decreased. So in most instances, assets destroyed in an insurable incident represent only a part of the total reported insurable values. Destroyed assets are usually replaced with comparable or equivalent materials compatible with existing manufac-

Continued on following page

PERSPECTIVE

Complying with SEC rule . . .

Continued from preceding page

basis, the same value can be used for property insurance. The purpose of the policy is still to indemnify a loss or destruction of property physically existing at a certain location. But what about the assumed replacement cost for an entirely reconfigured facility (e.g., current 15 building complex replaced by one or two structures?) Will the insurance carrier agree to an amount of coverage by location which bears little or no resemblance to assets currently employed? By examining how property insurance values are presently established, we can gain some insight toward answering this question.

Most often, the amount of insurance coverage is determined by negotiations between the insured and the carrier. Many firms estimate reproduction cost new by applying price trends to the gross costs of asset accounts. This entails some analysis of annual additions, but only by gross totals. Price trends are usually not applied to individual asset classes (e.g., an automatic welder) because there is not sufficient detail in the asset records. The gross trending by account technique does not provide as much accuracy trending by asset class; the result may only coincidentally represent insurable value, unless it is initially based upon an appraisal of the property. In lieu of company generated figures, the carrier develops an estimate, often without benefit of an asset verification or valuation.

We view the SEC disclosure requirement as one additional reason for registrants to implement and maintain valid asset records. Specific trending of detailed asset records provides the basis for more accurate insurance coverage, as well as providing needed SEC disclosure data.

A more difficult problem is posed when a company reports replacement cost to the SEC based on the elimination of, say, three present facilities and the replacement by a new one. In effect, if that company then secures property coverage only for the assumed replacement plant, it is self-insuring for the plants now existing. However, if assets will not be replaced, why insure them? And it is management's ultimate decision to insure or not insure certain assets.

Each company must analyze its own approach to the SEC replacement cost disclosure. In some cases it may be necessary to maintain data for both existing assets and assumed replacements, and identify the reasons for the differences. The final resolution of the amount of insurance coverage will depend largely upon the advice of the insurance carrier and valuation engineers.

One basis for arriving at replacement cost should be a firm's property records. It seems logical that the application of equipment and construction price trends to historical costs will provide the necessary information. Not so! Viable industry trends are not currently available. In addition, several property record deficiencies exist which preclude an oversimplified trending approach.

Asset records often do not contain any detail. Many firms account for their property in aggregate; that is, assets acquired are grouped together and accounted for as one entry. In some cases only two group costs are maintained: one for buildings and one for machinery and equipment. How can these historical cost groups be accurately trended forward to current replacement costs?

The replacement cost of one type or class of productive equipment may vary widely from year to year as compared with another class. Yet, on a corporation's financial records several property classes are grouped together as one historical cost group. Also, the aggregate dollar amount may represent several years of acquisitions, further complicating the mere indexing of this group cost.

Another problem with current property records is the classification of asset costs. When new facilities are built, too much

reliance for property identification and costing is placed solely on the contractors' invoices. Assets are often misclassified as part of a building account when, in fact, those items (and the related costs) functionally serve as part of the equipment. This results in the improper assignment of depreciation lives, since equipment usually depreciates over a shorter time period than buildings.

Our experience shows that these property classification problems are inherent in all firms, regardless of size. Typically, a minimum of 20% to 30% of new plant costs are misclassified as buildings, when they are actually for equipment.

One result of the initially poor asset identification and classification is that asset retirements are not even recorded. If no detail exists on an asset by asset basis, it is very difficult, if not impossible, to identify the cost basis of individual retirements. This common occurrence of unrecorded retirements results in the gross cost of the assets being overstated. And, trending of these costs will yield too high a replacement cost.

The task of developing accurate replacement cost data may be formidable for some companies, particularly for machinery and equipment. General trending of historical group costs, while simple, may not be sufficient in future years' reporting. A more detailed long range plan should be initiated. The key factor to remember in formulating a solution is the fact that developing replacement costs of fixed assets is not a basic accounting function, but an engineering and valuation problem.

Because of the disclosure time constraint placed on many firms whose fiscal year ends December 31, 1976, the tasks of establishing and perpetuating a replacement cost data base must be divided between short and long term. No one approach or solution is applicable to all industries or firms. As

a starting point, we recommend a thorough planning study be undertaken to evaluate the available property records and define the specific, alternative solutions most applicable to each company.

The planning study will recommend both short and long term plans for initially generating, updating, and maintaining the replacement cost data base. These plans should be reviewed with and approved by the company's auditors and SEC attorneys, so that all parties agree that the plans meet audit and legal requirements.

One of the important steps in determining replacement cost is the classification of facilities or portions of a facility by type of productive capacity. There are three basic categories, as follows:

- Productive capacity is measured by space (e.g., retail space, seating in a restaurant, warehousing).

- Process oriented productive capacity is measured by unit of output (e.g., refineries, paper mills, breweries, chemical, cement, and steel plants).

- Productive capacity is tied to individual machines (e.g., machine shops, plastic molding plants, tire plants).

The approaches will vary for each of the above categories. For the first type, the short and long term approaches are similar. For example, the current costs for constructing a firm's "fast food" restaurants are derived either from records of recent construction or from engineering estimates. If the restaurants vary in size, the functional relationship of construction cost to size must also be analyzed (cost per seat varies with size). The costs for site work must be analyzed separately, since this cost varies by the specific location (e.g., hilly, marshy, etc.).

For the second type, the short term approach is a combination of trending accurate historical cost records and comparing the results to current industry statistics on capital costs per unit of output. Process facilities within an industry often vary widely in sophistication and specific equipment employed, such that the industry average may be wholly inappropriate to a particular facility. The historical cost trending is appropriate only if the records have been adequately maintained. And then,

only as an interim solution for 1976. Trended replacement costs should always be tested for reasonableness by comparing them to current standards.

A longer range plan includes a more discrete analysis of each facility, probably every five years, to define technology changes affecting replacement costs.

The third type of facility is the most difficult. In the short term, recent historical costs or replacement costs (e.g. an insurance appraisal) can be trended. Adjustments are applied for unrecorded asset retirements and for observed inefficiencies in plant layout. Again, the results must be compared for reasonableness to construction and engineering standards. For some plants, additional work will likely be necessary to analyze in detail the specialized equipment. A long term program of asset verification (inventorying or sampling) should be instituted, with item asset records maintained. The replacement costs can be perpetuated by trending each asset class, which reflects current price changes for specific types of assets.

At present, only the large corporations are affected by the replacement cost disclosure requirement. In the future, other firms will be required to make the same disclosures. Several firms currently exempt from the requirement are contemplating disclosure this year. As replacement cost data is better understood by the financial community, lending institutions may require private firms to disclose such information, much like they require audited financial statements. ■



R. Grabowski

D. Blaine

Manager . . .

Continued from preceding page

turing systems and processes. There may not even be any latitude to replace assets with anything but exact duplicates of the destroyed asset. To the extent "asset values" represent something beyond replacement by the most equivalent or comparable assets, we are entering another dimension of risk management.

Risk management is usually only concerned with the continuation of an organization or business in case of a physical damage loss. But loss could provide an opportunity to incorporate technological advances in a facility to improve productivity and lower production costs; in insurance terms, this is often considered a "betterment." The possibility of a betterment, in a real sense is a dynamic risk, and most often dynamic risks are a primary concern of general business management and beyond the responsibility of risk management.

Accordingly, where risk management does not have the authority or responsibility for an action, it should carefully weigh the advocacy of reporting devices, like the new SEC rule, in its functional area. It could have implications beyond that intended or foreseen at the time of reporting.

Property insurance premiums are a function of rates and reported insurable values. To the extent that reported insurable values do not reflect the most accurate replacement or ACV costs, rates are adjusted to provide an adequate premium. As our domestic inflation went from 1% to 2% per year to double digits, and then downward to today's 6% to 7%, business and government began to recognize the need to do something about historic "acquisition costs" and more realistic replacement cost values. To the best of our knowledge, insurers have not uniformly required insurable values on a standardized basis, and insureds vary in the uniformity of reported insurable values. In casual approach to insurable values by in-

dividual insurers and insureds. To that extent, it's possible that individual insureds may be benefiting or may be penalized in their premium costs because of insurable value reporting differences.

Property insurance contracts are essentially contracts of indemnity or reimbursement. Determining the amount to be indemnified can be quite complex and difficult in some physical damage losses and even more so in business interruption losses.

As presently envisioned by SEC, "replacement cost of productive capacity" can be interpreted and developed in a number of ways. It can mean that cost of replacing capacity within the existing business framework of the entity; it can also include "the entity's normal approach to replacement of capacity". In the question and answer portion of the staff accounting bulletin Release No. 7, the SEC interpretation touches on the recognized subjectivity of productive capacity estimates, and that the replacement cost data that may be compiled for a company will be based on a mixture of different replacement cost methods and assumptions.

Our purpose here is not to minimize the SEC's attempt at defining a difficult subject; it is rather to point out that risk managers must be sensitive to those areas where risk management and SEC objectives coincide and where they differ. The new SEC rule will influence both the balance sheet and income statement; it considers the need for better reporting to stockholders, lenders, auditors, legislators, etc. This attempt to meet various other needs may not coincide with the risk managers' objectives, in terms of appropriate data to minimize total cost of risk.

Risk management, before endorsing new asset valuation concepts, like the SEC's should consider if the insurer is ready to provide a contract that can be priced where there are different reporting criteria. Will the insurer provide a loss settlement clause which indemnifies for loss of "equivalent productive capacity" if the reporting of values were based on this same criteria? You might try settling a loss where units

are a measure of productive capacity; would "equivalent productive capacity" mean the same number of units but a production cost significantly lower because of new technology, or additional plant investments, or relocation to another site because of lower labor costs, lower utility rates, etc.? At this point, it seems we've stepped away from indemnity to dynamic business risks.

Our concern is that if risk managers promote a new concept in their insurance contracts, we are then introducing a great deal of uncertainty in an industry already hurting from financial losses of the past few years. Isn't it very likely that insurers will increase rates to compensate or offset some of this uncertainty in reporting?

Most companies are now using computers to ease the workload. This makes it possible to handle property asset reporting and insurable value calculations as just another routine function. The physical tools are available to process data; sufficient time and effort is required to develop the necessary computer program to come up with the necessary reports. Commitment by corporate management is required and a recognition and appreciation of the value of more accurate replacement costs and ACV data.

Accurate replacement cost data should be a risk management tool; current replacement cost data, and the methodology required to prepare this data can be considered by corporate accounting departments as a possible short term input for compliance with the new SEC reporting rules. As the insurance value system has evolved at Kaiser Aluminum, we've been able to integrate appraisal and other objective data into our system to correct and update historical acquisition costs. By this process, we end up with a current replacement cost for corporate assets that most reflects the replacement cost for existing assets.

The challenge to risk management is to communicate this emerging standardization of insurable values to the insurance industry. As the industry recognizes the impact of this change, rate review by insurers should result, hopefully, in more equitable rates for all insureds. ■

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Legal brief

Employer administering a benefit plan becomes agent for the insurer

IN A SUIT AGAINST Blue Cross-Blue Shield of Alabama (Blue Cross) seeking recovery under a group insurance policy, the Court of Civil Appeals of Alabama has ruled that the employer's handling of the task of administering the policy demonstrated the existence of an agency relationship between the employer and the group insurer. Thus, the court concluded that Blue Cross could not deny an employee coverage whose claim arose during the period for which he had paid his premium but before he actually received notice that the group policy had been cancelled.

The abstracts published in this column were prepared by Cases Unlimited Inc., Evanston, Ill.

William Thornton, a former employee of the Gunter-Dunn Co. (Gunter) had been permitted to continue in the company's group medical insurance plan provided by Blue Cross after suffering a disability. Because Thornton no longer received a salary, he was required to submit his premium to Gunter directly. In compliance Thornton submitted his check dated March 15, 1972 to Gunter for his insurance premium. On March 27th Thornton's wife was injured in an automobile accident and was hospitalized. Her medical costs in the amount of \$656.60 were submitted to Blue Cross. The claim was rejected because the group policy had been cancelled effective March 20th. Gunter had requested the policy cancelled effective March 31st because it had decided on a new group plan. The trial court ruled in favor of the Thorntons.

While noting that there were no Alabama decisions directly controlling these facts, the court observed that "there is a definite trend, both in Alabama and other jurisdictions, to view this problem as one of agency." Consequently, the court stated that "If, under a group insurance policy, the employer is the agent of the insurer for the purpose of collecting the employee's premiums, then the insurer remains liable on the policy to those employees whose premiums the employer had collected or deducted from wages, even after the group master policy has been cancelled because the employer had not paid the entire premium." Finding support in the evidence for the existence of an agency relationship between Gunter and Blue Cross, the court concluded that Thornton's payment of premium prior to notice of the cancellation precluded Blue Cross from denying him coverage. *Blue Cross-Blue Shield of Alabama v. Thornton*, Court of Civil Appeals of Alabama, December 10, 1975, rehearing denied January 7, 1976, Bradley, J., 325 So.2d 187 (BI/01/Au.-\$3)

Banker's blanket bond

In this action a bank sought to recover for a loss of over \$300,000 sustained as a result of allowing a customer, a partnership dealing in used cars, to draw on deposits which were ultimately dishonored. The bank brought suit against its surety on a banker's blanket bond. While the United States District Court for the Eastern District of Virginia ruled that the bank did not establish forgery as a matter of law and therefore could not recover under that section of the bond, it believed the bank was entitled to recover its losses under

that section of the bond relating to false pretenses.

The court pointed out that the authority of a partner in the used car partnership to sign its corporate floor planner's president's signature as the drawer of checks had ended in December 1973, but that the partner nevertheless continued in January 1974 to sign the checks as before. Under these circumstances the court believed that the partner's encircled initials which followed the drawer's signature on each check established the existence of an agency relationship and removed the case from the ambit of forgery, for purposes of the banker's blanket bond.

But the court emphasized that where the used car partnership knew that its authority to utilize the checks of its corporate floor planner had been withdrawn in December 1973, but one partner nevertheless continued to sign such checks as before and submit them to the bank for deposit, the deposit of these checks was unequivocally intended to, and did in fact, deceive. Such action by the partnership, according to the court, fell within the ambit of "false pretenses," for purposes of the bond. *Clarendon Bank & Trust v. Fid. & Deposit Co. of Md.*, United States District Court for the Eastern District of Virginia, December 22, 1975, Clarke, J., 406 F.Supp. 1161 (BI/03/Au.-\$3)

Professional liability policy

Here an insured physician brought an action to determine whether the Aetna Casualty and Surety Co. was obligated under its professional liability policy to defend the insured in a medical malpractice suit. The Supreme Court of Nebraska held that where an insurance agency transferred the insured's malpractice policy to a different insurance company without notice to the insured, the notice given to the agency by the insured of the malpractice suit against him constituted notice to the original insurer whose policy was still in effect at the time of the alleged malpractice. Thus, according to the court, Aetna was obligated to carry out the terms of the insurance contract with the insured.

The court noted that the word "immediate" in referring to the notice required in an insurance policy means with reasonable celerity, with reasonable and proper diligence. What is a reasonable time, the court stated, depends upon all the facts and circumstances of each particular case. Ordinarily, an agent having authority to solicit insurance, receive and forward applications, deliver policies, and collect premiums is a general agent of the insurance company, the court observed. Notice to him will satisfy an insurance policy requirement that notice must be sent to the company.

Finally, the court pointed out that the revocation of an agent's authority does not become effective as between the principal and third persons until they receive notice of the termination. The court emphasized that the physician in this case did what most reasonable persons would do in this situation; he notified the agent who sold him the policy. There is no evidence, the court stated, that notice of the termination was sent to him or that he knew the agency contract had been

canceled. *Zukaitis v. Aetna Cas. & Sur. Co.*, Supreme Court of Nebraska, December 24, 1975, Blue, J., 236 N.W.2d 819 (BI/05/A.-\$3)

Bankers' blanket bond

Does the unauthorized withdrawal by a guardian from his ward's account in a savings and loan association constitute a loss by reason of "dishonest abstractions" within the meaning of a bankers' blanket bond? No, according to a Missouri appellate court which ruled that the loss occurred because of the bank's own negligence in failing to note a withdrawal restriction placed on the account.

Helen Carey, as guardian of her three minor children, opened an account with the Hamiltonian Federal Savings and Loan Assn. The probate court ordered that a restriction be placed on the account requiring that withdrawals could be made only upon its order. Through negligence, a Hamiltonian employee failed to note the restriction and thereafter its tellers did not receive notice of the court order. At various times thereafter Mrs. Carey withdrew \$8,126.05 from the account without the benefit of court orders. A public administrator was later appointed for the Carey children. In his official capacity, as guardian of the children, he demanded payment of \$8,545 from Hamiltonian. This sum represented the withdrawals made by Mrs. Carey plus interest. Hamiltonian paid the sum.

At the time that these withdrawals were made, Hamiltonian carried a savings and loan blanket bond with the Reliance Insurance Co. that indemnified it against "on premises" losses of property "through . . . abstraction or removal from the possession . . . of

the insured. . . ." Hamiltonian demanded reimbursement from Reliance for the \$8,545 it had paid the guardian but Reliance refused payment. Hamiltonian's suit against Reliance resulted in a judgment in favor of the insurance company.

Hamiltonian appealed contending that its loss was covered under the bond's "abstraction or removal from the possession" clause. Also the bank asserted that it was not necessary to establish that dishonesty was involved. While the court recognized that no specific language in the bond required the "abstraction or removal" to be a dishonest one, the court believed that in view of the bond's language taken as a whole, it was meant to mean a dishonest abstraction or removal.

In emphasizing this, the court stated, "Primarily, the blanket bond is designed to protect the financial institution against the risks of dishonesty." Inasmuch as Hamiltonian had stipulated that the loss occurred because of its own employee's clerical error and negligence, the court concluded that the bankers' bond did not cover the claim. *Hamiltonian Fed. S. & L. v. Reliance Ins. Co.*, Missouri Court of Appeals, St. Louis District, September 2, 1975, Weier, P. J., 527 S.W.2d 440 (BI/01/F.-\$3)

(Copies of the entire decisions described in this column may be obtained by writing to Business Insurance, att. Managing Editor 740 N. Rush St., Chicago, Ill. 60611. Please enclose a \$3 check made out to Cases Unlimited Inc., for each case, and specify the code number of the opinion, which is at the end of each brief.)

Insurer hit with penalty for denying valid claim

SANTA ANA, CA.—A \$5.4 million verdict, of which \$5.3 was for punitive damages, has been brought by a jury here against the Washington National Insurance Co., Evanston, Ill., in a civil "breach of faith" case brought by an attorney who suffers from a rare and incurable brain disease called presenile dementia.

Plaintiff Julius Austero, 57, Newport Beach, Ca., won the case on the argument that Washington National Insurance committed a breach of faith when it refused to pay him disability benefits because he failed to continue premium payments.

The \$5.4 million verdict is thought to be the largest ever made in the country to an individual by a jury in a breach of faith case.

During arguments in the case, it was brought out that Mr. Austero's disability policy, which expired March, 1973, lapsed due to his failure to maintain premium payments.

Attorneys for Washington National, which is the official medical-disability insurance carrier for attorneys throughout California as well as for many teachers and Civil Service groups, contended that the policy contained a clause that required "total disability" in order to make payouts. The defense team said that although Mr. Austero was partially disabled he was able

to perform some duties.

Herb Hafif, a 1974 Democratic gubernatorial candidate and Mr. Austero's attorney, however, countered that the "total disability" clause conflicts with a provision of California law that calls for payment of benefits for a "substantial" inability to perform duties associated with a job.

He insisted that the Newport Beach attorney was barred by his malady from reacting to the expiration date of his disability policy. Moreover, he said that the disease, which he pointed out now has reached the point where the plaintiff is unable to participate in a conversation, had its onset before the lapse in premium payments by at least two years.

If Washington National had paid disability benefits to the plaintiff, Mr. Austero would have received \$250 a month until age 65. It was reported that he earned a peak of \$125,000 a year as an attorney practicing in Anaheim, Ca.

Mr. Hafif described the lawsuit as a "taxpayers' suit" due to the fact that once received, most of the \$5.4 million could go to state and federal taxes.

He estimated that Mr. Austero could die before Washington National completes its appeals in higher courts.

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people

Denver hires J. Love for new risk position

The city and county of Denver created the position of director of risk management and named **Jack Love** to fill it, effective September 1. Previously, Mr. Love was provisional risk manager for San Diego County (BI, May 3). In his new position, he is responsible for safety and the full risk management function. Mr. Love will report to the finance director of the city and county. **Clifford Burkert**, Denver's safety director, died in November 1975. After trying to find a replacement for him as well as for someone with a risk management background, it was decided to restructure the job.

Anheuser-Busch Co. Inc., St. Louis, Mo. named **Robert E. Mathieu**, 47, manager of employee benefits and services on August 2. Previously, he was corporate compensation and benefits manager at Emerson Electric Co., St. Louis. No one has been appointed to replace him there yet. At Anheuser-Busch, Mr. Mathieu reports to the director of employee relations and is responsible for supervising health, pensions and personnel records administration. He replaces **Vincent R. Jackiewicz**, who was named manager, employee projects and planning in the employee relations department. He still is responsible for the company's employee stock purchase and savings plan.

Effective August 16, **Thomas J. Ahern**, 28, was appointed corporate risk manager at United Air Lines Inc., Elk Grove Village, Ill. He reports to **Don H. Hansen**, director of corporate insurance, who previously held that position before his promotion (BI, May 31). Mr. Ahern formerly served as an attorney on the legal division staff at United. Before that, he worked for CNA Insurance. His new responsibilities include "most phases of corporate insurance," according to Mr. Hansen, who sees the job as a "back-up position."

Richard W. Zeitler joined Koch Industries Inc., Wichita, Kan. on August 2 as risk manager. He replaces **Howard E. Tyrrell**, who left for Belcher Oil Co., Miami (BI, July 26). Mr. Zeitler reports to the vp-finance. Previously, he was director of insurance at Johns-Manville; he also worked for Johnson & Higgins of Colorado Inc., Denver, as assistant vp.

Chicago Transit Authority (CTA) promoted **John E. Blum**, 27, to public safety, promotion and inspection coordinator on July 5. He formerly was safety inspector. He reports to the manager of public safety and is responsible for accident investigation and report preparation; he is not involved in internal safety control nor the insurance aspects of public safety. CTA is self-insured. Previously, the function was informally shared by **Tom Boyle**, his boss, and himself.

Former risk manager **Robert E. Spencer**, 53, last month joined Seattle-based Parker, Smith & Feek Inc., an insurance brokerage firm, as manager of its risk management department and market coordinator. Mr. Spencer has spent 13 years in the insurance field, most recently as corporate risk manager for Golden Cycle Corp., Bellevue, Wa. His responsibilities there included the con-

trol of domestic and international transportation, mining and land development risks. He also has developed self-insurance programs in employee benefits and once directed a worldwide cargo claims service. At Golden Cycle, **Charles C. (Chuck) Williams**, controller, has taken over Mr. Spencer's responsibilities in addition to his other duties. He reports to the executive vp-administration and is in charge of the Northwest conglomerate's overall insurance program.

Edwin L. Tomlinson, 45, was named insurance manager for Ethyl Corp., Richmond, Va. in July. He succeeds **James I. Brierly**, who died May 3. Mr. Tomlinson joined Ethyl Corp. in 1964 and most recently held the title of assistant insurance manager. In his new position he is responsible for property/casualty insurance programs as well as workers' compensation. He reports to the treasurer of the company.

Robert MacPhail was promoted to director, employee services department for Dart Industries Inc., Los Angeles. He assumes responsibilities for the company's employee benefit programs on a worldwide basis. Mr. MacPhail, who joined the company in February 1974 as assistant director-employee services department, succeeds **Wendell Fish**, who continues as corporate group vp, employee services. He reports to the vp of corporate relations. Before joining Dart, Mr. MacPhail worked at Quaker Oats Co.

Carl A. Herman, 45, was elected vp, employee relations at Schick Inc., Lancaster, Pa. He replaces **L. K. Miller**, who left Schick to work for a private consulting firm. Mr. Herman will be responsible for the design and administration of Schick's insured benefits program, and for the planning and funding of traditionally uninsured benefits such as pensions. He heads personnel functions as well as public and employee relations for the small appliances manufacturer. Before joining Schick, Mr. Herman was director of administration for Mazda Motors of America, Compton, Ca. He has also held personnel and industrial relations positions with the Chrysler Corp. Mr. Herman reports to Schick's senior vp of finance and administration and supervises a staff of 20.

A new position, director-insurance services, was created at Westinghouse Health Systems' Occupational Program Center, Cleveland, and **David A. Descoteau**, 32, was hired to fill it, effective July 12. His responsibilities include developing mechanisms to recover insurance payments for outpatient alcoholism services provided at the Center. Mr. Descoteau reports to **Wade H. Williams Jr.**, project director, who previously had performed the function among his other duties. "We identified a need for a person specialized in this area with a group health and HMO background," Mr. Williams said. Mr. Descoteau formerly was manager, health care delivery systems for G. D. Searle & Co., Skokie, Ill., where he worked on developing an HMO for the company.

John Bidlake has been named

director of employee relations for Continental Airlines, Los Angeles, replacing **Ed Cathell**, who resigned. Mr. Bidlake was formerly director of compensation and benefits for Northrop Corp., Los Angeles. He began his new job on July 26. Mr. Bidlake is responsible for the airline's employee benefits program and reports to Continental's vp of personnel relations.

H. Gordon Heile, insurance manager for ITE-Imperial Corp. in Spring House, Pa. left ITE August 10 to join Robert Christian Agency in Willow Grove, Pa., a brokerage firm handling mostly commercial business. He had served in that capacity for two and a half years. Mr. Heile's position at ITE was eliminated following the takeover of ITE by Gould Inc., based in Chicago. **James Mascarella** is risk manager and director of insurance there. Mr. Heile chose to remain in the Delaware Valley area rather than join Gould's insurance department in Chicago. ITE also had an assistant insurance manager, **Lou DiMaria**, who is now on the Gould corporate staff located in Spring House in a safety management post, reporting to Gould's corporate director of safety. A clerk from ITE's insurance department was retained as insurance administrator for the electronic groups.

Business Insurance wants to know of readers moving into new or different risk management, employee benefit or safety/loss positions. We are interested in administrative, staff and support positions as well as managerial level jobs. If you or anyone you know is on the move, please contact our Chicago office, 312-649-5279.

Bizarre case for Baza'r is now settled

SALEM, OR.—The Oregon Supreme Court has ruled that **Hendrika Bakker**, former employee of the Baza'r discount store chain, cannot obtain damages for "emotional distress" she claimed to have suffered after being searched as a shoplifter suspect.

The majority opinion, written by Justice Edward Howell, also ruled that Ms. Bakker could ask for and obtain workers' compensation benefits. The opinion thus sustained an earlier decision before Multnomah County Circuit Court Judge Robert E. Jones.

According to the initial lawsuit, Ms. Bakker went to her job at Baza'r, on July 18, 1973, carrying with her a shopping bag bearing the name of another Portland store, containing personal clothing.

A Baza'r guard, according to the suit, approached Ms. Bakker and touched her while checking the shopping bag. She later sued on charges of assault and battery and "intentional infliction of emotional distress."

A jury awarded her general and punitive damages against Baza'r for \$32,500. Earlier, however, Ms. Bakker had filed a claim for workers' compensation insurance benefits. Her claim was rejected on the basis that the alleged injury did not arise from her job with Baza'r.

Judge Jones ruled that Oregon's workers' compensation insurance law prohibited Ms. Bakker seeking damages from her employer.

Supreme Court Justice Howell sustained an "adequate" case for assault and battery but ruled that the battery charged was "not intentional."

dates for buyers

Sept. 9-10: Charles D. Spencer & Associates—Employers with experience in dealing with Health Maintenance Organizations will be among the speakers at the third annual HMO conference. "Before activation" topics will include selecting employer designates, the information required, and the HMO in collective bargaining situations. "After activation" topics are employer checklists of their responsibilities, coordination of programs, and the meaning of "fair and equal access." The conference fee is \$175; contact Charles D. Spencer & Associates Inc., 222 W. Adams St., Chicago, Ill. 60606.

Sept. 9-10: International Safety Academy—Safety program development and improvement with consultative help from ISA officials is offered. Among the workshop topics are total job analysis, measurement techniques and instruction programs. Cost is \$225. Write the International Safety Academy, P.O. Box 4365, 1021 Georgia Avenue, Macon, Ga. 31208.

Sept. 17: Stanford University—Earthquake risk analysis, soil-structure interaction and the measurement of dynamic properties of buildings will be among topics at the inauguration of the John A. Blume Earthquake Engineering Center. Stanford's symposium will include laboratory demonstrations and operation of data processing equipment for earthquake research. For further information contact Earthquake Symposium, Department of Civil Engineering, Stanford University, Stanford, Ca. 94305.

Sept. 20-21: Wharton School of the University of Pennsylvania—Scientific methods will be applied to all aspects of risk management: Analyzing pure risk situations, insurance purchasing decisions, deductibles, protection projects, probability distributions and insurance cost budgeting. Techniques in competing for funds within a firm and obtaining the greatest risk reduction per dollar of budgeted premiums will be explained. Mathematical techniques using hand calculators will be taught. Cost is \$395 per person plus \$50 registration fee per company. The September meeting will be held in New York; an Oct. 18-19 meeting will be in Chicago. Contact The Wharton School, Program Coordinator, Office of Executive Education, University of Pennsylvania, Philadelphia, Pa. 19174; (215) 243-4855.

Sept. 20-23: Management Laboratories of America Inc.—A "Reinsurance Reanalysis" at the University of Dallas will discuss reinsurance decision-making, processing guidelines for managers, captive companies and pooling arrangements. Guest discussion leaders include excess and reinsurance company execu-

tives. Cost is \$325. For more information write the University of Dallas, Management Laboratories of America Inc., Irving, Tx., 75061, Attention: Bruce Evans.

Sept. 22-23: Connecticut Conference of Municipalities—Identifying exposures, risk control and risk funding for municipalities in the face of decreasing governmental immunity and tight markets is the subject of a seminar sponsored by northeastern state municipal leagues and the Risk Planning Group. Environmental protection standards and emergency planning systems will also be discussed. Cost is \$200; participants are limited to 60. The Holiday Inn, 50 Morgan St., Hartford Ct. is the site. Contact Patrick Hemingway, Connecticut Conference of Municipalities, 956 Chapel St., New Haven, Ct. 06510, (203) 772-2168.

Sept. 26-28: Houston Mariners Club: The eleventh annual Houston Marine Insurance Seminar will include topics on international employee benefits in the petroleum industry, marine product liability and laws, inland waterway operations, the Japanese hull market and insurance against political risks. Registration fee is \$60; the seminar will be at the Houston Oaks Hotel. Contact Houston Marine Insurance Seminar, c/o Weldon A. Schramm, P.O. Box 27635, Houston Tx. 77027.

Sept. 28-29: International Foundation of Employee Benefit Plans—How to plan and organize an efficient communications program will be the subject of a Communications Institute, as well as evaluating communication materials of seminar participants. The speakers include communications instructors and consultants. Cost is \$180 for members; \$240 for non-members. The conference will be held at the Hyatt Regency Hotel in New Orleans. Contact the International Foundation of Employee Benefit Plans, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005.

Sept. 27-28: Marine Insurance Handbook Inc.—A Multiple Line Working Clinic aiding individual company staffs with their particular insurance problems will be held in Indianapolis, Ind. at the Stouffer's Inn. Topics to be discussed will depend on the current problems. Some of the topics planned include mercantile risks, replacement cost coverage without coinsurance, how to adjust coverage and loss exposure to inflation, and new liability hazards due to changing conditions in the construction, plastics and chemical fields. Fees are \$35 per day in advance; \$40 per person at the clinic. For more information contact Marine Insurance Handbook Inc., P.O. Box 723, Chicago, Ill. 60690.

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